Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD – PUBLIC SESSION AGENDA

Venue: Rowley Regis Community Hospital **Date:** 4th January 2018, 0930h – 1245h

Members:

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

In attendance:

Mrs C Rickards	(CR)	Trust Convenor
Mrs R Wilkin	(RW)	Director of Communications
Miss Clare Dooley	(CD)	Head of Corporate Governance

Board support

Ms R Fuller	(RF)	Executive Assistant

Time	Item	Title	Reference Number	Lead
0930h	1.	**Welcome, apologies and declarations of interest** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting.* **Apologies:**	Verbal	**Chair**
0931h	2.	**Patient Story**	Presentation	**EN**
0940h	3.	**Update on actions from previous patient stories**	Verbal	**EN**
0945h	4.	**Questions from members of the public**	Verbal	**Chair**
0950h	5.	**Chair's opening comments**	Verbal	**Chair**
		UPDATES FROM THE BOARD COMMITTEES		
0955h	6a	To: (a) receive the update from the Major Projects Authority meeting held on 15th December 2017 (b) receive the minutes from Major Projects Authority meeting held on 20th October 3017	To be tabled SWBTB (01/18) 001	**RS** **RS**
1005h	6b	To: (a) receive the update from the Quality and Safety Committee held on 22nd December 2017 (b) receive the minutes from the Quality and Safety Committee held on 24th November 2017	SWBTB (01/18) 002 SWBTB (01/18) 003	**OD** **OD**

Time	Item	Title	Reference Number	Lead
1015h	**6c**	To: (a) receive the update from the Finance and Investment Committee held on 22nd December 2017 (b) receive the minutes from the Finance and Investment Committee held on 24th November 2017	SWBTB (01/18) 004 SWBTB (01/18) 005	**MH** **MH**
	MATTERS FOR APPROVAL OR DISCUSSION			
1025h	**7.**	**Chief Executive's Report**	SWBTB (01/18) 006	**TL**
1045h	**8.**	**CQC Improvement Plan**	SWBTB (01/18) 007	**KD**
1105h	**9.**	**Winter Plan: EDD performance and bed closure position**	SWBTB (01/18) 008	**RB**
1120h	**10.**	**Integrated Quality & Performance Report**	SWBTB (01/18) 009	**TW**
	10.1	**IPR Persistent Reds – P08 November 2017**	SWBTB (01/18) 010	**TW**
	10.2	**Finance Report - P08 November 2017**	SWBTB (01/18) 011	**TW**
1135h	**11.**	**Decreasing Sickness Absence & Improving Employee Mental Well Being**	SWBTB (01/18) 012	**RG**
1150h	**12.**	**Nursing Career Escalator**	SWBTB (01/18) 013	**RG**
1205h	**13.**	**Trust Risk Register**	SWBTB (01/18) 014	**KD**
1215h	**14.**	**Building Sustainable Finances – Outline Financial Plan 2018/19**	SWBTB (01/18) 015	**TW**
	UPDATE ON ACTIONS ARISING FROM PREVIOUS MEETINGS			
1230h	**15.**	**Minutes of the previous meeting and action log** (a) To approve the minutes of the meeting held on 7th December 2017 as a true/accurate record of discussions (b) Update on actions from previous meetings (action log)	 SWBTB (01/18) 016 SWBTB (01/18) 017	 **Chair** **Chair**
	16.	**Matters arising**	Verbal	**Chair**
	MATTERS FOR INFORMATION			
1235h	**17.**	**Equality and Inclusion Report (January 2018)**	SWBTB (01/18) 018	**RG**
1240h	**18.**	**On-Boarding New Colleagues**	SWBTB (01/18) 019	**RG**
1245h	**19.**	**Any other business**	Verbal	**RG**
	20.	**Details of next meeting** The next public Trust Board meeting will be held on **Thursday 1st February 2018 starting at 09:30am in the Anne Gibson Boardroom at City Hospital**		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Major Projects Authority Committee Minutes

Venue Anne Gibson Committee Room, City Hospital Date 20th October 2017 0930 - 1100

Members Present:

Mr Richard Samuda	Non-Executive Director (Chair)		
Mr Toby Lewis	Chief Executive		
Mr Alan Kenny	Director of Estates and New Hospital	In attendance:	
Rachel Barlow	Chief Operating Officer	Miss Claire Wilson	Executive Assistant
Mr Tony Waite	Finance Director		
Mr Mark Reynolds	Chief Informatics Officer		
Mrs Raffaela Goodby	Director of People and OD		

1. Welcome, apologies and declarations of interest	Verbal
Mr Samuda welcomed the members to the meeting. Apologies were received from Mr Hoare and Dr Stedman. The members present did not have any additional interests to declare.	
2. Minutes of the previous meeting	SWBMPA (10/17) 001
The minutes of the previous meeting held on 18th August 2017 were agreed as a true record.	
3. Matters arising (action log)	SWBMPA (10/17) 002
All actions to be reviewed through the items on the agenda.	
3.1 MMH inventory & logistics update report	SWBMPA (10/17) 003
Mr Waite explained the project is operating to an extended timescale with a final report now expected in November 2017. The next 4 weeks will be used to stress test the models and look at devising the contingency solution options. An implementable solution and road map of implementation will be brought to the next meeting. Mr Samuda asked about current constraints. Mr Waite stated work is commencing on how the standard operating models will be delivered, and if any contingencies need to be put in place.	
Action: An implementable solution and road map of implementation will be brought to the next meeting.	
3.2 Workforce Consultation	SWBMPA (10/17) 004
The workforce consultation commenced on 25th September 2017. Mrs Goodby explained that steps have been taken to date to ensure that the small number of schemes planned for this additional round of consultations have been subject to thorough and robust scrutiny with regards to safety and quality before being put forward for the consultations with staff.	

There may be a need for another workforce consultation if the Trust's pay spend reductions cannot be met through temporary pay reduction measures.

3.3 Accredited manager programme	SWBMPA (10/17) 005

At the last meeting the dates for the programme were scrutinised to ensure they were fully aligned with the roll out of the EPR training. Mrs Goodby explained work has commenced with the operational teams to source appropriate dates. However, discussions have taken place in relation to delaying the digital champion training dates, which could impact on the proposed accredited manager programme dates.

Mrs Goodby asked the committee for assurance that the proposed dates can be locked down. Mr Lewis agreed the dates will be reviewed and confirmed at a future executive group meeting.

Action:
Dates to be revised and agreed at an executive group meeting

3.4 Revised programme for midland met	SWBMPA (10/17) 006

Mr Kenny explained that on the 25th September 2017 Carillion issued the Trust with a revised Schedule 9 variation which confirmed that the forecast date for practical completion of the Midland Met Hospital would be the 24th June 2019. A delay of 11 months from the original contract date. On-going work is commencing to identify and understand the impact and consequences of the delay.

The key associated risks relate to:

- The Trust's contract with HCA for non-retained estate at City which requires the Trust to have vacated this land by 31.12.19.
- MES – the need to ensure handover of the key MES equipment by 30th April 2019 and the relatively fixed programme once the kit is on production schedules from mid-2018.
- The critical path of the Level 4 plantroom and the closeness of revised completion date to the practical completion date of 24th June 2019.
- The impact of delay to retained estate schemes at STC which involve relocating services to current inpatient or emergency service locations at Sandwell.

Mr Lewis raised his concerns that the committee need to focus as much time on the hard FM supplies as well as the structural aspects as there are numerous changes commencing within Carillion (including new higher temporary management).

Mr Lewis and Mr Kenny will have discussions with Carillion about hard FM to ascertain they are suitable for contract.

Action:
Mr Lewis and Mr Kenny will have discussions with Carillion about hard FM to ascertain they are suitable for contract.

3.5 Revised Capital Programme 2017/17 – 2019/20	Verbal

Mr Lewis stated that the revised plan will be brought to the next meeting.

Work is currently commencing on additional controls being put in place by the board to ensure capital plans decisions do not impact on each other and that the scopes are deliverable. Mr Waite explained that programme will also been reviewed in Finance Investment Committee to source the capital programme not the expenditure, to ensure the finical sustainability is adhere too.

Action:
Revised Plan to be brought to next meeting.

4.0 Digital Plan 4.1 Digital Delivery scorecard	SWBMPA (10/17) 007

Mr Reynolds gave an update on the various digital work streams.

Infrastructure
Infrastructure works are delayed due to the lack of capacity of third line staff. This is especially impacting storage and LAN works. Three short term contractors have been recruited, to address these issues. Two new permanent members of staff commence in October 2017 and January 2018.

Digital delivery
Discussions have commenced about digital postage project and that the process needs to be in place by March for cost savings to take effect.

EPR
System testing has commenced and integrating testing is about to start. By January, testing will have been completed, and any defects will have been resolved.

Collaboration
Numbers of projects on this work stream are rated as red. Mr Lewis suggested the none technical scopes are devised for these projects and once the new person is in post they will be able to deliver.

Midland Met Hospital
The Low Level network design has now been received. The High Level design is still outstanding. Informatics can now start to be reviewed and design aligned to the wider network service infrastructure.
Discussion commenced about the network coverage in Midland Met Hospital and that there needs to be adequate resources for patients and relatives. Mitigation plans to be devised.

4.2 Update from CEO on digital scorecard	Verbal

Mr Lewis will give an update at the next Trust Board meeting.

5.0 - People plan 5.1 Full delivery scorecard and year one delivery estimate.	SWBMPA (10/17) 008

Mrs Goodby gave an overview of the paper and explained the People Plan Balanced Scorecard demonstrates delivery against the proposed KPI metrics at month 5 2017/2018.

Mr Lewis asked for data on the dashboard to be amended to show if we are delivering and asked for the content of the people plan to be review to determine which data is relevant for this meeting, as this subject is also discussed at People and OD committee.

Action:

Dashboard to be amended to show if we are delivering and the content of the people plan to be review to determine which data is relevant for this meeting as subject is also discussed at People and OD committee.

6 Capital Plan for the estate 6.1 Estate Plan Document in Draft	SWBMPA (10/17) 009

Mr Kenny explained there are 18 projects that need to be undertaken on the Trusts Sandwell and City Hospital sites to support the Midland Metropolitan Hospital.

Subject to approvals, funding, and recognising the demand on in-patient accommodation it is planned that the work required to outpatient clinics and administration areas will be undertaken before Midland Met opens and that works on in-patient accommodation will take place once those services have moved.

Mr Kenny explained one of the issues they have is that there are no decant ward facilities which constraints the ability to progress a number of projects (specifically in-patient wards on the Sandwell site). Currently work is commencing at Rowley Regis.

<u>GP Services</u>
Discussion commenced about the GP services and revenue stream. Mr Kenny stated it will cost £5million to develop the GP services and they are looking at funding options. Mr Waite explained that we are exploring funding options that are available for us and work needs to commence with the national capital teams.
Mr Lewis agreed to update the board on the current situation.

Action:
Mr Lewis agreed to update the board on the current GP services situation.

7.0 Meeting Effectiveness	Verbal

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

8.0 Matters to raise to Trust Board.	Verbal

No items were raised.

9.0 Any Other Business	Verbal
No Items were raised.	

Next meeting is commencing on 15th December 2017, 0930 in the Anne Gibson Committee room at City Hospital.

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUALITY AND SAFETY COMMITTEE UPDATE	
Date of meeting	22 December 2017, 10.30 – 12.00 hours
Attendees	Ms. O. Dutton (Chair), Miss K. Dhami, Ms. R. Barlow, Ms. E. Newell, Ms. C. Parker and Mr. T. Waite.
Apologies	Apologies were received from Mr. R. Samuda and Ms. M. Perry
Key points of discussion relevant to the Board	• Patient Story: a video to the Board showing a Rowley Regis patient who has been transferred between sites. This will give the Board opportunity to talk about out of hours transfer issues. • Integrated Performance Report and Persistent Reds: The IPR and Persistent Reds data was reported. Progress in the last month was not sufficient and prospective improvement should be accelerated. A different approach is needed in Q4. We need to understand why there are still persistent reds and have plans in place with an insight into what the root cause is. Teams are being asked to work to milestones trajectory and month on month information, looking at the work that is being done behind the scenes. Oversight and assurance shall continue to be provided through routine consideration at the executive PMC and Executive Quality Committee. The following items were discussed in more detail: **MSA Breaches, Neutropenic Sepsis**, **62 day cancer** compliant at 87.2% at September vs. target of 85%; all other cancer targets continue to deliver. Q2 delivery of the full cancer target has therefore been achieved. As part of the transfer of Oncology Service NHSI have commissioned a review of the Trust's handling and management of SIs following comments made by UHB Oncologists. There are no concerns relating to patient safety. The external report will be brought back to Q&S at a future meeting. • Perinatal Mortality Progress Report: An update was given on the perinatal mortality review work and action plan. The final case reviews are being assessed by Dr. Stedman and should be completed by the first week in January. A report will be presented to the Quality & Safety Committee in January and the Board in February. An explanation was given why some cases have been regraded. Details of the lessons learned will also be outlined in the report giving reference to resources to alerts and triggers. • CQC Improvement Plan: December Deliverables (EQC): The CQC published their reports following inspection of some Trust services in March 2017, in which 131 areas for action were included. The relevant Clinical Groups were tasked with producing 'first cut' improvement plans to address the concerns raised, or confirm that action had already been taken. The draft plans have been subject to Executive scrutiny and final version was presented to the public Trust Board in December 2017. The timeline set for delivering the improvement plan in full is March 2018, with many actions being achieved by the end of this calendar year. The Executive Quality Committee (EQC) is tasked with monitoring and assessing improvement plan delivery, reporting to the CLE and Board Quality and Safety Committee. The Board in January will receive a report on achievements against the December delivery deadlines. • Safety Plan Progress Report: Work has now been moved to the groups to monitor the information and statistics in the Group Performance Reviews allowing Corporate Nursing to refocus their time on new projects. The Trust is sighted on two worry wards and a package of support will be provided by Corporate Nursing to triangulate with the Early Warning Trigger Tool. Everyone agreed that the Safety Plan has been a great success story. The corporate nursing team will be using their

QUALITY AND SAFETY COMMITTEE UPDATE	
	skills on other projects such as the sharing the learning from the Consistency of Care and Safety Plan Projects.
Positive highlights of note	The meeting discussions were felt to be useful and constructive.
Matters to escalate to the Board	The Committee wished to bring the following matters to Trust Board's attention: • Delayed progress in producing plans to address the Persistent Reds in the IPR.
Matters presented for information or noting	See above.
Decisions made	See above.
Actions agreed	No specific additional actions beyond those being progressed by management.

Olwen Dutton
CHAIR OF THE QUALITY AND SAFETY COMMITTEE MEETING
For the meeting of the Trust Board scheduled for 4 January 2018

Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUALITY AND SAFETY COMMITTEE MINUTES

Venue Anne Gibson Committee Room, City Hospital **Date** 24th November 2017; 1030 - 1200

Members attending:

Ms. M. Perry	Non-Executive Director & Chair
Mrs. E. Newell	Chief Nurse
Mr. T. Waite	Executive Director of Finance
Ms. K. Dhami	Director of Governance
Ms. R. Barlow	Chief Operating Officer
Ms. E. Newell	Chief Nurse
Ms. C. Parker	SWBH CCG

In attendance:

Mrs. S. Cattermole	Executive Assistant
Dr. N Trudgill	Deputy Medical Director

Minutes	**Paper Reference**
1. Welcome, apologies for absence and declarations of interest	**Verbal**
Apologies were received from Ms. O. Dutton and Mr. R. Samuda. The members present did not have any interests to declare.	
2. Minutes of the previous meeting	**SWBQS (11/17) 002**
The minutes of the previous meeting held on the 27th October 2017 were approved as a correct record.	
3. Matters and actions arising from previous meetings	**SWBQS (11/17) 003**
The matters and actions from previous meetings were agenda items.	
4. Patient story for the December Trust Board	***Verbal***
Ms. Newell confirmed that there would not be a patient story presentation for the Trust Board in December; instead there will be a video to the Board from members of the FAB Team (Fatigue and Breathlessness).	
5. Clinic Cancellations : 3-monthly review report	***SWBQS (11/17) 004***
Ms. Barlow outlined the report which was an update from the last report sent in August that highlighted the number of clinic cancellations and the cancellations through ERS following a query from Non-Exec Director Mike Hoare. Ms. Barlow confirmed that since the August Committee, the clinic cancellation form had been amended so that every time a clinic is cancelled the speciality had to clearly identify where they are moving the patient to. The problem alluded to in the previous meeting around patients being able to schedule several appointments through ERS several times. The number of reschedules of more than twice has been reduced, by daily monitoring of booking reports. The report shows patients who have rescheduled more than twice. A booking clerk will contact the patient and make them aware of the policy and remove the patient from the system in line with our access Policy. This does not happen for urgent or cancer slots. In relation to the ERS booking, all patients can re-schedule their appointment once as per all over clinics in line with the access Policy.	

A flag has been added to the system to alert the elective access team if a patient has rescheduled their appointment more than once, unless clinically urgent, the team will contact the patient and inform them of our policy. The patient will be discharged back to their GP if they attempt to reschedule their second appointment.

The standard operating policy is to date within a maximum of 2 weeks of cancellation. If this is not possible, the patients will be booked in chronological order along with all patients awaiting either a new or follow up appointment so that patients who have been cancelled are never disadvantaged.

The following improvements are required over the next few months so that we have more information available to fully assess the impact of clinic cancelations on patient's quality of care and if there are any safety aspects we need to consider:

- The information team will populate a report that will show the difference in time between when a patient was originally booked and when they eventually had their appointment scheduled. This will be separated into both Patient lead and trust led cancellations. This is due by the end of December.
- The ERS rescheduling tool will show which reschedules were patient led and which were trust led, with the aim of eradicating any pathway where the patient has rescheduled twice, as per the policy.
- We will be able to see the reason for cancellation of clinics and pick up any themes other than for annual leave. Specific focus will be on those clinics cancelled under 6 weeks and especially any under 3 weeks.

A further report will be brought back in February showing the improvement trajectory.

ACTION : Clinic cancellations : 3 –monthly review report back to the Committee in February 2018.

6. T&O Safety Summit : Action Plan Update	***SWBQS (11/17) 005***

Ms. Barlow informed Committee members that concerns were raised in past months regarding clinical leadership and adherence to Trust Policies and Procedures, which have resulted in substandard care provided to our Trauma and Orthopaedic patients. 2 recent deaths and the receipt of a Regulation 28 have further increased our level of concern. The tabled safety dashboard was developed to support the monitoring of agreed improvements and performance across the T&O service. Audits and data collection have evidenced that changes the T&O team have made have resulted in improved and sustained performance across a large number of areas. Of particularly note, 8 indicators have seen significant improvements in October. Although improvements have been seen, there are three areas which require specific attention in coming weeks. These are:

- Fully completed clerking proforma – the majority of incomplete proformas had only 1 or 2 sections incomplete. These sections contained information which were also contained within the written notes however the proforma itself was not fully completed.
- Mortality reviews within 42 working days – an update to the distribution list has been requested via IT to ensure the Mortality Lead in T&O is advised when a mortality review is required.
- Antibiotic review at 72 hours – improvements have been noted however it was not possible to easily identify whether review had been undertaken in all cases. Pun Sharma, Chief Pharmacist and his team are working on this to make further improvements.

The team are looking at information on a daily basis shift by shift and fortnightly GPO meetings will be chaired by the Group Director of Operations for Surgical Services and attended by the Lead for the Safety Dashboard, Ward Sister, Registrar representative and Anaesthetist representative. A focussed task and finish actions will be assigned to indicators which are not yet achieving the required standard.

Improvement checks will be seen through Unity (EPR) and process mapped through the Safety plan. It was also suggested that Mr. Lewis and Ms. Dutton visit a QIHD session to look at any lessons that have been learned through the process.

It was agreed that relationships with anaesthetics team and surgeons has improved since the summit. The team will be asked to look at coroner's inquest report and move forward into 2018 with improvements. Miss Dhami agreed to speak to Mr. Lewis about writing back to the Coroners with an update.

Ms. Newell suggested that we use the same approach for Sepsis and Mortality. Dr. Trudgill confirmed that Dr. Stedman is reviewing Perinatal Mortality cases and information will be provided at the Safety Summit day.

7. Integrated Performance report	***SWBQS (11/17) 007***

Mr. Waite summarised the IPR and the items discussed included the **RTT October** delivery 92.29% [92.01%, 92.97%, 93.59%] just compliant with the national standard of 92%. Failing to achieve 92% standard are now several specialities. Whilst the Trust is meeting its national obligations, the backlog is starting to grow and hence focus is recommended. **62 day cancer** compliant at 87.2% at September (a month in arrears reporting) vs. target of 85%; all other cancer targets continue to deliver. Q2 delivery of the full cancer target has therefore been achieved. October validated to deliver, with November under pressure. The issues were briefly discussed by Committee members. **ED 4 hour** performance for October 85.36% vs STF required standard of 90% with 2,800 [2,150] breaches of the standard. Anticipated non-compliance for November, currently tracking at c84.73%. **MSA Breaches** x 46 incurred in October mainly due to capacity pressures, but also due to a slow discharge flow. Ms. Barlow and Ms. Parker confirmed that that are completing a tour of duty on both sites later in the month to look at the pressures involved. Ms. Perry queried the information on the Clinical Effectiveness Cancer Care slide and was informed that we have a better compliance than some other Trusts. There are a very low number flowing through the pathway and a programme of works is being looked at to reduce the numbers.

7.1 Persistent Reds	**SWBQS (11/17) 007**

Mr. Waite highlighted the KPIs due for remediation becoming due by end Q3 [P09 December] in the table that was presented and which the RTT local standards deliveries which have previously been determined as deferred for remediation in Q4. The WHO safer surgery checklist requires new tactics to close the gaps and breaches are being monitored and followed up by specific clinician. Attention was also drawn to elective cancellations and bed moves after 10pm where extant performance suggests remediation in Q3 may be a significant challenge with Q4 revised target date realistic. Information will be reflected in the report to the Board.

8. Strategic Board Assurance Framework: quality updates	***SWBQS (10/17) 008***

The 2017/19 Strategic Board Assurance Framework has been reviewed and updated by Executive Leads (Trust risk owners) in October 2017. The report provided to the Quality and Safety Committee was presented for discussion of the status ratings of mitigating action delivery and to seek assurance how non-compliance will be addressed (including timescales).

Safety Plan – Ms. Newell confirmed that the daily report pulled by the EPR team now captures the complete 19 points of the safety plan as a means of mitigating any risks. Complete.

Quality Plan – Dr. Trudgill confirmed that we have appointed the Medical Examiners and work is being done to appoint the Structured Judgement Reviewers in due course. The improved process for the cremation fees will commence in the new year. Work is being done with the Mortality lead to ensure that the other actions are completed.

Quality Plan – CQC Inspection actions – it was confirmed that Mr. Ajai Tyagi is attending the Regional Paediatric ophthalmology meeting on November 3rd to look at the proposals for the admitted paediatric eye emergencies (trauma and infection requiring IV Abx) going to Children's Hospital – supported by on-call network and visiting middle grade. All other (ambulatory) emergencies to continue to be managed at BMEC supported by on call network.

R & D Plan – The clearer visual as to the timeframes within this objective are being picked up by the R&D Team.

9. Medical Appraisal and Action Plan	**SWBQS)11/17) 009**

Dr. Trudgill provided the Committee members with a summary of a recent review of the medical appraisal process. PReP is the electronic system used for recording of appraisals and revalidation information for permanent and fixed term doctors at the Trust (excluding doctors in training). However, doctors who were on short term /temporary contracts had appraisals outside of this system known as MAG Forms. Medical appraisal dates were inputted onto the Trust's Electronic Staff Record system to indicate that an appraisal had taken place. Dr. Trudgill outlined some of the issues that this approach had.

- There was no clear process for identifying those that were on short term contracts/MAG process who move to long term contracts and therefore should be moved to PReP. This could result in them falling outside of our monitoring processes.
- There were additional administration tasks involved in pulling together PReP and MAG information to give an overall picture of appraisal compliance for the Trust.
- If a doctor had completed an appraisal within the current financial year they were deemed compliant from a Trust appraisal requirement but could still be overdue an appraisal from a revalidation perspective which caused a conflict with quarterly AOA returns to GMC. There are now separate requirements for medical appraisals and the Trust Aspiring to Excellence PDR process.
- Some genuine reasons for deferred/late appraisals (e.g. ill health) for medical staff were not captured and recorded on our systems therefore these would have been recorded as 'unapproved missed appraisals'.

Measures are to be implemented to improve the issues identified above. Moving forward they will provide a more structured framework to work in which will enable us monitor and escalate appropriately. Also, doctors who do not have their appraisal on or before their due date will automatically be fed into the escalation process, unless there is an agreed deferral in place and referred to the GMC. Improvements should be seen from Q4.

10. Complaints Report : Q2	**SWBQS)11/17) 010**

Miss Dhami called out that in this quarter, it is reported that the complaints activity has decreased, from 235 to 203, with 97% of complaints received since April 2017 managed within their target date. Themes and outcomes remain consistent with previous quarters and show a continued focus on lessons learned, and quality responses that are caring, transparent, timely and responsive to the needs of complainants. There have been 9 breaches and these were responded to within a few days. Unfortunately 2 went over by 2 weeks but this was due to the matter of the investigation. Ms. Dhami also confirmed that, following a request from the Committee, there is now a system in place to capture data on the number of complaints received about agency and substantive staff. Ms. Perry suggested that the data be presented graphically in the quarterly report so comparisons to previous reports could be seen more clearly and suggested that arrows be put next to the numbers on the "at a glance" sheet.

63% of complaints closed in Q2 2017/18 (compared to 64% 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. It was suggested that this information be broken down further for Q4 and draw down performance at specialty level to establish if there is any correlation to the changes in patient pathways.

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 were briefly discussed.

Dr. Trudgill informed members of a system in place at another Trust where patients and staff complete a form about a member of staff who "made them smile" or to say "thank you." Members agreed that this could be a way forward for us to capture compliments and shout outs could be given at staff awards.

A brief update was given on the implementation of the purple phones.

A small amendment was asked to be made to the Positive Feedback complainant feedback sheet as the patients name redaction line had slipped.

11. Matters to raise to the Trust Board	**Verbal**
The Committee wished to bring the following matters to Trust Board's attention: • T&O Safety Summit action plan • Persistent reds	

12. Meeting Effectiveness	***Verbal***
The committee agreed that the meeting discussions were useful and constructive.	

13. Any other business	***Verbal***
There were no other matters for discussion.	

15. Date and time of the next meeting
Next meeting: 22 December 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 UPDATE	
Date of meeting	22nd December 2017, 0830h – 1000h
Attendees	Mr Mike Hoare (Chair), Mr Richard Samuda, Mr Harjinder Kang, Mr Tony Waite, Ms Rachel Barlow, Ms Dinah McLannahan, Mrs Lesley Barnett and Mrs Elaine Quinn.
Apologies	Apologies were noted from Ms Marie Perry & Mrs Raffaela Goodby.

Key points of discussion relevant to the Board	<u>Financial Performance and outlook, P08 November 2017</u>:
	• The Committee noted that P08 headline to date performance was in line with the revised plan. That revised plan being a [pre-STF] out-turn deficit of £3.9m and [post-STF] headline out-turn surplus of £1.0m.
	• That out-turn was noted as including the following key assumptions:
	  ○ £264.5m SWB CCG income (which has now been secured. Any data challenges will be considered as transitional support);
	  ○ £17.4m CIP delivery - £963k off track ytd at month 8;
	  ○ Production Plan delivery of £110m – on track at month 8, however the projection is challenging;
	  ○ £4m additional CIP+ stretch delivery – this has been identified and is mostly non-recurrent.
	• The Committee challenged and confirmed the prospective delivery of those assumptions and residual scope for mitigation. The Committee confirmed that out-turn as being objective and consistent with the trust's commitment to secure the best out-turn possible.
	• The Committee was advised of a recent notification of a national allocation of winter funding, with the Trust expecting to receive an allocation of £2m – of which £1.079m was expected to improve the headline reported financial out-turn and the balance to support winter bed capacity. The impact of any monies received shall be reflected in reporting P09 results and out-turn view.
	• The Committee noted that taper relief of £7m has been secured and received in cash from NHSE. In terms of accounting, this is expected to be recorded as income. This is to be challenged and confirmed at the next Audit & Risk Management Committee in January.
	• To date performance against original plan the Trust is reporting a surplus and a significant positive variance from that plan, which was noted as being driven by the use of non-recurrent technical items and specifically, the profit on asset disposal.
	• The Committee noted the underlying position to date is a deficit of £20.5m, an adverse variance to plan of £6.1m. This was in line with expectations previously reported to the Committee.
	• The Committee noted that the plan to reduce monthly run rate operating costs by c£3.5m between now and the end of the financial year was yet to be finalised. This would be further discussed at the Board meeting in January and consequently at the Committee and Board in finalising plans for next year.
	• Capital spend at £15.4m was noted as being £10.1m behind original plan to date. A revised capital plan is to be brought to the Committee meeting in January and then the Board meeting in February.

	• Pay costs (including agency workers) were noted to be £25.5m in November (vs. £26.4m previous month). Significant reduction in temporary pay costs are required to be consistent with 2017/18 plan assumptions. A focus on reduction in capacity and improved roster management is required. The Committee noted that medical agency bookings have now been centralised via the bank office. The reduction in bank rates has been published and takes effect from 6th January. This represents an assumed full-year saving of £0.5m. • The underlying non-pay position was noted to be impacted by over-performance on pass through drug costs which will be offset by income over-performance against budget. Ante natal pathway charges were also noted to be higher than planned in P08. The Trust continues to recognise these costs in full whilst it pursues a SLA with moderated costs. The non-pay programme is to be discussed at the January Board meeting. • The Committee noted that the cash flow forecast indicated that the requirement to secure cash borrowing to support operating costs is now not likely to crystallise in this financial year, based on the assumptions in relation to CCG payments, taper relief, capital phasing and winter pressures. <u>Strategic Board Assurance Framework Q2 Update:</u> • The Committee received and noted the Strategic BAF Q2 update. Mr Waite highlighted that there were no material changes to what had previously been reported. The BAF will be further scrutinised at the next meeting in January, prior to it being presented at the Board meeting in February.
Positive highlights of note	• The impact of mitigations and remedial actions to reduce reported costs in line with the revised plan out-turn is becoming evident.
Matters to escalate to the Board	The Committee determined that the following matters should be escalated for specific consideration by the Board: • The trajectory to reduce the monthly run rate spend by c£3.5m between now and the end of the financial year; • A revised Capital plan to be submitted to the January FIC and February Board meetings. The Committee determined that the following matters should be escalated for specific consideration by the January Audit & Risk Management Committee: • Key matters of accounting judgement: taper relief/all accruals; • Annual review of SWBH Trust as a going concern,
Matters presented for information or noting	None.
Decisions made	None.
Actions agreed	No specific additional actions beyond those being progressed by management.

Mike Hoare
CHAIR OF THE FINANCE AND INVESTMENT COMMITTEE
For the meeting of the Trust Board scheduled for 4th January 2018

Sandwell and West Birmingham Hospitals NHS
NHS Trust

FINANCE & INVESTMENT COMMITTEE MINUTES

Venue: Anne Gibson Committee Room, City Hospital **Date**: 24 November 2017, 0830h – 1000h

Members present:		**In attendance:**	
Mr Mike Hoare	Chair	Ms Dinah McLannahan	Deputy Finance Director
Mrs Marie Perry	Non-Executive Director		
Mr Tony Waite	Director of Finance		
Ms Rachel Barlow	Chief Operating Officer		
Mrs Raffaela Goodby	Director of OD	Mrs Elaine Quinn	Executive Assistant

Minutes	**Paper Reference**
1. Welcome, apologies and declarations of interest	**Verbal**
The Chair welcomed all to the meeting. Apologies had been received from Mr Samuda and Mr Kang. The members present did not have any interests to declare.	
2. Minutes of the previous meeting held on 27 October 2017	**SWBFI (11/17) 002**
Ms. Perry felt that item 7 (meeting effectiveness feedback) was not sufficiently clear and asked that it be noted that although the transparency of reporting and candour of discussion was clear in terms of the Trust's financial position, the clarity/reporting style of the reports provided room for improvement in how that is presented for ease of understanding. The minutes were otherwise agreed as a true record.	
2.1. Matters arising and update on actions from the previous meetings	SWBFI (11/17) 002(a)
The outstanding actions were discussed as follows: <u>Item 3: Grip & Control Measures.</u> Mr Waite updated the Committee on the routine CIP meetings on a Friday morning that assess grip and control. He reported that the ten actions in this respect had now been closed and that controls are now in place. Although it was considered too early to tell at present, the mitigations were to be kept in view to assure their impact/effectiveness. <u>Item 6: Financial Outlook and update on meeting with NHSi FD</u> To be discussed as part of the agenda/meeting.	
3. Strategic Board Assurance Framework Q2 Update	**SWBFI (11/17) 003**
The Committee received and noted the Strategic BAF Q2 update. Mr Waite highlighted that the RAG rating and key actions remained unchanged to those reported at the November Board meeting. The Committee challenged and confirmed that the assessment remained appropriate.	

The Committee noted that the 2018/19 financial forward look was scheduled to be discussed at the December Private Board meeting.

4. Financial Performance – P07 October 2017	**SWBFI (11/17) 004**

Mr Waite updated the Committee in relation to the meeting that he and Mr Lewis had had with the Regional Finance Director of NHSI. This was in respect of any prospective change in forecast out-turn for 2017/18 and consequent non-compliance with the agreed control total for the year.

The Trust remained committed to achieving the best out-turn possible consistent with the safe delivery of services. That was currently a £4m deficit before STF and consequent headline £1m surplus after STF. The Committee noted that this was a significant moderation on a prospective deficit of up to £18m if P06 run rate was perpetuated.

The Committee challenged and confirmed the revised plan actions to secure that out-turn as appropriate and noted the risks to that achievement – specifically winter and bed closures. The Committee noted that P07 headline performance was in line with the revised plan.

Mr Waite noted that a formal response to NHSI was required by 1 December and which would reflect the current view. Further, that the Trust would continue to assess opportunities and risks and seek to use the time to formal reporting of P09 results in January to conclude any formal amendment to forecast. [Post meeting note – the response to NHSI has been made available to Board members].

The Committee noted the assumptions within that out-turn of income recovery of £264.5m from SWBCCG. It challenged and sought assurance as to the position in respect of data challenges outstanding. Mr Waite confirmed that there remained a c£3m difference of view and which was the subject of on-going negotiation. He stated that this was now being progressed within the context of CCG statement of commitment and the development of an Accountable Care System (ACS) basis of doing business in 2018/19. He expected the out-turn sum to be secured, with contract signature and close out expected in December.

The Committee noted the reported headline year to date surplus and a significant positive variance from plan. This was noted as being driven by non-recurrent technical items and specifically the profit on asset disposal. The Committee noted the underlying position to date is a deficit of £19m, an adverse variance to plan of £5.7m. This was in line with expectations previously reported to the Committee.

The Committee noted that a recovery plan to secure sound finances was being developed by the Executive Team and that is designed to address both 2017/18 and 2018/19 recurrently. It was noted that the monthly run rate of spend needed to reduce by c£3.6m (9% operational expenditure). This would be further discussed at the private Board meeting in December and consequently at the Committee and Board in finalising plans for next year.

Capital spend at £13.8m was noted as being £9m behind original plan to date. Discussions were on-going within the executive to finalise a revised plan and with NHSI to conclude an appropriate CRL for the year.

The Committee noted that the cash flow forecast indicated a potential requirement to borrow in Q4 of the current year based on prudent assumptions. Mr Waite indicated that this remained subject to routine scrutiny and that any requirement to borrow may be managed to Q1 of the new financial year.

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

The Committee wished to highlight the following matters:

- The impact of mitigations and remedial actions to reduce reported costs in line with the revised plan out-turn is becoming evident.

The Committee determined that there were no matters to be escalated for specific consideration by the Board.

6. Meeting Effectiveness Feedback	**Verbal**

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

8. Any Other Business	**Verbal**
There were no other items of business.	
Details of the next meeting	**Verbal**
The next Finance and Investment Committee meeting will be held on 22nd December 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 – January 2018

Chief Executive's Report

The Board meets at Rowley Regis. In our visits after the meeting we will have chance to talk with staff about progress since the CQC report, notably around staffing levels. Community services at the Trust were rated as good by the CQC in 2014, and we want to ensure in 2018, when we are re-inspected, that the issues raised in the 2017 report have been addressed. Internal data suggests no cause for concern in quality of care, albeit we continue to monitor patients who deteriorate after admission. By adding our community wards to the Consistency of Care programme in medicine (who generate most transfers) we aim to create a structured dialogue between wards where handover issues do arise.

More broadly, the Board agenda has a focus on the CQC Improvement Plan (Going for Good) and in particular the 57 recommendations we expected to conclude action on by the end of 2017. The majority have been delivered, but there is work to do in January to ensure outcomes from those actions. A number have not yet been achieved, and I will chair a review next week on progress in paediatric ophthalmology, which the Board will recall is both an internal capacity issue, and a matter of structuring a regional emergency response – a matter raised with NHS Improvement in summer 2017, and on which regulatory assistance has been promised in the weeks ahead. The Executive Quality Committee (EQC) and the Board's quality and safety committee will continue to oversee implementation of the plan.

I will update the meeting orally on progress with deploying our Electronic Patient Record solution. We had aimed to do this in November 2017, and then March 2018. Neither timescale has proved achievable. The latest expectation is that we can mobilise from spring 2018, which would still create a year's headroom between this implementation and Midland Met moves. In addition to the structured governance of the Digital Committee and information into the Major Projects Authority, a regular operational meeting of senior clinicians, which I chair, is now seeking to achieve sign off on the product. This is a precursor to deploying new Standard Operating Procedures and commencing formal staff training. A paper outlining our approach to being a digital employee is being developed which simply confirms existing policy expectation – that people will have support and training, and that PDR objectives will include digital expectations. By the end of 2018-19 we would expect all employees to working digitally as of course.

Whilst the Board papers contain an indication of our budget plans for 2018-19 we will devote the majority of our private Board to our cost reduction programme. During February and March we will explore that in the public Board as we frame plans to reduce monthly expenditure by £3m: A material sum.

1. Our patients

The latest Safety Plan data continues to show great compliance with our Always events aim. The paper last month suggested a fall in falls and pressure ulcers over the period. We would expect that the deployment of EPMA will show a fall in medication errors too. During quarter four our focus is on

sustaining this success, learning from the implementation to help with other programmes, and making sure that our 40-hour escalation process closes out the handful of delayed or missed checks. The Quality and Safety committee should see performance data monthly as we look to ensure that this work becomes part of how we do business round here. Dave Baker is working through how this data is best made available to patients and visitors at ward level in a visually coherent form.

Everyone involved is frustrated that a fifth of patients attending our emergency departments continue to wait longer than four hours. There is no lack of effort to tackle the position and the Board rehearsed last time what more is needed. The vast majority of issues continue to arise "out of hours". Our base challenge remains discharge volume and timeliness and we will discuss again Expected Date of Discharge compliance in the Board. Progress to achieve what we aimed to by October is now well behind and we need to reinvigorate the work and ensure that it has clinical attention.

On the back of the programme to look at care after the oncology transfer, we are been involved in a desktop independent review of our serious incident work. That will report in February. During 2017 we changed our own SI process to try to improve traction and ensure actions taken after TTRs were implemented. At the March Board meeting we will examine progress with actions from SIs during this last fiscal year. We need to ensure that we close the loop on learning from events, and our Learning Hub, which is referenced in our CQC Improvement Plan will be the latest attempt to try to do that beyond the areas where incidents arise.

The Risk Register continues to drive the agenda we have, both in the Board and at CLE. Through the Executive Quality Committee we are reviewing Group's structures for governance to make sure that the same clarity if true locally. The focus suggested for Board discussion is in areas where our residual score remains red after completion of actions taken. We need to discuss what level of tolerance can be accepted for that position or what additional actions are needed.

During February we go live with our Purple Point service. Developed with Healthwatch this is a seven day a week service aimed at helping patients or carers who have a concern about their care. The service can also be used for praise or other feedback. Initially delivered in five key languages, our team will triage callers to the right place and aim to find a resolution to concerns. Success will be measured through that, and through a wider reduction in complaints and some improvement in Friends and Family scores. Giving patients and their relatives a very clear route through which to raise their voice is part of our commitment to openness and transparency. It also reflects our longstanding recognition of carers as a partner in the care that we offer.

2. Our workforce

At the time of writing we have flu vaccinated 77.5% of patient facing staff. Once again this means we are among the top "performers" nationally and locally. Our aim was 80% and work continues in coming days to vaccinate 120 more employees to meet that goal. Elaine Newell and Raffaela Goodby, as well as the OH team who we met last month, deserve congratulations for their efforts driving this programme this year – our fifth year of real and distinctive success on this measure.

During 2017 we have stabilised our sickness rate and in some departments seen dramatic improvements. We are also making strides to ensure that absence among medical staff is reported so that support can be provided to trainees and others. As requested by the Board the papers contain a paper outlining a renewed approach to addressing sickness and encouraging wellness and attendance.

Whilst the Trust is not an outlier presently, nor are we upper decile in cutting absence and we want to achieve real success if we are create stable teams best able to provide great care.

Notwithstanding a missing, or sadly potentially stolen angel from our chapel, our Christmas celebrations have gone well. The decorating contest illustrated the scale of ingenuity in many parts of our Trust, and we provided free food to employees working over the bank holiday periods. 2018 will be our last Christmas in our current sites and so we will give thought over the coming months to how that can mark part of the exit and bereavement process, before we gear up in 2019 for the shift into Midland Met.

Work on recruitment and retention remains crucial to quarter four delivery of our plans and our longer term sustainability. During 2017 we have real success on nurse recruitment into our wards and medical recruitment into our A&E. We continue to need to work hard to address gaps in community nursing and midwifery, and to recruit physicians in acute facing specialties. The Board considers a radical proposal designed to support retention in nursing, and more broadly to create a single escalator from band 2 care assistants to senior nursing. What lies behind the work is an intent to ensure that seniority as a clinician can be achieved without needing to move into management. Given how enshrined the alternative is, both culturally and in some contractual forms, we will want to work explicitly to promote this career path. Such experts will then offer the mentorship and inspiration to more junior colleagues to progress.

In February we commence the Accredited Manager programme which forms a key part of our People Plan. Over 700 line managers will demonstrate excellence in a variety of areas of work, including people management. Linked to our digital work this will also include supporting managers to think about how to manage employees' use of technology. The programme is a major investment of time and effort, and will of course need to be replicated for any new joiners stepping into management roles. Whilst we have always had an extensive voluntary programme of management development, and investing at scale in leadership in 2015-16, this programme is both mandatory and competency based. As a line manager 360-degree feedback will form part of your appraisal from 2018-19.

3. Our commissioners

We believe we have reached agreements with our principal commissioners over the financing of 2017-18. In particular our agreement seeks to end the process of transactional contracting behaviour between the parties, as we aim to create a new model for finances on a "one pound in Sandwell" basis in 2018-19. There is considerable compromise from all parties, which is encouraging. Weekly chairs' meetings attended by accountable officers will aim during January to structure the 2018-19 contract sum and framework, as we move towards a very different contract form in 2019-20.

We served notice on the provision of complex gynae-oncology surgery in April 2017, after national arbitration failed to address the 40% income cut for the service. It has taken considerable time to mobilise an alternative provision and position remains in a degree of flux. Given this, and with patient care as our priority, we have undertaken to continue the service in quarter 4 of 2017-18. A risk summit will be held in February to discuss mobilisation of the replacement service.

4. Our regulators

Contained in the private Board papers are draft papers associated with the undertakings process. This is a national position aimed at helping non-FT providers to a regulatory footing on a par with that used

by Monitor. The crucial issue for discussion will be the right timescales under which compliance can be achieved in the key areas highlighted for urgent action. Those being:

- Care Quality Commission ratings
- 52 week breaches
- Emergency care wait standards
- Financial position

We would aim to conclude this process by the time of the February board meeting.

5. Sustainability and Transformation Partnership

Further to the Board's discussion on the proposed Black Country Pathology service, meetings continue to try to develop an acceptable commercial framework for that proposition. We remain focused, for the reason of staff clarity, on decision making when we meet in February.

There has been limited wider STP activity since the last Board. However, we are working to respond to a national expectation that STPs can operate as Accountable Care Systems. In our patch, as in most others, this will involve local places having systems, which then contribute to an aggregate position. We need to continue to focus on place at a level that is meaningful to patients and local communities, and to direct our efforts based on a recognition that vertical integration/coordination with primary care creates the majority of value for care, with a further benefit from horizontal integration. The work we are doing on the SWB ACS recognises that reality and is a strong basis on which to contribute to wider STP discussions.

Attached to the report are the routine annexes on recruitment and on staffing cover. Both merit discussion in the meeting, as both show some deviation to expectation. There is no Clinical Leadership Executive update because the meeting was run as a financial improvement workshop. An update on Proms is appended. We are no longer an outlier, which is positive.

Also included, as the request of non-executive colleagues, are the QIA and EIA documents associated with the solid tumour oncology service transfer. As we might expect these show risk, for which the proper response is a cogent post implementation monitoring framework overseen by regulators.

Toby Lewis
Chief Executive
December 29th 2017

Appendix A: Oncology Services Quality Impact and Equality Impact Assessments
Appendix B: Safe staffing data
Appendix C: Recruitment Scorecard
Appendix D: Patient Reported Outcome Measures (PROMs) Update

Appendix A

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Oncology Services – Quality Impact and Equality Impact Assessments**
SPONSOR (EXECUTIVE DIRECTOR):	Toby Lewis, Chief Executive
AUTHOR:	Stephen Hildrew, Directorate General Manager
DATE OF MEETING:	4th January 2018

EXECUTIVE SUMMARY:

For the avoidance of doubt this document is a draft document which does not yet have the approval of NHS England.

Commencing in October 2017, and concluding by the end of March 2018, NHS England have commissioned oncology outpatients and solid tumour chemotherapy direct from UHB via their Edgbaston site. This reflects the breakdown in service sustainability on our sites because of the medical cover arrangements. The Board had asked to see the quality impact and equality impact assessments completed by this project. They are attached.

They illustrate to a degree the risks to be managed with this change. These risks might usefully be considered in three parts:

- The transition risk: Existing and new patients and their referrers need to be moved to a new location, and whilst UHB have helpfully constructed a mirrored service delivery model there remains a move error risk. Considerable attention and oversight is being paid to that.
- The patient access risk: This is best understood in two parts – new patients who may choose not to travel the slightly increased distance for service (bearing in mind the patients will be post diagnosis), or long term patients, notably end of life patients, who may alter their palliation treatment choices.
- The wider service risk: Multi professional cancer care and recruitment to physician and surgeon roles may be impacted over time by the absence of an on-site oncology presence.

The equality impact assessment does not per se consider issues of poverty. The concern expressed by clinical teams is that less well-off patients may decline to make the trip. To a degree the additional patient transport provision being put on by NHS England may address the matter.

Given that the decision to relocate is not alterable, the issue is what data monitoring will be in place for 2018-19 to track impacts. The oversight board has been asked to confirm that.

REPORT RECOMMENDATION:

The Board are requested to receive this update.

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	**x**	Equality and Diversity		Workforce	
Comments:					
ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:					
PREVIOUS CONSIDERATION:					
Dec Trust Board					

Click to return to menu

Author and Review History

Title

Sandwell Oncology Solid Tumour Site Transition Project

Name	Version Number	Author / Reviewer	Action	Date	Notes
Robert Game, Project Director, NHSI/ NHSE	*v1*	*Author*	*Initial*	*04/12/2017*	*Initial document completion.*
Stephen Hildrew, General Manager, SWBH	*v2*	*Reviewer*	*Review*	*21/12/2017*	*Amended for SBWH operational understanding*
Stephen Hildrew, General Manager, SWBH	*V3*	*Reviewer*	*Review*	*28/12/2017*	*Amended following Trust feedback*

Quality & Equality Impact Assessment

Instructions

There are 4 domains relating to patient care: ***Safety, Effectiveness, Experience and Impacts and an Equality Impact Assessment in this tool.***

Begin the tool by completing this sheet and then complete Safety assessment first.

Please work through this tool to identify the impact of your proposed service changes against the status quo. Complete the four worksheets with either text or using the drop down boxes in highlighted in white. Calculations are then automated.
You will also need to complete the Equality Impact Assessment (EIA) to demonstrate compliance with the Equality Act 2010.
Results are displayed in the summary sheet.

Menu

Assessments

Other views

On completion please send a copy to the Chief Nursing Officer via the following.

Goto Version and History using link below using link:
Version & Notes

Prepared for NHSE - Specialised Commissioning

Title:	Sandwell Oncology Solid Tumour Site Transition Project

Summary description of the change proposal:

Implemention of a temporary transition plan for the provision of solid tumour oncology services for Sandwell and West Birmingham patients.
Some changes are to be made to oncology outpatient and chemotherapy services for solid tumour patients at Sandwell and West Birmingham Hospitals NHS Trust (SWBH). Consultant oncology time for the solid tumour service offered by SWBH is currently provided by doctors from University Hospitals Birmingham (UHB). Due to the unsustainability of staffing at the Sandwell and City sites, patients will be referred to the region's cancer centre at UHB for their outpatient appointments and chemotherapy, or to the Royal Wolverhampton Trust (RWT). All three trusts are working together with NHS Improvement, NHS England and other key partners to implement an interim solution which serves the best interests of patients. At the same time, a cancer review is taking place to look at the long term options for oncology services across West Birmingham and the Black Country.

Completed by:	Robert Game, Project Director, NHSI / NHSE
Date:	4th December 2017
Initial or Review	Initial

Review Group	Authorisation Group	**Outcome**	Not Considered
Date:	04/12/2017		
Max Review Date:	03/12/2018		

Notes

QIA and EIA to be reviewed at SWBHT Board meeting on 4th January 2017

Please enter the CCG total population (thousands)

589 ,000

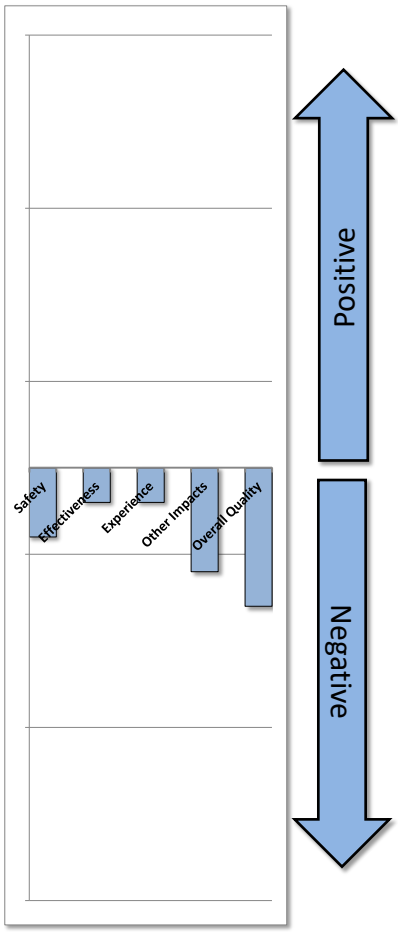
NHS
Northern, Eastern and Western Devon Clinical Commissioning Group

Summary of Quality & Equality Impact Assessment

Date of print: 29/12/2017

Northern, Eastern and Western Devon Clinical Commissioning Group

Quality Impact Assessment Overview



Title of change proposal

Sandwell Oncology Solid Tumour Site Transition Project

Summary description of the change Proposal

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At the same time, a cancer review is taking place to look at the long term options for oncology services across West Birmingham and the Black Country.

Total Quality Impact

Total Quality Score	- 40	Reduction in overall quality - look to mitigate
Total Impact score (using absolute values)	**40**	Medium Impact
Other Impacts Score	- 30	Negative effect on other impacts

Equality Impact

Equality Impact Assessment: Groups affected	13	Consider actions to mitigate
Sum of +ve and -ve impacts	-17	Equality Impact Assessment Complete
Engagement Activity	No	

Completed by:	Robert Game, Project Director, NHSI / NHSE
Reviewed by:	Authorisation Group
Outcome of Review:	Not Considered
Date of Review:	04/12/2017

Click to return to menu

Safety

Geography, hospital, department or other area this applies to:	Describe the change proposed and the clinical area(s) the change applies to.
Three local hospitals SWBHT, UHB, RWT - Oncology Outpatients and Chemotherapy services.	*Some changes are to be made to oncology outpatient and chemotherapy services for solid tumour patients at Sandwell and West Birmingham Hospitals NHS Trust (SWBH). Patients will be referred either University Hospital Birmingham (UHB) or to the Royal Wolverhampton Trust (RWT) for their outpatient appointments and chemotherapy,*

Description	What is the impact on the SAFETY of patients of implementing the change proposed including any improvement actions? (Please add a description of evidence)
Consider: *Avoidable Harm to patients* *Waiting leading to harm* *Impact on Safeguarding* *Suitably qualified and experienced staffing* *Safe levels of staffing* *Infrastructure* *Clean & Safe environment* *Treatment procedures* *Communication* *Administration*	*1. Avoidable harm to patients - Transition of patients to another site for treatment has the potential to disrupt or delay the course of treatment. Mitigation includes monthly monitoring of access times for patients receiving treatment and a case by case patient list managed between SWBH/UHB..* *2. Risk of late stage chemo patients stopping treatment due to distance to travel causing earlier mortality than necessary due to lack of willingness to travel for palliative chemotherapy. 3. Waiting leading to harm- Potential for patients to be lost in transition process, potential that patients may not wish to transfer, patients experiencing greater transport costs and extended time to travel as a result of the relocation. Mitigation includes independent monitoring of any changes in performance data, introduction of patient call/recall system that support on-going patient updates to all clinical teams, review patient transport access to service. 4. Impact on safeguarding - ensure the provision of high-quality care to prevent safeguarding concerns, providing an effective response where harm caused by delay does occur and working with other agencies such as social services to promote patient safety. 5. Levels of staffing - Clinical resource across SWBH / UHB / RWT may not be sufficient to support transition. Mitigation through undertaking a review of the current provision , identifying the gaps and ensuring patient safety, Specialised Commissioning to manage and commission any changes required and to ensure that the service is sustainable during and post transition. 6. Infrastructure - Insufficient time to safely transfer patients into new service, Incomplete and/or inaccurate data flows through lack of IT integration between Trusts.*

-2	Total Impact	
		Band
220	Number of patients affected per week of the change	2
52	Time, in weeks, the change will continue.	5

Impact Description

Minor injury or illness, requiring minor intervention
Requiring time off work for >3 days
Increase in length of hospital stay by 1-3 days

4./

Effectiveness

Geography, hospital, department or other area this applies to:	Describe the change proposed and the clinical area(s) the change applies to.
Three local hospitals SWBHT, UHB, RWT - Oncology Outpatients and Chemotherapy services.	*Some changes are to be made to oncology outpatient and chemotherapy services for solid tumour patients at Sandwell and West Birmingham Hospitals NHS Trust (SWBH). Patients will be referred either University Hospital Birmingham (UHB) or to the Royal Wolverhampton Trust (RWT) for their outpatient appointments and chemotherapy,*

Description	What is the impact on the EFFECTIVENESS of care on patients, of implementing the change proposed including any improvement actions? (Please add a description of evidence)
Consider: *HCAI* *NICE* *National Evidence Base* *Effect on Health Outcomes* *Promotion of self care* *Leadership* *Competence* *Reliability* *Responsiveness* *Use of Evidence* *Attach key documents*	*1. HCAI - No impact arising from the reloctaion of services alone to another organisation.* *2. NICE guidelines - Best practice in developing and delivering cancer services for adults will not differ solely due to the reloaction of service. Adherence to NICE Guidelines remains to ensure that that people with cancer, and their families and carers, are well informed, cared for and supported from before formal diagnosis onward.* *3. Effect on Health Outcome - There are no identifed detremental effects identified on outcomes due to the relocation of services to another location. 4. Reliability - Consultant oncology time for the solid tumour service offered by SWBH is currently provided by doctors from University Hospitals Birmingham (UHB). Due to the unsustainability of staffing at the Sandwell and City sites patients will be referred to the regional cancer centre.* *4. Responsiveness - There is a risk that referral to another centre for treatment will affect ability of services to respond in a timely manner due to increased pressure on these services to respond to demand.* *5. Change of effectiveness of cancer pathways as referring clinicians may refer to different hospitals due to a perception that the Trust "does not do cancer". Significant impact on other services, and waste of resources.*

-1 Total Impact Score

Impact Description
Peripheral element of treatment suboptimal

Patient Experience

Geography, hospital, department or other area this applies to:	Describe the change proposed and the clinical area(s) the change applies to.
Three local hospitals SWBHT, UHB, RWT - Oncology Outpatients and Chemotherapy services.	*Some changes are to be made to oncology outpatient and chemotherapy services for solid tumour patients at Sandwell and West Birmingham Hospitals NHS Trust (SWBH). Patients will be referred either University Hospital Birmingham (UHB) or to the Royal Wolverhampton Trust (RWT) for their outpatient appointments and chemotherapy,*

Description	What is the impact on the EXPERIENCE of care on patients, of implementing the change proposed including any improvement actions? (Please add a description of evidence)
Consider: *Waiting* *Patient Autonomy* *Dignity, respect & compassion* *Travel to place of care* *Informed Choice* *Control of care* *Responsiveness* *Empathy & Caring* *Family & Friends Test* *Feedback complaints* *Feedback from PALs* *Attach key documents*	*1 Patient Autonomy- the options presented to patients are mofe limited in terms of location for the provision of services in the interim.* *2. Travel to place of care- Patients experience greater transport costs and extended time to travel as a result of the relocation. Mitigated through the Transport working group understanding the options available if large number of patients are identified and need to be managed in a different way. The Transport group will generate business case(s) if required for potential additional transport solution(s).* *3. Informed Choice- Significant potential that patients will not wish to transfer to a different site due to a lack of local services, and closer hospitals with oncology services not being offered as a preferential choice due to existing capacity issues (Walsall, Dudley, Good Hope). Patients to be managed on a patient by patient basis, numbers of patients naturally reduces over time as new patients expectations are managed in accordance with new pathway.* *4. Friends and Family test - Report from Trusts will be presented to the Operations Group periodically to ensure that all feedback is identifed, trends discussed, issues and any potential solutions escalated as appropriate.* *5. Feedback & Complaints- Complaints to be included in the Transition project metrics. These are reviewed at the Operatons and Clinical group for action and resolution.* *6. Feedback from PALS - PALS report from SWBHT will be presented to the Operations Group periodically to ensure that all feedback is identifed, issues discussed and escalated as appropriate.*

-1	Total Impact Score

Impact Description
Informal complaint/inquiry

Click to return to menu

Other Impacts

Geography, hospital, department or other area this	A description of the clinical area(s) the change impacts on.
Three local hospitals SWBHT, UHB, RWT - Oncology Outpatients and Chemotherapy services.	*Some changes are to be made to oncology outpatient and chemotherapy services for solid tumour patients at Sandwell and West Birmingham Hospitals NHS Trust (SWBH). Patients will be referred either University Hospital Birmingham (UHB) or to the Royal Wolverhampton Trust (RWT) for their outpatient appointments and chemotherapy,*

Description	Please describe how the change proposed may impact on other parts of the health and social care economy or other services or ability to deliver the change. (Please add a description informing the score)
Consider: *Shared risk with partner agencies* *Clarity of accountability & clinical leadership* *Cost effectiveness* *Engagement of staff in design & Implementation* *Location of service* *Public and Patient involvement in development & feedback* *Environmental consideration* *Social value (Social Value Act 2012) Impact* *Privacy Impact (Personal data)* *Impact on other partner organisations* *Impact on employees and other staff, contractual & welfare* *Reputation* *Visitors, temporary residents & carers.* *Sufficient change management proposed?*	*Clarity of accountability and clinical leadership - MDT structure to remain in place at SWBH, however impact on clinical representation at these MDTS from appropriate oncologists yet to be determined. Patients transferred to RWT will not be represented at their local MDT, instead being managed through a RWT MDT, losing the link to their local hospital Trust.* *Cost effectiveness - significant increase in cost of provision due to stranded costs left at SWBH due to transition of services* *Engagement of staff in design & implementation - this has not been possible as the multi-organisation group was not able to affect the outcome of the decision to withdraw oncology support from SWBH hospital sites.* *Location of service - significantly affected, as there will be no local oncology service for Sandwell residents.* *Reputation - significant effect on SWBH as a hospital trust due to removal of oncology services, lack of ability to recruit clinicians significantly increased by the lack of an on-site oncology service. Impact on other hospital services unmapped and undetermined.*

Choose the key impact type

Reputation

Total Impact Score

-3

Please indicate other key impacts.

Financial sustainability	Yes	*Staff Experience*	Yes	*Carers*	No
Impact on Partner Organisations	Yes	Environment	No	Reputation	Yes

220	Number of patients, carers or public affected per week.	Band 2

Impact Description

Medium-term reduction in public confidence. Moderate external criticism of organisation/individual by staff/GPs on social media.
Local media coverage with criticism by another statutory organisation.
Front page negative local media coverage Local negative lead broadcast item.
National broadsheet coverage limited to inside pages.
National broadcast news coverage.
Trade (HSJ etc...) media coverage.
Heavy increase in PALS/complaints contacts about issue.
National negative broadsheet coverage of issue.
Difficult MP enquiries and/or requests to meet to discuss/criticism.
Escalation internally or externally to ministerial level.
Difficult Healthwatch presentation with criticism/escalation.
Difficult Health and Wellbeing Board presentation with criticism/escalation.
Persistent and effective campaigning.
OSC escalation to ministerial level.
Loss of civil court proceedings due negligence or

Click to return to menu

Measurement (quality indicators)

How will the Impact of Safety, Effectiveness and Experience described above be measured?

Measurement Description	Current or New Measure	Method of implementation	Responsible lead	Start Date
Mortality of transferring patients	*Current measure*	*National cancer reports*	NHS England	01/10/2017
Patient refusals	*New measure*	*Local measurement*	SWBH	01/10/2017
Patient DNA/Cancellations	*New KPI*	*Local measurement*	UHB / RWH	22/10/2017
New to follow up ratios	*New KPI*	*Local measurement*	UHB / RWH	22/10/2017

Attach relevent documents or links in the upload attachements sheet by clicking below:

Go to Upload Attachments

Click to return to menu

Equality Impact Assessment

Click here to go to Useful Links...

In order to demonstrate compliance with the Equality Act 2010
Do I need to complete this analysis?
- If you are introducing change, you should complete this analysis.
What do I need to do?
- Be proportionate to your work - you will know the significance of the work you are carrying out
- Be reasonable in your judgement and completion of the analysis
- Be honest in your appraisal and actions that you will undertake to address any (negative/ positive) issues
- Use intelligent information for your analysis that helps you to understand who are your customers and how they will be affected by your project/ plan
- Share your work with the Equality & Diversity lead, especially if you have any concerns and/or do not understand anything in this tool.

When considering the potential impact on those that share protected characteristics, think about:
- if there are any unintentional barriers to particular communities
- whether your project/ plan will bring about positive improvements
- if it creates good opportunities for accessing services
- will it improve personal choice for one particular group and not another
- the consequences for individual people; people can have more than one protected characteristic
- both people who use the service and staff
Have you identified any potential discrimination or adverse impact that cannot be legally justified?

Geography, hospital, department or other area this applies to:	**A description of the clinical area(s) the change impacts on.**
Three local hospitals SWBHT, UHB, RWT - Oncology Outpatients and Chemotherapy services.	*Some changes are to be made to oncology outpatient and chemotherapy services for solid tumour patients at Sandwell and West Birmingham Hospitals NHS Trust (SWBH). Patients will be referred either University Hospital Birmingham (UHB) or to the Royal Wolverhampton Trust (RWT) for their outpatient appointments and chemotherapy,*

Equality and Diversity Profile Screening

Protected Groups	Potential People with protected characteristics	Does this group currently use/access the service?	What impact will there be on each group from the proposal?	No's people Affected	Impact Score	Is there any particular information on this group relating to the proposal? Outline any evidence of current use. Outline evidence from engagement activities including involving communities. Any further information?	Has there been specific engagement or consultation with this group?
Sex / Gender	Women	Yes	Neutral		0		No
	Men	Yes	Neutral		0		
Race / Ethnic Group	Asian	Yes	Neutral		0		No
	Asian British	Yes	Neutral		0		
	Black	Yes	Neutral		0		
	Black British	Yes	Neutral		0		
	Chinese	Yes	Neutral		0		
	Gypsy or Roma	Yes	Neutral		0		
	Irish	Yes	Neutral		0		
	Mixed Heritage	Yes	Neutral		0		
	White	Yes	Neutral		0		
	White British	Yes	Neutral		0		
	other ethnic backgrounds	Yes	Neutral		0		
Disability	Physical	Yes	Adverse impact	1	-1	Difficulty due to increased travel distance/confusion of any changes	No
	Sensory (hearing and/or partial sight)	Yes	Adverse impact	1	-1	Difficulty due to increased travel distance/confusion of any changes	
	Deaf people	Yes	Neutral	1	0		
	Learning Disabilities	Yes	Adverse impact	1	-1	Difficulty due to increased travel distance/confusion of any changes	
	Mental Health	Yes	Adverse impact	1	-1	Difficulty due to increased travel distance/confusion of any changes	
	Dementia	Yes	Adverse impact	1	-1	Difficulty due to increased travel distance/confusion of any changes	
	Other long term conditions	Yes	Adverse impact	1	-1	Difficulty due to increased travel distance/confusion of any changes	
Sexual Orientation	Lesbian, gay men and bisexual	Yes	Neutral		0		No
Gender reassignment	Men to women	Yes	Neutral		0		No
	Women to men	Yes	Neutral		0		
	Trans	Yes	Neutral		0		

Age	<5 years old	No	Neutral	0	0		No
	5 - 18 years old	No	Neutral	0	0		
	18 - 65 years old	Yes	Neutral	0	0		
	65 - 85 years old	Yes	Adverse impact	1198	-5	Difficulty due to increased travel distance/confusion of any changes	
	>85 years old	Yes	Adverse impact	72	-1	Difficulty due to increased travel distance/confusion of any changes	
Faith or Belief		Yes	Neutral		0		No
Maternity and Pregnancy		No	Neutral		0		No
Marriage and Civil Partnership		Yes	Neutral		0		No
Others	Asylum seekers and refugees	Yes	Adverse impact	1	-1	Difficulty due to increased travel distance/confusion of any changes	
	Travellers	Yes	Adverse impact	1	-1	Difficulty due to increased travel distance/confusion of any changes	
	Variation in care provision	Yes	Adverse impact	1	-1	Difficulty due to increased travel distance/confusion of any changes	No
	Rurally Isolated	Yes	Adverse impact	1	-1	Difficulty due to increased travel distance/confusion of any changes	No
	Parity of Esteem	Yes	Adverse impact	1	-1	Difficulty due to increased travel distance/confusion of any changes	No
Inequalities Check	Least deprived parts of the population	Yes	Unknown	1	1		
	Most deprived parts of the population	Yes	Adverse impact	1	-1	Difficulty due to increased travel distance	
Have you engaged in public engagement activities?						No	No
Total number of groups affected		34	13			Groups covered by engagement activities.	0
Total Impact Score		-17					

Next Steps (Summary)
Outline any actions to ensure equality and engagement?

EIA Completed? Yes

Click to return to menu

Please upload your attachments in this workbook.

C:\Users\polaks\Desktop\Dummy document for

Click to return to menu

Guide to completion of the tool

A copy of the policy can be found here on the website.

1. Fullscreen. Sometimes it is easier to work in fullscreen mode to see as much as possible on the screen. Buttons to enter and exit fullscreen mode are on the main menu.

Navigation. Use the Hyperlinks or the buttons to navigate around the workbook - hyperlinks are always underlined in blue. These go purple after they have been clicked. You may then return to the main menu by clicking on the return to menu in the top left hand corner of the worksheet.

Work in turn on each worksheet from Safety, Effectiveness, Experience and other impacts using the NEXT buttons. Finally review the summary (which can be printed).

2. Any white area requires your input into the tool, either with narrative, inserting documents or using the drop down lists. Orange areas show information that has been entered or feedback from figures entered into scoring.

3. Where you add narrative please describe the evidence behind any assertions made or the score chosen. In addition detailed evidence such as papers, links to data etc may be added in each section by embedding the document as an object (see help files in excel to do this).

4. The calculation in the QIA matrix is designed to give a graphical view of the relative scores. Scores can be positive or negative.

5. To ensure consistency of scoring please use the decision matrix tab which gives a narrative guidance to the score meaning.

Useful Links…

http://www.legislation.gov.uk/ukpga/2010/15/contents

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/85041/equality-duty.pdf

http://www.equalityhumanrights.com/private-and-public-sector-guidance/public-sector-providers/public-sector-equality-duty

http://www.legislation.gov.uk/ukpga/2010/15/contents

https://www.gov.uk/equality-act-2010-guidance

https://www.gov.uk/government/publications/public-sector-quick-start-guide-to-the-public-sector-equality-duty

http://www.devonhealthandwellbeing.org.uk/library/needs-assessments/

http://www.swscn.org.uk/improving-quality/parity-of-esteem/

Below are the Quality Equality Impact Assessment Policy and Equality and Diversity Policy

Review body - threshold for authorisation	Very High Risk	High Risk	Medium Risk	Low Risk	No Risk

Total Score

Composite or any individual Quality score	<20	20-50	51 - 80	>80
Rating	Low Impact	Medium Impact	High Impact	Very High Impact
Review & Approval Required by	Governing Body			

	-5	-4	-3	-2	-1	0	1	2	3	4	5
	Negative					Neutral	Positive				
	Catastrophic	Major	Moderate	Minor	Negligible	Neutral	Negligible	Minor	Moderate	Major	Excellence
Safety	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Minimal injury requiring no/minimal intervention or treatment. No time off work	No effect either positive or negative	Minimal benefit requiring no/minimal intervention or treatment.	Minor benefit, requiring minor intervention Reduction in length of hospital stay by 1-3 days	Moderate benefit requiring professional intervention Reduction in length of hospital stay by 4-15 days	Major benefit leading to long-term improvement/reduction in disability Reduction in length of hospital stay by >15 days Improvement in management of patient care with long-term effects	Incident leading to enhanced benefit Multiple permanent benefit or irreversible positive health effects
Effectiveness	Totally unacceptable level or effectiveness of treatment	Non-compliance with national standards with significant risk to patients if unresolved	Treatment or service has significantly reduced effectiveness	Overall treatment suboptimal	Peripheral element of treatment suboptimal	No effect either positive or negative	Peripheral element of treatment optimal	Overall treatment optimal	Treatment has significantly improved effectiveness	Compliance with national standards with significant benefit to patients	Totally acceptable level of effective treatment
Experience	Gross failure of experience if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards	Multiple complaints/ independent review Low performance rating Critical report	Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards	Formal complaint (stage 1) Local resolution Single failure to meet internal standards	Informal complaint/inquiry	No effect either positive or negative	Informal positive expression/inquiry	Letter of praise Local recognition Meets internal standards	Letter of praise to board Local recognition Repeatedly meets internal standards	Multiple letters of praise / positive independent review Repeatedly exceeds internal standards	Consistently exceeds local and national standards of experience verified by external scrutiny.
Patient Numbers						0	1-50 patients	51-200 patients	201 - 500 patients	500 - 1000 patients	>1000 patients

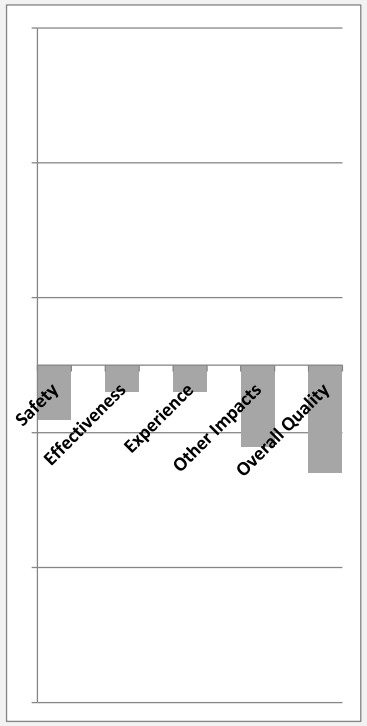
Other Impacts Scorer

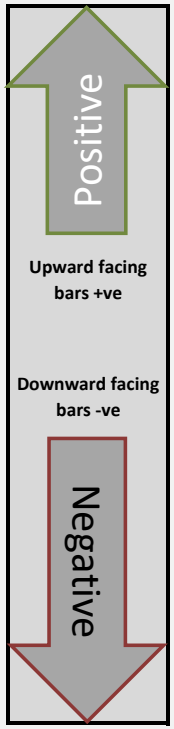
	-5	-4	-3	-2	-1	0	1	2	3	4	5
	Negative					Neutral	Positive				
	Catastrophic	Major	Moderate	Minor	Negligible	Neutral	Negligible	Minor	Moderate	Major	Excellence
Financial sustainability	>1.51% over performance against budget	1% - 1.5% over performance against budget	0.5% - 1% over performance against budget	0.26% - 0.5% over performance against budget	0 - 0.25% over performance against budget	On budget	0 - 0.25% under performance against budget	0.26% - 0.5% under performance against budget	0.5% - 1% under performance against budget	1% - 1.5% under performance against budget	>1.51% under performance against budget
Staff Experience	Sustained and open external criticism of the organisation by staff in local, national and social media. Industrial action taken. External review of staff pratices.	Medium term and open external criticism of the organisation by staff in local, national and social media. Negative staff side industrial action. Critical staff survey.	Short term and open external criticism of the organisation by staff in local and social media. Negative staff side action. Negative staff survey.	Criticism of the organisation by staff in internally. Negative staff side. Negative staff survey.	Internal criticism of the organisation.	No effect either positive or negative	Internal praise of the organisation.	Praise of the organisation by staff in internally. Positive staff side. Positive staff survey.	Short term and open external praise of the organisation by staff in local and social media. Positive staff side action. Positive staff survey.	Medium term and open external praise of the organisation by staff in local, national and social media. Positive staff side.. Praise in staff survey.	Sustained and open external praise of the organisation by staff in local, national and social media. Exemplar for staff side. External exemplar of staff pratices.
Carers	Carers role, personal health and welfare is significantly damaged over a sustained period.	Carers role, personal health and welfare is damaged over a medium period.	Carers role, personal health and welfare is temporarily damaged.	Carers role and personal health and welfare suffers temporarily.	Carers role suffers temporarily	No effect either positive or negative	Carers role enhanced temporarily	Carers role and personal health and welfare enhanced temporarily.	Carers role, personal health and welfare is temporarily signifcantly enhanced	Carers role, personal health and welfare is significantly enhanced over a medium period.	Carers role, personal health and welfare is significantly enhanced over a sustained period.
Reputation	Loss of public confidence. Sustained and open external criticism of organisation/individual by (named) staff/GPs on social media. Sustained criticism by MPs/ministers leading to resignation of chair/chief officer. Sustained external criticism of organisation/individual by staff/GPs on social media leading to resignation of chair/chief officer. Local and national broadcast/print/trade news coverage over more than seven days. PMQ discussion with Governmental and shadow parties critical of CCG. Political crisis as result of CCG action/inaction. Loss of criminal proceedings.	Long-term reduction of public confidence. Sustained criticism by MPs. Sustained external criticism of organisation/individual by staff/GPs on social media. Sustained criticism of organisation/individual by staff/GPs in media. Sustained PALS/complaints contacts. National broadcast news coverage over more than two days. Local broadcast news coverage over more than three days. Front page trade press coverage. Front page broadsheet coverage. Escalation and public comment at ministerial/PM level with intervention. Sustained criticism by Health and Wellbeing Board and intervention. National/international recognition of campaigning. OSC escalation to ministerial level with intervention. Loss of civil court proceedings due wilful act. Criminal proceedings.	Medium-term reduction in public confidence. Moderate external criticism of organisation/individual by staff/GPs on social media. Local media coverage with criticism by another statutory organisation. Front page negative local media coverage Local negative lead broadcast item. National broadsheet coverage limited to inside pages. National broadcast news coverage. Trade (HSJ etc…) media coverage. Heavy increase in PALS/complaints contacts about issue. National negative broadsheet coverage of issue. Difficult MP enquiries and/or requests to meet to discuss/criticism. Escalation internally or externally to ministerial level. Difficult Healthwatch presentation with criticism/escalation. Difficult Health and Wellbeing Board presentation with criticism/escalation. Persistent and effective campaigning. OSC escalation to ministerial level. Loss of civil court proceedings due negligence or maladministration.	Short-term reduction in public confidence. Internal criticism by staff. Local print media coverage limited to inside pages/small articles. Moderate social media comment with criticism by patient/s and/or carer/s. Increase in PALS/complaints contacts about issue. MP enquiry. Healthwatch questions/FOI/ request to present. Health and wellbeing Board request to meet. Overview and scrutiny committee (OSC) presentation request. Active social media campaigning. Loss of civil court proceedings.	Public awareness of issue. Discussion among staff. Questions from staff/other NHS organisation. Limited critical social media comment. Questions from public/FOI. Healthwatch interest or questions. Health and Wellbeing board interest or questions. Overview and scrutiny committee interest or questions. Interest from campaigning. organisation Civil court proceedings.	No effect either positive or negative	Public awareness of issue. Discussion amoung staff. Questions from staff/other NHS organisation. Limited supportive social media comment. Questions from public/FOI. Healthwatch interest or questions. Health and wellbeing board interest or questions. Overview and scrutiny committee interest or questions. Interest from campaigning organisations.	Short-term improvement in public confidence. Internal support by staff. Local print media coverage limited to inside pages/small articles. Moderate social media comment with support by patient/s and/or carer/s. Increase in PALS/complaints contacts about issue. MP enquiry. Healthwatch questions/FOI/ request to present. Health and wellbeing Board request to meet. Overview and scrutiny committee (OSC) presentation request. Active social media campaigning.	Moderate external improvement of organisation/individual by staff/GPs on social media. Local media coverage with positive comment by another statutory organisation. Front page positive local media coverage Local positive lead broadcast item. National broadsheet coverage limited to inside pages. National broadcast news coverage. Trade (HSJ etc…) media coverage. Heavy increase in PALS/compliments contacts about issue. National positive broadsheet coverage of issue. Positive MP enquiries and/or requests to meet to discuss/support. Escalation of positive work internally or externally to ministerial level. Supportive Healthwatch presentation with positive/escalation. Positive Health and Wellbeing Board presentation with support/escalation. Persistent and effective campaigning. OSC escalation to ministerial level	Long-term enhancement of public confidence. Sustained support by MPs. Sustained external support of organisation/individual by staff/GPs on social media. Sustained positive stories of organisation/individual by staff/GPs in media. Sustained PALS/compliments contacts. National broadcast news coverage over more than two days. Local broadcast news coverage over more than three days. Front page trade press coverage. Front page broadsheet coverage. Escalation and public comment at ministerial/PM level with intervention. Sustained support by Health and Wellbeing Board and intervention. National/international recognition of campaigning. OSC escalation to ministerial level with intervention.	Enhancement of public confidence. Sustained and open external support of organisation/individual by (named) staff/GPs on social media. Sustained support by MPs/ministers leading to ministerial support of chair/chief officer. Sustained external support of organisation/individual by staff/GPs on social media leading to positive recognition of chair/chief officer. Sustained support of organisation/individual by staff/GPs in media leading to positive recognition of chair/chief officer. Local and national broadcast/print/trade news coverage over more than seven days. PMQ discussion with Governmental and shadow parties enhancing reputation of CCG. Political positive reform as result of CCG action.
Impact on Partner Organisations	A large number of partner organisations will experience sustained and critical service pressure or disruption.	Partner organisations will experience sustained and major service pressure or disruption.	Partner organisations will experience time limited and major service pressure or disruption.	Partner organisations will experience short term and service pressure or disruption.	A partner organisation may experience brief service pressure or disruption.	No effect either positive or negative	A partner organisation may experience brief service pressure relief or improvement.	Partner organisations will experience short term and service pressure relief or improvement.	Partner organisations will experience time limited and major service pressure relief or improvement.	Partner organisations will experience sustained and major service pressure relief or improvement.	A large number of partner organisations will experience sustained and service critical pressure relief or improvement.
Environment	Carbon emissions, energy use, waste, water, transport, chemical impacts and biodiversity have a catastrophic negative impact or decrease local biodiversity etc)	Carbon emissions, energy use, waste, water, transport, chemical impacts and biodiversity have a major negative impact or decrease local biodiversity etc)	Carbon emissions, energy use, waste, water, transport, chemical impacts and biodiversity have a moderate negative impact or decrease local biodiversity etc)	Carbon emissions, energy use, waste, water, transport, chemical impacts and biodiversity have a minor negative impact or decrease local biodiversity etc)	Carbon emissions, energy use, waste, water, transport, chemical impacts and biodiversity have a neglible negative impact or decrease local biodiversity etc)	No effect either positive or negative	Carbon emissions, energy use, waste, water, transport, chemical impacts and biodiversity have a neglible positive impact or decrease local biodiversity etc)	Carbon emissions, energy use, waste, water, transport, chemical impacts and biodiversity have a minor positive impact or decrease local biodiversity etc)	Carbon emissions, energy use, waste, water, transport, chemical impacts and biodiversity have a moderate positive impact or decrease local biodiversity etc)	Carbon emissions, energy use, waste, water, transport, chemical impacts and biodiversity have a major positive impact or decrease local biodiversity etc)	Carbon emissions, energy use, waste, water, transport, chemical impacts and biodiversity have a catastrophic positive impact or decrease local biodiversity etc)

Click to return to menu

Quality Impact Table and Weighting adjustment

0 Defect (-ve) / Benefit (+ve)	1 +ve / -ve impact score per pt (-10 to 10)	2 No. pts affected by defect / benefit (by	3 No. wks pt affected (max 52)	4 Weighting	5 Outcome Score
Safety	-2	2	5	100%	- 20
Effectiveness	-1	2	5	100%	- 10
Experience	-1	2	5	100%	- 10
Total quality impact score (using absolute values)					**40**
Overal Quality (total include positive benefits score and negative disbenefits scores)					- 40
Other Impacts	-3	2	5	100%	- 30
Global Quality Impact Score					-70





Decision Matrix Guidance

(Use hyperlink to review detailed guidance

Total Score

Composite or any individual Quality score	<20	20-50	51 - 80	>80
Rating	Low Impact	Medium Impact	High Impact	Very High Impact
Review & Approval Required by	Governing Body			

Appendix B

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:	4th Jan 2018

EXECUTIVE SUMMARY:

Nov Summary

The summary level Unify data demonstrates overall % fill rates during the November period at 97.9% and 95.7% respectively (day) and 968.7 and 104.9% respectively (Night).

The 6 monthly nursing workforce / acuity review is currently in progress and will conclude week ending 3rd Dec. This assessment uses recommended acuity tools to inform and support professional judgement when determining ward based staffing levels. Following analysis of data a detailed report will be submitted to the February Board.

Early warning trigger data demonstrates an overall improvement in performance against key quality and safety indicators with the exception of D16 and L5. Neither of these areas are shown to have fallen below the recommended safe staffing levels on the Unify return and both are subject to a rigorous monitoring and improvement programme which will see clear improvements within one month.

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:

Dec 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%				

	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%
Apr-15	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)	300	345	225	180	555	555	0	0	115.0%	80.0%	100.0%	#DIV/0!	276	3.3	0.7	3.9
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Jul-17	RXK02	CITY HOSPITAL	30894	29888	14741	13461	28584	26702	9817	10265	96.7%	91.3%	93.4%	104.6%	9579	5.9	2.5	8.4
	RXK10	ROWLEY REGIS HOSPITAL	3075	3000	4281	3966	2850	2490	3915	3879	97.6%	92.6%	87.4%	99.1%	2269	2.4	3.5	5.9
	RXK01	SANDWELL GENERAL HOSPITAL	25308	24971	14711	14847	22287	22588	13274	13555	98.7%	100.9%	101.4%	102.1%	9811	4.8	2.9	7.7
			59577	58204	33958	32454	54276	52335	27006	27699	97.7%	95.6%	96.4%	102.6%	21935	16	9	26
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	292	345	232	183	573	555	0	18	118.2%	78.9%	96.9%	#DIV/0!	249	3.6	0.8	4.4
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Aug-17	RXK02	CITY HOSPITAL	29837	27218	14638	12947	27665	24649	9611	10160	91.2%	88.4%	89.1%	105.7%	9277	5.6	2.5	8.1
	RXK10	ROWLEY REGIS HOSPITAL	3567	3346	4843	4529	2923	2671	4011	3988	93.8%	93.5%	91.4%	99.4%	2571	2.3	3.3	5.7
	RXK01	SANDWELL GENERAL HOSPITAL	27288	24118	15703	14697	19737	22381	14390	13733	88.4%	93.6%	113.4%	95.4%	9906	4.7	2.9	7.6
			60984	55027	35416	32356	50898	50256	28012	27899	90.2%	91.4%	98.7%	99.6%	22003	16	9	26
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	292	341	225	210	555	555	0	9	116.8%	93.3%	100.0%	#DIV/0!	221	4.1	1.0	5.0
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Sep-17	RXK02	CITY HOSPITAL	29975	29324	14254	13068	27601	25914	9786	9775	97.8%	91.7%	93.9%	99.9%	9578	5.8	2.4	8.2
	RXK10	ROWLEY REGIS HOSPITAL	4077	3925	5520	5029	2790	2790	3825	3802	96.3%	91.1%	100.0%	99.4%	2479	2.7	3.6	6.3
	RXK01	SANDWELL GENERAL HOSPITAL	23096	23380	14607	14929	22186	19522	13397	14684	101.2%	102.2%	88.0%	109.6%	9901	4.3	3.0	7.3
			57440	56970	34606	33236	53132	48781	27008	28270	99.2%	96.0%	91.8%	104.7%	22179	17	10	27
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	300	307	232	217	573	536	0	55	102.3%	93.5%	93.5%	#DIV/0!	174	4.8	1.6	6.4
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Oct-17	RXK02	CITY HOSPITAL	30867	29794	14429	13236	28148	27059	9541	10173	96.5%	91.7%	96.1%	106.6%	10063	5.6	2.3	8.0
	RXK10	ROWLEY REGIS HOSPITAL	4215	4054	5695	5318	2883	2894	3951	3883	96.2%	93.4%	100.4%	98.3%	2613	2.7	3.5	6.2
	RXK01	SANDWELL GENERAL HOSPITAL	27170	26684	16362	16357	21864	22266	14852	16136	98.2%	100.0%	101.8%	108.6%	11129	4.4	2.9	7.3

			62552	60839	36718	35128	53468	52755	28344	30247	97.3%	95.7%	98.7%	106.7%	23979	18	10	28
Nov-17	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	285	315	225	210	555	527	0	27	110.5%	93.3%	95.0%	#DIV/0!	142	5.9	1.7	7.6
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
	RXK02	CITY HOSPITAL	29837	29413	14421	13001	27261	26670	9670	9875	98.6%	90.2%	97.8%	102.1%	9713	5.8	2.4	8.1
	RXK10	ROWLEY REGIS HOSPITAL	3951	3772	5319	5175	2698	2686	3687	3675	95.5%	97.3%	99.6%	99.7%	2495	2.6	3.5	6.1
	RXK01	SANDWELL GENERAL HOSPITAL	26841	25880	16620	16475	21943	21656	15566	16284	96.4%	99.1%	98.7%	104.6%	11132	4.3	2.9	7.2
			60914	59380	36585	34861	52457	51539	28923	29861	97.5%	95.3%	98.2%	103.2%	23482	19	11	29
3-month Avges	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	292	321	227	212	561	539	0	30	109.8%	93.4%	96.1%	#DIV/0!	179	4.8	1.4	6.2
	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!
	RXK02	CITY HOSPITAL	30226	29510	14368	13102	27670	26548	9666	9941	97.6%	91.2%	95.9%	102.8%	9785	5.7	2.4	8.1
	RXK10	ROWLEY REGIS HOSPITAL	4081	3917	5511	5174	2790	2790	3821	3787	96.0%	93.9%	100.0%	99.1%	2529	2.7	3.5	6.2
	RXK01	SANDWELL GENERAL HOSPITAL	25702	25315	15863	15920	21998	21148	14605	15701	98.5%	100.4%	96.1%	107.5%	10721	4.3	2.9	7.3
	Total	*Latest 3 month average====>*	60302	59063	35970	34408	53019	51025	28092	29459	97.9%	95.7%	96.2%	104.9%	23213	4.7	2.8	7.5

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

Org: RXK Sandwell And West Birmingham Hospitals NHS Trust

Period: November_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)	Only complete sites your organisation is accountable for	Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day	
							Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
		Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours		
		RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Critical Care - Sandwell	300 - GENERAL MEDICINE	301 - GASTROENTEROLOGY	2880	2928	348	468	2640	2739	0	66	101.7%	134.5%
		RXK01	SANDWELL GENERAL HOSPITAL - RXK01	AMU A - Sandwell	300 - GENERAL MEDICINE	320 - CARDIOLOGY	3450	3317	1380	1679	3450	3404	1380	1621	96.1%	121.7%
		RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Older Persons Assessment U	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1380	1391	1035	1081	1035	1035	1035	1368	100.8%	104.4%
		RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 1 - Paediatrics	420 - PAEDIATRICS	110 - TRAUMA & ORTHOPAEDICS	744	612	360	354	1364	979	330	341	82.3%	98.3%
		RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 2 - Surgery	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS	1725	1679	1380	1293	1035	1035	1035	1023	97.3%	93.7%
		RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 3 - T&O/Stepdown	110 - TRAUMA & ORTHOPAEDICS	160 - PLASTIC SURGERY	1725	1615	1725	1610	1035	1035	1725	1702	93.6%	93.3%
		RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 4	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1725	1598	1725	1604	1322	1345	1725	1633	92.6%	93.0%
		RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 5	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1437	1431	1437	1184	1150	1437	1437	1127	99.6%	82.4%
		RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon Ground - PAU/Adoles	420 - PAEDIATRICS	110 - TRAUMA & ORTHOPAEDICS	1080	990	330	126	0	0	1034	781	91.7%	38.2%
		RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Newton 3 - T&O	110 - TRAUMA & ORTHOPAEDICS	430 - GERIATRIC MEDICINE	1725	1725	1725	1696	1035	1035	1725	1690	100.0%	98.3%
		RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Newton 4 - Stepdown/Stroke/N	314 - REHABILITATION	300 - GENERAL MEDICINE	1380	1339	1035	1035	1380	1368	1035	1035	97.0%	100.0%
		RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Newton 5 - Haematology	304 - CLINICAL PHYSIOLOGY	300 - GENERAL MEDICINE	690	690	345	356	690	690	345	345	100.0%	103.2%
		RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Priory 2 - Colorectal/General S	100 - GENERAL SURGERY	100 - GENERAL SURGERY	1725	1690	1035	1023	1035	1035	690	851	98.0%	98.8%
		RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Priory 4 - Stroke/Neurology	300 - GENERAL MEDICINE	400 - NEUROLOGY	2070	1811	1035	1259	2070	1736	1035	1322	87.5%	121.6%
		RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Priory 5 - Gastro/Resp	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1380	1380	1035	1023	1322	1380	690	1023	100.0%	98.8%
		RXK01	SANDWELL GENERAL HOSPITAL - RXK01	SAU - Sandwell	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS	1725	1684	690	684	1380	1403	345	356	97.6%	99.1%
		RXK02	CITY HOSPITAL - RXK02	CCS - Critical Care Services -	300 - GENERAL MEDICINE	301 - GASTROENTEROLOGY	2880	3066	360	336	2640	2706	0	0	106.5%	93.3%
		RXK02	CITY HOSPITAL - RXK02	D5/D7 - Cardiology (Female/M	320 - CARDIOLOGY	300 - GENERAL MEDICINE	3450	3404	690	632	2760	3082	0	0	98.7%	91.6%
		RXK02	CITY HOSPITAL - RXK02	D11 - Male Older Adult	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1035	1035	1092	1012	1035	1035	690	678	100.0%	92.7%
		RXK02	CITY HOSPITAL - RXK02	D15 - Gastro/Resp/Haem (Ma	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1035	1052	977	701	1035	1035	632	690	101.6%	71.8%
		RXK02	CITY HOSPITAL - RXK02	D16 - (Female)	301 - GASTROENTEROLOGY	340 - RESPIRATORY MEDICINE	1035	1069	977	701	1035	1035	632	690	103.3%	71.8%
		RXK02	CITY HOSPITAL - RXK02	D19 - Paediatric Medicine	420 - PAEDIATRICS	120 - ENT	810	777	97	65	660	462	330	88	95.9%	67.0%
		RXK02	CITY HOSPITAL - RXK02	D21 - Male Urology / ENT	101 - UROLOGY	120 - ENT	1081	1086	690	644	736	759	690	713	100.5%	93.3%
		RXK02	CITY HOSPITAL - RXK02	D26 - Female Older Adult	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1035	1017	1092	1017	1035	1035	690	678	98.3%	93.1%
		RXK02	CITY HOSPITAL - RXK02	D27 - Oncology	502 - GYNAECOLOGY		571	481	402	294	720	528	360	324	84.2%	73.1%
		RXK02	CITY HOSPITAL - RXK02	AMU 2 & West Midlands Pois	300 - GENERAL MEDICINE	305 - CLINICAL PHARMACOLOGY	1725	1736	345	350	1725	1403	345	368	100.6%	101.4%
		RXK02	CITY HOSPITAL - RXK02	D43 - Community RTG	318- INTERMEDIATE CARE	430 - GERIATRIC MEDICINE	1380	1230	1380	1357	1035	1035	1035	1035	89.1%	98.3%
		RXK02	CITY HOSPITAL - RXK02	D47 - Geriatric MEDICAL	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1035	943	1219	1213	690	690	690	690	91.1%	99.5%
		RXK02	CITY HOSPITAL - RXK02	Female Surgical Ward	101 - UROLOGY	120 - ENT	1035	1086	655	684	471	908	126	391	104.9%	104.4%
		RXK02	CITY HOSPITAL - RXK02	Labour Ward - City	501 - OBSTETRICS	501 - OBSTETRICS	3795	3153	690	655	3749	3277	690	667	83.1%	94.9%
		RXK02	CITY HOSPITAL - RXK02	City Maternity - 1	501 - OBSTETRICS	424- WELL BABIES	1035	1190	690	713	1035	1000	345	345	115.0%	103.3%
		RXK02	CITY HOSPITAL - RXK02	City Maternity - 2	501 - OBSTETRICS	424- WELL BABIES	1035	1035	650	678	1035	1000	345	333	100.0%	104.3%
		RXK02	CITY HOSPITAL - RXK02	AMU 1 - City	300 - GENERAL MEDICINE	320 - CARDIOLOGY	2415	2386	1035	966	2415	2426	1035	1058	98.8%	93.3%
		RXK02	CITY HOSPITAL - RXK02	Neonatal	422- NEONATOLOGY		2415	2535	690	569	2415	2311	690	644	105.0%	82.5%
		RXK02	CITY HOSPITAL - RXK02	Serenity Birth Centre - City	501 - OBSTETRICS	501 - OBSTETRICS	1035	1132	690	414	1035	943	345	483	109.4%	60.0%
		RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BM	Ophthalmology Main Ward - C	130 - OPHTHALMOLOGY	180 - ACCIDENT & EMERGENCY	285	315	225	210	555	527	0	27	110.5%	93.3%
		RXK10	ROWLEY REGIS HOSPITAL - RXK10	Eliza Tinsley Ward - Commun	318- INTERMEDIATE CARE	300 - GENERAL MEDICINE	1035	983	1380	1293	690	690	1035	1012	95.0%	93.7%
		RXK10	ROWLEY REGIS HOSPITAL - RXK10	Henderson	318- INTERMEDIATE		897	822	1299	1288	598	586	897	908	91.6%	99.2%
		RXK10	ROWLEY REGIS HOSPITAL - RXK10	Leasowes	318- INTERMEDIATE CARE		984	978	1260	1260	720	720	720	720	99.4%	100.0%
		RXK10	ROWLEY REGIS HOSPITAL - RXK10	McCarthy	318- INTERMEDIATE		1035	989	1380	1334	690	690	1035	1035	95.6%	96.7%

Fill rate indicator return
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Org: RXK Sandwell And West Birmingham Hospitals NHS Trust

Period: November_2017-18

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

Comments

Only complete sites your organisation is accountable for

Validation alerts (see control panel)	Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day	
						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		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 (%)
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Critical Care - Sandwell	300 - GENERAL MEDICINE	301 - GASTROENTEROLOGY	2880	2928	348	468	2640	2739	0	66	101.7%	134.5%
			Total			60914	59380	36585	34861	52457	51539	28923	29861		

RXK01	SANDW	0	0	0	0	0	0	0	0	0	0	0			1	1
RXK01	SANDW	0	0	0	0	0	0	0	0	0	0	0			0	1
RXK01	SANDW	0	0	0	0	0	0	0	0	0	0	0			1	1
RXK01	SANDW	0	0	0	0	0	0	0	0	0	0	0			0	0

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

Ward name	Main 2 Specialties on each ward	Main 2 Specialties on each ward	Day Registered midwives/nurses	Day Care Staff	Day Registered midwives/nurses	Day Care Staff	Night Registered midwives/nurses	Night Care Staff	Night Registered midwives/nurses	Night Care Staff	Day	Day	Night	Night	Care Hours Per Patient Day (CHPPD)				Note
	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall	
Critical Care - Sandwell	300 - GENERAL MEDICINE	100 - GENERAL SURGERY	2880	2928	348	468	2640	2739	0	66	101.7%	134.5%	103.8%	#DIV/0!	219	25.9	2.4	28.3	
AMU A - Sandwell	300 - GENERAL MEDICINE	320 - CARDIOLOGY	3450	3317	1380	1679	3450	3404	1380	1621	96.1%	121.7%	98.7%	117.5%	1144	5.9	2.9	8.8	
Older Persons Assessment Unit (OPAU) -	430 - GERIATRIC MEDICINE	430 - GERIATRIC MEDICINE	1380	1391	1035	1081	1035	1035	1035	1368	100.8%	104.4%	100.0%	132.2%	588	4.1	4.2	8.3	New Oct 16
Lyndon 1 - Paediatrics	420 - PAEDIATRICS	110 - TRAUMA & ORTHOPAEDICS	744	612	360	354	1364	979	330	341	82.3%	98.3%	71.8%	103.3%	446	3.6	1.6	5.1	
Lyndon 2 - Surgery	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS	1725	1679	1380	1293	1035	1035	1035	1023	97.3%	93.7%	100.0%	98.8%	785	3.5	3.0	6.4	
Lyndon 3 - T&O/Stepdown	110 - TRAUMA & ORTHOPAEDICS	160 - PLASTIC SURGERY	1725	1615	1725	1610	1035	1035	1725	1702	93.6%	93.3%	100.0%	98.7%	815	3.3	4.1	7.3	
Lyndon 4	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1725	1598	1725	1604	1322	1345	1725	1633	92.6%	93.0%	101.7%	94.7%	968	3.0	3.3	6.4	
Lyndon 5 - Acute Medicine	100 - GENERAL SURGERY	300 - GENERAL MEDICINE	1437	1431	1437	1184	1150	1437	1437	1127	99.6%	82.4%	125.0%	78.4%	956	3.0	2.4	5.4	Data from 25/9/2017
Lyndon Ground - PAU/Adolescents	420 - PAEDIATRICS	110 - TRAUMA & ORTHOPAEDICS	1080	990	330	126	0	0	1034	781	91.7%	38.2%	#DIV/0!	75.5%	377	2.6	2.4	5.0	
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	1725	1725	1696	1035	1035	1725	1690	100.0%	98.3%	100.0%	98.0%	869	3.2	3.9	7.1	
Newton 4 - Stepdown/Stroke/Neurology	314 - REHABILITATION	300 - GENERAL MEDICINE	1380	1339	1035	1035	1380	1368	1035	1035	97.0%	100.0%	99.1%	100.0%	838	3.2	2.5	5.7	
Newton 5 - Haematology	304 - CLINICAL PHYSIOLOGY	300 - GENERAL MEDICINE	690	690	345	356	690	690	345	345	100.0%	103.2%	100.0%	100.0%	394	3.5	1.8	5.3	
Priory 2 - Colorectal/General Surgery	100 - GENERAL SURGERY	100 - GENERAL SURGERY	1725	1690	1035	1023	1035	1035	690	851	98.0%	98.8%	100.0%	123.3%	682	4.0	2.7	6.7	
Priory 4 - Stroke/Neurology	300 - GENERAL MEDICINE	400 - NEUROLOGY	2070	1811	1035	1259	2070	1736	1035	1322	87.5%	121.6%	83.9%	127.7%	696	5.1	3.7	8.8	
Priory 5 - Gastro/Resp	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1380	1380	1035	1023	1322	1380	690	1023	100.0%	98.8%	104.4%	148.3%	887	3.1	2.3	5.4	
SAU - Sandwell	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS	1725	1684	690	684	1380	1403	345	356	97.6%	99.1%	101.7%	103.2%	468	6.6	2.2	8.8	See N2
CCS - Critical Care Services - City	300 - GENERAL MEDICINE	301 - GASTROENTEROLOGY	2880	3066	360	336	2640	2706	0	0	106.5%	93.3%	102.5%	#DIV/0!	230	25.1	1.5	26.6	
D5/D7 - Cardiology (Female)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	3450	3404	690	632	2760	3082	0	0	98.7%	91.6%	111.7%	#DIV/0!	866	7.5	0.7	8.2	Merged with D5/D7
D11 - Male Older Adult	430 - GERIATRIC MEDICINE	430 - GERIATRIC MEDICINE	1035	1035	1092	1012	1035	1035	690	678	100.0%	92.7%	100.0%	98.3%	597	3.5	2.8	6.3	
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	1052	977	701	1035	1035	632	690	101.6%	71.8%	100.0%	109.2%	608	3.4	2.3	5.7	
D16 - (Female)	301 - GASTROENTEROLOGY	340 - RESPIRATORY MEDICINE	1035	1069	977	701	1035	1035	632	690	103.3%	71.8%	100.0%	109.2%	603	3.5	2.3	5.8	
D19 - Paediatric Medicine	420 - PAEDIATRICS	120 - ENT	810	777	97	65	660	462	330	88	95.9%	67.0%	70.0%	26.7%	303	4.1	0.5	4.6	
D21 - Male Urology / ENT	101 - UROLOGY	120 - ENT	1081	1086	690	644	736	759	690	713	100.5%	93.3%	103.1%	103.3%	435	4.2	3.1	7.4	
D26 - Female Older Adult	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1035	1017	1092	1017	1035	1035	690	678	98.3%	93.1%	100.0%	98.3%	601	3.4	2.8	6.2	
D27 - Oncology	502 - GYNAECOLOGY		571	481	402	294	720	528	360	324	84.2%	73.1%	73.3%	90.0%	402	2.5	1.5	4.0	
AMU 2 & West Midlands Poisons Unit - C	300 - GENERAL MEDICINE	305 - CLINICAL PHARMACOLOGY	1725	1736	345	350	1725	1403	345	368	100.6%	101.4%	81.3%	106.7%	493	6.4	1.5	7.8	
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	1230	1380	1357	1035	1035	1035	1035	89.1%	98.3%	100.0%	100.0%	712	3.2	3.4	6.5	
D47 - Geriatric MEDICAL			1035	943	1219	1213	690	690	690	690	91.1%	99.5%	100.0%	100.0%	523	3.1	3.6	6.8	
D7 - Cardiology (Male)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	0	0	0	0	0	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	Merged with D5
Female Surgical (D17)	101 - UROLOGY	120 - ENT	1035	1086	655	684	471	908	126	391	104.9%	104.4%	192.8%	310.3%	382	5.2	2.8	8.0	
Labour Ward - City	501 - OBSTETRICS	501 - OBSTETRICS	3795	3153	690	655	3749	3277	690	667	83.1%	94.9%	87.4%	96.7%	334	19.3	4.0	23.2	
City Maternity - M1	501 - OBSTETRICS	424- WELL BABIES	1035	1190	690	713	1035	1000	345	345	115.0%	103.3%	96.6%	100.0%	540	4.1	2.0	6.0	
City Maternity - M2	501 - OBSTETRICS	424- WELL BABIES	1035	1035	650	678	1035	1000	345	333	100.0%	104.3%	96.6%	96.5%	524	3.9	1.9	5.8	
AMU 1 - City	300 - GENERAL MEDICINE	320 - CARDIOLOGY	2415	2386	1035	966	2415	2426	1035	1058	98.8%	93.3%	100.5%	102.2%	734	6.6	2.8	9.3	
Neonatal			2415	2535	690	569	2415	2311	690	644	105.0%	82.5%	95.7%	93.3%	764	6.3	1.6	7.9	
Serenity Birth Centre - City	501 - OBSTETRICS	501 - OBSTETRICS	1035	1132	690	414	1035	943	345	483	109.4%	60.0%	91.1%	140.0%	62	33.5	14.5	47.9	
Ophthalmology Main Ward - City	130 - OPHTHALMOLOGY	180 - ACCIDENT & EMERGENCY	285	315	225	210	555	527	0	27	110.5%	93.3%	95.0%	#DIV/0!	142	5.9	1.7	7.6	
Eliza Tinsley Ward - Community RTG	318- INTERMEDIATE CARE	300 - GENERAL MEDICINE	1035	983	1380	1293	690	690	1035	1012	95.0%	93.7%	100.0%	97.8%	632	2.6	3.6	6.3	
Henderson	318- INTERMEDIATE CARE		897	822	1299	1288	598	586	897	908	91.6%	99.2%	98.0%	101.2%	671	2.1	3.3	5.4	
Leasowes	318- INTERMEDIATE CARE		984	978	1260	1260	720	720	720	720	99.4%	100.0%	100.0%	100.0%	548	3.1	3.6	6.7	
MCCarthy	318- INTERMEDIATE CARE		1035	989	1380	1334	690	690	1035	1035	1	96.7%	100.0%	100.0%	644	2.6	3.7	6.3	
	Trust Totals		**60914**	**59380**	**36585**	**34861**	**52457**	**51539**	**28923**	**29861**	**1**	**95.3%**	**98.2%**	**103.2%**	**23482**	**4.7**	**2.8**	**7.5**	

Recruitment Activity Report

Report Date: 20/12/2017

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	Board plan
Band 5 Nurses	SIP	FTE	Establishment		983.64	992.21	981.67	981.95	981.97	817.62	817.62	828.09	828.09	828.09	828.09	828.09	812.17
		FTE	FTE In Post		839.93	819.86	815.91	807.19	801.52	692.36	689.60	697.08	703.92	704.32	720.30	717.57	723.84
		FTE	New Starters		5.83	7.77	7.65	6.92	5.23	43.67	15.33	13.05	5.53	26.33	7.62	7.62	
		FTE	Leavers		14.21	7.29	14.05	11.88	7.07	15.80	12.55	6.21	5.13	10.35	10.35	10.35	
			Vacancies in month		143.71	172.35	165.76	174.76	180.45	125.26	128.02	131.01	124.17	123.77	107.79	110.52	**88.33**
	Offers External Applicants	FTE	Conditional offers (in month)		5.60	9.44	25.80	40.92	10.27	15.92	13.80	6.00	5.53				
		FTE	Offers Confirmed (in month)		3.00	11.54	5.33	15.55	16.74	16.74	8.00	8.41	18.61				
Band 6 Nurses	SIP	FTE	Establishment		582.16	585.28	585.28	585.48	587.18	437.83	438.83	445.21	445.21	445.21	445.21	445.21	438.83
		FTE	FTE In Post		531.19	538.07	536.75	539.65	546.48	400.83	399.81	403.91	408.78	411.66	409.41	409.88	404.78
		FTE	New Starters		2.40	2.45	5.50	1.80	3.56	7.00	7.33	8.80	5.00	1.00	3.73	3.73	
		FTE	Leavers		2.80	1.92	2.68	4.43	4.20	5.61	4.57	3.93	2.12	3.25	3.25	3.25	
		FTE	Vacancies in month		50.97	47.21	48.53	45.83	40.70	37.00	39.02	41.30	36.43	33.55	35.80	35.33	34.05
	Offers External/Internal Applicants	FTE	Conditional offers (in month)		9.80	3.52	9.51	2.00	3.00	15.73	9.60	3.61	2.93				
		FTE	Offers Confirmed (in month)		2.00	2.72	6.16	1.00	0.00	2.73	5.95	5.00	3.00				
Band 5 Community Nurses	SIP	FTE	Establishment							164.35	164.35	165.47					
		FTE	FTE In Post							131.27	132.62	139.82	139.82	139.82	139.82	139.82	132.62
		FTE	New Starters							2.00	2.20	2.46	2.00	1.00	1.00	1.00	
		FTE	Leavers							4.48	0.40	0.00	1.00	0.40	0.40	0.40	
		FTE	Vacancies in month							33.08	33.08	25.65	25.65	25.65	25.65	25.65	31.73
	Offers External Applicants	FTE	Conditional offers (in month)							1.46	1.00	0.00	0.00				
		FTE	Offers Confirmed (in month)							1.46	1.00	2.00	2.00				
Band 6 Community Nurses	SIP	FTE	Establishment							143.55	143.55	150.15	150.15	150.15	150.15	150.15	143.55
		FTE	FTE In Post							133.94	136.02	140.32	140.32	140.32	140.32	140.32	136.02
		FTE	New Starters							0.00	1.36	2.60	0.00	1.60	1.60	1.60	
		FTE	Leavers							1.00	1.00	1.00	0.00	1.00	1.00	1.00	
		FTE	Vacancies in month							9.61	9.61	9.61	9.61	9.61	9.61	9.61	9.61
	Offers External Applicants	FTE	Conditional offers (in month)							2.00	2.36	0.00	1.00				
		FTE	Offers Confirmed (in month)							0.60	1.96	1.00	1.60				
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	24.16	23.16	31.16	39.16	41.24	44.24	44.24	42.56	42.97	
		FTE	New Starters		0.00	0.80	0.60	2.00	0.00	13.76	5.00	3.00	0.00	0.00	2.10	2.10	
		FTE	Leavers		0.00	0.00	0.00	0.00	0.00	1.00	2.00	0.00	0.00	1.68	1.69	1.69	
		FTE	Vacancies in month		-20.03	-18.91	-15.71	-15.91	-14.91	-22.91	-30.91	-32.99	-35.99	-35.99	-34.31	-34.72	-34.72
	Offers External Applicants	FTE	Conditional offers (in month)		0.00	0.00	0.80	4.92	9.00	3.00	0.00	0.00	0.00				
		FTE	Offers Confirmed (in month)		0.00	1.80	0.00	0.00	4.00	4.00	3.00	2.00	0.00				
Band 6 Midwives	SIP	FTE	Establishment		208.10	208.10	184.30	184.30	184.30	184.30	184.30	184.14	183.80	183.80	183.80	183.80	183.80
		FTE	FTE In Post		129.87	127.67	124.49	126.89	127.09	129.53	125.43	125.85	124.59	122.35	122.68	122.48	122.48
		FTE	New Starters		0.00	0.00	1.00	0.60	0.00	2.84	2.00	0.00	0.60	1.60	1.05	1.05	
		FTE	Leavers		0.81	0.00	2.72	2.93	1.00	1.00	2.32	1.26	2.84	1.26	1.26	1.26	
		FTE	Vacancies in month		78.23	80.43	59.81	57.41	57.21	54.77	58.87	58.29	59.21	61.45	61.12	61.32	61.36
	Offers External/Internal Applicants	FTE	Conditional offers (in month)		1.00	1.00	0.60	4.00	0.00	0.00	0.60	0.00	0.00				
		FTE	Offers Confirmed (in month)		0.00	0.80	0.00	0.00	0.00	0.00	1.00	0.60	0.00				
Consultants	SIP	FTE	Establishment		313.96	315.53	313.73	313.73	321.10	320.10	320.10	320.10	320.10	320.10	320.10	320.10	320.10
		FTE	FTE In Post		284.47	285.17	281.97	280.57	283.37	284.82	291.12	292.25	292.70	289.70	289.16	289.01	286.74
		FTE	New Starters		2.00	6.00	1.40	2.00	5.00	6.00	3.00	1.00	1.00	2.00	2.39	2.39	
		FTE	Leavers		3.30	3.00	5.85	3.00	3.00	1.00	2.05	0.55	4.00	2.54	2.54	2.54	
		FTE	Vacancies in month		29.49	30.36	31.76	33.16	37.73	35.28	28.98	27.85	27.40	30.40	30.94	31.09	33.36
	Offers External Applicants	FTE	Conditional offers (in month)		3.00	0.00	3.00	3.00	0.00	2.00	3.00	1.00	1.00				
		FTE	Offers Confirmed (in month)		0.00	0.00	1.00	0.00	5.00	5.00	0.00	1.00					
Band 2 HCAs	SIP	FTE	Establishment		499.95	504.70	500.70	513.20	511.56	511.56	511.56	517.50	517.50	517.50	517.50	517.50	507.48
		FTE	FTE In Post		437.09	442.07	454.05	445.58	445.64	463.12	478.00	484.14	495.34	496.56	497.38	497.81	487.90
		FTE	New Starters		2.53	10.41	2.00	10.00	13.61	31.80	15.00	15.80	5.40	5.00	4.61	4.61	
		FTE	Leavers		3.92	1.40	3.00	5.25	8.51	9.13	4.51	4.60	4.18	4.18	4.18	4.18	
		FTE	Vacancies in month		62.86	62.63	46.65	67.62	65.92	48.44	33.56	33.36	22.16	20.94	20.12	19.69	19.58
	Offers External Applicants	FTE	Conditional offers (in month)		11.61	10.16	28.41	58.00	19.00	14.41	4.60	1.60	2.53				
		FTE	Offers Confirmed (in month)		7.25	2.61	3.00	1.00	16.50	22.00	5.00	13.40	4.80				
Band 3 HCAs	SIP	FTE	Establishment		93.14	93.38	93.38	93.54	92.48	92.48	92.48	93.97	91.73	91.73	91.73	91.73	90.24
		FTE	FTE In Post		92.71	92.63	88.57	88.57	88.37	84.16	87.71	90.71	92.71	93.11	92.51	92.10	87.68
		FTE	New Starters		0.00	0.00	0.00	0.00	0.46	0.00	0.96	2.00	1.00	0.00	0.18	0.18	
		FTE	Leavers		1.00	1.80	1.92	0.00	0.00	2.00	0.00	0.00	0.60	0.60	0.60	0.60	
		FTE	Vacancies in month		0.43	0.75	4.81	4.97	4.11	8.32	4.77	3.26	-0.98		-0.78	-0.37	2.56
	Offers External/Internal Applicants	FTE	Conditional offers (in month)		0.00	2.26	0.00	1.00	0.00	5.24	1.00	2.00	2.00				
		FTE	Offers Confirmed (in month)		0.00	5.21	1.80	0.00	0.00	0.00	0.00	1.00	0.00				
		FTE															

Notes:

Establishment: Establishment from Jan 18 has been adjusted to take account of reduction in consultants by 4.00, B5 staff nurses by 5.45 and B2 HCAs by 4.08 as a result of cessation of gynaecology oncology. Establishment from Dec 17 has been adjusted to take account ofof a reduction of 2.24 B3 HCAa as a result of Community Out of Hours restruture

New starters - : 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 -: Figures based on terminations received into ESR and assuming that managers are submitting termination data in a timely fashion.

Leavers: With the exception of band 5 staff nurses and midwives, the leaver figure is based on the WTE leaving the organisation. For band 5 staff nurses/midwives, this also includes the WTE moving internally to take into account the impact of internal promotion.

Turnover forecast: Based on average for the staff group/band over the previous year.

Band 5 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

Recruitment of HCAs: Delays have been identified with appointment of band 2 HCAs to vacancies which has been escalated to Groups

Data source:

Patient Reported Outcomes Measures (PROMs) - Update

Background

- Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. Currently these include total knee and hip replacements. The health gains following surgical treatment are measured using pre- and post-operative patient completed surveys.
- In October 2017, following consultation NHS England took the decision to discontinue mandatory collection of varicose vein and groin-hernia surgery PROMs data, as data was perceived to be of limited value. Following discussion with internal stakeholders, the collection of PROMs for varicose vein surgery and groin hernia was also discontinued.
- Information is collected through surveys which incorporate a general Health Status Questionnaire (EQ-5D index), a Visual Analogue Scale (VAS) and a procedure specific instrument. For knee replacement the procedure specific Instrument is the Oxford Knee Score and for hip replacement it is the Oxford Hip Score.
- Surveys are conducted pre-operatively and then 6 months post operatively.
- NHS Digital publishes national-level and organisation-level PROMs data each quarter. Data is provisional until a final annual publication is released each year. From this data it is possible to compare the average adjusted health gain against the national benchmark and identify whether the Trust is an outlier using statistical control charts.
- Data on the 'Average patient reported health gain' is also published on the NHS Choices website.

Performance

NHS Digital published finalised data for the 2015/16 financial year in August 2017. The latest provisional data for 2016/17 was published in November 2017. Data was reported for all four procedures as the mandatory collection of PROMs data was only discontinued for varicose vein and groin surgery in October 2017.

Table 1 below compares the average adjusted health gain for patients treated in the Trust and compares this with the national value. Data is show for the finalised data for 2015/16 and the latest provisional data for 2016/17 which was published in November 2017

	Health Status Questionnaire **Average adjusted health gain**			
	Finalised data for April 15– March 16 (Published August 2017)		Provisional data for April 16– March 17) (Published November 2017)	
	National	**SWBH**	**National**	**SWBH**
Hernia repairs	**0.088**	**0.074**	**0.087**	**0.069**
Hip replacement	**0.438**	**0.435**	**0.444**	**0.459**
Knee replacement	**0.320**	**0.253**	**0.323**	**0.308**
Varicose vein surgery	**0.096**	**0.082**	**0.092**	**0.112**

	SWBH below England average		SWBH above England average

Conclusion

Action has been taken over the last two years to improve PROMs outcomes. This has included the distribution of pre-operative PROMs Booklets by post and encouraging patients to attend a 'joint club' to gain advice and information pre-operatively. In addition, Information on expected outcomes from surgery is communicated in a variety of formats. Patients are also supplied with a point of contact following discharge to access appropriate advice and direct access to clinic if required. Focussed data gathering has also improved the return of completed questionnaires from patients.

The provisional data for 2016/17 for the average adjusted health gain for the general health status questionnaire highlights that the reported gain following varicose vein surgery or primary hip replacement is currently above the national rate. In addition, although the gain reported for the knee replacement is below the national rate in this period, the average adjusted health gain reported for the procedure specific measure (Oxford Knee Score) in the same period is above the national rate (National16.523, SWBH 16.653).

Previously, in 2014/15, the Trust had been identified as a statistical outlier for the average adjusted health gain for the general health questionnaire for knee replacement. The Trust has not been identified as a statistical outlier for any of the measures for any procedure in either the finalised data for 2015/16 or the provisional data for 2016/17.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	CQC Improvement Plan
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Allison Binns, Deputy Director of Governance
DATE OF MEETING:	4 January 2018

EXECUTIVE SUMMARY:

Of the 101 actions identified within the CQC's inspection report published in October 2017, 57 were time-lined by the Trust as requiring completed actions by December 2017.

Two thirds of the actions (36) have been delivered and plans are being made to evidence successful achievement over the next 3 months. Of those actions that are off plan and not yet complete, half (10) have a revised date for the proposed action to be achieved whilst the other half (11) require implementation at pace. Weekly monitoring will be instituted to prevent further slippage.

On-going progress in delivering the Improvement Plan will be monitored by the Board Quality and Safety Committee and the Executive Quality Committee.

REPORT RECOMMENDATION:

The Board is recommended to receive and **NOTE** the progress made in delivering the CQC Improvement Plan actions due for completion by December 2017, and seek **ASSSURANCE** from the Executive that where there has been slippage the revised timeline will be met.

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

Accept	Approve the recommendation	Discuss
✓		✓

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

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

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

Safe, high quality care

PREVIOUS CONSIDERATION:

Quality and Safety Committee, Clinical Leadership Executive and the Executive Quality Committee

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Trust Board: 4 January 2018

CQC Improvement Plan

1. Introduction

1.1 Following the CQC Inspection in March 2017 and publication of their report in October 2017, an improvement plan was developed to address the 101 areas identified where the Trust 'must' and 'should' take action.

1.2 The Trust took the decision to timeline improvement as requiring action within 3 months (by December 2017) or 6 months (by March 2018) depending on the nature of the concern and the work required to achieve successful delivery.

1.3 This report provides detail on those actions which were targeted for completion by December 2017. Work is continuing on the other areas to ensure the March target is met, with progress being monitored by the Executive Quality Committee.

2. Progress

2.1 57 actions have a target date for completion of December 2017. Group Directors of Operations were given responsibility for overseeing delivery of the actions relating to their area; progress reports have been provided by them (see Appendix 1).

2.2 The actions were categorised as those that were completed, those that were not complete and those which were not complete but had a revised date. Leads are progressing those actions not already implemented as planned, ensuring practices are embedded.

Actions completed	Actions off track but with a revised date	Actions off track with no confirmed date
36	10	11

2.3 Highlighted below are some examples of the changes made to improve services or experiences for patients and visitors in response to the CQC inspection findings. Monitoring will continue to ensure that these are sustained and those not yet achieved but in progress are in place within the revised timeframe.

2.3.1 Some concerns were raised about the **safety of equipment on the trolleys used during resuscitation** and whether we were following national guidance. It has been confirmed that the trollies follow the guidance set out by the Resuscitation Council (UK).

2.3.2 Both of our main Emergency Departments are achieving or close to achieving **patients being treated within an hour** (City Hospital, 59 minutes, and Sandwell Hospital, 64 minutes), which the introduction of a Rapid Assessment and Treatment model has helped to achieve. Our new Electronic Patient Record (EPR), Unity, will help ensure that patients are cared for on the most effective pathway, but in the meantime all junior doctors within the Emergency Departments have confirmed their knowledge of and agreement to use the standardised proformas to ensure pathways are correctly followed.

2.3.3 In Medicine, the Consistency of Care programme has promoted the completion of our **admission and ongoing care documentation**. Standards for completion, by all disciplines, have been shared and this has shown a vast improvement and sustained practice across the majority of areas.

At the time of the CQC visit in March 2017, the Endoscopy service was in the process of **re-securing Joint Advisory Group Accreditation**. This was successfully awarded to the service in July 2017.

2.3.4 Consultants are integral to ensuring that the patients assigned to **pooled surgical lists** are appropriate. We have confirmed that practices meet national guidance for booking of patients onto operating lists.

2.3.5 The **turnaround for imaging such as x-rays and CT scans has improved** (mostly > 90%) such that this should not prevent a patient being discharged in a timely manner. At daily capacity meetings, wards are able to identify where there may be delays in a patient pathway through imaging to escalate issues. Additionally the **appointment booking system used in imaging is available for ward staff to view** so that they can escalate any delays or request appointments be brought forward. All junior doctors are aware now of these escalation opportunities.

2.3.6 Potential issues of **patient and visitor accidents occurring on the escalators** in the Birmingham Treatment Centre (BTC) were highlighted necessitating better signage, providing a warning to users and a reminder to all staff working in the BTC to report all accidents using the corporate incident reporting system.

2.3.7 The daily Staff Communication bulletin has been used to **re-introduce the Safeguarding team to staff**, including their pictures and contact details.

2.3.8 The Community wards have introduced **a red box on each ward for blood and other specimens to be kept in whilst waiting for collection**. This ensures that the patient details on the sample request form are not visible and prevents breaching Information Governance.

3. Monitoring

3.1 Over the next quarter (January -March 2018) monitoring of the actions and assessment of improvement will be undertaken. There are a number of ways assurance will be gained. An inspection template will be developed based on the CQC's recommended actions. As well as checking that the actions have been completed the in-house inspectors will talk to staff and patients to see that the changes have made a difference and that all are aware.

3.2 The in-house inspections will consist of observational checks as well as conversations with staff and patients. The Trust already has processes for producing data in performance reports, scorecards, dashboards and the Safety Plan. Where available, data will be tracked through existing processes and monitored to gain assurance that the improvement has been sustained.

3.3 Where clear standards are available, audit will be used to assess the impact of the changes and monitor any trajectories. This will be done through peers and where appropriate, the use of internal audit.

3.4 **Appendix 2** identifies the methods for monitoring and gaining assurance for each of the actions identified as for completion by December 2017.

4. Conclusion

4.1 There have been many improvements made over the last few months to address the recommendations made by the CQC inspectors, some of which are already showing s quantifiable benefits. Monitoring these changes will now focus on ensuring the practice changes are embedded providing assurance of sustainability and that the right change was implemented.

4.2 Those actions not yet implemented will be monitored closely on a weekly basis preventing further delays in actions being implemented. The delayed actions largely relate to recommendations within the Surgical Services, specifically BMEC, and Emergency Care.

5. RECOMMENDATIONS

5.1 The Board is recommended to receive and NOTE the progress made in delivering the CQC Improvement Plan actions due for completion by December 2017; and

5.2 Seek ASSURANCE from the Executive that where there has been slippage the revised timeline will be met.

Allison Binns
Deputy Director of Governance
27 December 2017

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Our Improvement Plan:

responding to the Care Quality Commission inspection findings in March 2017

Extract of actions to be completed by December 2017

Services inspected:

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

December 2017

[NB: CQC reports published on 31 October 2017]

Where EVERYONE Matters

Going for Good:
Our approach in the next 12 months

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

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

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

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

Status	G	Action completed and CQC concern addressed	A	Action on track to be delivered by the agreed date	R	Action off track and revised date set and stated

EMERGENCY AND URGENT CARE

Ref: MD= must do SD= should do	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer	By when?	How will successful completion be evidenced?	Summary note of improvement made and confirmation that the concern raised has been addressed	STATUS
URGENT AND EMERGENCY SERVICES (A&E): SANDWELL GENERAL HOSPITAL							
MD1 (S)	The trust must take action to ensure storage and availability arrangements of emergency medicines required for resuscitation follow Resus Council Guidance and robust arrangements are put in place to manage the risk and ensure that medicines for resuscitation were protected from tampering.	• All our trolleys must meet RC (UK) requirements and medications brought to 2222 calls by resus nurse in secure bags. Medications kept on trolleys are supplied in sealed bags (x2 adrenaline 1:10,000)	Elaine Newell	December 2017	Checking audits show 100% compliance for content and frequency.	All trolleys compliant with RC (UK) requirements and medications. Audit programme in place to run in Q4 to assess compliance.	**G**
MD3 (S)	The trust must take action to ensure patients in the ED receive treatment within one hour of arriving in line with the Royal College of Emergency Medicine (RCEM) recommendation.	• The Trust has extremely good 'first 15 minute' triage implementation • Putting RATs consistently into our departments will make sure that we commence treatment in most cases inside one hour	Liz Miller	~~December 2017~~ January 2018	Scorecard data must show 95% consistent delivery	Trust wide median waiting time is 65 minutes. City @ 59 minutes and Sandwell @ 64 minutes. RATs now consistently in place between 10-22.00 and Band 2 HCA overnight Monday, Tuesday, Friday and Saturday to improve waiting times.	**R**
MD4 (S)	The trust must take action to ensure there is a clearly agreed and resourced system in place for safely	• An escalation process was deployed prior to, and reinforced since, the CQC inspection – following Board	Nuhu Usman	December 2017	The results of the survey showing that all staff are aware of the escalation arrangements and feel	All staff issued with the escalation policy and action cards. Survey not yet completed	**R**

Status	G	Action completed and CQC concern addressed	A	Action on track to be delivered by the agreed date	R	Action off track and revised date set and stated

Ref: MD= must do SD= should do	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer	By when?	How will successful completion be evidenced?	Summary note of improvement made and confirmation that the concern raised has been addressed	STATUS
	managing the condition of patients queuing on trolleys when the ED is very busy.	level discussions on risk • Staff awareness of the escalation arrangements will be tested by anonymised survey, and line management 1:1s			confident to use them.		
MD6 (S)	The trust must take action to ensure doctors use the appropriate proforma in place for effective clinical pathways.	• A list of Unity cross checked proformas will be provided to every ED doctor, and will be made available to all locum attendees as well	Prem John	December 2017	Q4 audit of 'missing opportunity' patients to identify whether medical staff proforma awareness was the root cause.	All proformas issued to junior doctors and signed for.	**G**
MD7 (S)	The trust must take action to ensure sufficient substantive registrar cover overnight for the safety of patients.	• The process for booking and administering locums in ED has been fundamentally changed, with all bookings now undertaken through the bank office.	Liz Miller	December 2017	Rota compliance achieved, with combined vacancy and sickness position not exceeding 3% of shifts	Substantive funding has been allocated to a second registrar overnight. National difficulties in recruitment are resulting in this post being filled via temporary staffing. Efforts will continue to actively recruit to this vacancy.	**R**
MD8 (S)	The trust must take action to ensure there is a designated appropriately safe room available within which to care for patients with mental ill health.	• Identify a designated room for the use of patients with Mental Health issues • Communicate to all staff through safety briefings, the intended room.	Liz Miller	~~December 2017~~ January 2018	All staff able to articulate which room has been designated.	An appropriate room Identified for mental ill health patients at City ED (room 14). The same in Sandwell ED (room 6) but this does requires some work, which be completed during January. Briefings in January will remind staff of the availability and use of these rooms .	**R**
MD10 (S)	The trust must take action to ensure unplanned re-attendance rate to the ED	• A specific audit of re-attendance will be undertaken to understand for November	Liz Miller	December 2017	Reducing trend evidenced through the urgent care score card.	Rate decreased from average 8.5 to 6.81 with action plan to decrease further. Daily validation process in place and a re-	**G**

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	within seven days is reduced.	patients what lay behind re-attendance rates • Commence GP direct booking work on both sites during November 2017				attenders MDT occurs resulting in some pathways being tightened (e.g. early pregnancy and PV bleeds)	
MD12 (S)	The trust must take action to ensure patients are treated within one hour of arriving.	• Review RATS process and modify as required to improve arrival to treatment times. • Review current waiting times through arrival to treatment pathway to identify areas to reduce waiting time.	Liz Miller	December 2017	Performance dashboard shows 95% of patients seen within 1 hour consistently.	Trust wide median waiting time is 65 minutes. City @ 59 minutes and Sandwell @ 64 minutes. RATs now consistently in place between 10-22.00 and Band 2 HCA overnight Monday, Tuesday, Friday and Saturday to improve waiting times.	**R**
MD14 (S)	The trust must take effective action to mitigate the increasing risks to patients from overcrowding in the ED.	• An escalation process was deployed prior to, and reinforced since, the CQC inspection – following Board level discussions on risk	Nuhu Usman	December 2017	Staff awareness of the escalation arrangements will be tested by anonymised survey, and line management 1:1s	All staff issued with the escalation policy and action cards. Survey not yet completed	**R**
SD2 (S)	Reviewing arrangements in place in order to successfully rotate staff between Sandwell Hospital and City Hospital ED sites.	• Reintroduce a revised and well communicated rotation programme	Liz Miller	~~December 2017~~ March 2018	Staff opinion on the new rotational regime shows broad support	Rotation programme review occurring with an emphasis on band 5/6 development and competencies to be achieved. Staff engagement is taking place. Newly qualified nurses need to remain at base for the first 6 months, along with their preceptor, which limits numbers available for rotation. Rotational programme being introduced on a phased basis, to commence in March.	**R**

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URGENT AND EMERGENCY SERVICES (A&E): CITY HOSPITAL, INCL. BMEC							
SD4 (C)	The trust should review cleaning schedules and include the windows above the minors' area, which were not part of the housekeeping schedule and had not been cleaned for several months.	• The cleaning schedule will be amended	Steve Clarke	December 2017	Cleaning schedule in place to include windows above minors.	BMEC Cleaning schedule has been amended. BMEC ED manager and Domestic Supervisor have undertaken site inspections; no issues noted.	**G**
SD6 (C)7	The trust should improve the communication of waiting times to patients, especially if electronic displays are not in use.	• We will use electronic systems to display time to be seen	Liz Miller	December 2017	Reduction in 'left without seen' rates	Display boards in departments need reconfiguring. This is currently being investigated	**R**
						Electronic system not currently in place in BMEC. Whiteboard has been ordered on which the ED Sister will record current wait times updated hourly	**R**
SD7 (C)	Look for ways to improve patient privacy in the department.	• We will explore whether there are any cost effective design changes we can make in advance of the move to Midland Met	Alan Kenny	~~December 2017~~ March 2018	Reduction in formal and informal complaints	A review has been undertaken with clinical staff to identify ways to improve patient privacy and dignity in the department. Where improvement works can be made quickly these are scheduled for completion by January 2018. Where works require alterations which will impact on clinical services, where possible these will be undertaken between January and March 2018. Finding out from the eye units at Moorfields and Manchester how services	**R**

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						are configured without impacting clinical flow in the ED	
SD12 (C)	Introduce a water dispenser in the BMEC ED waiting room to ensure vulnerable patients have quick access to water at all times.	• Install water dispenser	Steve Clarke	~~December 2017~~ January 2018	Water available in BMEC ED.	Water dispenser ordered and delivered (as at 27/12/17), awaiting installation by Estates.	**R**
SD13 (C)	Implement SLAs with other trusts so that paediatric patients are kept safe at all times.	• The Trust has put a formal proposal to BCH and NHS England to address this risk, which has been on the corporate risk register in public for some time. We anticipate resolution over the next eight weeks	Medical director	December 2017	Compliance from Q1 with the regional standards we are seeking to co-opt others into adopting	Mr Tyagi is liaising with Mr Abbot to develop out of hours cover proposal Retinopathy of prematurity screening for newborn babies SLA signed and in train (15/12/17) providing 24/7 rota cover In the meantime the following has been actioned for in-hours provision • VAF approved for post • Substantive JD and plan submitted to RCOpth 15.12.17 • Locum post requested 14.12.17 to cover during recruitment Second SWBH consultant daytime access for support is available	**R**
EMERGENCY DEPARTMENT: BMEC							
MD15 (C)	Increase availability of specialist medical staff and anaesthetists to minimise	• The Trust has put a formal proposal to BCH and NHS England to address this risk,	Medical director	December 2017	Compliance from Q1 with the regional standards we are seeking to co-opt	VAF approved for post Substantive JD and plan submitted to RCOpth 15.12.17	**R**

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	the risk that children, particularly those younger than three years of age, who attended department receive timely and appropriate treatment.	which has been on the corporate risk register in public for some time. We anticipate resolution over the next eight weeks			others into adopting	Locum post requested 14.12.17 to cover during recruitment Second SWBH consultant daytime access for support is available	
MD16 (C)	Robust policies and procedures are in place to manage the effective security of prescription forms at a local level.	• Secure place for storing prescription forms identified • Nurse in charge of ED to distribute forms each day and document. • Medical staff to document for each prescription provided (name, RXK) • Medical staff to hand back at the end of their shift to NIC with list of patients in receipt • All medical staff and nurses taking charge to be advised of procedure and agree to implement.	Bushra Mushtaq	December 2017	Evidence that 100% of relevant staff understand and will adhere to process. Documentation log shows adherence to process in all cases.	Combination safe boxes have been ordered which will be fixed to the wall. In the meantime Audit forms have been ordered alongside FP10s to record RXK etc Interim forms are being used to record information which is returned to the NIC at the end of each shift. Medical and nursing staff have been advised of procedure however we are not yet fully compliant	**R**
MD17 (C)	The storage of fluids are tamper proof, in line with Resuscitation Council guidelines.	• Assess the existing resuscitation trolleys against the resus policy approved checklist. • Communicate to all ED clinical staff regarding the expected stock on resus trolleys (nothing additional)	Laura Young	December 2017	Evidence that all those checking the trolleys have been advised of what should and should not be on the trolley and will implement.	Resus trolleys have been assessed and confirmed as adhering to Trust policy. ED NIC undertakes daily checks of trolleys No additional items have been noted on resus trolleys	**G**

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		• Identify who checks trolleys and when and communicate to relevant nursing staff. (removing anything additional) • Nurse checker to document on log anything additional being added to trolleys, remove and advise staff of error in safety briefings.			Checking audits show 100% compliance for content and frequency. Log shows any trolley equipment discrepancies and safety briefings show comms.		

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MEDICAL CARE

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer	By when?	How will successful completion be evidenced?	Summary note of improvement made and confirmation that the concern raised has been addressed	STATUS
MEDICAL CARE: SANDWELL GENERAL HOSPITAL							
MD22 (S)	Guidance from the Resuscitation Council (November 2016) is being followed.	• Trust policy and practice already meets the Resuscitation Council guidelines	Helen Cope	Complete	Resus team audit trollies for compliance monthly in Q4	Concern addressed	**G**
SD15 (S)	Using a consistent approach for documentation across the medical service. We saw variations in fridge temperature documentation and patient records.	• Develop standards for documentation and publicise these as part of the Consistency of Care programme	April Hawkins	December 2017	Weekly Audit shows compliance against core standards at >90%	Documentation standards developed and in place. Areas of concern are OPAU but much improvement seen, D16 is a new hotspot and is being closely managed by the Matron. Lyndon 5 is also receiving enhanced support.	**G**
SD17 (S)	Updating the disinfectant solution log to ensure it reflects clearly how long a solution has been premade for.	• Develop posters for display in key areas directing staff on the correct process	April Hawkins	December 2017	Contemporaneous entries in the log to demonstrate compliance	Posters in place in the clinical areas	**G**
SD18 (S)	Staff are consistently completing relevant risk assessment documentation.	• Shift by shift documentation handover regime implemented in October 2017	Elaine Newell	December 2017	Achievement of Consistency of Care programme goals	Shift by shift checks in place and evidence available on S Drive to demonstrate check and challenge.	**G**

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SD22 (S)	Continue with improvements to gain JAG accreditation for the endoscopy unit.	• JAG accreditation was achieved in July 2017	Mark Anderson	December 2017	JAG accreditation retained	Completed and monitoring ongoing requirements.	**G**

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SURGERY

Ref	Issue identified by the CQC Inspectors	Improvement actions to be taken to address the concern	Lead officer	By when?	How will successful completion be evidenced?	Summary note of improvement made and confirmation that the concern raised has been addressed	STATUS
SURGERY: SANDWELL GENERAL HOSPITAL							
SD24 (S)	Review the system of pooling surgical patients to ensure that patients are not put at risk.	• All Directorates required to confirm adherence with national guidance; reinforced through Directorate Reviews • Booking teams provided with clear rules regarding pooling • Review of pooled patients in accordance with national guidance	Tina Robinson	December 2017	• Patients will be pooled in accordance with national guidance • Booking teams are able to articulate national guidance and how they book patients in accordance with this	Directorate confirmation that pooling rules are being adhered to via Directorate Review Meeting. Booking and pooling rules shared with booking teams via Theatre Improvement project team; spot checks have confirmed adherence Local guidance checked and confirmed as compliant with national guidance	**G**
SD25 (S)	Identify a non-executive board member to champion theatres issues at board level and support the service.	• The whole Board champions theatre issues and visits theatres. The Theatre Management Board provides reports through the Quality and Safety Committee and the chair of that committee will take a particular interest	Richard Samuda	December 2017	• Minutes of Board meetings	The Board Quality and Safety Committee, chaired by a NED, will devote part of its March 2018 meeting to Theatre issues and invite theatre staff to attend. The Board will schedule another visit to the theatres at Sandwell Hospital in April 2018	**G**
SD27 (S)	All junior doctors are familiar with escalation process should patients treatment or discharge be delayed by imaging department issues.	• The Red to Green programme will address this issue and give Trust-wide visibility for any delays • Trainee doctors will be inducted into the process for escalating patients delays but the introduction of ward based	Rachel Barlow	December 2017	• Junior doctors are able to articulate escalation process • Reduced delays evidenced through R2G	Turnaround times for in-patient imaging improved to: Radiology • City 90% • Sandwell 97% CT • City 83% • Sandwell 90%	**G**

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		consultants should mitigate any risk				This is reported daily through the capacity meeting to ensure a responsive service. The CRIS (radiology reporting system) is available on all the wards. A note to all juniors on how to access this has been circulated in December.	
SD30 (S)	Wider learning is promoted through complaint trends being shared across all areas of the trust.	• This is to be included in the new Governance Scorecard which will be reviewed at Group Management Board and assessed monthly at EQC	Kam Dhami	December 2017	• Agendas and Minutes of GMB evidence review of complaints and trends	Governance scorecard shared at Executive Quality Committee since November. In addition Governance Business Partnering is being developed to support Groups Regular agenda item on GMB with complaint themes discussed Review of complaints by area undertaken at QIHD	**G**
SURGERY: CITY HOSPITAL, INCL. BMEC							
SD34 ©	Wider learning should be promoted through complaint trends being shared amongst all areas of the Trust.	• This is to be included in the new Governance Scorecard which will be reviewed at Group Management Board and assessed monthly at EQC	Kam Dhami	December 2017	• Agendas and Minutes of GMB evidence review of complaints and trends	Governance scorecard shared at Executive Quality Committee since November. In addition Governance Business Partnering is being developed to support Groups Regular agenda item on GMB with complaint themes discussed Review of complaints by area undertaken at QIHD	**G**
SD36 ©	Ensure all BMEC staff can identify a deteriorating patient; and that this is recorded in a structured	• Audits undertaken as part of the Safety Plan show this is being routinely undertaken. • Competency sign off process to	Laura Young	December 2017	• Competency assessment for all current BMEC staff to be reviewed at Critical	Competency assessment has been developed and is being reviewed by Directorate Triumvirate	**R**

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	way in order to monitor the effectiveness of this.	be undertaken under oversight of Chief Nurse			Care Board		

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OUTPATIENTS AND DIAGNOSTIC IMAGING

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer	By when?	How will successful completion be evidenced?	Summary note of improvement made and confirmation that the concern raised has been addressed	STATUS
OUTPATIENTS AND DIAGNOSITC IMAGING: SANDWELL GENERAL HOSPITAL							
MD35 (S)	All staff are up to date with their safeguarding mandatory training.	• This is tracked as a priority and since the inspection we meet the Cquin for compliance. We have a revised and robust system to maintain this position.	Raffaela Goodby	December 2017	Sustained performance above 90%	Delivery of level 3 Children sustained above 90%. L3 Children 90.21% Further work needed to meet compliance at level 2. L2 Adults 88.3% L2 Children 88.21%	**R**
SD40 (S)	Staff in the phlebotomy department confirm the time when numbing cream has been applied by the children's outpatients department prior to taking any blood samples.	• The blood request form will have the time of when the numbing cream is applied and time when the patient is ready for blood test	Jonathan Walters	December 2017	Spot check audits with 100% compliance	Times of cream application now documented on the forms. As a further check, parents are also asked how long the cream has been on.	**G**
SD41 (S)	Patients are given the opportunity to be weighed in private.	• Scales moved to areas not in view of waiting room.	Trish Kehoe	December 2017	• Unannounced inspection	Scales are near a power point and as private as possible. Staff have been instructed to be mindful that the weight does not need calling out, so as to maintain dignity.	**G**
SD43 (S)	Hand hygiene compliance is regularly monitored and recorded in the outpatients department.	• This is already the case and will be reiterated through a specific action in the QIHD programme for outpatients	Bev Jackson	December 2017	• This will form part of our unannounced inspection process	Identified a champion who is checking staff with use of UV light box and carrying out education.	**G**

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SD45 (S)	Patients' notes are kept securely at all times in the outpatients department.	• This issue of largely resolved by the introduction of digital casenotes	Trish Kehoe	December 2017	• Re-audit to check no paper stores remain in sight	Discussed at November QIHD. All staff informed of what is required and consequences. Staff have signed to assure they have understood. Message also sent to all clinicians.	**G**
SD46 (S)	Staff know who the safeguarding leads are at the trust.	• A renewed publicity drive will set out the balance of responsibility between each employee and local service leads, and the expert help they can obtain from specialist service leads	Ruth Wilkin	December 2017	• Sample audit question will be included in Your Voice staff survey	Films of each safeguarding lead have been published through Communications bulletin with explanations of the roles and responsibilities of the leads and employees. Their roles will also be published as a payslip attachment in January 2018. The Q4 Your Voice includes questions on safeguarding and will be reported by end of March 2018.	**G**
SD48 (S)	Equipment and furniture in the outpatients department is moved regularly to enable a thorough clean.	• Written SOP to define roles and responsibilities, including frequency of 'whole space' cleaning to be agreed with Chief Nurse	Steve Clarke	December 2017	• Q4 audit of area to show compliance with revised SOP	Deep clean carried out and weekly schedule altered to include movement of furniture. Monitored by Supervisors.	**G**
MD38 (C)	The trust must ensure patient notes are kept securely and confidentially.	• All stores of notes moved behind locked doors • Lockable trolleys in use to Q1 2018-19 then replaced by EPR	Laura Young	December 2017	Unannounced inspection	**BMEC**: Issues with notes is now resolved with case note scanning. Secure storage of episodic notes is in place 11.10.17.	**G**
MD39 (C)	The trust must ensure sharps bins and clinical waste are stored securely	• Reiteration of Trust process within BMEC • Sharps bins and clinical waste	OPD Manager	December 2017	OPD Manager to present audit of compliance to Directorate Quarterly	**BMEC**: HODS for review of processes. 11.10.17 No issues reported and all aware of I/C and waste management needs.	**G**

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	and safely.	stored securely within Imaging.			Governance Meeting in January 2018	Visual function have no sharps.	
MD41 (C)	The trust must ensure there are improvements with staff completion of mandatory training.	• Mandatory training corporate review reporting to Executive in December 2017 • Full implementation plan during 2018 to consistently achieve full year compliance	Raffaela Goodby	~~December 2017~~ March 2018	Quarterly compliance reviewed via Group Review	A mandatory training review has been completed by the Deputy Director of OD & Learning and will be shared with the Executive Team in January. During 2018 we will implement a new approach and move to national e-learning, that can easily 'passport' prior learning.	**R**
SD49 (C)	The trust should ensure staff working in the outpatients department have their competencies checked regularly and that this is evidenced.	• All BMEC nursing HODS to initiate a review of competencies to be undertaken annually during appraisals. For this to be evidenced in PDR documentation • Band 2 CARE cert to be updated	Laura Young	December 2017	Inclusion of BMEC OPD in next Chief Nurse educational competency audit process	Proforma designed and implemented gaining confirmation of competency, and listing each member's specific competencies. These are reviewed annually as part of PDR.	**G**
SD50 (C)	The trust should ensure that staff receive training to improve awareness of who the trust safeguarding leads are.	• A renewed publicity drive will set out the balance of responsibility between each employee and local service leads, and the expert help they can obtain from specialist service leads	Ruth Wilkin	December 2017	Sample audit question will be included in Your Voice staff survey	Films of each safeguarding lead have been published through Communications bulletin with explanations of the roles and responsibilities of the leads and employees. Their roles will also be published as a payslip attachment in January 2018. The Q4 Your Voice includes questions on safeguarding and will be reported by end of March 2018.	**G**

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SD52 (C)	The trust should ensure all incidents are reported including those involving patient falls on the escalator in the Birmingham Treatment Centre.	• Notices have been placed on escalators reiterating the arrangements for reporting and escalating concerns	Alan Kenny	December 2017	Trust incident reporting BTC Building log Minutes	Additional signs have been placed around the escalators advising of the need to report incidents.. Works required have been responded to and completed. Staff working in BTC were reminded of the requirement to report incidents at the November QIHD.	**G**
SD53 (C)	The trust should ensure patients in the BMEC outpatients waiting area are kept informed of waiting times and late-running clinics.	• Whiteboards will display wait times	HODs in OPD	~~December 2017~~ January 2018	Unannounced visits	A whiteboard has been ordered on which the NIC in outpatients will update regularly to display OP waiting times.	**R**
SD56 (C)	The trust should ensure there are chaperone notices in the outpatient's department.	• BMEC OPD Manager to source and display appropriate signage.	Laura Young	~~December 2017~~ January 2018	Notices visible	Poster developed 11.12.17 – approved alterations. Forwarded to other OPD areas. Asked for Medical Illustration to print.	**R**
SD57 (C)	The trust should ensure there is clear signage in the outpatient department.	• BMEC OPD Manager to arrange a working group including patient and public to look at what signage would help to improve the environment. • Main OPD: Implementation of Intouch Calling Screens that identify clinic name/department	Laura Young	~~December 2017~~ January 2018	Screens working in all areas	Signage ordered (black on yellow) as agreed	**R**

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CHILDREN AND YOUNG PEOPLE

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer	By when?	How will successful completion be evidenced?	Summary note of improvement made and confirmation that the concern raised has been addressed	STATUS
CHILDREN AND YOUNG PEOPLE: BMEC							
MD45 (C)	Medical staffing meets needs of patients and the service.	• Demand and capacity exercise for paediatric ophthalmology to clearly identify productivity and capacity changes required • Inclusion of any resultant costs in Trust level investment plan for 2018-19	Dave Baker	December 2017	Demand and capacity to be in balance by summer 2018	VAF for second consultant signed off and with medical staffing. Mr Ghauri offered all non-trainees access to Paediatric clinics for training (trainees already on programme) Paediatric Surgical Standards are achieved. Play therapist for engaging with children.	**R**
SD59 (C)	That a strategy for services for children and young people is developed and embedded, and there is improved reporting about service plans and priorities.	• A single service plan will be developed for consideration by the Group and Executive	Bushra Mushtaq	~~December 2017~~ January 2018	A plan is agreed and signed off by the COO and Medical Director, and delivery is tracked via directorate performance review	BMEC is represented on CYP Board, Children's Safeguarding Board, CCIC Group Joint Paediatric Surgeon / Anaesthetic Group Service plan to be finalised and confirmed at Group Management Board in January	**R**

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END OF LIFE CARE

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer	By when?	How will successful completion be evidenced?	Summary note of improvement made and confirmation that the concern raised has been addressed	STATUS
END OF LIFE CARE: SANDWELL GENERAL HOSPITAL							
SD62 (S)	Updated 'Anticipatory Medication Guidelines'. We could not be assured staff were following the most up-to-date guidelines.	• Guideline reviewed and updated in Feb 2017 • Ensure latest version is available on Connect • Communicate to all clinical staff that guidelines has been updated via QIHD sessions and staff bulletin system • Review of data from Supportive Care Plan audit to ensure correct prescribing adhering to the guidelines	Tammy Davies	December 2017	Monitoring evidences guideline compliance by individual staff members. Results of SCP audit to be reviewed by Lead palliative care nurse to ensure adherence to guidelines. Audit repeated 6 monthly and any prescribing discrepancies to be communicated to relevant staff. 100% compliance with prescribing in line with guideline to be demonstrated by audit	Guidelines updated and available on Connect. Audit of 20 notes undertaken for patients on SCP. 100% prescribing compliance with anticipatory prescribing	**G**
SD63 (S)	Mandatory training for mortuary staff includes infection control training.	• All staff are up to date with mandatory training for infection control	Jonathan Walters	December 2017	Completed mandatory training available on ESR	All compliant	**G**
SD65 (C)	The service must ensure they are preventing, detecting and controlling the spread of infections,	• Policies and SOPs in place and regularly updated, SOPs include: • PROC-MORT-C-C5, E3-2 Body Fluid (Biohazard) Spillages	Jonathan Walters	December 2017	Incident review of non-compliance to be undertaken and acted upon	All procedures have been reviewed and are in place for the prevention, detecting and controlling the spread of infections.	**G**

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Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer	By when?	How will successful completion be evidenced?	Summary note of improvement made and confirmation that the concern raised has been addressed	STATUS
	including those that are health care associated in the mortuary department.	• PROC-MORT-C-E3-9 Infected Cases • PROC-MORT-C-C5, E3-3 Leaking Bodies • PROC-MORT-C-C5.6-1 General Cleaning • PROC-MORT-C-E6,C5-1 Releasing Cadavers to Undertakers Infected Cases • All SoPs available on i-passport • All relevant PPE available in department				Review of all PPE. Complete	
SD66 (C)	The trust should ensure they have updated 'Anticipatory Medication Guidelines'. We could not be assured staff were following the most up-to-date guidelines.	• Guideline reviewed and updated in February 2017 • Ensure latest version is available on Connect • Communicate to all clinical staff that guidelines has been updated via QIHD sessions and staff bulletin system • Review of data from Supportive Care Plan audit to ensure correct prescribing adhering to the guidelines	Tammy Davies	December 2017	Results of SCP audit to be reviewed by Lead palliative care nurse to ensure adherence to guidelines. Audit to be repeated 6 monthly and any prescribing discrepancies to be communicated to relevant staff.	Guidelines updated, reviewed and available on Connect. Audit of 20 notes undertaken for patients on SCP. 100% prescribing compliance with anticipatory prescribing	**G**
SD67 (C)	The trust should review the safeguarding vulnerable adults policy.	• The policy will be reconsidered by the Executive Quality Committee	Elaine Newell	December 2017	Minute of committee confirms re-examination	Safeguarding policy reviewed by Patient Safety Committee in August 2017 and available on Connect	**G**

Status	G	Action completed and CQC concern addressed	A	Action on track to be delivered by the agreed date	R	Action off track and revised date set and stated

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer	By when?	How will successful completion be evidenced?	Summary note of improvement made and confirmation that the concern raised has been addressed	STATUS
SD68 (C)	The trust should review the anticipatory medicines policy.	• Communicate to all clinical staff that guidelines have been updated (Feb 2017) via QIHD sessions and staff bulletin system • Review of data from Supportive Care Plan audit to ensure correct prescribing adhering to the guidelines	Tammy Davies	December 2017	Policy monitoring evidences policy compliance by individual staff members. 100% compliance with prescribing in line with guideline to be demonstrated by audit	Guidelines updated, reviewed and available on Connect. Audit of 20 notes undertaken for patients on SCP. 100% prescribing compliance with anticipatory prescribing	**G**

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Status	G	Action completed and CQC concern addressed	A	Action on track to be delivered by the agreed date	R	Action off track and revised date set and stated

COMMUNITY IN-PATIENTS

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer	By when?	How will successful completion be evidenced?	Summary note of improvement made and confirmation that the concern raised has been addressed	STATUS
COMMUNITY INPATIENTS							
MD54 (CO)	The service must comply with the requirements of the *Data Protection Act 1998*, and ensure staff keep service user's personal data safe and secure at all times.	• Install a box to store blood samples waiting for collection to ensure sensitive information is not left in sight • Staff to undertake their mandatory IG training	Tammy Davies	December 2017	0% of data protection breaches observed during matron monthly ward reviews Team meeting minutes, agenda and attendance to demonstrate communication to all staff regarding responsibilities with IG and data protection >95% compliant with IG mandatory training	Red boxes in place on each ward to store blood samples awaiting collection. Ward reviews by matron and head of nursing have been undertaken showing 0% IG breaches. Evidence of reiteration of IG responsibilities communicated in team meetings. Register of attendance and team meeting minutes reviews and demonstrate communication. Service has confirmed IG training showing as > 95%.	**G**
MD58 (CO)	The service must ensure that staff work in accordance with medicine management policies, procedures and national best practice and legislation.	• Medicines management policy to be discussed in ward meetings and in individual coaching sessions to ensure all staff are aware of policies, procedures and individual responsibilities • Named Pharmacist for Rowley Regis hospital to attend wards	Tammy Davies	December 2017	Agendas, minutes and attendance demonstrated discussion of medicines management policy with 100% of staff Monthly report produced by pharmacist indicating 0% areas of concern with regards to medicines	0% medicines management issues on EWTT audits. Medicines management discussed during staff 1-1s and ward meetings and documented in minutes Twice weekly pharmacy visits underway and full compliance with medicines management (including storage)	**G**

Status	G	Action completed and CQC concern addressed	A	Action on track to be delivered by the agreed date	R	Action off track and revised date set and stated

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer	By when?	How will successful completion be evidenced?	Summary note of improvement made and confirmation that the concern raised has been addressed	STATUS
		twice weekly to review medication storage, prescriptions and administration. Areas of concern to be discussed with Ward Managers and matron • Monthly medicines management audits to be undertaken for each ward with results outlined in the EWTT and reviewed by the GDON			management 0% medicines managements errors shown on EWTT		
SD69 (CO)	Staff should review the use of magnetic information boards above patient bed spaces and ensure these accurately reflect the needs of the patients.	• Full review of the use of magnetic boards and their relevance for community wards to be undertaken by ward mangers and matron. This will include a survey of staff / patients and relatives. • If the use of magnetic boards are continued, each shift leader will be given the responsibility of ensuring information in accurate	Tammy Davies	December 2017	n/a	Following full review and staff and patient comments, magnetic boards have been removed from ward. Patients are in rehab so rarely by their beds. eBMS is used to note important information The change has been communicated via huddles and team meetings.	**G**
SD73 (CO)	The service should review how and when it reviews delays to patient care, and what aspects of patient care are monitored.	• Daily board rounds to take place with discussions to highlight any delays in care • The Trust collates Delayed Transfer of Care data and this is	Tammy Davies	December 2017	EDD compliance league table to demonstrate delivery of promises made to patients	Daily board round attendance monitored and compliance achieved Delayed transfer of care data collected and submitted to head of capacity	**G**

Status	G	Action completed and CQC concern addressed	A	Action on track to be delivered by the agreed date	R	Action off track and revised date set and stated

Ref	Issue identified by the CQC Inspectors	Improvement actions taken / planned to address the concern	Lead officer	By when?	How will successful completion be evidenced?	Summary note of improvement made and confirmation that the concern raised has been addressed	STATUS
		examined daily by senior staff. • All community wards will implement Red/Green approaches and improvement in reducing red days will be monitored via Group Performance Reviews. • EDD performance for all ward admissions will be tracked and made visible at ward level from March 2018. • Over 7 day LOS reviews to operate again across all Trust sites				2 weekly stranded patient meetings are now taking place and each ward is undertaking an audit of patient LOS to look for trends in root cause. This will then be discussed with the head of capacity and appropriate 3rd parties (e.g. social services). This is being displayed on ward notice boards.	

Status	
G	Action completed and CQC concern addressed
A	Action on track to be delivered by the agreed date
R	Action off track and revised date set and stated

Status	G	Action completed and CQC concern addressed	A	Action on track to be delivered by the agreed date	R	Action off track and revised date set and stated

Appendix 2

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
CQC Improvement Plan
Assurance Monitoring Methods

Ref: MD= must do SD= should do	Audit (clinical and internal)	Observation	Ask staff	Ask Patients	Central data
MD1 (S)	X	X			
MD3 (S)	X				X
MD4 (S)			X		
MD6 (S)	X	X	X		
MD7 (S)			X		X
MD8 (S)		X	X		
MD10 (S)					X
MD12 (S)	X				X
MD14 (S)			X		
SD2 (S)			X		
SD4 (C)	X		X		
SD6 (C)		X	X	X	
SD7 (C)		X		X	
SD12 (C)		X			
SD13 (C)					X
MD15 (C)					X
MD16 (C)		X	X		
MD17 (C)	X	X			
MD22 (S)	X	X			
SD15 (S)	X	X			
SD17 (S)		X	X		
SD18 (S)	X	X			
SD22 (S)					X
SD24 (S)			X		
SD25 (S)					X
SD27 (S)			X		
SD30 (S)					X
SD34 (C)					X
SD36 (C)	X		X		
MD35 (S)					X
SD40 (S)	X	X			
SD41 (S)		X			
SD43 (S)	X	X	X		
SD45 (S)	X	X			
SD46 (S)			X		
SD48 (S)	X	X			
MD38 (C)		X	X		
MD39 (C)		X	X		
MD41 (C)					X
SD49 (C)		X	X		
SD50 (C)			X		
SD52 (C)			X		X
SD53 (C)		X		X	
SD56 (C)		X		X	
SD57 (C)		X		X	
MD45 (C)					X
SD59 (C)					X
SD62 (S)		X	X		
SD63 (S)					X
SD65 (C)			X		
SD66 (C)		X	X		
SD67 (C)		X	X		
SD68 (C)		X	X		
MD54 (CO)		X	X		
MD58 (CO)	X	X	X		
SD69 (CO)		X	X		
SD73 (CO)			X		X

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD PUBLIC

DOCUMENT TITLE:	**Winter Plan: EDD performance and bed closure position**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow Chief Operating Officer**
AUTHOR:	**Rachel Barlow Chief Operating Officer**
DATE OF MEETING:	**4th January 2018**

EXECUTIVE SUMMARY

This paper outlines the Trusts performance against delivery of the improvement plans for winter urgent care preparedness aligning our intention to improve ED performance to 90% against the 4 hour standard and to work within the designed and funded bed base.

ED performance has sharply deteriorated to 78% month to date, equating to a daily average of 127 patients waiting over 4 hour for admission or discharge compared to our goal of 57. 63% of breaches are out of hours. Regionally and nationally we have been an outlier at times in month and must improve. We have 48 additional beds open as of the 27th December.

Our inpatient bed issue is 2 fold in December 1) the persistent issue of outflow of non-complex discharges ie LOS above plan and 2) the inpatient conversion rate from AMU at Sandwell.

The ED improvement and bed closure programme is behind plan with 6 out of 12 implementation activities behind plan.

The paper outlines milestones for January and additional intervention and support.

The recommendation remains that we persevere with the improvement plans as designed ensuring no further slippage with CEO review mid-January.

The revised improvement trajectory over Q4 is steep and requires rapid change;

Month	Performance	Daily breach
December forecast outturn	78%	127
January	85%	86
February	88%	69
March	90%	57

Appendices include:
Appendix 1 summarises the next steps of improvement effort and actual performance vs expectation on the ED improvement plan
Appendix 2 summarises the next steps of improvement effort by the end of December and actual performance vs expectation on the Bed Flow Improvement Plan
Appendix 3 The EDD league table

REPORT RECOMMENDATION:

The Trust Board are asked to consider progress, slippage and the revised trajectory for improvement.

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:

Accessible and responsive services, quality and safety plan, financial plan

PREVIOUS CONSIDERATION:

Previous Trust Board agenda item related to urgent care performance / winter/beds

Winter Plan: EDD performance and bed closure position

1. Introduction

ED performance has sharply deteriorated to 78% month to date, equating to a daily average of 127 patients waiting over 4 hour for admission or discharge compared to our goal of 57. 63% of breaches are out of hours. Regionally and nationally we have been an outlier at times in month and must improve. We have 48 additional beds open as of the 27th December.

Table 1 bed model assumptions vs December actuals		
Daily numbers	**Bed model assumption**	**December 1-28th**
Average daily ED attendances	608	569
WMAS arrivals per day	150 predicted	157 (Sandwell 12% increased activity against prediction)
Admissions to AMU	65 / day	73/day
Medicine admission to inpatient beds (direct or from AMU)	45 /day	51/day (72% of this increase is at Sandwell)
Average LOS (including AMU)	7.51 days	8.23 days

The improvement approach remains centred on our ED and Patient Flow improvement plans. Both have elements that are behind plan with 6/12 schemes delayed in delivery. The table below should be considered alongside the appendices 1 and 2 (Performance vs expectation 1. ED improvement and 2. Patient Flow) in terms of performance against the KPIs associated with these interventions.

Table 2 Summary of improvement initiatives and completeness
Key: √ yes, X no, red behind timeline, green within timeline, blue completed

Improvement theme		started	complete	Due for completion
Lack of substantive post holders leads to inconsistency	Recruitment plan	√	X	Ongoing over 18 months and on track
	Leadership development programme	√	X	On track aligned with accredited line manager programme in Q4
	Feedback staff assessment and structure individual development programmes	√	X	Feedback to be completed by first week in January and development cycle to be completed by March
Departmental management after 7pm	Confirm and implement new on call and OOH leadership model	√	X	For implementation in February
Timeliness of clinical decision making	Achieve consistency in practice through smart rostering	√	X	Annualised rosters published for medical staff. Nursing rotas will be intelligently rostered from Q4.
	Implement AMAA development	√	√	

Patient flow	Implement ADAPT	√	X	Admission completed but EDD compliance not yet gained. Milestones set to improve performance in Q4
	Implement Admit/ pull model	√	X	Complete implementation in January
	Implement OPAU at scale	√	X	Issues with staffing have delayed sustained changes. For implementation in January.
	Implement no delay for TTAs	√	X	On track for completion in January
	Criteria led discharge	√	X	On track for implementation in January
	Red to green	√	√	

2. Improvement focus until end January

a) ED

Compliance with the professional standards of Rapid Assessment and Treatment (RATs), handovers and huddles (the MDT meeting to coordinate the running of the department) are essential ways of working. Recent review showed whilst many staff had progressed in terms of assessment outcomes against both potential and high performance levels, there remains a third of staff who are in shift leadership roles who are not practicing leadership behaviours we have set with consistency.

Over the next 8 weeks all staff who are unable to perform these standards consistently will be supported in their development with an outcome at 8 weeks of full compliance with the set standards are consistently practiced. Each member of staff will have a documented and supported development plan. 360 degree assessment will form part of the support and development programme. Where residual competency or conduct issues are identified they will be managed within the relevant Trust policies.

RATs 24/7 will be implemented in December, extending overnight. This is an important quality initiative enabling early assessment and diagnostics for all majors patients. Winter funding has been granted by NHSI for this initiative.

An additional ENP out of hours (OOH) at weekends to support the minor injury activity has been introduced at City with an aim to improve the non-admitted 4 hour performance.

Both RATS and the OOH ENP could have a 4% improvement on 4 hour performance.

Other initiatives and additional support to improve performance include:

- SIFT is the process by which an ED clinical team identify patients for admission or discharge with relevant investigations completed prior to patient movement, unlike RATS there is not expected to be any onwards further assessment. At the end of the process the decision will be made and patients ED journey complete. Cubicle areas are converted to chaired areas and the capacity increased 8 fold over a 2 hours period through this space. This will be introduced in January at City and at Sandwell in February. This is expected to save 10 breaches a day on each site (2% performance improvement).

- The ED Directorate and speciality leadership presence needs to increase at the Sandwell site with performance against internal standards deteriorating in month on this site. City has demonstrated improvement. This matter has been formally raised with the Directorate and Group team and an enhanced senior operational rota has been re-instated in the EDs to support delivery of consistent professional standards. This includes both increased presence from the Directorate General Manager and Speciality lead. This is expected to further reduce avoidable breaches by 10 a day (2% performance improvement).
- The HR business partner is supporting the staff development work.
- A review of staffing against the new clinical models and activity will be completed by mid-January.

b) Admit-pull model and Consultant of the week

The high impact elements of the patient flow improvement plan such as the Admit-Pull model and the Consultant of the Week are regrettably behind plan. The Medicine leadership team have fallen behind with implementation planning and execution. Intensive support from key executive directors, deputy colleagues and the PMO team has been planned into January to support the implementation approach and effectively mobilise clinical teams to work differently. The support to the leadership team and clinicians will be heavily weighted with individual and team coaching activities.

The Admit-pull MDT implementation thus far has progressed in that the Consultant of the Week is reviewing patients in AMU (and possibly avoiding admission) but has fallen short of managing the bed flow.

In parallel the Consultant of the Week, commitment free approach to clinical teams on wards has commenced for elderly care and respiratory. The gastroenterology model will be a hybrid model until February with consistency of a consultant across a fortnight on the wards but with 2 afternoon scheduled commitments. We are recruiting into all specialties at consultant level to achieve a sustainable clinical model. Cardiology already practices a Consultant of the Week model but need on-boarding to the Admit-Pull model. The implementation of a full Consultant of the Week rota cycle will be completed by the beginning of February.

A table top test and practice admit / pull session accompanied by a learning video will be published in early January to provide a teaching and orientation aid to clinicians, operational managers and the capacity team. At the start and end of every rotation of consultants to the Consultant of the Week rota, there will be an introduction briefing and outturn results published that are centred around Expected Date of Discharge (EDD) compliance and Length of Stay (LOS) goals to meet demand. This will have both executive and group leadership input. Clinical team interactions and supervisions are weighted on the perceived and observed team readiness. This is not just a process change but a behavioural change. There is good insight from Clinical Directors to the changes required but a challenge remains in implementation and sustained change in practice across the wider leadership team. The Clinical Group and Directorate team are expected to work now with supportive intervention from the executive team. A governance infrastructure from directorate to board level will be implemented and centred around EDD and LOS goals.

The above improvement efforts aim to contribute a 6 % improvement in ED performance and reduce LOS by a day.

3. Beds

Community and social care capacity remains available to support outflow. Our inpatient bed issue is 2 fold in December 1) the persistent issue of outflow of non-complex discharges ie LOS above plan and 2) the inpatient conversion rate from AMU at Sandwell.

The LOS for medicine in acute beds remains circa 1 day above that modelled. We are underperforming in the non-complex discharge planning and managing to a well set EDD. Our EDD compliance in December was 24.8 % of patients went home on the AMU set EDD which remains fairly static compared to the previous month. 60% of patients go home on or before the EDD including AMU discharges.

Appendix 3 is an example of the league table. This shows the current baseline without benefit of the consistency of the Consultant of the Week model. Currently that 9/32 consultants do not make changes to the EDD; 7/32 consultants make more than 3 changes to the EDD during a patients ward stay. 4/32 consultants discharge patients on or before the EDD date and 15/32 consultants discharge 40% of their patients after the intended EDD. It is anticipated that the Consultant of the Week model will assist in reducing LOS as it embeds in January. Both EDD and LOS will be the outcome criteria measured at ward and consultant level; this will be reviewed fortnightly at consultant level with the Consultant of the Week teams.

Whilst the actual medical takes are 8 admissions a day above plan despite significant increase in ambulatory care activity (100% increase in activity compared to baseline in September), the conversion rate from AMU to inpatient beds has fundamentally changed between November and December with an increase of 9 patients a day being admitted to inpatient beds. 72% of this increase is at Sandwell. The Sandwell site also has 12% more WMAS activity than expected possibly suggesting an increase in acuity as well as demand. Our ambaulance waiting times remain competitive regionally.

In the meantime with unfunded beds remain open subject to ongoing risk assessment. NHSI have written to confirm funding of the beds over the winter period.

Elective inpatient surgery has been reduced as we approached the festive season to support bed flow. The financial and performance impact of this is being assessed.

4. Risks

The risks to ED performance remains:

- Failure to achieve consistent ED standards
- Failure to implement and gain the intended benefits of the consultant of the week and admit-pull model

  Both are mitigated by the above approaches.

- Increased demand
- Failure of other parts of the A&E delivery system or neighbouring provider trusts – to be reviewed at A&E delivery group
- Flu outbreak or other infection control issue that impacts on bed flow – mitigation in line with outbreak plans and decant facilities

5. Recommendation and conclusion

The recommendation remains that we persevere with the improvement plans as designed ensuring no further slippage with CEO review mid-January.

The revised improvement trajectory over Q4 is steep and requires rapid change;

Month	Performance	Daily breach
December forecast outturn	78%	127
January	85%	86
February	88%	69
March	90%	57

The Trust Board are asked to consider progress, slippage and the revised trajectory for improvement.

Rachel Barlow
Chief Operating Officer
December 2017

Appendix 1 Performance vs expectation ED Improvement Plan

RAG key; BLUE – delivered/ complete, GREEN within timeline, RED delayed but will be delivered

Improvement theme and expected impact	Key activities	Breach impact (45)	KPI expectation	KPI Actual	Future milestones	Status RAG
Lack of substantive staff and new starters leads to inconsistency in compliance	Deliver recruitment plan for medics and nursing designed for next 18 months	8	Recruit 6 consultants this year	5 WTE offered roles	Recruitment activities aligned to milestones for medical and nursing staff continue	G
	Leadership development programme for shift leaders		100% accredited managers	To measure end Q4	Leadership programme aligned to accredited manager training in Q4	G
	Feedback to staff the assessment of practicing clinical professional standards with consistency and design individual development plans		70% patients seen < 1 hour from arrival 70% patients DTA'd within 2 hours of arrival	City 57% Sandwell 44% City 32% Sandwell 18%	Plan for staff to be supported to achieve consistent practice by March HR and OD to support development process on above time scale Speciality leadership team to profile their rota to support underperformance in January	R
Departmental Management after 7pm	Confirm OOH leadership and on-call model for implementation in Q3	7	<55 breaches a day	127 breaches a day of which 63% of breaches OOH	Engagement concluded in December. Due to go live in February with induction and training programme.	R

Timeliness of clinical decision making in ED	Achieve consistency of practice at an individual level or via smart rostering	10	70% patients seen < 1 hour from arrival 70% patients DTA'd within 2 hours of arrival	City 57% Sandwell 44% City 32% Sandwell 18%	Annualised medical rosters in place	**R**
	Implement new AMAA developments including effective streaming and plan for single referral model to be in place Q3		20 direct from ED to AMAA a week Baseline was 11 a day	142 direct from ED to AMAA a week	Agree local tariff for AMAA with CCG Complete scoping and business care for single referral centre for establishment in Q1	**B**
Additional schemes	RATS 24/7	10	70% patients seen < 1 hour from arrival 70% patients DTA'd within 2 hours of arrival	Report in January	In place 4 days a week over late December; will scale up in January to 7 days a week.	**G**
	SIFT	10	As above	Report in January	Implement at City in early January Scale up environment and staffing to implement at Sandwell in February	**G**

	Leadership oversight at Sandwell	10	Reduce 4 hour breaches	Report in January	Specialty leadership to be based at Sandwell	**G**
Patient flow from the wards to home	Embed revised ADAPT (Advanced Discharge Planning Team) approach	20	See appendix 2			**R**
	Deliver readiness for implementation of admit/pull model in November including Consultant of the week in main admitting specialities					**R**
	Scope and implement OPAU at scale with direct admissions from ED					**R**
	Implement solution for 'No delays for TTAs'					**R**
	Agree and start delivery of 6 week programme to refresh red to green by end October					**B**

Appendix 2 Performance vs expectation Bed Flow Improvement Plan

RAG key; GREEN – delivered/ complete RED delayed but will be delivered

Improvement theme	Key activities	Bed reduction impact	KPI expectation	KPI Actual	Key milestones of delivery	Status RAG
Embed revised ADAPT (Advanced Discharge Planning Team) approach	Complete MDT admission in AMU EDD planned with social and therapy assessment EDD handed over to ward team with named social worker	10	100% admission completion in AMU 80% compliance with EDD	100% on pilot ward Compliance 35% for ADAPT group	Evaluate ADaPT list with DTOC list to validate is all patients requiring social care support for discharge are identified on AMAA In sequence with COW work to improve EDD compliance within LOS goals Publish named social care team photos on all ward areas start of December – delayed until start of January	R
Admit pull model	Consultant of the week (COW) who will be commitment free and based on a single ward in main admitting specialities – gastroenterology, respiratory, geriatrics and cardiology Daily MDT meeting on AMU, facilitating early specialist review where necessary and planning admission to the in-patient bed base 24 hours in advance. Planning discharge with MDT will enable the patient to be admitted to the right type of bed	15	80% EDD compliance Compliance with board round / job plan	24.8% EDD compliance on wards To be measured in January	Implement governance framework for ward / consultant KPIS for EDD and LOS COW rotas to be fully implemented by February Test MDT test at City to refine implementation approach at Sandwell Support implementation through buddy and executive coaching	R

Implement OPAU at scale with direct admissions from ED Establish an ambulatory pathway pilot from WMAS to AMAA to avoid admission and ED attendance	Test direct admit model and streaming process to ongoing elderly care ward – complete Design workforce plan to in-reach from OPAU to ED – complete	5	Reduce LOS by 1 day for this group Admission avoidance goal TBC	Early results show > 1 day LOS reduction	Move from pilot to implementation phase of direct admission for OPAU from ED with medical in-reach model to ED daily M-F in January Work up ambulatory pathway plan with WMAS in January	**R**
Implement solution for 'No delays for TTAs'	Pilot on D15/16 Confirm pre- pack TTA schedule at ward level Training and engagement plan Agree pharmacy workforce model for full ward rollout	10	Reduce LOS by 1 day for this group Admission avoidance goal TBC	await December data	Complete scheduled implementation	**G**
Criteria led discharge	Identified phase 1 pathways: • Fast track end of life • COPD • Non cardiac chest pain	5	Reduce LOS by 1 day for this group Admission avoidance goal TBC	Measure in January	Complete PDSA improvement cycle in December Aim to roll out criteria led discharge pathways in January	**G**

Agree and start delivery of 6 week programme to refresh red to green by end October	Red to green re-established in November		further improvement themes informed through red themes		Refine and implement sustained governance and performance arrangements to align with ward dashboard for COW / EED and LOS and stranded patient arrangements in December	**B**

Appendix 3 EDD league table

last 2 weeks in November, first 4 in December

How Many Times was EDD Changed?

Changes - Number of times that the expected date of discharge has been reset since the original set on leaving AMU or the direct admission ward

RANK		Changes	Discharges	Movement
1	Z	0	7	▲
2	A	0	4	⇆
3	F	0	1	▲
4	I	0	1	▲
5	Q	0.05	20	▲
6	H	0.08	24	▼
7	J	0.08	12	▲
8	V	0.19	16	▲
9	P	0.21	19	▼
10	D	1	15	▼
11	AD	1	2	▲
12	Y	1.25	8	▲
13	AE	1.25	4	▼
14	C	1.5	8	⇆
15	B	1.62	65	▼
16	S	1.93	15	▲
17	O	2	5	⇆
18	T	2.06	35	▼
19	AB	2.49	35	⇆
20	K	2.5	12	▼
21	AF	2.59	17	▲
22	E	2.63	41	▼
23	AA	2.71	28	▼
24	R	3	97	▼
25	X	3.25	55	⇆
26	N	3.43	7	▼
27	M	3.68	19	▼
28	G	3.8	60	▼
29	AC	4	4	▼
30	L	4	3	▼
31	U	4.5	6	▼
32	W	5	2	▼

More Than 3 changes on average

Discharged on/before EDD?

The percentage of patients who were discharged on or before their expected date of discharge (Set prior to leaving AMU or the direct admission ward)

RANK		Compliance %	discharges	Movement
1	F	100%	1	▲
2	K	100%	12	▲
3	L	100%	3	▲
4	AC	100%	4	▲
5	AE	100%	4	▲
6	O	80%	5	▲
7	AA	79%	28	▲
8	AF	76%	17	▲
9	G	75%	60	⇆
10	S	73%	15	▲
11	R	72%	97	⇆
12	V	69%	16	▲
13	M	68%	19	▼
14	U	67%	6	▲
15	X	64%	55	⇆
16	AB	63%	35	▲
17	Y	63%	8	▲
18	E	59%	41	▼
19	N	57%	7	▼
20	T	57%	35	▼
21	B	52%	65	▼
22	C	50%	8	▼
23	H	50%	24	▼
24	W	50%	2	▼
25	AD	50%	2	▲
26	Q	45%	20	▼
27	Z	43%	7	▼
28	P	37%	19	▼
29	D	27%	15	▼
30	J	8%	12	▼
31	A	0%	4	▼
32	I	0%	1	▼

LESS THAN 60%

Overall

Combination of EDD changes and Discharge before EDD performance

RANK		Combined SCORE
1	F	4
2	AE	18
3	V	20
4	K	22
5	O	23
6	S	26
7	Z	28
8	H	29
9	Y	29
10	AF	29
11	AA	30
12	Q	31
13	A	33
14	AC	33
15	L	33
16	AB	35
17	R	35
18	I	36
19	AD	36
20	C	36
21	B	36
22	J	37
23	P	37
24	G	37
25	T	38
26	D	39
27	E	40
28	X	40
29	M	40
30	N	45
31	U	45
32	W	56

MEDICINE EDD CONSULTANT LEAGUE TABLE | last 6 weeks

key
- ▲ UP
- ▼ DOWN
- ⇆ NO Movement from previous 6 weeks

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Integrated Quality & Performance Report P08 November 2017
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance & Performance
AUTHOR:	Yasmina Gainer, Head Performance Management & Costing
DATE OF MEETING:	4 January 2018

EXECUTIVE SUMMARY:

IPR – Key indicators summary – P08 November 2017 :

- × **ED 4 hour** performance for November 82.68% being non-compliant with national 95% standard and STF 90% standard; 3,168 [2,800] breaches of the 4hr waiting time standard. Expected non-compliance for December; as at time of writing performance tracking at c78%.
- × **62 day cancer** not compliant at 82.3% for October vs. standard of 85%; remediation to secure November & Q3 delivery expected. Performance across all other cancer targets continues to deliver with a high 96.8% 2WW delivery. Impact of prospective changes to oncology services on measured performance being assessed & could risk future compliance.
- ✓ **RTT** November aggregate delivery 92.4% being compliant with national standard of 92%. Work ongoing to secure specialty level compliance by March 2018. Total waiting list dropped in month to c29,500 patients; backlog of patients >18wks at 2,322. December delivery risks compromise due to winter pressures and consequent likelihood of some cancellation of inpatient planned care activities.
- × **Acute Diagnostic waiting times** within 6 weeks not compliant as at November delivering 98.89% vs the 99% target. 103 breaches in total, mainly for MRIs and with specific compromise due to last day of month equipment failure. Full recovery expected in December.
- × **MSA Breaches** x131 incurred in November mainly due to capacity pressures. Joint review with CCG to confirm safety compliance and classification of capacity for acceptable breaches of this standard.
- × **52 week incomplete breaches** x3 in November on the incomplete pathway.
- ✓ **Mortality rate** indicators remain within confidence limits. MDO review of emergent divergence between weekday and weekend rates. Notably, the RAMI methodology has changed and the mortality team are observing the impact over the coming months.
- ✓ **VTE** delivers full year to national standard at 97.5% in November.
- ✓ **MRSA** – no cases year to date
- × **Neutropenic sepsis** remains below 100% standard. In November 7/43 (17%) patients did not receive treatment within the required 1hr timeframe.
- ✓ **CDiff** – compliant with target; in month 1x case; x17 cases year to date tracking closely to the year to date target of 20.
- × **Elective Operations Cancellations** consistently under-delivering. Non-clinical, on the day cancellations as a percentage of elective activity were at 1.0% [1.1%] against 0.8% target; 47 on day cancellations of which 70% were unavoidable.
- × **Theatre In-Session Utilisation** at 75.3% in November, consistently below the Trust 85% target.
- × **Hip fractures** best practice tariff performance in month at 70% [82%]. Hence remains below 85% standard on a persistent basis.

- **Sickness rates** In month for November reported at 4.68%; cumulative sickness rate at 4.51%. Short-term sickness increased in November to 962 cases [889, 706; 664], long term 246 cases [251, 216; 232] month on month.

Requiring attention – action for improvement :

Neutropenic Sepsis
- Shows improvement but stubborn to further reduction to secure 100% local 'always event' compliance standard. MD to action improvement continuous.

Who Safer Surgery
- Continuous to be under scrutiny by MD and Cardiology being the non-compliant area.
- Reporting into IPR is not timely.

Cancellations & Theatre Utilisation
- Avoidable cancellations continue in high proportions
- Theatre utilisation is not improving and variable between c70-75%, in-session is already 210mns (3.5hrs only) so the utilisation should be much higher as true operating time only

RTT
- 52 week breaches – several months now with numerous breaches. Assurance that RTT training is fully rolled out is required.
- Delivery to standard too close for comfort at 92% with a number of failing specialities (x5)

Cancer
- Manage December performance to ensure Q3 is delivered, having failed October target against 62 Days.

Recovery Action Plans (RAPs) Update

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: **failing target** after successful delivery in previous months – the service is reacting to this.
2. Safeguarding training: all levels of the training **are now delivering** to the 85% standard and this is a very good outcome for the training team.
3. Dementia and Falls Assessments (Community); Data quality review ongoing for these indicators involving the GDN. Performance still **under expected trajectories**
4. Cancelled on day operations: **sustainable progress not yet embedded** – Theatre Improvement Project overseeing
5. Maternity indicators are now delivering **other than the CO monitoring**. The Director of Midwifery is reviewing breaches at patient level and addressing issues as appropriate. Many breaches counted, now confirmed as women coming from out of areas and the team will communicate with GPs to address this where possible.
6. ED 4hrs being managed separately, but also under RAP.

CQUINs 2017/18 – Q2 Position

- Q2 results now confirmed by commissioners with a lost funding at £215k year to date (Q1 and Q2 year to date).
- Major risk continue to be Sepsis, ECDS / PCCMDS and readiness to present auditable records for schemes which are declared as delivering
- A year end forecast is being worked up.

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		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:

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

PREVIOUS CONSIDERATION:

Operational Management Committee, Performance Management Committee, CLE, Q&S

Sandwell and West Birmingham Hospitals NHS Trust

Integrated Quality & Performance Report

Month Reported: November 2017

Reported as at: 21/12/2017

TRUST BOARD

Contents

November 2017

Infection Control

Cdiff - compliant (but full year risk given recent trajectory)
- x1 C. Diff cases reported during the month of November;
- x17 cases year to date against trajectory maximum of 20;
- most recent two months exceed trajectory - excalted to DCNO for oversight
- An annual trajectory of 30 has been agreed with the CCG for 17/18.

MRSA - compliant
- Nil cases of MRSA Bacteraemia were reported in November;
- Nil cases on a year to date basis.
- Annual target set at zero.

MRSA Screening - compliant overall, but not in all groups/directorates
November month:
- Non-elective patients screening 93.4%
- Elective patients screening 89.4%
- Both indicators are compliant with 80% target in-month and year to date

Elective screening is compliant with standard at trust level, but Medicine&EC and PCCT are not.
Group need to take forward with Infection Control lead to ensure improvement is visible.

MSSA - compliant
MSSA Bacteraemia (expressed per 100,000 bed days)
Year to date rate at 6 compared to target of 9.42.

Harm Free Care

Safety thermometer - not compliant
- 94.5% reported for November;
- 94.6% year to date;

NHS Safety Thermometer target 95% consistent marginal failure

- x66 [x86] falls reported in November with x3 [x1] fall resulting in serious injury,
- x603 falls reported year to date
- In month, 32 falls within community, 33 falls in acute setting and 1x in Imaging.
- Falls remain subject to ongoing CNO scrutiny and emergent tracking of impact of Safety Plan on falls reduction.
- A request for a threshold review has been made to DON to ensure a closer link to admissions or other appropriate metrics.

- x9 [x6] avoidable, hospital acquired pressure sores reported in November of which x6grade 3, x3 grade 2
- x4 separate cases reported within the DN caseload.
- CNO keep in view

x6 [x4] serious incidents reported in November;
routine collective review in place and reported to the Q&S Cttee.

- No never event was reported in November; x3 year to date
- WHO Safer Surgery (Audit - brief and debrief - % lists where complete) as at November 97.9% vs the 100% target.

Clinician/list specific follow up by Group Director of Ops to secure 100% compliance

No medication error causing serious harm in November;
x1 case in last 18 mnths

x31 (x48) DOLS have been raised in November of which 31 were 7-day urgents;
cases lower than last months but higher to previous months

- Venous Thromboembolism (VTE) Assessments in at 97.5% [97.1%] compliant with 95% standard across all Groups for November
- Residual 214 assessments missed in November; being addressed through Safety Plan roll out to secure 100% compliance.

Obstetrics

C-section rate - not compliant
- The overall Caesarean Section rate for November is 26.2% (30.2%) and 25.6% year to date just above the 25% target, driven by non-elective cases
- Elective and non-elective rates are 8.6% and 17.6%% respectively in the month.
- 7/10 months elevated - matter considered at Q&S & Board and to be kept in view.

- Adjusted perinatal mortality rate (per 1000 births) for November is 4.16 vs. threshold level of 8;
- The indicator represents an in-month position and which, together with the small numbers involved provides for sometimes large variations.
- The year to date position 6.25 is within the tolerance rate of 8.0.
- Nationally, this indictor is monitored using a 3 year cumulative trend, based on which the Trust is within normal confidence limits.

New indicators in the IPR this month
- Stillbirth rate (per 1000 babies) for November is 2.10
- Neonatal Death Rate (Corrected) (per 1000 babies) is 2.10 in November

- Post Partum Haemorrhage (>2000ml) x2 cases against a threshold of 4 cases in November, 17x case year to date and below target

- Puerperal Sepsis within normalised range following new sepsis pathways being implemented; ongoing review by Group Director & MD for assurance.

No maternal death was reported in November;
x1 death last 18mnths recorded in August.

- Breastfeeding initiation performance reports quarterly; September quarterly count is at 75.49% compliant with the 74% target.

Mortality & Readmissions

Mortality - compliant
- The Trust overall RAMI for most recent 12-mth cumulative period is 108 (available data is as at August) reporting a revised RAMI methodology which needs to be monitored over the next few months to see the impact and comparison to historic approach
- RAMI for weekday and weekend each at 103 and 124 respectively. MDO review reportable to November Q&S
- SHMI measure which includes deaths 30-days after hospital discharge is at 102 for the month of June (latest available data).
- **RAMI New Methodology effective from 1st Dec17:** CHKS RAMI was developed over ten years ago. it has become more complex and this along with other reasons led to a review. The Clinical Effectiveness team will be monitoring changes in methodology and any impact resulting from this on the organisation or benchmark.

- Deaths in Low Risk Diagnosis Groups (RAMI) - month of August is 71. This indicator measures in-month expected versus actual deaths so subject to larger month on month variations.
- Crude in-month mortality rate for October is 1.3% [1.1%] normalising to previous long term avg of 1.3%, decrease month on month and the same for the period last year;
- The rolling crude year to date mortality rate remains consistent at 1.3 and consistent with last year same period unaffected by the one off increased performance in July.
- There were x133 [x109] deaths in our hospitals in the month of October; slightly higher than last year same period which was at 108.

Mortality Reviews within 42 Days - not compliant
- Mortality review rate in September at 42% and continually below target; an exception report has been requested from the MD office to identify causes and improvements
- Revised Learning from Deaths arrangements being implemented and which will provide for routine 100% review.

- Readmissions (in-hospital) reported at 7% in October increasing to last month;

- 7.2% rolling 12 mths. The equivalent, latest available peer group rate is at 7.8% .

Stroke Care & Cardiology

Patient Stay on Stroke Ward - compliant
- WD 5 reporting for November indicates that 93.3% [100%] of patients are spending >90% of their time on a stroke ward - compliant with the 90% operational threshold

Admission - not compliant
- November admittance to an acute stroke unit within 4 hours is at 77.6% [74.5%] below the national standard of 80%. Delays in transfer for 7 patients e.g.
- No bed capacity for x3 patients, atypical symptoms/unclear presentation for x2 patients, 1x patient refused admission initially but was admitted following discussion with family and 1x delay with inpatient transfer from Lyndon 5

Scans - compliant
- Pts receiving CT Scan within 1 hour of presentation is at 83% in November, but being consistently compliant with 50% standard;
- Pts receiving CT Scan within 24 hrs of presentation delivery in month at 98% [98.2%] meeting the 95% standard in month

Thrombolysis - not compliant
At 75% as at November, but patient notes are still being validated for clinical reasons affecting the procedure initiation.

Angioplasty - compliant
For November 95.5% compliance on both Primary Angioplasty Door to balloon time (<90 minutes) and 95.2% Call to balloon time (<150 minutes) & delivering consistently against 80% targets

RACP - compliant
RACP performance for November at 100% [100%] exceeding the 98% target for over 20 consecutive mths

TIA Treatments - compliant
- TIA (High Risk) Treatment <24 Hours from receipt of referral delivery as at November is at 100% against the target of 70%.
- TIA (Low Risk) Treatment <7 days from receipt of referral delivery at November is 95.7% against a target of 75%.

Cancer Care

Cancer standards - compliant across all standards other than 62 Days
- October delivery across all headline cancer targets but failing 62 Days at 82.3%; nationally the trust performs well on this target
- October 2WW delivering 96.8% against the 93% standard significantly improving historical performance levels
- November expected to recover 62 Days and continuous to deliver all other cancer targets
- Impact of prospective changes to oncology & gynae-oncology services on performance being assessed - estimated at c1-2% adverse & which may compromise delivery of standards

Patient Waiting times - not compliant:
- x11.0 [x9.0] patients waited longer than the 62 days at the end of October.
- 4 [x1] patients waited more than 104 days at the end of October
- The longest waiting time for treatment for a patient as at the end of October was at 125 days

Neutropenic sepsis - not compliant
- (7/43 patients) - 17% of neutropenic sepsis November cases failed to receive treatment within prescribed period (less than 1hr).

Residual number of missed cases ; the aim is to achieve 100% target consistently.

Inter-Provider Transfers - not compliant
- 67% of Tertiary referrals were met within 38 days by the Trust for the month of September - the consistent failure to meet this target requires attention and escalated to GDO for review & assurance. Cancer team track breaches and provide RCAs for each.

Patient Experience - MSA & Complaints

MSA - not compliant
- There were x131 (46) MSA breaches in November, all pre-approved by COO.
- During November the Trust continued to experience peaks of emergency activity for medical admissions and a down-turn in discharges resulting with the capacity pressures and hence need to MSA breaches.

Friends & Family - not compliant
- reporting of performance is undergoing a full review as part of 'persistent red' initiative.

Performance and reporting will improve through this. Scores and response rate remain low.

Complaints - not compliant
'- The number of complaints received for the month of November is 99 [66] with 2.0 [1.4] formal complaints per 1000 bed days, showing an increase to previous rates, but lower to last year same period (2.8).
- 90% [100%] have been acknowledged within target timeframes (3 days).
- 19% [24%] month of responses have been reported beyond agreed target time; escalated to DG for remedy.

Patient Experience - Cancelled Operations

Cancelled Ops - not compliant
- 47 [48] sitrep declared late (on day) cancelations were reported in November.
- Of the 48 patients who were cancelled, 14 (30%) were avoidable;
- Elective operations cancelled at the last minute for non-clinical reasons, as a proportion of elective admissions, was 1.1% in October [1.1%] (since Jun16 consistently failing the tolerance of 0.8%)

28 Day Breaches - compliant
- There were no breaches of the 28 days guarantee in November;
- Year to date x3 28 day breaches were incurred
- No urgent cancellations took place during the month of November

Theatre Utilisation - not compliant
- Theatre utilisation is consistently below the target of 85%; 75.3% in month, 72.9% year to date
- The utilisation indicator alone does not measure productivity and throughput of patients needs to be taken into consideration too. The Trust operates a 210 mins(3.5hrs) sessions rather than 4hrs and hence it can be argued that in-session utilisation should therefore be even higher than 85%.
- Intensive planned care focus aims to improve booking rates and hence utilisation will improve as a result, but will always depend on level of cancellations and bed-capacity in the organisation.

Emergency Care

ED 4hr standard - not compliant
- The Trust's performance against the 4-hour ED wait target in November was 82.68% [85.36%] against the 90% STF & 95% national target
- 3,168 breaches were incurred in November

ED quarterly performance trend for 17/18: Q1 at 83.3% ; Q2 at 87.1%;

WMAS Handovers - partially compliant
- WMAS fineable 30 - 60 minutes delayed handovers at 207 [143] in November. An increase month on month.
- x6 [x4] cases were > 60 minutes delayed handovers in November - the Trust performs very well in this category with only 30 breaches year to date > 60 mins

- Handovers >60mins (against all conveyances) 0.14% in November increasing to last months and against target of 0.02% . This performance is against total WMAS conveyances of 4,424 in November which was less than in October.
- Handovers >60mins are at 0.09% on a year to date basis against the 0.02% target.

Fractured NOF - not compliant
- Fractured Neck of Femur Best Practice Tariff delivery for November is at 70% [82%] below the 85% target but improvement to last month.
- Consistently below target.

DTOCs accounted for 592 [512] bed days utilised in November; of which 149 [272] beds were fineable to BCC.
Sustained elevated levels of DTOCs; system plan to remedy remains to be assured.

Referral To Treatment

RTT - compliant overall, but not at every Specialty Level
- RTT incomplete pathway for November is at 92.4% [92.29%] ; continuing to perform to national standard of 92% at trust level, but below internal trajectory which includes specialty level compliance improvement
- The backlog (.18wks) as at end of November stands at 2,322 patients

- 5x treatment specialities which continue to under-perform against 92% standard are: T&O, Oral surgery, Plastic Surgery, Dermatology, Cardiology

- December delivery is under pressure at this stage, but intensive focus is being provided

52 Week Breaches - not compliant
- There are 3x 52 week breaches in November on the incomplete pathway.

Acute diagnostic waits - not compliant
'Diagnostic DM01 performance forecast for November has failed the standard of 99% and delivered 98.89%; 103 total breaches of which mainly are due to MRI equipment failure and expected to recover in December.

Data Completeness

- Data issues with SUS result in no reporting for latest periods. This will be reinstated next month.
- The Trust's internal assessment of the completion of valid NHS Number Field within inpatient data sets compliant in mnth with 99.0% operational threshold but below YTD (98.3%). OP and A&E datasets deliver to target.
- ED required to improve patient registration performance as this has a direct effect on emergency admissions.
- Patients who have come through Malling Health will be validated via the Data Quality Department.
- Ethnicity coding is performing for Inpatients at 91% against 90% target, but under-delivering for Outpatients. This is attributed to the capture of data in the Kiosks and revision to capture fields is being considered.
- Data Quality Committee has been re-instated and monthly meetings will take place to

Open Referrals - not compliant
- Open Referrals, patients in the system without a future waiting list activity, stand at 138,000 as at November showing a continuing, increasing trend again as administration / IT processes persistently do not close down referrals/pathways as appropriate.
- Recommendations have been made to COO on short and long-term improvements. This has to be agreed as yet.
- Low patient risk rated (green risk) amount to c15,000 (which are part of the 138,000 total), are subject to auto-closures since Jan2016. The recommendations include: key drivers for removing open referrals issues form the trust sustainably is IT solutions to be implemented (already developed but not implemented); this involves a) the 'Follow Up WL' to be complete (open referrals not on there now) and b) that referrals are closed automatically on discharge (a seamless process rather than user dependent which currently fails)

Staff

PDR - not compliant
- PDR overall compliance as at the end of November is at 86.3% against the 95% target.
- Medical Appraisal at 82.3%.

Sickness - not reported as yet for November
- In-month sickness for November is at 4.68% (4.49%) worsening to last month; the cumulative sickness rate is 4.48% [4.51%].
- The number of short term sickness 962 [889] cases showing another increase to last month; long term 246 [251] cases slightly less than last month

Turnover rate - not compliant
- The Trust annualised turnover rate is at 13.2% [13.4%] in November increasing to previous months, high against previous trend

Mandatory Training - not compliant
- Mandatory Training at the end of November is at 87.1% overall against target of 95%;
- Health & Safety related training is below the 95% target at 94.6% in November.
- Safeguarding training recovery plans (Level 2 Child & Adults) are hitting improvement trajectories and are delivering full standards.

CQUINs & Local Quality Requirements 2017/18

CQUINs : Q2 £215k cost of non-compliance (against the schemes for milestones up to Q2)
- 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.
- Q2 has been reported at the end of October and against Q2 milestones, a possible delivery at £2.23m . The Trust has declared achievements for all schemes other than for Sepsis (partial delivery) and eRS roll out (partial delivery), which has now been confirmed by the commissioners as Q2 delivery
- A year end forecast is being worked up

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; now fully compliant
- Community falls & dementia delivery is being addressed, but reporting issues remain
- Maternity indicators are being actively monitored for CO Monitoring but suffer from impact of out of area women who do not present in time ; BMI fully compliant now for 2 months
- On the Day Cancellations are subject to Theatre Improvement Project (TIP) focus
- Gynae 4 week community clinics are delivering in line with improvement trajectory, but has seen a worsening in month which is being investigated
- A&E including morning discharges and other A&E indicators are subject to an overall plan (RAP) and 'patient journey' project.
- The specific IPR page has been added to highlight and monitor areas of non-compliance against the LQRs (Local Quality Requirements).

STF Criteria & NHSI Single Oversight Framework

STF - £2.9m full year estimated cost of non-compliance

- 30% [c£3.1m] performance related STF to be assessed against achievement of ED 4hr improvement trajectory.

- Q1 £236k secured.
- Q2 & Q3 assessed as not secured due to likely non-compliance with 90% standard.
- Q4 assessed as not secured due to likely non-compliance with 95% March standard.

- Balance of STF [c£7.4m] related to achievement of financial plan.
- P07 financial performance reported as being on plan but supported by c£4.5m of unplanned non-recurrent measures.
- Out-turn suggests recovery of £4.9m of £7.4m of financial plan element of STF

Summary Scorecard - November (In-Month)

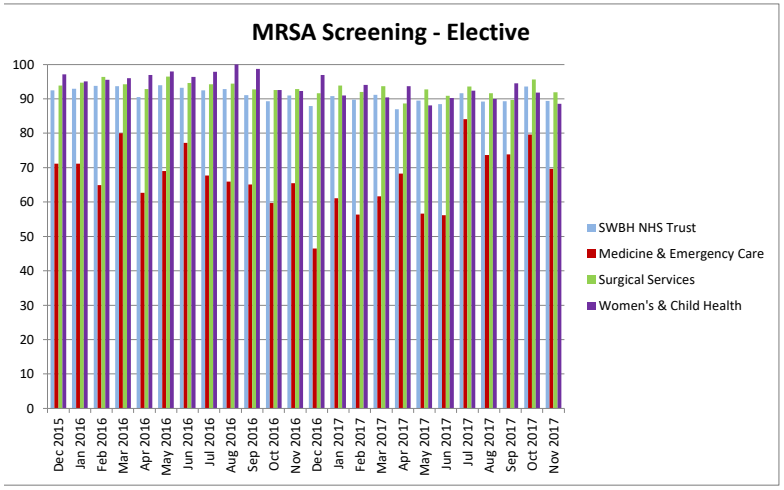
Summary Scorecard

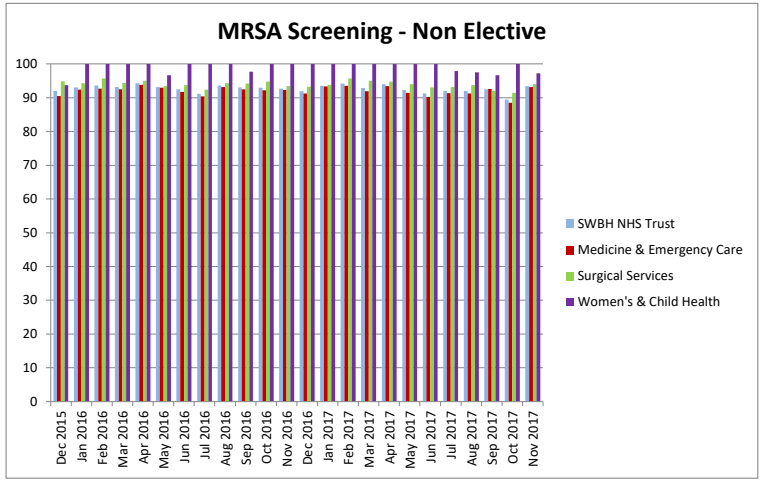
Section	Red Rated	Green Rated	None	Total
Infection Control	0	6	0	6
Harm Free Care	9	4	9	22
Obstetrics	4	5	6	15
Mortality and Readmissions	1	1	11	13
Stroke and Cardiology	1	10	0	11
Cancer	2	8	5	15
FFT. MSA, Complaints	16	0	5	21
Cancellations	5	3	0	8
Emergency Care & Patient Flow	9	6	4	19
RTT	7	1	6	14
Data Completeness	1	9	9	19
Workforce	5	1	13	19
Temporary Workforce	0	0	28	28
SQPR	10	0	8	18
Total	70	54	104	228

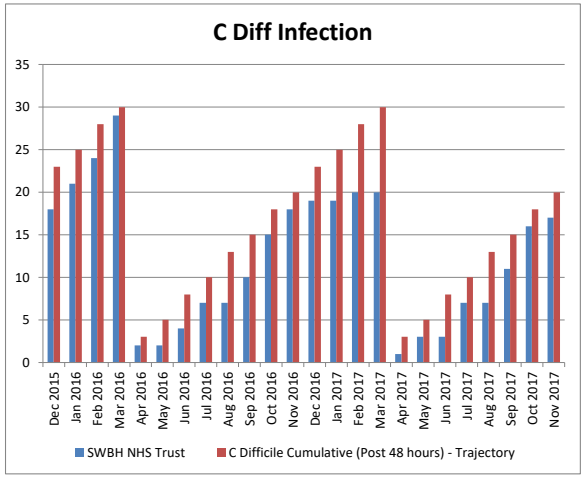
- Persistently red-rated performance (>12months) indicators are subject to improvement trajectories and monitoring.
- IBN002 is still an outstanding performance notice against which funding has been withheld now at risk of permanent removal. COO/FD have been asked for support to close this out (c£500k retained funding)

Patient Safety - Infection Control

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From Jun 2016) J J A S O N D J F M A M J J A S O N	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
4			C. Difficile	<= No	30	2.5		Nov 2017	1	0	0			0		1	17	
4			MRSA Bacteraemia	<= No	0	0		Nov 2017	0	0	0			0		0	0	
4			MSSA Bacteraemia (rate per 100,000 bed days)	<= Rate2	9.42	9.42		Nov 2017								5.0	5.9	
4			E Coli Bacteraemia (rate per 100,000 bed days)	<= Rate2	94.9	94.9		Nov 2017								0.0	9.1	
3			MRSA Screening - Elective	=> %	80	80		Nov 2017	69.6	91.9	88.5			50		89.4	89.8	
3			MRSA Screening - Non Elective	=> %	80	80		Nov 2017	93.1	94	97.2			100		93.4	92.1	

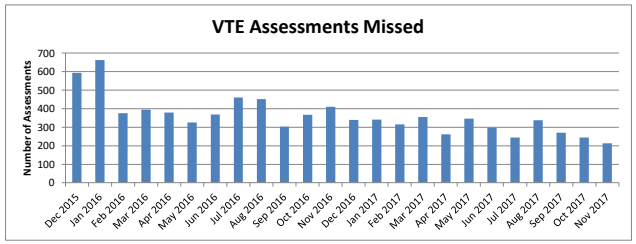


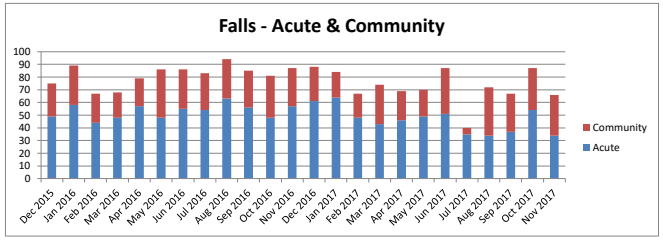


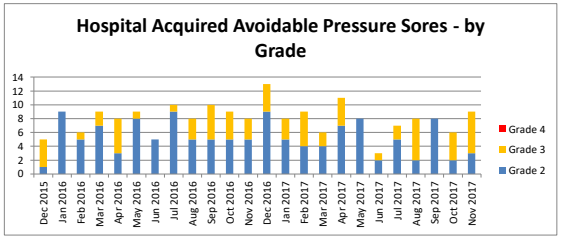


Patient Safety - Harm Free Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jun 2016) J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	Data Period	Group M	SS	W	P	I	PPCT	CO	Month	Year To Date	Trend
8		•d	Patient Safety Thermometer - Overall Harm Free Care	=> %	95	95																			Nov 2017								94.5	94.6	
8		•d	Patient Safety Thermometer - Catheters & UTIs	%			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	3.00	2.00	1.00	4.00	4.00	Nov 2017								0.35	0.22	
	NEW		Number of DOLS raised	No			-	-	-	-	-	25	22	15	14	23	15	14	6	27	22	20	48	31	Nov 2017	15	12	0	-	-	4		31	183	
	NEW		Number of DOLS which are 7 day urgent	No			-	-	-	-	-	25	22	14	14	23	15	14	6	27	22	20	48	31	Nov 2017	15	12	0	-	-	4		31	183	
	NEW		Number of delays with LA in assessing for standard DOLS application	No			-	-	-	-	-	6	0	0	0	0	0	0	0	3	0	0	0	0	Nov 2017	0	0	0	-	-	0		0	3	
	NEW		Number DOLs rolled over from previous month	No			-	-	-	-	-	4	15	14	8	8	15	12	9	7	12	5	5	3	Nov 2017	1	1	0	-	-	1		3	68	
	NEW		Number patients discharged prior to LA assessment targets	No			-	-	-	-	-	6	6	2	11	6	3	11	7	7	9	9	11	7	Nov 2017	3	1	0	-	-	3		7	64	
	NEW		Number of DOLs applications the LA disagreed with	No			-	-	-	-	-	1	0	1	1	0	1	0	2	1	2	1	0	2	Nov 2017	1	1	0	-	-	0		2	9	
	NEW		Number patients cognitively improved regained capacity did not require LA assessment	No			-	-	-	-	-	5	2	1	0	0	3	1	1	13	0	0	0	0	Nov 2017	0	0	0	-	-	0		0	18	
8			Falls	<= No	804	67	86	83	94	85	81	87	88	84	67	74	69	70	87	85	72	67	87	66	Nov 2017	22	10	1	0	1	32		66	603	
9			Falls with a serious injury	<= No	0	0	4	1	3	3	1	2	3	3	1	2	1	1	1	1	3	2	3	1	Nov 2017	0	0	0		0	1		1	13	
8			Grade 2,3 or 4 Pressure Ulcers (Hospital Aquired Avoidable)	<= No	0	0	5	10	8	5	9	8	13	8	9	6	11	8	3	7	8	8	6	9	Nov 2017	5	2	0			2		9	60	
	NEW		Avoidable Grade 2,3 or 4 Pressure Ulcers (DN Caseload Acquired)	<= No	0	0	1	4	3	2	0	2	5	6	8	6	5	8	4	8	4	4	6	4	Nov 2017						4		4	43	
3		•d•	Venous Thromboembolism (VTE) Assessments	=> %	95	95																			Nov 2017	96.1	98.4	96.2					97.5	96.6	
3			WHO Safer Surgery - Audit - 3 sections (% pts where all sections complete)	=> %	100	100																			Nov 2017	98.7	99.8	100.0		0.0			99.5	99.8	
3			WHO Safer Surgery - brief (% lists where complete)	=> %	100	100																			Nov 2017	99	98	100		0			98.7	99.4	
3			WHO Safer Surgery - Audit - brief and debrief (% lists where complete)	=> %	100	100																			Nov 2017	98	97	100		0			97.9	98.5	
9		•d•	Never Events	<= No	0	0	1	1	0	0	0	1	0	0	1	0	0	1	1	0	1	0	0	0	Nov 2017	0	0	0	0	0	0		0	3	
9		•d	Medication Errors causing serious harm	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	Nov 2017	0	0	0	-	0	0		0	1	
9		•d•	Serious Incidents	<= No	0	0	10	5	6	4	6	5	10	5	6	5	4	4	3	1	8	5	4	6	Nov 2017	3	0	2	0	0	1	0	6	35	
9			Open Central Alert System (CAS) Alerts	<= No			3	11	12	12	14	10	8	6	5	4	8	9	27	3	3	8	10	6	Nov 2017								6	74	
9		•d	Open Central Alert System (CAS) Alerts beyond deadline date	No	0	0	0	0	1	1	2	1	2	0	1	0	0	0	1	1	1	0	0	1	Nov 2017								1	4	

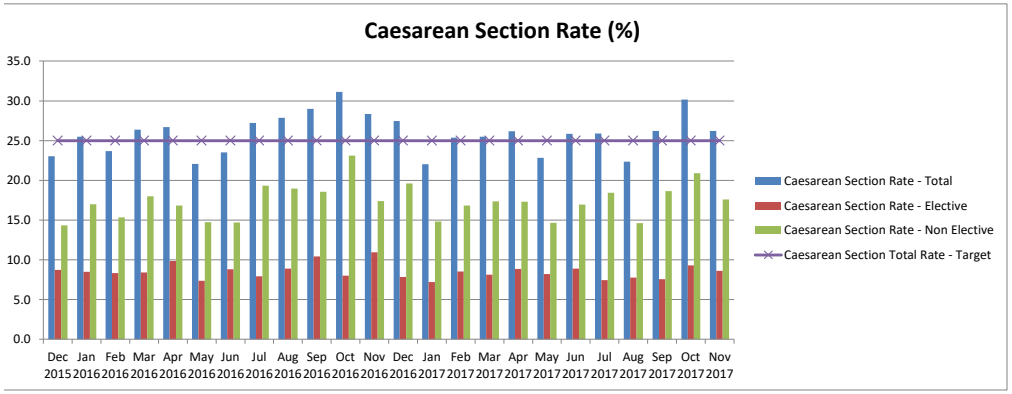


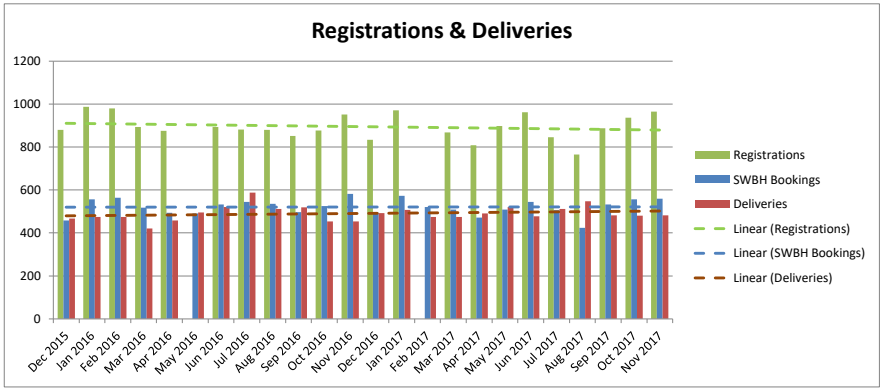




Patient Safety - Obstetrics

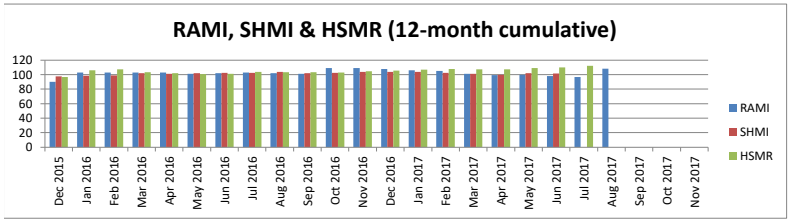
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory 2016-2017 Year	Trajectory 2016-2017 Month	Previous Months Trend (since Jun 2016) J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	Data Period	Month	Year To Date	Trend
3			Caesarean Section Rate - Total	<= %	25.0	25.0																			Nov 2017	26.2	25.6	
3		•	Caesarean Section Rate - Elective	<= %			9	8	9	10	8	11	8	7	9	8	9	8	9	7	8	8	9	9	Nov 2017	8.6	8.3	
3		•	Caesarean Section Rate - Non Elective	<= %			15	19	19	19	23	17	20	15	17	17	17	15	17	18	15	19	21	18	Nov 2017	17.6	17.3	
2		•d	Maternal Deaths	<= No	0	0																			Nov 2017	0	1	
3			Post Partum Haemorrhage (>2000ml)	<= No	48	4																			Nov 2017	2	17	
3			Admissions to Neonatal Intensive Care (Level 3)	<= %	10.0	10.0																			Nov 2017	2.29	1.93	
12			Adjusted Perinatal Mortality Rate (per 1000 babies)	<= Rate1	8.0	8.0																			Nov 2017	4.16	6.25	
12			Stillbirth Rate (Corrected) (per 1000 babies)	Rate1			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2.11	2.10	Nov 2017	2.10	2.10	
12			Neonatal Death Rate (Corrected) (per 1000 babies)	Rate1			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	4.22	2.10	Nov 2017	2.10	3.15	
12			Early Booking Assessment (<12 + 6 weeks) - SWBH Specific	=> %	90.0	90.0														.					Nov 2017	77.6	77.4	
12			Early Booking Assessment (<12 + 6 weeks) - National Definition	=> %	90.0	90.0																			Nov 2017	155.9	137.3	
2			Breast Feeding Initiation (Quarterly)	=> %	74.0	74.0		-->	-->		-->	-->		-->	-->		-->	-->		-->	-->		-->	-->	Nov 2017	-	76.31	
2		•	Puerperal Sepsis and other puerperal infections (variation 1 - ICD10 O85 or O86) (%) -	<= %			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	1.8	0.8	0.9	0.5	0.8	Nov 2017	0.75	1.78	
2		•	Puerperal Sepsis and other puerperal infections (variation 2 - ICD10 O85 or O86 Not O864) (%)	<= %			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	1.0	0.6	0.6	0.5	0.5	Nov 2017	0.50	1.18	
2		•	Puerperal Sepsis and other puerperal infections (variation 3 - ICD10 O85) (%)	<= %			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	1.0	0.0	0.0	0.0	0.0	Nov 2017	0.00	0.79	

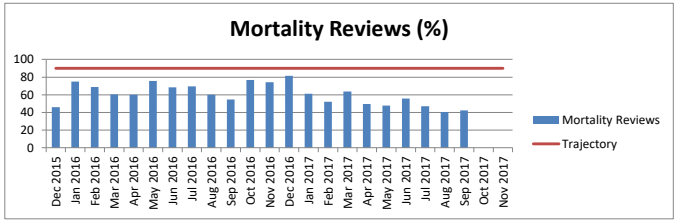


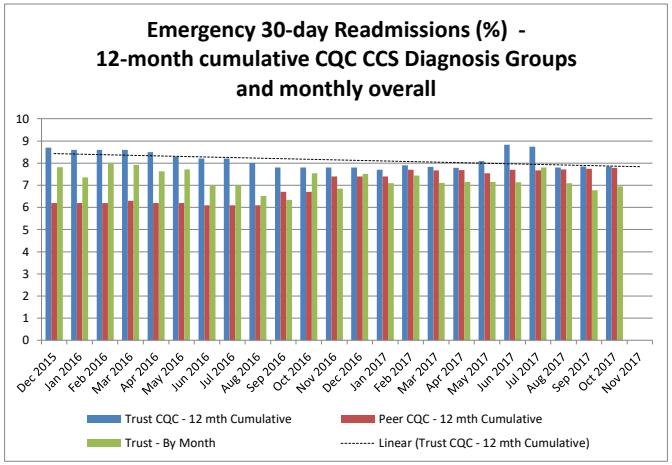


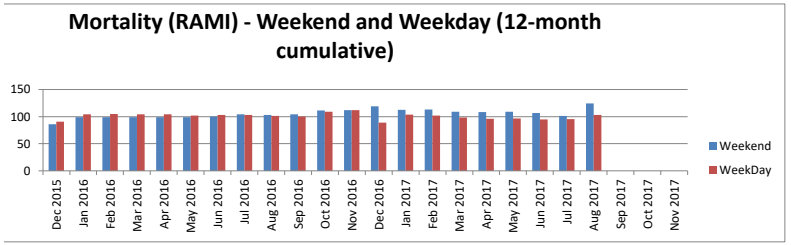
Clinical Effectiveness - Mortality & Readmissions

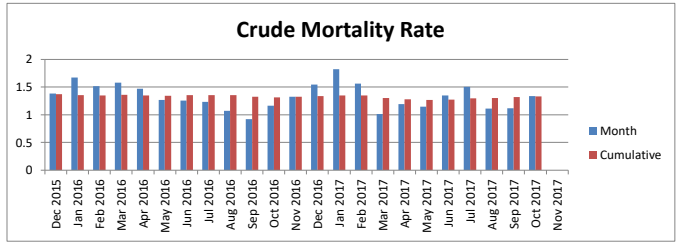
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jun 2016) J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
5			Risk Adjusted Mortality Index (RAMI) - Overall (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	102	103	102	101	109	109	108	106	105	101	99	100	98	97	108	-	-	-	Aug 2017									502	
5			Risk Adjusted Mortality Index (RAMI) - Weekday Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	103	103	101	100	109	112	89	104	102	98	96	97	95	95	103	-	-	-	Aug 2017									486	
5			Risk Adjusted Mortality Index (RAMI) - Weekend Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	100	104	103	104	111	112	119	112	113	109	109	109	106	101	124	-	-	-	Aug 2017									549	
6			Summary Hospital-level Mortality Index (SHMI) (12-month cumulative)	SHMI	Below Upper CI	Below Upper CI	103	102	104	102	102	104	104	104	103	101	100	102	102	-	-	-	-	-	Jun 2017									304	
5			Hospital Standardised Mortality Rate (HSMR) - Overall (12-month cumulative)	HSMR			101	104	103	103	103	105	106	107	108	108	107	109	110	112	-	-	-	-	Jul 2017									438.4	
5			Deaths in Low Risk Diagnosis Groups (RAMI) - month	RAMI	Below Upper CI	Below Upper CI	3	103	43	56	94	139	84	105	72	88	62	61	78	78	71	-	-	-	Aug 2017								71		
3			Mortality Reviews within 42 working days	=> %	90	90																-	-	Sep 2017	40	58	0			0		42	47	
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (by month)	%			1.3	1.2	1.1	0.9	1.2	1.3	1.5	1.8	1.6	1.0	1.2	1.1	1.3	1.5	1.1	1.1	1.3	-	Oct 2017								1.34		
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (12-month cumulative)	%			1.4	1.4	1.4	1.3	1.3	1.3	1.3	1.3	1.4	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	-	Oct 2017									1.30	
	NEW		Deaths in the Trust	No			123	119	102	87	108	129	143	172	139	100	105	113	129	142	109	109	133	-	Oct 2017								133	840	
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			7.0	7.0	6.5	6.3	7.5	6.8	7.5	7.1	7.4	7.1	7.2	7.2	7.1	7.8	7.1	6.8	7.0	-	Oct 2017								6.95		
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			7.8	7.6	7.5	7.4	8.0	7.3	7.1	7.2	7.2	7.1	7.1	7.0	7.1	7.1	7.2	7.2	7.2	-	Oct 2017									7.16	
5			Emergency Readmissions (within 30 days) - CQC CCS Diagnosis Groups (12-month cumulative)	%			8.2	8.2	8.0	7.8	7.8	7.8	7.8	7.7	7.9	7.8	7.8	8.1	8.8	8.7	7.8	7.8	7.8	-	Oct 2017	-	-	-			-			7.85	







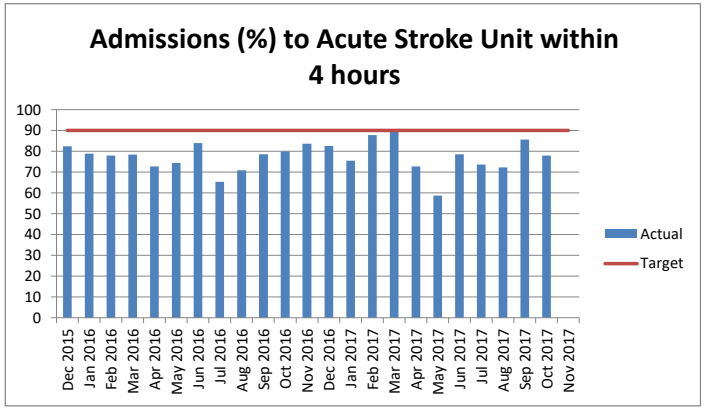


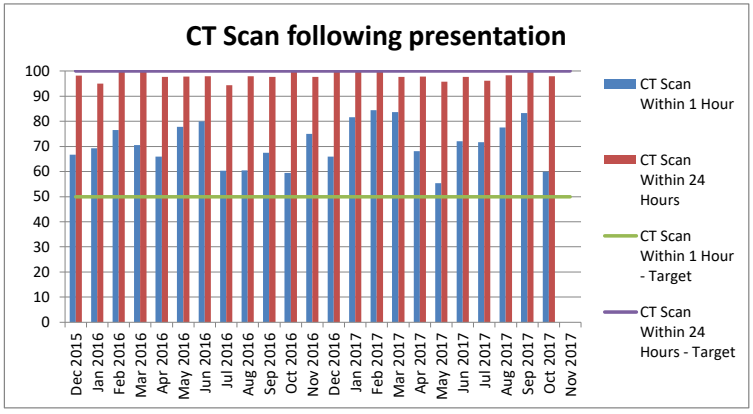


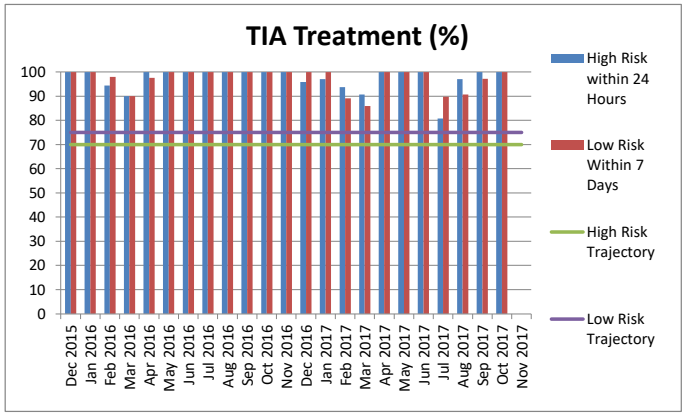
Notes: RAMI changes to new methodology which may impact the trust's performance. The changes are effective from 1st December 2017 and November results above are reported on that new basis.
The Clinical Effectiveness team will monitor the impact to the Trust and resulting benchmark.

Clinical Effectiveness - Stroke Care & Cardiology

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (Since Jun 2016) J J A S O N D J F M A M J J A S O N	Data Period	Month	Year To Date	Trend
3			5WD: Pts spending >90% stay on Acute Stroke Unit	=> %	90.0	90.0		Nov 2017	93.3	93.3	
3			5WD: Pts admitted to Acute Stroke Unit within 4 hrs	=> %	80.0	80.0		Nov 2017	77.6	73.9	
3			5WD: Pts receiving CT Scan within 1 hr of presentation	=> %	50.0	50.0		Nov 2017	83.0	71.4	
3			5WD: Pts receiving CT Scan within 24 hrs of presentation	=> %	95.0	95.0		Nov 2017	98.0	97.0	
3			5WD: Stroke Admission to Thrombolysis Time (% within 60 mins)	=>	85.0	85.0		Nov 2017	75.0	65.1	
3			5WD: TIA (High Risk) Treatment <24 Hours from receipt of referral	=>	70.0	70.0		Nov 2017	100.0	96.9	
3			5WD: TIA (Low Risk) Treatment <7 days from receipt of referral	=>	75.0	75.0		Nov 2017	95.7	95.8	
3			Stroke Admissions - Swallowing assessments (<24h)	=> %	98.0	98.0		Nov 2017	100.0	100.8	
9			Primary Angioplasty (Door To Balloon Time 90 mins)	=> %	80.0	80.0		Nov 2017	95.5	94.4	
9			Primary Angioplasty (Call To Balloon Time 150 mins)	=> %	80.0	80.0		Nov 2017	95.2	95.8	
9			Rapid Access Chest Pain - seen within 14 days	=> %	98.0	98.0		Nov 2017	100.0	100.0	



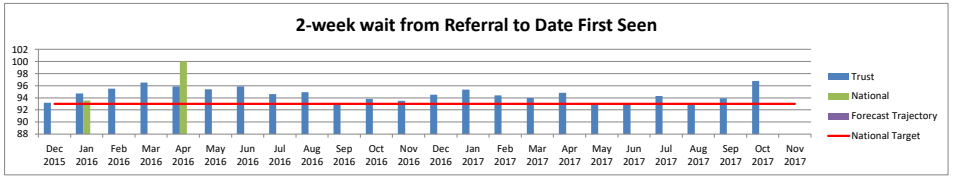


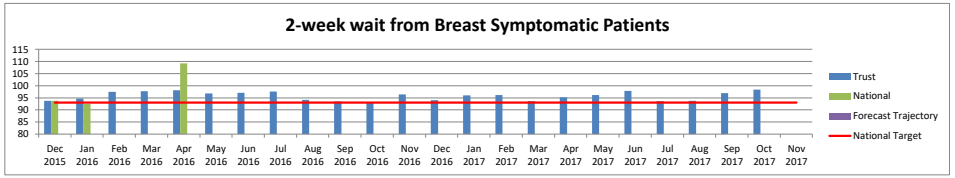


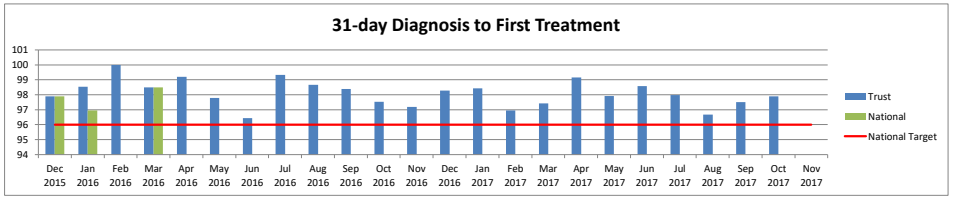
The stroke indicators in the IPR are based on 'patient arrivals' not 'patient discharged' as this monitors pathway performance rather than actual outcomes which may / may not change on discharge.
National SSNAP is based on 'patient discharge' which is more appropriate for outcomes based reporting.
Both are valid, but designed for slightly different purposes, however they will align overall, especially over a longer period of time (eg annually)

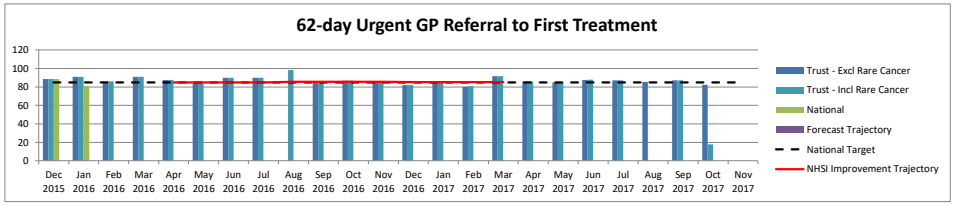
Clinical Effectiveness - Cancer Care

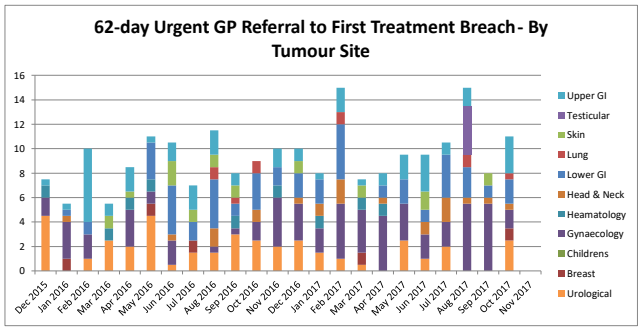
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jun 2016) J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
1			2 weeks	=> %	93.0	93.0																			Oct 2017	95.2	98.0	96.3			0.0		96.8	94.2	
1			2 weeks (Breast Symptomatic)	=> %	93.0	93.0																			Oct 2017		-						98.4	96.1	
1			31 Day (diagnosis to treatment)	=> %	96.0	96.0																			Oct 2017	97.7	97.6	100.0			0.0		97.9	97.9	
1			31 Day (second/subsequent treatment - surgery)	=> %	94.0	94.0																			Oct 2017								94.4	97.7	
1			31 Day (second/subsequent treatment - drug)	=> %	98.0	98.0																			Oct 2017								100.0	100.0	
1			31 Day (second/subsequent treat - radiotherapy)	=> %	94.0	94.0																			Oct 2017								-	0.0	
1			62 Day (urgent GP referral to treatment) Excluding Rare Cancer	=> %	85.0	85.0																			Oct 2017	84.1	82.4	75.0			0.0		82.3	85.9	
1	NEW		62 Day (urgent GP referral to treatment) Including Rare Cancer	=> %	85.0	85.0																			Oct 2017	15.9	17.7	25.0			0.0		17.7	76.3	
1			62 Day (referral to treat from screening)	=> %	90.0	90.0																			Oct 2017	0.0	95.8	100.0			0.0		96.2	97.9	
1			62 Day (referral to treat from hosp specialist)	=> %	90.0	90.0																			Oct 2017	90.5	92.9	100.0			0.0		92.7	92.1	
1			Cancer - Patients Waiting over 62 days	No			7	7	12	8	10	11	10	8	15	8	8	10	10	11	11	9	11	-	Oct 2017	3.5	6.0	1.5			0.0		11.0	68.5	
1			Cancer - Patients Waiting over 104 days	No			2	3.0	3.0	4.0	1.5	1.5	2.5	1.5	4.0	5.0	5.0	2.0	1.0	1.5	5.0	1.0	4.0	-	Oct 2017	2.0	2.0	0.0			0.0		4.0	19.5	
1			Cancer - Longest Waiter in days	No			130	113	131	140	133	77	107	120	150	162	140	139	106	102	184	141	125	-	Oct 2017	125	110	90			0		125		
1			Neutropenia Sepsis Door to Needle Time Greater Than 1 Hour	=> No	0.0	0.0	12	13	5	15	12	12	19	17	8	6	11	6	4	10	3	7	8	7	Nov 2017	7	0	0			0		7	56	
	NEW		IPT Referrals - Within 38 Days Of GP Referral for 62 day cancer pathway	%			33	50	43	67	50	0	0	33	0	50	0	0	0	25	25	67	0	-	Oct 2017	-	-	-			-		0	17	

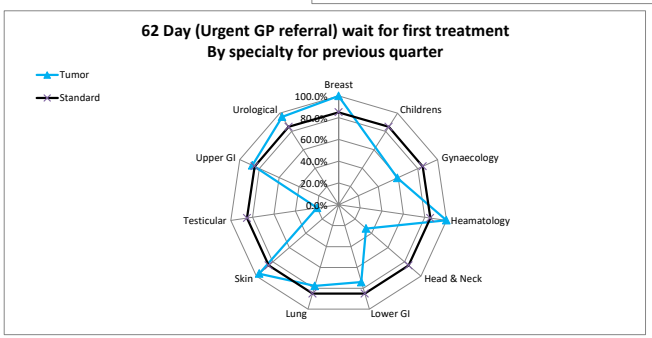


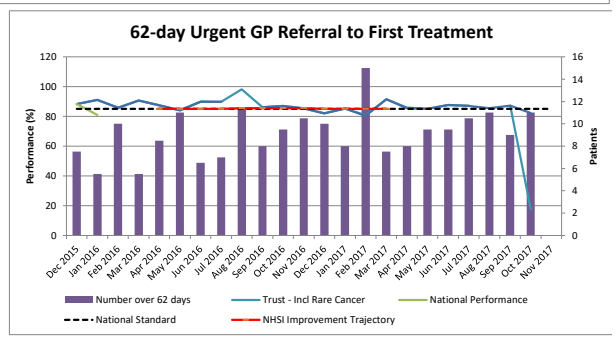






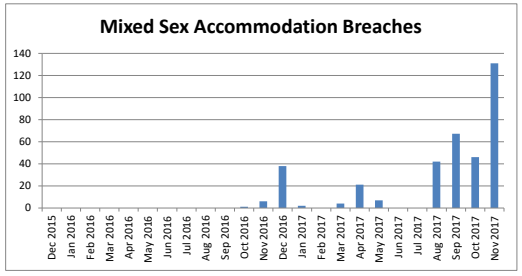


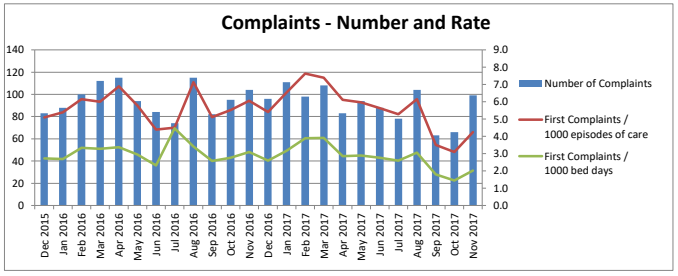


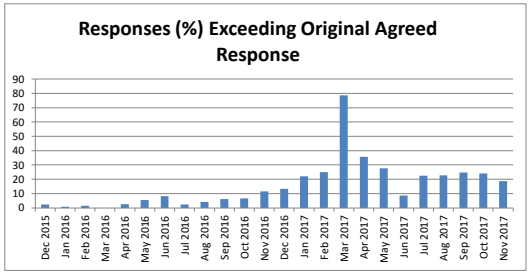


Patient Experience - FFT, Mixed Sex Accommodation & Complaints

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jun 2016) J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
8		•b•	FFT Response Rate - Adult and Children Inpatients (including day cases and community)	=> %	50.0	50.0	17	17	13	20	22	17	10	15	9.7	7.9	9.3	11	11.07	12	13	10	19	9.7	Nov 2017								10	12	
8		•a•	FFT Score - Adult and Children Inpatients (including day cases and community)	=> No	95.0	95.0	83	86	83	86	88	94	97	97	95	96	95	92	92.15	83	83	83	82	85	Nov 2017								85		
8		•b•	FFT Response Rate: Type 1 and 2 Emergency Department	=> %	50.0	50.0	10	7.8	7.5	7.1	5.6	4.8	5.9	5.4	4.3	4.2	5.5	3.8	2.35	3.8	2.8	3.4	3	3.4	Nov 2017	3.4							3.4	3.5	
8		•a•	FFT Score - Adult and Children Emergency Department (type 1 and type 2)	=> No	95.0	95.0	87	86	83	78	73	75	73	77	76	73	75	71	73.33	72	75	73	73	58	Nov 2017	58							58		
8			FFT Response Rate: Type 3 WiU Emergency Department	=> %	50.0	50.0	0.1	1.3	0.6	0.5	0.5	0.3	1.2	0.6	0	0	0.1	0	-	0	-	-	-	-	Jul 2017	-							0.0	0.0	
8			FFT Score - Adult and Children Emergency Department (type 3 WiU)	=> No	95.0	95.0	50	95	100	86	64	100	100	65	0	0	0	0	0	0	0	-	-	-	Aug 2017	-							0		
8			FFT Score - Outpatients	=> No	95.0	95.0	88	86	89	88	88	89	90	88	88	90	90	89	88.02	91	89	89	91	92	Nov 2017								92		
8	NEW		FFT Score - Maternity Antenatal	=> No	95.0	95.0	100	94	86	79	86	90	86	97	11	95	88	90	75	90	50	90	93	76	Nov 2017								76		
8	NEW		FFT Score - Maternity Postnatal Ward	=> No	95.0	95.0	100	100	100	74	81	93	90	91	29	83	91	86	72.55	73	81	84	89	81	Nov 2017								81		
8	NEW		FFT Score - Maternity Community	=> No	95.0	95.0	100	98	96	91	100	100	50	0	0	80	100	100	0	0	50	0	0	0	Nov 2017								0		
8			FFT Score - Maternity Birth	=> No	95.0	95.0	0	0	100	87	71	88	90	88	23	92	82	83	68.75	76	58	48	83	74	Nov 2017								74		
8			FFT Response Rate - Maternity Birth	=> %	50.0	50.0	0	0	1.4	15	5.9	17	13	8.2	5.4	21	8.9	11	6.987	7.1	5.2	5.2	13	6.9	Nov 2017								7	8	
13		•a	Mixed Sex Accommodation Breaches	<= No	0.0	0.0	0	0	0	0	1	6	38	2	0	4	21	7	0	0	42	67	46	131	Nov 2017	129	2	0		0	0		131	314	
9		•	No. of Complaints Received (formal and link)	No			84	74	115	82	95	104	96	111	98	108	83	94	88	78	104	63	66	99	Nov 2017	47	28	7	1	1	6	9	99	675	
9			No. of Active Complaints in the System (formal and link)	No			147	127	143	144	152	148	157	176	177	194	205	184	185	184	167	154	##	148	Nov 2017	75	36	13	2	3	8	11	148		
9		•a	No. of First Formal Complaints received / 1000 bed days	Rate1			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	2.6	3.1	1.8	1.4	2.0	Nov 2017	1.4	4.7	1.1			0		2.02	2.43	
9			No. of First Formal Complaints received / 1000 episodes of care	Rate1			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	5.3	6.2	3.5	3.1	4.2	Nov 2017	4	6.4	1.9			0		4.25	5.00	
9			No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)	=> %	100	100	100	96	100	100	99	100	100	99	98	94	100	100	100	100	100	98	##	90	Nov 2017	95	91	80	50	100	75	91	90	98	
9			No. of responses which have exceeded their original agreed response date (% of total active complaints)	<= %	0	0	8.2	2.4	4.2	6.3	6.6	11	13	22	25	79	36	28	8.649	23	23	25	24	19	Nov 2017	25	11	13	0	33	37.5	6.7	19	23	
9			No. of responses sent out	No			103	103	80	110	87	79	79	76	95	84	67	106	87	83	67	85	73	65	Nov 2017	18	21	6	3	1	9	7	65	633	
14		•e•	Access to healthcare for people with Learning Disability (full compliance)	Yes / No	Yes	Yes	-	•	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jul 2016	N	N	N	N	N	N	N	No		

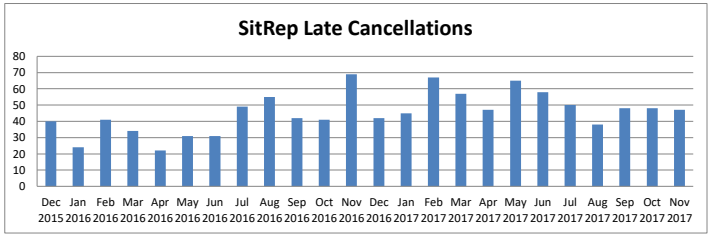


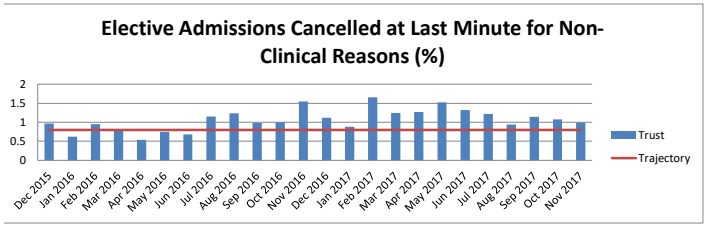


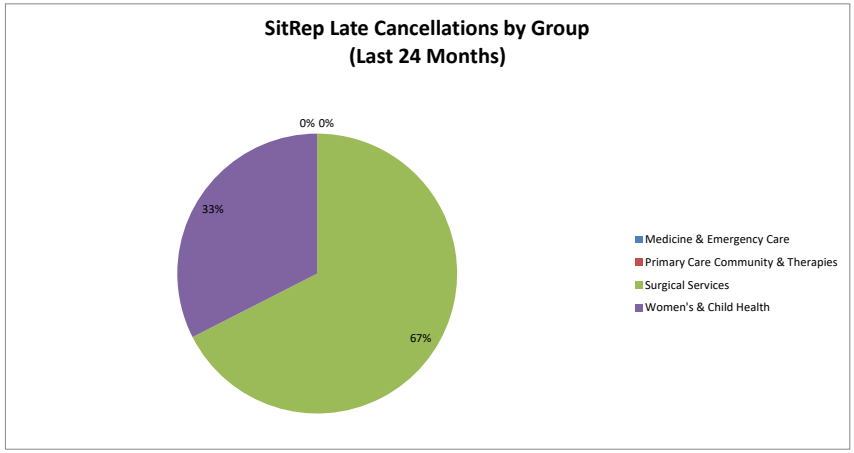


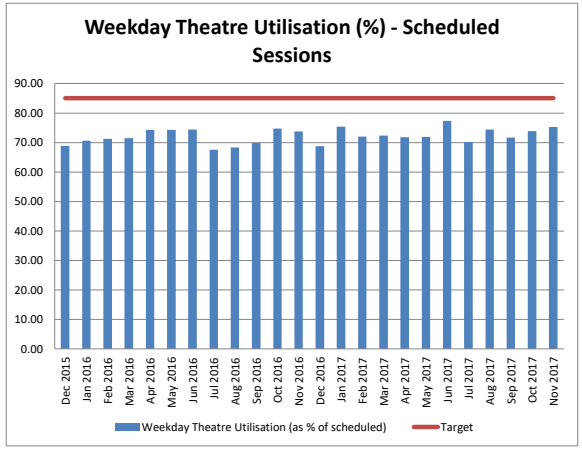
Patient Experience - Cancelled Operations

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jun 2016) J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
2			No. of Sitrep Declared Late Cancellations - Total	<= No	320	27	31	49	55	42	41	69	43	45	67	57	47	65	58	50	38	48	48	47	Nov 2017	3	35	8			1		47	410	
2			No. of Sitrep Declared Late Cancellations - Avoidable	No			11	9	9	15	17	28	19	13	19	17	24	27	20	21	12	31	11	14	Nov 2017	3	8	2			1		14	169	
2			No. of Sitrep Declared Late Cancellations - Unavoidable	No			19	40	43	27	22	41	18	29	48	37	23	37	37	29	26	17	31	33	Nov 2017	0	27	6			0		33	233	
2		•	Elective Cancellations at last minute for non-clinical reasons (as a percentage of elective admissions)	<= %	0.8	0.8																			Nov 2017	0.29	1.40	2.67			0.11		1.0	1.2	
2		•e•	Number of 28 day breaches	<= No	0	0	0	0	0	0	1	0	3	6	0	0	1	0	0	0	2	0	0	0	Nov 2017	0	0	0			0		0	5	
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	Nov 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	Nov 2017	0.0	0.0	0.0			0.0		0	0	
3			No. of Sitrep Declared Late Cancellations (Pts. >1 occasion)	<= No	0	0	1	2	0	0	1	3	4	0	3	0	3	1	3	1	1	0	1	1	Nov 2017	0	1	0			0		1	11	
			Multiple Hospital Cancellations experienced by same patient (all cancellations)	<= No	0	0	43	56	51	60	49	50	63	61	62	67	51	45	72	55	53	71	70	62	Nov 2017	4	52	6			-		62	479	
3			All Hospital Cancellations, with 7 or less days notice	<= No	0	0	229	241	223	258	234	273	272	269	284	257	219	230	250	245	213	243	294	244	Nov 2017	18	193	33			-		244	1938	
3			Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0																			Nov 2017	0.0	77.1	78.8			54.0		75.3	72.9	



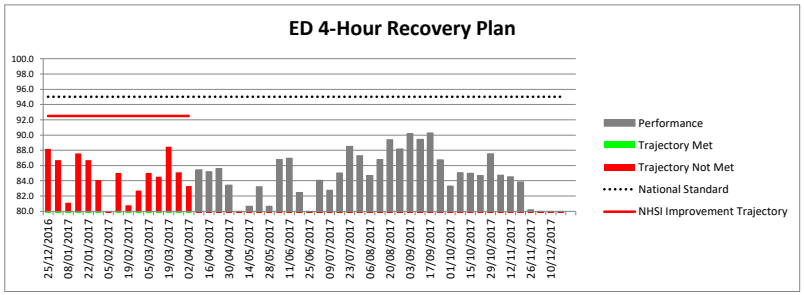


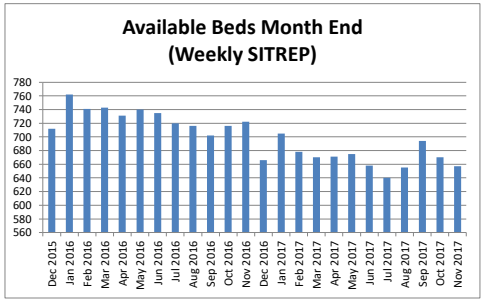


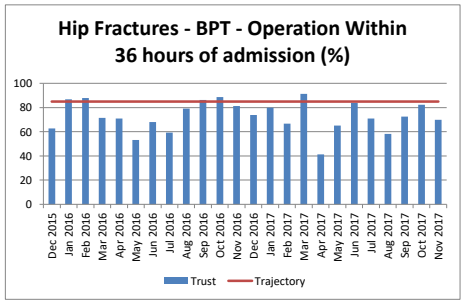


Access To Emergency Care & Patient Flow

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From) J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	Data Period	Unit S	Unit C	Unit B	Month	Year To Date	Trend
2			Emergency Care 4-hour waits	=> %	95.00	95.00																			Nov 2017	80.3	82.9	99.4	82.68	84.89	
2			Emergency Care 4-hour breach (numbers)	No			1625	2168	1884	2051	2676	3237	3324	2821	3046	2875	2814	3549	3014	2686	2177	2150	2800	3168	Nov 2017	1636	1525	7	3168	22358	
2			Emergency Care Trolley Waits >12 hours	<= No	0.00	0.00																			Nov 2017	0	0		0	0	
3			Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15.00	15.00																			Nov 2017	14	15	60	15	14	
3			Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60	60																			Nov 2017	64	59	108	65	63	
3			Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0																		-	Oct 2017	8.42	8.38	3.89	8.08	8.15	
3			Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0																			Nov 2017	4.50	6.16	2.43	5.15	5.48	
11			WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	<= No	0	0	70	122	112	135	112	162	193	162	129	107	110	159	242	111	127	90	143	207	Nov 2017	136	71		207	1189	
11			WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	<= No	0	0	1	8	6	9	16	21	19	11	13	5	0	12	6	1	0	1	4	6	Nov 2017	5	1		6	30	
11			WMAS - Handover Delays > 60 mins (% all emergency conveyances)	<= %	0.02	0.02																			Nov 2017	0.22	0.05		0.14	0.09	
11			WMAS - Emergency Conveyances (total)	No			4099	4363	4204	4138	4233	4261	4622	4410	4034	4206	4137	4376	4254	4429	4278	4174	4557	4424	Nov 2017	2294	2130		4424	34629	
2			Delayed Transfers of Care (Acute) (%)	<= %	3.5	3.5																			Nov 2017	1.6	4.0		2.5	2	
2			Delayed Transfers of Care (Acute) (Av./Week) attributable to NHS	<= No	<10 per site	<10 per site																			Nov 2017	6	8.75		15		
2			Delayed Transfers of Care (Acute) - Total Bed Days (All Local Authorities)	<= No	3.5% of available	3.5% of available	588	617	530	483	509	503	674	629	512	583	546	501	483	635	539	512	598	538	Nov 2017				538	4352	
			Delayed Transfers of Care (Acute) - Total Bed Days (All Local Authorities) as % of Available Beds	%	3.5	3.5	3.1	3.1	2.7	2.6	2.7	2.7	3.4	3.1	2.8	2.9	2.9	2.5	2.6	3.4	2.8	2.8	3.2	2.9	Nov 2017				2.90	2.88	
2			Delayed Transfers of Care (Acute) - Finable Bed Days (Birmingham LA only)	<= No	0	0	251	245	287	215	266	272	449	435	309	375	324	258	312	370	256	288	272	149	Nov 2017				149	2229	
2			Patient Bed Moves (10pm - 6am) (No.) -ALL	No			451	578	533	525	546	679	666	682	633	586	584	651	536	580	574	633	674	657	Nov 2017				657	4889	
2			Patient Bed Moves (10pm - 6am) (No.) - exc. Assessment Units	No			204	268	246	248	219	273	251	249	228	221	229	234	205	245	216	233	231	268	Nov 2017				268	1861	
			Hip Fractures - Best Practice Tarriff - Operation < 36 hours of admission (%)	=> %	85.0	85.0																			Nov 2017				70	67.3	

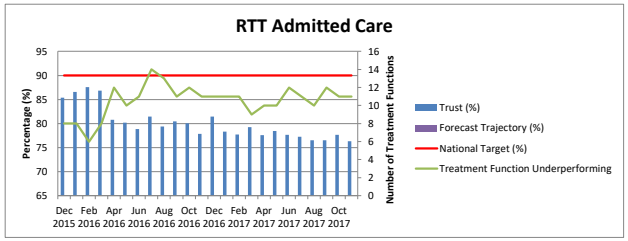


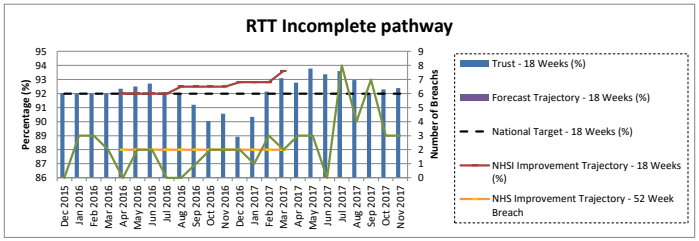


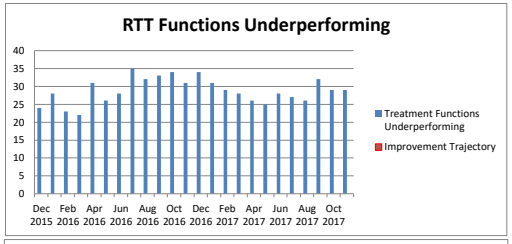


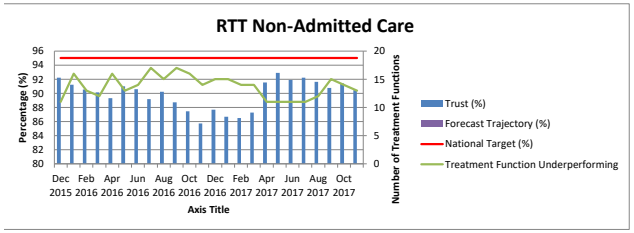
Referral To Treatment

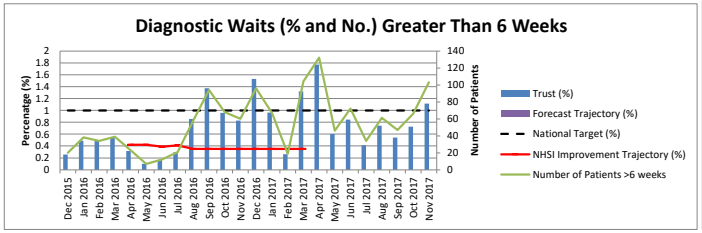
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jun 2016) J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
2			RTT - Admittted Care (18-weeks)	=> %	90.0	90.0																			Nov 2017	87.0	75.0	79.5			73.6		76.32		
2			RTT - Non Admittted Care (18-weeks)	=> %	95.0	95.0																			Nov 2017	80.1	91.2	95.2			87.1		90.46		
2			RTT - Incomplete Pathway (18-weeks)	=> %	92.0	92.0																			Nov 2017	92.0	91.7	94.1			93.0		92.40		
	NEW		RTT - Backlog	No			2515	2870	2968	3289	3728	3417	3908	3204	2578	2214	2327	2024	2188	2115	2304	2571	2451	2322	Nov 2017	398	1264	77			169		2322		
2			Patients Waiting >52 weeks	<= No	0	0	4	4	0	1	4	3	2	0	3	6	5	3	2	10	10	14	7	7	Nov 2017	0	7	0			0		7	66	
2	NEW		Patients Waiting >52 weeks (Incomplete)	<= No	0	0	2	0	0	1	2	2	2	1	3	2	3	3	0	8	4	7	3	3	Nov 2017	0	3	0			0		3	36	
2			Treatment Functions Underperforming (Admitted, Non-Admitted, Incomplete)	<= No	0	0	28	35	32	33	34	31	34	31	29	28	26	25	28	27	26	32	29	29	Nov 2017	5	17	1.0			4.0		29		
			Treatment Functions Underperforming (Incomplete)	<= No	0	0	3	4	4	5	6	6	8	5	4	5	5	4	5	5	4	5	4	5	Nov 2017	1	3	0			1		5		
2			Acute Diagnostic Waits in Excess of 6-weeks (End of Month Census)	<= %	1.0	1.0																			Nov 2017	2.4	1.2	0.0		0.7	0.0		1.12		
			Acute Diagnostic Waits in Excess of 6-weeks (In Month Waiters)	No			419	502	470	500	711	817	498	902	387	577	942	931	650	833	652	1336	914	1064	Nov 2017	234	88	-		742	-		1064		

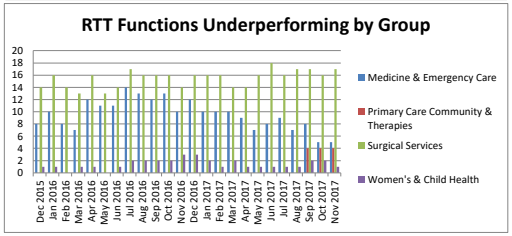


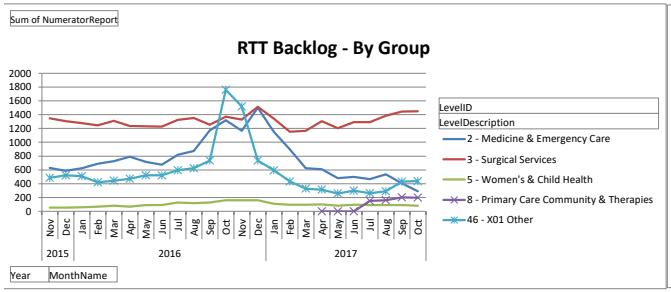


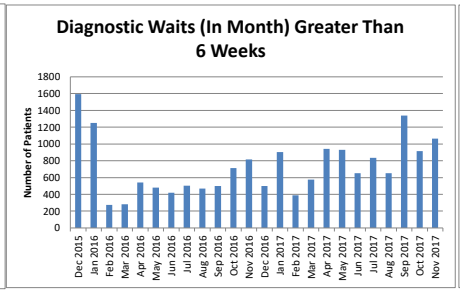


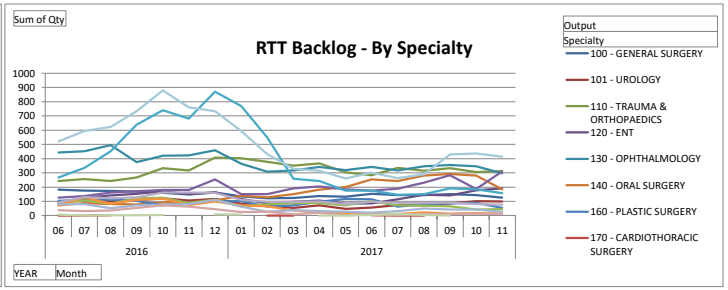






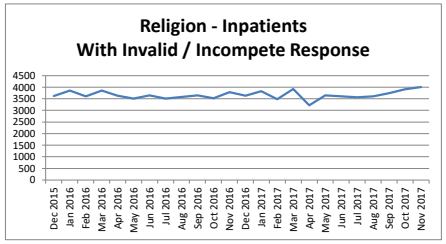


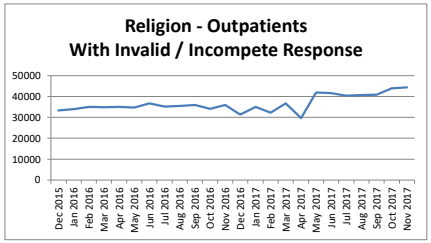


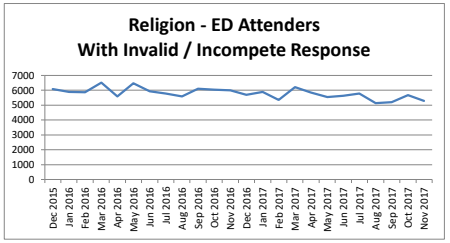


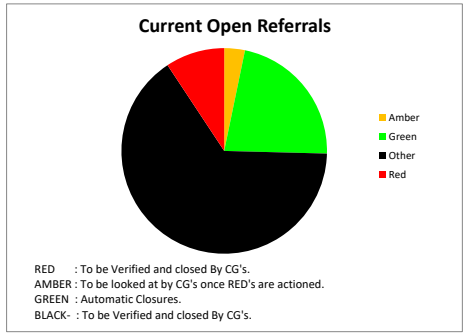
Data Completeness

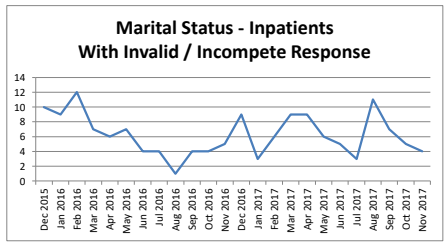
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jun 2016) J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
14			Data Completeness Community Services	=> %	50.0	50.0																			Nov 2017							61.2	61.2		
2			Percentage SUS Records for AE with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0											.						.	.	Sep 2017								99.6		
2			Percentage SUS Records for IP care with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0											.						.	.	Sep 2017								99.0		
2			Percentage SUS Records for OP care with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0											.						.	.	Sep 2017								99.3		
2			Completion of Valid NHS Number Field in acute (inpatient) data set submissions to SUS	=> %	99.0	99.0	96.9	96.3	97.9	96.5	97.3	97.5	98.3	97.7	98.3	97.7	98.2	98.3	97.4	98.4	98.5	99.1	97.6	98.4	Nov 2017								98.4	98.2	
2			Completion of Valid NHS Number Field in acute (outpatient) data set submissions to SUS	=> %	99.0	99.0	99.5	99.4	99.5	99.5	99.5	99.5	99.6	99.6	99.5	99.5	99.4	99.5	99.4	99.5	99.5	99.6	99.6	99.6	Nov 2017								99.6	99.5	
2			Completion of Valid NHS Number Field in A&E data set submissions to SUS	=> %	95.0	95.0	97.2	97.0	96.7	97.0	97.2	97.6	97.0	97.7	97.3	97.3	97.3	97.4	96.3	97.2	97.0	97.5	97.2	97.6	Nov 2017								97.6	97.2	
2			Ethnicity Coding - percentage of inpatients with recorded response	=> %	90.0	90.0																			Nov 2017								91.6	90.9	
	NEW		Ethnicity Coding - percentage of outpatients with recorded response	=> %	90.0	90.0																			Nov 2017								92.4	90.4	
	NEW		Protected Characteristic - Religion - INPATIENTS with recorded response	%			69.5	69.8	69.2	68.9	69.6	69.2	69.1	68.7	69.2	68.8	70.3	70.6	69.6	70.1	70.1	69.4	70.4	70.2	Nov 2017								70.2	70.1	
	NEW		Protected Characteristic - Religion - OUTPATIENTS with recorded response	%			57.8	58.0	57.8	57.9	58.1	57.5	56.9	57.0	57.2	56.9	56.7	52.9	53.2	53.1	53.5	54.5	53.8	53.5	Nov 2017								53.5	53.8	
	NEW		Protected Characteristic - Religion - ED patients with recorded response	%			64.3	66.5	65.3	64.0	64.3	64.1	64.7	64.1	64.7	64.2	64.7	67.2	65.3	66.2	66.7	67.0	66.1	67.3	Nov 2017								67.3	66.3	
	NEW		Protected Characteristic - Marital Status - INPATIENTS with recorded response	%			100.0	100.0	100.0	100.0	100.0	100.0	99.9	100.0	99.9	99.9	99.9	100.0	100.0	100.0	99.9	99.9	100.0	100.0	Nov 2017								100.0	100.0	
	NEW		Protected Characteristic - Marital Status - OUTPATIENTS with recorded response	%			39.9	40.1	40.8	40.3	40.4	39.9	35.8	40.8	41.3	41.5	41.3	41.1	41.9	41.4	41.0	40.9	40.4	39.8	Nov 2017								39.8	41.0	
	NEW		Protected Characteristic - Marital Status - ED patients with recorded response	%			41.9	40.9	39.5	40.6	40.9	41.5	40.8	40.5	41.3	41.1	39.8	42.7	42.0	42.2	40.2	40.6	40.7	41.6	Nov 2017								41.6	41.2	
2			Maternity - Percentage of invalid fields completed in SUS submission	<= %	15.0	15.0																			Nov 2017								6.8	6.7	
2			Open Referrals	No			204,824	206,563	210,740	215,396	219,866	222,444	225,175	228,846	230,675	235,998	239,934	245,160	250,072	254,761	258,800	262,603	270,519	274,113	Nov 2017	63,236	139,237	34,844	7,455	666	28,675		274,113		
	NEW		Open Referrals without Future Activity/ Waiting List: Requiring Validation	No			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	123,475	126,271	129,941	134,026	138,043	Nov 2017	36,135	67,111	19,739	3,631	596	10,158		138043		

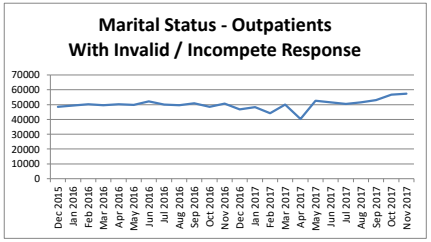


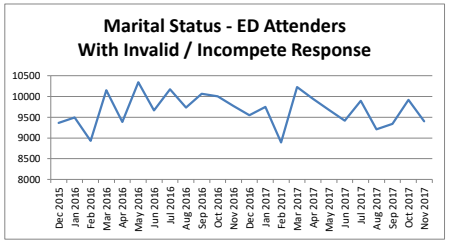






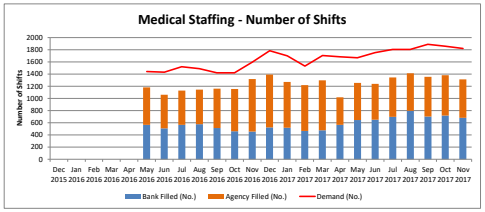


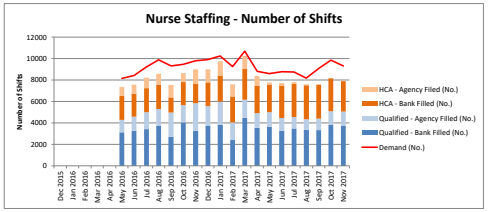




Temporary Workforce

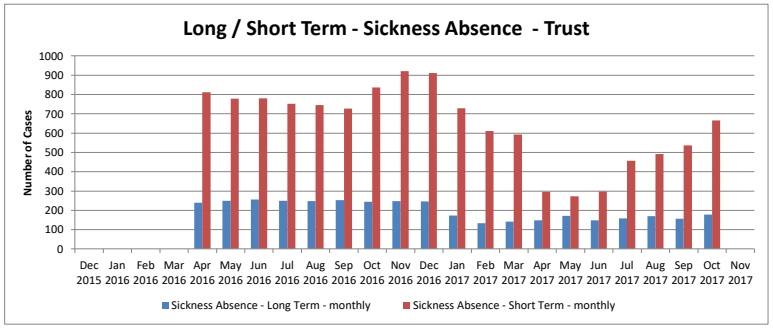
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jun 2016) J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
			Medical Staffing - Number of instances when junior rotas not fully filled	<= %	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-	-	-	-	-	
			Medical Staffing - Demand	No			1429	1523	1491	1419	1419	1596	1786	1699	1534	1703	1682	1669	1753	1805	1804	1887	1858	1823	Nov 2017	1317	353	124	0	29	0	0	1823	14281.0	
			Medical Staffing - Total Filled	%			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	74.52	78.27	71.86	74.33	71.91	Nov 2017	69.9	74.8	78.2	0	100	0	0	72	72.2	
			Medical Staffing - Bank Filled	%			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	51.75	56.52	51.77	52.06	52.02	Nov 2017	45.2	80.3	48.5	0	24.1	0	0	52	52.9	
			Medical Staffing - Agency Filled	%			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	48.25	43.48	48.23	47.94	47.98	Nov 2017	54.8	19.7	51.6	0	75.9	0	0	48	47.1	
			Medical Staffing - Filled Shifts - Snr Consultant	No			110	107	137	177	243	237	187	152	217	270	120	214	219	258	320	312	329	324	Nov 2017	215	73	9	0	27	0	0	324	2096.0	
			Medical Staffing - Filled Shifts - Jnr Doctor	No			951	1021	1010	998	951	1108	1196	1144	1001	1026	896	394	1019	1087	1092	1074	1052	987	Nov 2017	706	191	88	0	2	0	0	987	7601.0	
			Nursing - Demand	No			8413	9220	9887	9312	9476	9802	9935	####	9268	####	8825	8616	8784	8760	8197	9080	9849	9335	Nov 2017	4453	2035	1193	2	103	1259	290	9335	71446	
			Nursing - Total Filled	%			89.33	89.21	86.98	81.13	91.18	92.03	90.68	92.75	95.55	95.8	95.29	90.22	87.78	89.1	92.59	83.87	83.29	85.1	Nov 2017	86.9	91.8	58	50	64.1	91.74	100	85	88.3	
			Nursing - Qualified - Bank Filled	%			43.41	41.68	43.12	35.83	46.77	36.3	41.77	40.3	27.07	43.52	42.07	46.67	42.61	44.43	44.12	43.91	46.36	47.2	Nov 2017	43.1	47.3	57.1	100	36.4	61.82	21.4	47	44.7	
			Nursing - Qualified - Agency Filled	%			17.56	19.34	18.41	29.95	18.76	28.38	20.17	22.55	18.71	16.76	16.32	17.77	15.48	13.94	13.03	13.92	15.87	16.4	Nov 2017	19.6	15.5	3.32	0	33.3	11.43	26.6	16	15.4	
			Nursing - HCA - Bank Filled	%			28.57	26.95	26.56	18.6	25.02	19.83	24.59	25.29	27.18	28.13	30.44	33.05	39.06	39.63	41.94	41.6	37.36	36.0	Nov 2017	37	36.3	39.6	0	30.3	26.67	52.1	36	37.3	
			Nursing - HCA - Agency Filled	%			11.07	12.01	11.92	15.62	9.444	15.49	13.48	14.48	12.91	11.59	10.74	2.509	2.84	1.999	0.909	0.46	0.402	0.4	Nov 2017	0.28	0.96	0	0	0	0.09	0	0	2.6	
			AHPs - Radiography - Demand (Shifts)	No			97	79	55	269	332	321	290	526	332	525	332	372	315	334	335	231	235	198	Nov 2017	0	0	0	0	198	0	0	198	2352	
			AHPs - Radiography - Filled (Shifts)	No			97	73	55	249	324	299	256	496	302	502	329	359	315	290	323	230	232	190	Nov 2017	0	0	0	0	190	0	0	190	2268	
			AHPs - Physiotherapy - Demand (Shifts)	No			156	192	55	63	38	190	186	276	478	356	180	242	257	104	99	100	108	88	Nov 2017	0	0	0	0	0	88	0	88	1178	
			AHPs - Physiotherapy - Filled (Shifts)	No			156	192	55	63	38	190	186	274	478	346	180	242	257	104	99	98	107	87	Nov 2017	0	0	0	0	0	87	0	87	1174	
			AHPs - Other - Demand (Shifts)	No			336	289	66	96	139	96	567	413	530	1009	459	527	471	511	536	482	532	460	Nov 2017	130	40	0	13	60	131	86	460	3978	
			AHPs - Other - Filled (Shifts)	No			336	288	55	95	95	200	567	412	527	885	457	527	471	508	534	476	520	445	Nov 2017	128	40	0	13	60	131	73	445	3938	
			Admin - Demand (Shifts)	No			1954	1902	2147	2765	2839	2479	2442	2381	4128	5135	4198	4228	4423	4054	4429	4091	4015	3928	Nov 2017	709	631	45	296	83	342	1822	3928	33366	
			Admin - Filled (Shifts)	No			1937	1855	2061	2450	2589	2452	2405	2348	4026	5079	4162	4184	4423	4031	4412	4025	3951	3838	Nov 2017	700	630	40	296	80	337	1755	3838	33026	
			Facilities - Demand (Shifts)	No			1947	1442	1451	2160	2185	1997	2172	2066	1971	2485	1795	2031	2101	1996	2182	2025	2059	2122	Nov 2017	12	69	0	0	15	2	2024	2122	16311	
			Facilities - Filled (Shifts)	No			1933	1405	1397	1942	2135	1969	2107	1992	1926	2425	1737	1999	2101	1966	2165	2006	2019	2098	Nov 2017	12	69	0	0	15	2	2000	2098	16091	
			Interpreters - Demand (Shifts)	No			5358	5110	5034	5321	5026	5508	4803	5159	4983	5634	4511	5139	5291	5101	4905	5116	5343	5699	Nov 2017	-	-	-	-	-	-	-	5699	41105.0	
			Interpreters - Total Filled	%			99.7	99.7	99.6	99.4	99.6	99.5	99.5	99.5	99.6	99.6	99.9	99.7	99.7	99.8	99.9	99.8	99.6	99.7	Nov 2017	-	-	-	-	-	-	-	100	99.8	
			Interpreters - Bank Filled	%			78	76.6	76.4	76.7	78.6	77.6	76.9	78.4	79.5	78	77.3	78.5	77.7	77	77	78.3	77.9	78.7	Nov 2017	-	-	-	-	-	-	-	79	77.8	
			Interpreters - Agency Filled	%			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	23.0	23.0	21.7	22.1	21.3	Nov 2017	-	-	-	-	-	-	-	21	22.2	
			Interpreters - Unfilled	%			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	0.2	0.1	0.2	0.4	0.3	Nov 2017	-	-	-	-	-	-	-	0	0.3	

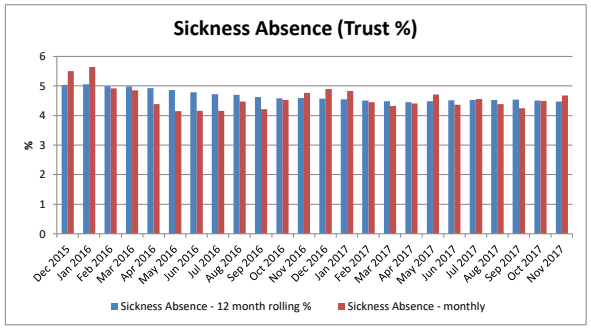




Workforce

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jun 2016) J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
7		b	WTE - Actual versus Plan (FTE)	No			771	818	871	866	790	783	845	786	730	768	772	796	816	847	816	816	756	741	Nov 2017	199.8	169	94.45	45.53	23.58	97.85	111.3	741		
3		b	PDRs - 12 month rolling	=> %	95.0	95.0																			Nov 2017	76.9	85.7	83.1	82.5	77.3	87.9	84.9		86.3	
7		b	Medical Appraisal	=> %	95.0	95.0																			Nov 2017	64.4	72.3	69.8	60.0	77.4	100.0	66.7	71.5	82.3	
3		b	Sickness Absence (Rolling 12 Months)	<= %	3.15	3.15																			Nov 2017	4.7	4.7	4.2	3.2	4.3	4.1	4.8	4.48	4.5	
3	NEW		Sickness Absence (Monthly)	<= %	3.15	3.15																			Nov 2017	5.4	5.0	4.4	3.7	3.4	4.1	4.8	4.68	4.5	
3	NEW		Sickness Absence - Long Term (Monthly)	No			256	249	247	253	245	247	246	253	205	213	214	241	218	225	232	216	251	246	Oct 2017	51	49	34	9	8	26	1	251	1597	
3	NEW		Sickness Absence - Short Term (Monthly)	No			780	752	745	727	837	922	911	956	808	785	414	445	444	612	664	706	889	962	Oct 2017	173	159	128	50	31	121	4	889	4174	
3			Return to Work Interviews following Sickness Absence	=> %	100.0	100.0																			Nov 2017	69.1	89.2	82.1	87.0	78.1	81.3	80.9	80.2	79.1	
3			Mandatory Training	=> %	95.0	95.0																			Nov 2017	81.9	86.9	87.2	90.6	87.4	89.0	91.9		87.1	
3			Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-	-	-		-	
3			Mandatory Training - Health & Safety (% staff)	=> %	95.0	95.0																			Nov 2017	89.5	0.0	90.7	95.8	91.2	0.0	96.7		94.6	
7		b	Employee Turnover (rolling 12 months)	<= %	10.0	10.0																			Nov 2017								13.2	12.4	
	NEW		Nursing Turnover	%			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	12.6	12.7	-	-	-	Aug 2017								13	12	
7			New Investigations in Month	No			3	8	4	4	3	0	3	4	3	9	14	1	3	4	4	2	7	4	Nov 2017	1	1	1	0	0	0	1	4		
7			Vacancy Time to Fill	Weeks			23	24	24	21	25	21	21	21	22	21	20	21	23	25	20	21	21	21	Nov 2017								21		
7			Professional Registration Lapses	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Nov 2017	0	0	0	0	0	0	0	0	0	
7			Qualified Nursing Variance (FIMS) (FTE)	No			317	339	343	341	313	293	305	268	246	257	256	276	281	289	287	269	252	244	Nov 2017								244		
15			Your Voice - Response Rate	No			-->	-->	-->	-->	-->	-->	-->	16.0	-->	-->	-->	-->	-->	18.8	-->	-->	-->	-->	Jul 2017	11.8	15.3	15.9	23.7	23.8	29	21.2	18.8		
15			Your Voice - Overall Score	No			-->	-->	-->	-->	-->	-->	-->	3.70	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	Jan 2017	3.68	3.79	3.66	3.82	3.58	3.83	3.64	3.7		





CQUINs 2017/18 Schemes (page 1 of 2)

Ref	CQUIN	Annual Plan Values (£)	Funding missed YTD (£)	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	Q2 Comments and Trust View on Delivery (not confirmed by commissioners as yet)	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 survey; the focus therefore is on the other 2 questions to be targeted for improvement.	Oct-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 drink 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 savoury pre-packed meals available 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.	Oct-17				
1c	National			**Staff Health & Wellbeing : Improving uptake of flu vaccination for front line staff within Providers**	**Acute & Community**	Year 1 - achieving update of flu vaccination for frontline clinical staff of 70%	No returns		Report %age achieved	Report %age achieved	n/a											Report	Report	Campaign planned and the Trust is confident that this target will be delivered again this year.	Oct-17				
2a	National	£678,891	£42,431k	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	Partially met										Report	Report	Ony 66% (74% in Q1) of sample patients that NEEDED sepsis screening were screened. This needs Exec support and intervention required. The Sepsis team informs that a new documentation process will highlight a higher delivery going forward. EPR is expected to deliver a system based recording of patients.	Oct-17				
2b	National		£42,431k	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 & acute settings in sample 2a who received IV AB within 1 hr of diagnosis	Q1 numbers found to have sepsis in ED & acute settings in sample 2a who received IV AB within 1 hr of diagnosis	Q1 numbers found to have sepsis in ED & acute settings in sample 2a who received IV AB within 1 hr of diagnosis	Q1 numbers found to have sepsis in ED & acute settings in sample 2a who received IV AB within 1 hr of diagnosis	Partially met	Partially met										Report	Report	Of the above screened sample patients, 76% (57% in Q1) of septic patients receive their antibiotics within one hour. Outliers need to be understood and improvements to be led by the ward teams Requires Exec team attention and focus on improvement. MQuAC in August tables an agenda item on why the mortality rate due to sepsis is going up; potentially the lack of screening and timely treatment may be a factor. EPR is expected to deliver a system based recording of patients.	Oct-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	Met	Met										Report	Report	Delivered for Q2 at 94% based on sampled patients notes.	Oct-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		Oct-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	Met										Report	Report	The Trust submitted a robust and well progressed plan, the improvement trajectory is tracking against the plan we re-attenders reducing and partnerships in place to support patients across the system.	Oct-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	Report	Report	Report	Met	Met										Report	Report	The Trust offers A&G for all services. The GP referrals to this facility need encouraging.	Oct-17				
7	National	£678,891	£130,000k	**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	Partially met										Report	Report	**a)** The plan has not fully delivered at this stage to open up 80% of available slots in eRS. **b)** Discussions with CCG are required to negotiate expectations of 4% ASIs by year end, which is unrealistic in terms of paper referrals still ongoing taking slots which would be otherwise visible in eRS (if GPs were to stop paper referring then all slots would be available to them in eRS therefore reducing ASIs). Deputy COO Planned Care is in discussions with CCG.	Oct-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	Met										Report	Report	**a)** Awaiting confirmation, but a the Trust submitted a robust and well progressed plan in terms of ECDS being in place, however issues with Patient First issues means the trust is unable to deliver to this deadline (EPR will take over when in place) **b)** specific Q2 reporting focuses on non-elective discharge processes in acute and community - for this part the Trust has submitted returns in line with the 'Patient Flow' project which included EDD and ADAPT looking specifically at discharges	Oct-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. **From a Q1 payment perspective, the funding of £448k will be payable to the Trust.**					
				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 Screening	**Acute & Community**																						

CQUINs 2017/18 Schemes (page 1 of 2)

Ref	CQUIN	Annual Plan Values (000s)	Full Year Delivery	Funding missed YTD (£)	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	Q2 Comments and Trust View on Delivery (not confirmed by commissioners as yet)	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		Met		Report			Report					The community team have produced a plan which captures the baseline position based on 6 months up to Sept17, assessing wounds older than 4 weeks having audited all resulting patients. Based on this audit a clear training and improvement plan will be produced for Q3 with a repeat audit in Q4 to measure improvements. A monthly review cycle has been put in place to ensure this is embedding plans.	Oct-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		Met		Report			Report					CQUIN lead has produced a plan which has been agreed with the host commissioner.	Oct-17				
	Specialised	£150,000			Haemoglobinopathy improving pathways		Ongoing	Baseline Report, annual Q1	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		Met		Report			Report					This is a well-established scheme, which has been in place over the last couple of years and tracking well.	Oct-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 And 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 (Pedicrid)		n/a		Partially met		Report			Report					The data set provision is outstanding as Cerner development is awaited	Oct-17				
	Specialised	£141,197			Activation systems for patients with long term conditions		HIV					n/a		Met		Report			Report					Scheme progressed with HIV Long Term Conditions within PCCT.	Oct-17				
	Public Health	£55,978		£0k	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		Not Met		Report			Report					Not progressed as yet, but PH are aware that trust is progressing this; at this stage they have not confirmed that they will withdraw any funding due to the missed Q2 milestone.	Oct-17				
	Public Health	£31,228			Bowel Screening			Report	Report	Report	Report	Met		Met		Report			Report					Scheme reports to the national screening programme and has been ongoing for the last 2 years	Oct-17				
	Public Health	£39,417			Bowel Scoping			Report	Report	Report	Report	Met		Met		Report			Report					Scheme reports to the national screening programme and has been ongoing for the last 2 years	Oct-17				
	Public Health	£92,044			Breast Screening			Report	Report	Report	Report	Met		Met		Report			Report					Scheme reports to the national screening programme and has been ongoing for the last 2 years	Oct-17				

Local Quality Indicators - 2017/2018

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory		Previous Months Trend (From Jun 2016)																		Data Period	Group							Month	Year To Date	Trend
					Year	Month	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N		M	SS	W	P	I	PCCT	CO			
			Safeguarding Adults Advanced Training	=> %	85	85	-	-	-	80	80	81	81	80	79	81	81	81	79	83	86	85	85	86	Nov 2017								86.397	83.41	
			Safeguarding Children Level 2 Training	=> %	85	85	73	72	73	71	71	73	75	76	77	77	78	79	78	78	83	86	86	87	Nov 2017								86.8	81.8	
			WHO Safer Surgery - Audit - brief and debrief (% lists where complete) - SQPR	=> %	100	100	99	100	99	100	98	97	95	97	99	99	98	98	98	99	99	99	99	98	Nov 2017	97.9	97.4	100			-		97.9	98.5	
			Morning Discharges (00:00 to 12:00) - SQPR	=> %	35	35	17	17	13	16	16	17	17	20	17	16	16	15	17	17	15	16	15	15	Nov 2017	11.5	11.1	16.2			36		14.6	15.7	
			ED Diagnosis Coding (Mental Health CQUIN) - SQPR	=> %	85	85	87	87	87	87	85	86	86	86	86	87	86	86	85	84	84	84	84	85	Nov 2017								85.4	84.8	
			CO Level >4ppm Referred For Smoking Cessation - SQPR	=> %	90	90	73	80	83	76	83	92	80	78	93	87	80	86	76	82	82	85	79	80	Nov 2017								80.5	81.5	
			BMI recorded by 12+6 weeks of pregnancy - SQPR	=> %	90	90	79	79	78	87	86	82	81	84	81	77	78	80	79	88	92	94	93	96	Nov 2017								95.6	87.4	
			CO Monitoring by 12+6 weeks of pregnancy - SQPR	=> %	90	90	81	82	82	75	76	76	75	73	78	79	76	75	75	74	71	74	80	76	Nov 2017								75.9	74.9	
			Community Gynae - Referral to first outpatient appointment Within 4 weeks of referral	=> %	90	90	24	17	19	29	25	8	11	33	66	83	93	95	92	67	38	13	20	65	Nov 2017								65.5	65.0	
			Community Gynae - New to follow-up Ratio Less than 1 to 2	=> %	95	95	95	97	92	97	95	96	96	95	96	92	97	98	97	94	94	97	86	89	Nov 2017								89.2	94.6	
			Community Gynae - Onward Referral Rate	<= %	10	10	7	5	2	4	3	12	7	6	7	4	2	4	5	7	5	1	2	5	Nov 2017								5.2	4.2	
			Community Nursing - Falls Assessment For Appropriate Patients on home visiting caseload	=> %	100	100	70	61	55	65	42	77	69	60	62	58	69	-	57	58	57	54	55	52	Nov 2017								52.5	57.2	
			Community Nursing - Pressure Ulcer Risk Assessment For New community patients at intial assessment	=> %	95	95	75	65	63	71	47	80	71	63	65	63	77	-	63	65	66	62	63	63	Nov 2017								63.2	65.4	

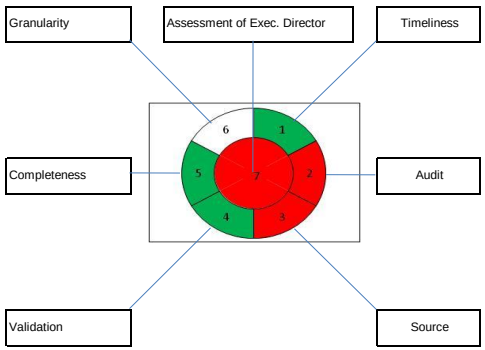
Legend

Data Sources	
1	Cancer Services
2	Information Department
3	Clinical Data Archive
4	Microbiology Informatics
5	CHKS
6	Healthcare Evaluation Data (HED) Tool
7	Workforce Directorate
8	Nursing and Facilities Directorate
9	Governance Directorate
10	Nurse Bank
11	West Midlands Ambulance Service
12	Obstetric Department
13	Operations Directorate
14	Community and Therapies Group
15	Strategy Directorate
16	Surgery B
17	Women & Child Health
18	Finance Directorate
19	Medicine & Emergency Care Group
20	Change Team (Information)

Indicators which comprise the External Performance Assessment Frameworks		
●		NHS TDA Accountability Framework
	a	Caring
	b	Well-led
	c	Effective
	d	Safe
	e	Responsive
	f	Finance
●		Monitor Risk Assessment Framework
●		CQC Intelligent Monitoring

Groups	
M	Medicine & Emergency Care
A	Surgery A
B	Surgery B
W	Women & Child Health
P	Pathology
I	Imaging
PCCT	Primary Care, Community & Therapies
CO	Corporate

Data Quality - Kitemark



Each outer segment of indicator is colour coded on kitemark to signify strength of indicator relative to the dimension, with following key:

Red	Insufficient
Green	Sufficient
White	Not Yet Assessed

The centre of the indicator is colour coded as follows:

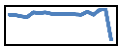
Red / Green	As assessed by Executive Director
White	Awaiting assessment by Executive Director

If segment 2 of the Kitemark is Blank this indicates that a formal audit of this indicator has not yet taken place

Medicine Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																Data Period	Directorate			Month	Year To Date	Trend
			Year	Month	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N		EC	AC	SC			
Patient Safety - Inf Control	C. Difficile	<= No	30	3																			Nov 2017	1	0	0	1	13	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0																			Nov 2017	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective (%)	=> %	80	80																			Nov 2017	77	75	40	69.6		
Patient Safety - Inf Control	MRSA Screening - Non Elective (%)	=> %	80	80																			Nov 2017	94	89	94	93.1		
Patient Safety - Harm Free Care	Number of DOLS raised	No			-	-	-	-	-	19	20	14	14	16	9	7	5	12	13	9	19	15	Nov 2017	4	11	0	15	89	
Patient Safety - Harm Free Care	Number of DOLS which are 7 day urgent	No			-	-	-	-	-	19	20	12	14	16	9	7	5	12	13	9	19	15	Nov 2017	4	11	0	15	89	
Patient Safety - Harm Free Care	Number of delays with LA in assessing for standard DOLS application	No			-	-	-	-	-	4	0	0	0	0	0	0	0	1	0	0	0	0	Nov 2017	0	0	0	0	1	
Patient Safety - Harm Free Care	Number DOLs rolled over from previous month	No			-	-	-	-	-	3	14	12	8	8	11	6	6	4	8	3	2	1	Nov 2017	0	1	0	1	41	
Patient Safety - Harm Free Care	Number patients discharged prior to LA assessment targets	No			-	-	-	-	-	5	6	2	11	5	1	6	3	1	3	5	6	3	Nov 2017	0	3	0	3	28	
Patient Safety - Harm Free Care	Number of DOLs applications the LA disagreed with	No			-	-	-	-	-	1	0	1	1	0	0	0	2	1	2	0	0	1	Nov 2017	0	1	0	1	6	
Patient Safety - Harm Free Care	Number patients cognitively improved regained capacity did not require LA assessment	No			-	-	-	-	-	5	2	1	0	0	1	1	1	5	0	0	0	0	Nov 2017	0	0	0	0	-	
Patient Safety - Harm Free Care	Falls	<= No	0	0	47	39	47	44	34	41	47	50	38	34	36	39	34	34	28	31	48	22	Nov 2017	8	14	0	22	272	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	2	1	2	2	0	2	3	3	1	2	1	1	0	0	1	1	3	0	Nov 2017	0	0	0	0	7	
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	3	5	5	4	5	7	9	5	5	4	5	4	2	4	7	5	3	5	Nov 2017	1	4	0	5	35	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			Nov 2017	96.2	91.7	97.8	96.1		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	100.0	100.0																			Nov 2017	98.7	100.0	0.0	98.7		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	100.0	100.0																			Nov 2017	99	100	0	99.0		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	100.0	100.0																			Nov 2017	98	95	0	97.9		
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			Nov 2017	0	0	0	0	1	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Nov 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			Nov 2017	0	3	0	3	14	
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100	98																	-	-	Sep 2017	50	31	43	40		

Medicine Group

Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			9.2	9.0	8.6	8.3	10.0	9.7	9.9	9.5	9.4	9.4	9.5	9.2	9.2	10.2	9.1	10.7	11.4	-	Oct 2017				**11.4**		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			9.7	9.5	9.3	9.2	10.0	9.3	9.4	9.4	9.4	9.4	9.4	9.3	9.3	9.4	9.4	9.6	9.7	-	Oct 2017					**9.5**	

Medicine Group

Section	Indicator		Trajectory Year	Trajectory Month	Previous Months Trend J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	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																		-	Oct 2017		100.0		100.0	93.4	
Clinical Effect - Stroke & Card	Pts admitted to Acute Stroke Unit within 4 hrs (%)	=> %	90.0	90.0																		-	Oct 2017		78.0		78.0	73.8	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 1 hr of presentation (%)	=> %	50.0	50.0																		-	Oct 2017		60.0		60.0	69.5	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 24 hrs of presentation (%)	=> %	100.0	100.0																		-	Oct 2017		98.0		98.0	97.6	
Clinical Effect - Stroke & Card	Stroke Admission to Thrombolysis Time (% within 60 mins)	=> %	85.0	85.0																		-	Oct 2017		100.0		100.0	62.1	
Clinical Effect - Stroke & Card	Stroke Admissions - Swallowing assessments (<24h) (%)	=> %	98.0	98.0																-			Nov 2017		100.0		100.0	100.8	
Clinical Effect - Stroke & Card	TIA (High Risk) Treatment <24 Hours from receipt of referral (%)	=> %	70.0	70.0																		-	Oct 2017		100.0		100.0	97.0	
Clinical Effect - Stroke & Card	TIA (Low Risk) Treatment <7 days from receipt of referral (%)	=> %	75.0	75.0																		-	Oct 2017		100.0		100.0	96.6	
Clinical Effect - Stroke & Card	Primary Angioplasty (Door To Balloon Time 90 mins) (%)	=> %	80.0	80.0																			Nov 2017		95.5		95.5	94.4	
Clinical Effect - Stroke & Card	Primary Angioplasty (Call To Balloon Time 150 mins) (%)	=> %	80.0	80.0																			Nov 2017		95.2		95.2	95.8	
Clinical Effect - Stroke & Card	Rapid Access Chest Pain - seen within 14 days (%)	=> %	98.0	98.0																			Nov 2017		100.0		100.0	100.0	
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0																		-	Oct 2017			95.2	95.2		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Oct 2017			97.7	97.7		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		-	Oct 2017			84.1	84.1		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			3.5	3	4	3.5	1	2.5	2	1.5	3	2.5	2	2	4.5	1	2.5	2	3.5	-	Oct 2017	-	-	3.50	3.50	18	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			1	2	1.5	2	0	0	1	1	1	1	1	0	1	0	0	0	2	-	Oct 2017	-	-	2.00	2.00	4	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			130	113	107	140	75	71	107	111	135	105	140	91	106	97	99	81	125	-	Oct 2017	-	-	125	125		
Clinical Effect - Cancer	Neutropenia Sepsis Door to Needle Time Greater than 1hr	=> No	0.0	0.0	12	13	5	15	12	12	19	17	8	6	0	6	4	10	3	7	8	7	Nov 2017	-	-	7	7	45	
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0.0	0.0	0	0	0	0	0	6	30	2	0	4	21	7	0	0	3	61	46	129	Nov 2017	129	0	0	129	267	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			28	25	40	23	27	40	35	40	45	42	34	42	40	27	49	24	26	47	Nov 2017	28	16	3	47	289	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			62	46	47	55	56	63	62	66	61	75	79	79	91	83	82	74	59	75	Nov 2017	45	26	4	75		

Medicine Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate			Month	Year To Date	
			Year	Month	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N		EC	AC	SC			
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Nov 2017	-	1.69	-	0.29		
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	2	0	0	0	Nov 2017	0.0	0.0	0.0	0	3	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	0	0	6	1	0	6	2	4	6	2	3	11	3	5	2	8	2	3	Nov 2017	0.0	3.0	0.0	3	37	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	54	28	32	28	57	44	29	51	37	41	28	35	63	31	62	41	#####	#####	Nov 2017	0.0	0.0	0.0	0.0		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Nov 2017	0.00	0.00	0.00	0.00	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour waits (%)	=> %	95.0	95.0																			Nov 2017	80.3	82.9	Site S/C	81.6	83.9	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			1187	1333	1227	1280	1579	1750	1866	1776	1769	1721	1662	1742	1580	1483	1280	1257	1636	1714	Nov 2017	1481	1	232	1714	12354	
Emergency Care & Pt. Flow	Emergency Care Trolley Waits >12 hours	<= No	0	0																			Nov 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													-						Nov 2017	14.0	15.0	Site S/C	15	14	
Emergency Care & Pt. Flow (Group Sheet Only)	Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60.0	60.0																			Nov 2017	64.0	59.0	Site S/C	62	59	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0																		-	Oct 2017	8.4	8.4	Site S/C	8.4	8.5	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0																			Nov 2017	4.5	6.2	Site S/C	5.4	5.8	
Emergency Care & Pt. Flow	WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	<= No	0	0	70	122	112	135	112	162	193	162	129	107	110	159	242	111	127	90	143	207	Nov 2017	136	71		207	1189	
Emergency Care & Pt. Flow	WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	<= No	0	0	1	8	6	9	16	21	19	11	13	5	0	12	6	1	0	1	4	6	Nov 2017	5	1		6	30	
Emergency Care & Pt. Flow	WMAS - Turnaround Delays > 60 mins (% all emergency conveyances)	<= %	0.02	0.02																			Nov 2017	0.22	0.05		0.14	0.09	
Emergency Care & Pt. Flow	WMAS - Emergency Conveyances (total)	No			4099	4363	4204	4138	4233	4261	4622	4410	4034	4206	4137	4376	4254	4429	4278	4174	4557	4424	Nov 2017	2294	2130		4424	34629	
RTT	RTT - Admittted Care (18-weeks) (%)	=> %	90.0	90.0																			Nov 2017	0.0	85.0	90.9	87.0		
RTT	RTT - Non Admittted Care (18-weeks) (%)	=> %	95.0	95.0																			Nov 2017	0.0	66.4	94.2	80.1		
RTT	RTT - Incomplete Pathway (18-weeks) (%)	=> %	92.0	92.0																			Nov 2017	0.0	89.1	96.9	92.0		
RTT	RTT - Backlog	<= No	0	0	674	821	873	1172	1319	1168	1500	1154	897	622	610	479	497	467	538	407	288	398	Nov 2017	0	339	59	398		
RTT	Patients Waiting >52 weeks	<= No	0	0	0	1	0	0	1	2	1	0	0	1	1	2	1	7	4	1	0	0	Nov 2017	0	0	0	0		
RTT	Treatment Functions Underperforming	<= No	0	0	11	14	13	12	13	10	12	10	10	10	9	7	8	9	7	8	5	5	Nov 2017	0	4	1	5		

Medicine Group

RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0																		Nov 2017	0	2.94	0.48	2.38

Medicine Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	
			Year	Month	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N		EC	AC	SC			
Data Completeness	Open Referrals	No			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	83,160	84,417	85,453	62,769	63,236	Nov 2017	13,925	25,568	23,743	63236		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Req	No			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	39,488	40,216	40,844	35,242	36,135	Nov 2017	11,641	14,488	10,006	36135		
Workforce	WTE - Actual versus Plan	No			213	220	229	231	229	231	244	202	194	208	205	199	227	236	223	223	204	200	Nov 2017	110.1	86.62	0	200		
Workforce	PDRs - 12 month rolling (%)	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Nov 2017	75.24	78.03	0		79.5	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Nov 2017	50	72.34	0		77.0	
Workforce	Sickness Absence - 12 month rolling (%)	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Nov 2017	4.80	4.72	0.00	4.74	4.69	
Workforce	Sickness Absence - In month	<= No	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Nov 2017	5.51	5.27	0.00	5.35	4.99	
Workforce	Sickness Absence - Long Term - In month	No			60	49	47	43	45	40	39	39	33	40	53	59	48	45	54	49	51	-	Oct 2017	21	30	0	51	359	
Workforce	Sickness Absence - Short Term - In month	No			195	180	179	162	194	206	243	223	207	182	66	68	80	131	145	157	173	-	Oct 2017	73	99	0	173	820	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100	100	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Nov 2017	64.1	73.0	0.0		69.74	
Workforce	Mandatory Training (%)	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Nov 2017	82.85	81.25	0		81.7	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-		-	
Workforce	New Investigations in Month	No			0	1	1	0	0	0	0	0	1	2	3	0	0	1	1	0	0	1	Nov 2017	0	1	0	1		
Workforce	Nurse Bank Fill Rate %	=> %	100	100	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	Apr 2016				85		
Workforce	Nurse Bank Shifts Not Filled (number)	<= No	0	0	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	Apr 2016				710		
Workforce	Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00				-	-	
Workforce	Your Voice - Response Rate (%)	No			-->	-->	-->	-->	-->	-->	-->	8	-->	-->	-->	-->	-->	11.8	-->	-->	-->	-->	Jul 2017	10.9	9.6	20.5	11.8		
Workforce	Your Voice - Overall Score	No			-->	-->	-->	-->	-->	-->	-->	3.68	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	Jan 2017	3.51	3.90	3.58	3.68		

Surgical Services Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate					Month	Year To Date	Trend
			Year	Month	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N		GS	SS	TH	An	O			
Patient Safety - Inf Control	C. Difficile	<= No	7	1																		Nov 2017	0	0	0	0	0	0	4	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0																		Nov 2017	0	0	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80	80																		Nov 2017	94.2	96.88	0	0	62.79	91.9		
Patient Safety - Inf Control	MRSA Screening - Non Elective	=> %	80	80																		Nov 2017	93.07	97.16	0	100	85.71	94.0		
Patient Safety - Harm Free Care	Number of DOLS raised	No			-	-	-	-	-	4	0	0	0	2	1	3	0	12	7	6	15	12	Nov 2017	10	0	0	2	0	12	56	
Patient Safety - Harm Free Care	Number of DOLS which are 7 day urgent	No			-	-	-	-	-	4	0	0	0	2	1	3	0	12	7	6	15	12	Nov 2017	10	0	0	2	0	12	56	
Patient Safety - Harm Free Care	Number of delays with LA in assessing for standard DOLS application	No			-	-	-	-	-	0	0	0	0	0	0	0	0	0	0	0	0	0	Nov 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	3	1	2	1	1	Nov 2017	1	0	0	0	0	1	13	
Patient Safety - Harm Free Care	Number patients discharged prior to LA assessment targets	No			-	-	-	-	-	0	0	0	0	1	0	3	0	6	5	2	2	1	Nov 2017	1	0	0	0	0	1	19	
Patient Safety - Harm Free Care	Number of DOLs applications the LA disagreed with	No			-	-	-	-	-	0	0	0	0	0	1	0	0	0	0	0	0	1	Nov 2017	1	0	0	0	0	1	2	
Patient Safety - Harm Free Care	Falls	<= No	0	0	4	12	12	9	10	12	13	8	6	6	10	7	11	11	4	5	5	10	Nov 2017	8	2	0	0	0	10	63	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	1	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	Nov 2017	0	0	0	0	0	0	1	
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	0	2	2	0	4	0	1	1	2	1	1	3	0	2	0	0	2	2	Nov 2017	2	0	0	0	0	2	10	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																		Nov 2017	97.85	98.71	0	99.4	98.86	98.4		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	100.0	100.0																		Nov 2017	100	100	96.45	100	100	99.8		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	100.0	100.0																		Nov 2017	100	0	97.44	0	98.7	98.2		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	100.0	100.0																		Nov 2017	100	0	97.44	0	97.4	97.4		
Patient Safety - Harm Free Care	Never Events	<= No	0	0	0	1	0	0	0	1	0	0	0	0	0	1	1	0	0	0	0	0	Nov 2017	0	0	0	0	0	0	2	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Nov 2017	0	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																		Nov 2017	0	0	0	0	0	0	7	
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100	98.0																	.	Sep 2017	67	0	0	50	0	58.3		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			5.5	6.6	5.4	5.9	6.0	5.1	5.9	6.0	6.3	5.7	6.2	6.5	6.3	7.3	6.9	6.0	6.0	-	Oct 2017						6.0		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			6.76	6.73	6.61	6.5	6.99	6.3	6.11	6	5.95	5.84	5.83	5.86	5.92	5.98	6.09	6.1	6.1	-	Oct 2017							6.0	

Surgical Services Group

Surgical Services Group

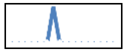
Section	Indicator	Measure	Trajectory		Previous Months Trend																Data Period	Directorate					Month	Year To Date	
			Year	Month	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N		GS	SS	TH	An	O			
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0																			Oct 2017	98.0	-	0.0	-	-	98.03		
Clinical Effect - Cancer	2 weeks (Breast Symptomatic)	=> %	93.0	93.0																			Oct 2017	98.4	-	-	-	-	98.44		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0																			Oct 2017	97.6	-	0.0	-	-	97.56		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																			Oct 2017	82.4	-	0.0	-	-	82.35		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			1	4	7	4	7	4	5	5	8	2	2	5	3	8	3	2	6	-	Oct 2017	-	-	-	-	-	6	27	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			0	1	2	2	2	2	2	0	2	1	1	1	0	2	2	0	2	-	Oct 2017	2	-	0	-	-	2	8	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			170	201	292	245	351	191	158	103	193	105	119	114	98	134	108	84	110	-	Oct 2017	110	-	0	-	-	110		
Clinical Effect - Cancer	Neutropenia Sepsis Door to Needle Time Greater than 1hr	=> No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Nov 2017	0	-	0	-	-	0	0	
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	1	0	8	0	0	0	0	0	0	0	39	6	0	2	Nov 2017	0	0	0	2	0	2	47	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			27	24	38	30	37	29	26	32	25	36	24	29	20	28	29	18	16	28	Nov 2017	5	13	1	0	9	28	192	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			48	41	45	47	51	39	45	62	63	66	78	61	51	57	50	38	40	36	Nov 2017	14	2	8	2	10	36		
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Nov 2017	2.03	2.56	0	0.61	0.58	1.4		
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	0	0	1	0	3	4	0	0	0	0	0	0	0	0	0	0	Nov 2017	0	0	0	0	0	0	0	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	22	45	43	32	29	57	31	35	49	45	32	49	38	41	28	37	35	35	Nov 2017	21	7	0	2	5	35	295	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	76	70.5	71.6	73.7	75.3	75.7	73	77.1	75.3	75.3	76.4	75.8	77.9	73.9	74.7	74.8	75.8	77.1	Nov 2017	76.5	76.6	0.0	96.4	75.0	77.07		
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	Nov 2017	0	0	0	0	0	0	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (%)	%	95.0	95.0	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	97.5	97.5	99.2	99.8	99.4	Nov 2017	-	-	-	-	99.36	-	-	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	<= No	0	0	80	119	121	63	92	76	109	70	68	112	137	109	93	106	69	73	84	80	Nov 2017	39	34	0	0	7	80	751	
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	Nov 2017	-	-	-	-	0	-	-	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0	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	3.6	4.3	5.4	3.9	-	Oct 2017	-	-	-	-	3.89	-	-	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0	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	2.8	2.3	2.0	1.0	2.4	Nov 2017	-	-	-	-	2.43	-	-	
Emergency Care & Pt. Flow	Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15	15	19	14	41	15	26	14	14	0	0	0	0	0	-	0	0	0	0	0	Nov 2017	-	-	-	-	60	0	0	
Emergency Care & Pt. Flow	Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60	60	106	121	110	103	107	100	99	-	-	-	-	-	-	-	-	-	-	-	Nov 2017	-	-	-	-	108	-	-	
Emergency Care & Pt. Flow	Hip Fractures BPT (Operation < 36 hours of admissions	=> %	85.0	85.0																			Nov 2017						70.0	67.3	

Surgical Services Group

Surgical Services Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																Data Period	Directorate					Month	Year To Date	
			Year	Month	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N		GS	SS	TH	An	O			
RTT	RTT - Admittted Care (18-weeks) (%)	=> %	90.0	90.0																		Nov 2017	70.6	64.2	0.0	0.0	83.3	75.0		
RTT	RTT - Non Admittted Care (18-weeks) (%)	=> %	95.0	95.0																		Nov 2017	87.2	89.2	0.0	0.0	94.8	91.2		
RTT	RTT - Incomplete Pathway (18-weeks) (%)	=> %	92.0	92.0																		Nov 2017	91.5	84.3	0.0	0.0	94.9	91.7		
RTT	RTT - Backlog	<= No	0	0	1227	1324	1350	1254	1369	1328	1514	1344	1153	1167	1304	1204	1293	1293	1385	1443	1447	1264		Nov 2017	602	366	0	0	296	1264		
RTT	Patients Waiting >52 weeks	<= No	0	0	2	3	0	1	2	0	1	0	2	2	4	1	1	1	5	9	4	7		Nov 2017	6	0	0	0	1	7		
RTT	Treatment Functions Underperforming	<= No	0	0	14	17	16	16	16	14	16	16	16	14	14	16	18	16	17	17	16	17		Nov 2017	9	6	0	0	2	17		
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0																		Nov 2017	1.2	0.0	0.0	0.0	0.0	1.16		
Data Completeness	Open Referrals	No			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	131,460	133,412	135,263	136,924	139,237		Nov 2017	48,227	15,724	0	5,193	70,093	139237		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Requ	No			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	59,198	60,880	63,030	64,953	67,111		Nov 2017	25,761	8,089	0	3,452	29,809	67111		
Workforce	WTE - Actual versus Plan	No			151	158	155	152	146	140	151	185	157	166	168	172	176	196	181	180	172	169		Nov 2017	52.21	28.37	39.97	18.04	30.46	168.97		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																		Nov 2017	84.7	86.2	94.1	81.7	84.1		85.9	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0																		Nov 2017	80.65	72.22	0	67.44	70.37		78.9	
Workforce	Sickness Absence - 12 month rolling (%)	<= %	3.15	3.15																		Nov 2017	4.4	5.7	6.6	4.6	2.2	4.7	4.7	
Workforce	Sickness Absence - In Month	<= %	3.15	3.15																		Nov 2017	4.1	7.2	5.3	5.4	2.4	5.0	4.9	
Workforce	Sickness Absence - Long Term - In Month	No			62	56	46	53	52	50	53	52	33	32	30	41	38	51	50	47	49	-		Oct 2017	15.0	9.0	14.0	9.0	0.0	49.0	306.0	
Workforce	Sickness Absence - Short Term - In Month	No			161	162	168	169	181	173	181	166	149	138	61	50	55	96	96	119	159	-		Oct 2017	43.0	42.0	33.0	37.0	0.0	159.0	636.0	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100	100																		Nov 2017	86.6	86.0	93.9	92.1	88.2	89.2	85.3	
Workforce	Mandatory Training	=> %	95.0	95.0																		Nov 2017	87.4	85.1	92.5	88.3	80.7		86.4	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		Jan-00	-	-	-	-	-		-	
Workforce	New Investigations in Month	No			0	2	0	1	3	0	0	2	1	2	2	0	0	2	2	2	4	1		Nov 2017	0	0	1	0	0	1		
Workforce	Nurse Bank Fill Rate	=> %	100.0	100.0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		Apr 2016						88.03	88	
Workforce	Nurse Bank Shifts Not Filled	<= No	0	0	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'	'		Apr 2016						238	238	
Workforce	Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		Jan-00						-	-	

Surgical Services Group

Workforce	Your Voice - Response Rate	No			-->	-->	-->	-->	-->	-->	-->	30	-->	-->	-->	-->	-->	15.3	-->	-->	-->	-->	Jul 2017	20.5	13.2	5.2	18.4	14.3	**15.3**	
Workforce	Your Voice - Response Score	%			-->	-->	-->	-->	-->	-->	-->	3.79	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	Jan 2017	3.53	3.29	3.85	3.6	3.69	**3.79**	

Women & Child Health Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																Data Period	Directorate			Month	Year To Date	Trend
			Year	Month	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N		G	M	P			
Patient Safety - Inf Control	C. Difficile	<= No	0	0																			Nov 2017	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0																			Nov 2017	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80.00	80.00																			Nov 2017	89.7			88.5		
Patient Safety - Inf Control	MRSA Screening - Non Elective	=> %	80.00	80.00																			Nov 2017	0	97.2		97.2		
Patient Safety - Harm Free Care	Number of DOLS raised	No			-	-	-	-	-	0	0	0	0	0	1	0	0	0	0	0	0	0	Nov 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	0	0	0	0	0	Nov 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	0	0	0	0	0	Nov 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	0	0	0	0	0	Nov 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	0	0	0	0	0	Nov 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	0	0	0	0	0	Nov 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	0	0	0	0	0	Jan-00	0	0	0	0	0	
Patient Safety - Harm Free Care	Falls	<= No	0	0	2	1	1	2	3	1	1	2	1	1	0	3	1	0	0	0	1	1	Nov 2017	0	1	0	1	6	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	Nov 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	1	0	0	0	Nov 2017	0	0	0	0	1	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			Nov 2017	98.8	94.6		96.2		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	100.0	100.0																			Nov 2017	100	100		100.0		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	100.0	100.0																			Nov 2017	100	100		100.0		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	100.0	100.0																			Nov 2017	100	100		100.0		
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			Nov 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0																			Nov 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			Nov 2017	0	2	0	2	4	

Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	Data Period	Directorate G	Directorate M	Directorate P	Month	Year To Date
Patient Safety - Obstetrics	Caesarean Section Rate - Total	<= %	25.0	25.0																			Nov 2017		26.2		26.2	25.6
Patient Safety - Obstetrics	Caesarean Section Rate - Elective	%			9	8	9	10	8	11	8	7	9	8	9	8	9	7	8	8	9	9	Nov 2017		8.6		8.6	8.3
Patient Safety - Obstetrics	Caesarean Section Rate - Non Elective	%			15	19	19	19	23	17	20	15	17	17	17	15	17	18	15	19	21	18	Nov 2017		17.6		17.6	17.3
Patient Safety - Obstetrics	Maternal Deaths	<= No	0	0																			Nov 2017		0		0	1
Patient Safety - Obstetrics	Post Partum Haemorrhage (>2000ml)	<= No	48	4																			Nov 2017		2		2	17
Patient Safety - Obstetrics	Admissions to Neonatal Intensive Care	<= %	10.0	10.0																			Nov 2017		2.29		2.3	1.9
Patient Safety - Obstetrics	Adjusted Perinatal Mortality Rate (per 1000 babies)	<= Rate1	8.0	8.0																			Nov 2017		4.16		4.2	
Patient Safety - Obstetrics	Stillbirth (Corrected) Mortality Rate (per 1000 babies)	Rate1			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1	Nov 2017		2.1		2.1	
Patient Safety - Obstetrics	Neonatal Death (Corrected) Mortality Rate (per 1000 babies)	Rate1			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	1	Nov 2017		2.1		2.1	
Patient Safety - Obstetrics	Early Booking Assessment (<12 + 6 weeks) (>=%) - SWBH Specific	=> %	90.0	90.0														-					Nov 2017		77.6		77.6	
Patient Safety - Obstetrics	Early Booking Assessment (<12 + 6 weeks) (%) - National Definition	=> %	90.0	90.0																			Nov 2017		156		155.9	
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100.0	97.0		N/A		N/A						N/A	N/A	N/A			N/A	N/A	-	-	Sep 2017	0	0	0	0.0	
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			4.7	4.4	4.2	3.9	5.4	5.9	5.0	4.0	5.4	4.7	4.6	4.5	4.8	4.3	3.7	4.3	4.3	-	Oct 2017				4.3	
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			5.4	5.2	5.2	5.1	5.4	5.0	5.0	5.0	4.9	4.8	4.8	4.7	4.7	4.7	4.7	4.7	4.6	-	Oct 2017					4.7
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0						#DIV/0!												-	Oct 2017	96.3		0	96.3	
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Oct 2017	100			100.0	
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		-	Oct 2017	75			75.0	
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			2	0	0.5	0.5	1.5	4	3	2	4.5	3.5	4.5	3	2	2	5.5	5.5	1.5	-	Oct 2017	1.5	-	0	1.5	24
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			1	0	0	0	0	0	0	0.5	1.5	3.5	3	1	0	0	3	1	0	-	Oct 2017	0	-	0	0	8
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			176	62	70	97	76	98	98	120	150	162	126	139	95	102	184	141	90	-	Oct 2017	90	-	0	90	
Clinical Effect - Cancer	Neutropenia Sepsis Door to Needle Time Greater than 1hr	=> No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Nov 2017	0	-	0	0	0

Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	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	Nov 2017	0			0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			9	15	15	15	12	9	12	14	14	12	13	8	12	6	12	8	8	7	Nov 2017	1	5	1	7	74	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			10	19	21	23	23	16	21	24	24	22	19	12	15	14	14	17	15	13	Nov 2017	0	0	0	13		
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Nov 2017	3.48		-	2.7		
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	Nov 2017	0			0	0	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	9	4	6	9	12	6	10	6	12	10	12	5	17	4	8	3	10	8	Nov 2017	8			8	67	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	74	76	76	76	79	79	71	80	83	81	83	82	82	80	79	77	73	79	Nov 2017	78.8	-		78.8		
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	Nov 2017	0	-	0	0	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			5	10	7	43	18	38	38	20	23	15	9	10	7	11	4	13	15	32	Nov 2017	7	0	25	32	101	
RTT	RTT - Admittted Care (18-weeks)	=> %	90.0	90.0																			Nov 2017	79.5			79.5		
RTT	RTT - Non Admittted Care (18-weeks)	=> %	95.0	95.0																			Nov 2017	95.2			95.2		
RTT	RTT - Incomplete Pathway (18-weeks)	=> %	92.0	92.0																			Nov 2017	94.1			94.1		
RTT	RTT - Backlog	<= No	0	0	93	130	121	129	161	161	160	111	96	96	98	81	97	91	91	90	81	77	Nov 2017	77			77		
RTT	Patients Waiting >52 weeks	<= No	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	Nov 2017	0			0		
RTT	Treatment Functions Underperforming	<= No	0	0	1	2	2	2	2	3	3	2	1	2	1	1	1	1	1	2	2	1	Nov 2017	1			1		
RTT	Acute Diagnostic Waits in Excess of 6-weeks	<= %	0.1	0.1																			Nov 2017	0			0.0		

Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	Data Period	Directorate G	Directorate M	Directorate P	Month	Year To Date	
Data Completeness	Open Referrals	No			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	32,486	33,158	33,869	34,430	34,844	Nov 2017	8,763	17,424	8,657	34844		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Requiring Validation	No			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	17,454	17,950	18,689	19,315	19,739	Nov 2017	5,376	11,490	2,873	19739		
Workforce	WTE - Actual versus Plan	No			99.2	97.1	118	116	107	109	126	119	111	116	119	124	116	117	108	96.9	92	94.5	Nov 2017	12	50.4	31.9	94.5		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			Nov 2017	85.9	76.6	89.8		87.1	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0																			Nov 2017	58.3	72.2	76.9		87.1	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			Nov 2017	3.52	5.05	3.48	4.2	4.5	
Workforce	Sickness Absence - in month	<= %	3.15	3.15																			Nov 2017	4.01	5.1	3.65	4.4	4.3	
Workforce	Sickness Absence - Long Term - in month	No			34	39	43	44	43	43	30	30	23	29	27	36	28	31	30	29	34	-	Oct 2017	5	21	8	34.0	215.0	
Workforce	Sickness Absence - Short Term - in month	No			94	111	96	106	113	125	114	142	83	105	50	41	40	88	89	91	128	-	Oct 2017	10	81	35	128.0	527.0	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0																			Nov 2017	86.1	78.7	85.1	82.13	84.08	
Workforce	Mandatory Training	=> %	95.0	95.0																			Nov 2017	83.5	86.7	88.8		87.7	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-		-	
Workforce	New Investigations in Month	No			0	1	1	0	0	0	0	0	0	1	3	1	0	0	0	0	1	1	Nov 2017	0	1	0	1		
Workforce	Admin & Clerical Bank Use (shifts)	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016				98	98	
Workforce	Admin & Clerical Agency Use (shifts)	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016				40	40	
Workforce	Medical Staffing - Number of instances when junior rotas not fully filled	0	0																										
Workforce	Your Voice - Response Rate	No			-->	-->	-->	-->	-->	-->	-->	13	-->	-->	-->	-->	-->	16	-->	-->	-->	-->	Jul 2017	14.1	12.6	24.8	16		
Workforce	Your Voice - Overall Score	No			-->	-->	-->	-->	-->	-->	-->	3.66	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	Jan 2017	3.54	3.72	3.6	3.7		

Women & Child Health Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate			Month	Year To Date	
			Year	Month	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N		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			244	253	219	255	119	131	109	126	-	-	157	250	268	-	-	-	-	-	Jun 2017		-		268	675	
WCH Group Only	HV (C2) - % of births that receive a face to face new birth visit by a HV =<14 days	=> %	95.0	95.0	86.7	92.4	86.1	87.6	85.3	84.6	95.7	90.5	88.3	-	83.9	80.8	87.2	88	87	81.6	92.5	-	Oct 2017		-		92.53	85.92	
WCH Group Only	HV (C3) - % of births that receive a face to face new birth visit by a HV >days	%			11.8	8.76	12.3	10.5	7.71	1117	3.23	7.22	9.56	4.81	13.5	16.9	9.89	10.5	9	11.4	7.99	-	Oct 2017		-		7.99	11.3	
WCH Group Only	HV (C4) - % of children who received a 12 months review by 12 months	=> %	95.0	95.0	94.8	98.6	96.6	95.8	90.1	93.9	94.6	95.6	97.2	96.2	89.6	92.2	94.6	93.8	89.8	91.7	95.9	-	Oct 2017		-		95.89	92.49	
WCH Group Only	HV (C5) - % of children who received a 12 months review by the time they were 15 months	%			97.1	100	100	99.5	98.8	98.4	98.5	99.3	1.29	95.8	92.1	89.2	88.7	80.3	97.8	89.1	0	-	Oct 2017		-		0	78.37	
WCH Group Only	HV (C6i) - % of children who received a 2 - 2.5 year review	=> %	95.0	95.0	96.6	96	96	94.3	91.5	95.4	94.1	93	92.1	90.1	86.1	80.5	88	86.8	81.3	89.2	92.7	-	Oct 2017		-		92.7	86.42	
WCH Group Only	HV (C6ii) - % of children who receive a 2 - 2.5 year review using ASQ 3	%			86	88.7	88.3	91.5	92.8	89.4	89.2	89.7	82.5	84.2	84.6	78.2	84.5	84.2	80.2	85.5	87.1	-	Oct 2017		-		87.08	83.52	
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	-	-	Sep 2017		-		1	1	
WCH Group Only	HV (C8) - % of children who receive a 6 - 8 week review	=> %	95.0	95.0	94.9	97.8	99.2	97	95	95.9	93.9	96.9	-	95.5	100	98.8	98.7	99.7	100	98.6	99.7	-	Oct 2017		-		99.73	99.33	
WCH Group Only	HV - % of infants for whom breast feeding status is recorded at 6 - 8 week check	=> %	100	100	99.7	99.8	99.5	99.3	94	93.6	87.9	98.6	-	86.1	99.4	100	98.7	99.1	98.8	99.3	99.2	-	Oct 2017		-		99.19	99.2	
WCH Group Only	HV - % of infants being breastfed at 6 - 8 weeks	%			41.7	49.3	40.6	39.6	40.7	37.6	43.5	43.5	-	42.2	37.6	43.5	37.8	42.9	35.6	42.2	37.9	-	Oct 2017		-		37.94	39.67	
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	-	-	-	-	-	-	-	-	-	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			391	391	365	413	313	132	306	377	-	357	365	390	361	401	403	329	386	-	Oct 2017		-		386	2635	
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	98.7	101	97.3	96.3	92.4	91.3	93.5	97.2	-	91.3	-	-	-	97.4	-	-	-	-	Jul 2017		97.5		97.45	97.45	
WCH Group Only	HV - No. of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 6 - 8 week developmental check	No			369	393	376	409	347	330	310	342	-	322	205	197	212	210	326	263	223	-	Oct 2017		-		223	1636	
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	95.4	96.7	94.9	89.4	86.6	86.5	88.6	-	97.9	-	-	-	98.4	-	-	-	-	Jul 2017		98.4		98.41	98.41	
WCH Group Only	HV - No. of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 9 - 12 months developmental check	No			355	393	375	346	347	339	323	343	-	-	26	20	19	28	317	24	21	-	Oct 2017		-		21	455	
WCH Group Only	HV - % of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 9 - 12 months developmental check	=> %	100	100	92	91.4	85.6	86.3	83.6	86.7	82.4	89.8	-	-	-	-	-	97.8	-	-	-	-	Jul 2017		97.8		97.77	97.77	

Women & Child Health Group

WCH Group Only	HV - movers into provider <1 year of age to be checked =<14 d following notification to HV service	No			42	42	38	45	41	34	31	63	-	-	125	171	151	134	193	125	135	-	Oct 2017		-		135	1034	
WCH Group Only	HV - all untested babies <1 year of age will be offered NBBS screening & results to HV.	Y/N			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00						

Pathology Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	Data Period	Directorate HA	HI	B	M	I	Month	Year To Date	Trend
Patient Safety - Harm Free Care	Never Events	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Nov 2017	0	0	0	0	0	0	0	
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Oct 2017	-	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Oct 2017	-	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Oct 2017	-	-	-	-	-	-		
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			2	1	2	1	2	3	2	4	1	2	1	1	1	0	1	0	3	1	Nov 2017	1	0	0	0	0	1	8	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			4	2	2	2	3	3	1	3	4	4	3	2	2	3	3	3	4	2	Nov 2017	1	0	0	0	1	2		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Nov 2017	-	-	-	-	-	-	-	
Data Completeness	Open Referrals	No			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	7,039	7,180	7,354	7,427	7,455	Nov 2017	2,266	0	2,547	0	2,642	7,455		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Requiring Validation	No			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	3,321	3,246	3,387	3,495	3,631	Nov 2017	1,229	0	1,233	0	1,169	3,631		
Workforce	WTE - Actual versus Plan	No			35.2	39	39.8	38.4	40	37	31	34.7	30.3	23.7	18.7	28.1	27.9	30.2	30.1	38.5	41.1	45.5	Nov 2017	9.9	7.6	13	9.3	-0.1	46		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Nov 2017	80	73	87	87	88		90.59	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Nov 2017	0	38	100	100	67		73.02	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Nov 2017	3.3	1.6	3.8	2.8	2	3.2	3.63	
Workforce	Sickness Absence - In Month	<= %	3.15	3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Nov 2017	1.9	3.0	6.5	0.9	3.2	3.74	3.31	
Workforce	Sickness Absence - Long Term - In Month	No			14	14	15	13	12	14	6	5	6	8	6	6	6	8	5	3	9	-	Oct 2017	2.0	0.0	3.0	2.0	0.0	9	43	
Workforce	Sickness Absence - Short Term - In Month	No			38	35	36	30	43	49	41	36	35	45	30	30	39	40	51	49	50	-	Oct 2017	10.0	1.0	21.0	8.0	5.0	50	289	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Nov 2017	92	95	82	97	90	87.0	86.3	
Workforce	Mandatory Training	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Nov 2017	93	88	90	94	91		91.3	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-		-	
Workforce	New Investigations in Month	No			0	0	0	2	0	0	0	1	0	0	0	0	0	0	0	0	0	0	Nov 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	-->	-->	-->	-->	-->	23.7	-->	-->	-->	-->	Jul 2017	15	31	20	36	33	24		
Workforce	Your Voice - Overall Score	No			-->	-->	-->	-->	-->	-->	-->	3.82	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	Jan 2017	3.5	3.3	3.9	4	3.9	3.82		

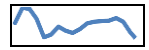
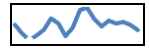
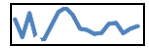
Imaging Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend
			Year	Month	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N		DR	IR	NM	BS			
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			Nov 2017	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0																			Nov 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	2.0	1.0	3.0	1.0	-	2.0	2.0	1.0	-	1.0	1.0	2.0	2.0	2.0	4.0	2.0	2.0	-	Oct 2017					8.3		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	=> %	0	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	16.0	17.0	18.0	19.0	21.0	-	Oct 2017						5.03	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 1 hr of presentation (%)	=> %	50.0	50.0																		-	Oct 2017			60		60	69.46	
Clinical Effect - Stroke & Card	Pts receiving CT Scan within 24 hrs of presentation (%)	=> %	100.0	100.00																		-	Oct 2017			98		98	97.6	
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Oct 2017	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Oct 2017	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Oct 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	Nov 2017	0	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			1	1	2	1	1	4	5	4	1	1	4	2	2	3	1	3	2	1	Nov 2017	1	0	0	0	1	18	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			2	2	2	0	1	4	9	3	2	2	1	3	4	5	2	4	3	3	Nov 2017	3	0	0	0	3		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Nov 2017	-	-	-	-	-	-	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			69	86	66	54	55	60	55	66	54	100	102	128	94	106	100	97	122	111	Nov 2017	111	0	0	0	111	860	
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0																			Nov 2017	0.73				0.73		
Data Completeness	Open Referrals	No			325	342	361	376	399	428	438	461	481	488	512	532	545	560	577	608	623	666	Nov 2017	666	0	0	0	666		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Requiring Validation	No			267	299	315	331	346	373	386	403	421	438	454	474	482	506	531	553	570	596	Nov 2017	596	0	0	0	596		
Workforce	WTE - Actual versus Plan	No			44	45	47	45	41	40	38	32	31	32	35	39	36	35	30	25	20	24	Nov 2017	14	3.1	1.7	1	23.6		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			Nov 2017	77.5	70	85.7	74.6		85.1	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0																			Nov 2017	84	0	0	75		87.0	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			Nov 2017	3.3	8.9	2.8	3.6	4.25	4.31	
Workforce	Sickness Absence - in month	<= %	3.15	3.15																			Nov 2017	3.4	0.0	1.4	3.4	3.35	3.61	
Workforce	Sickness Absence - Long Term - in month	No			8	8	7	6	7	13	10	15	13	9	6	10	7	7	4	6	8	-	Oct 2017	4.0	0.0	1.0	1.0	8.00	48.00	
Workforce	Sickness Absence - Short Term - in month	No			38	31	23	26	29	41	40	53	36	32	29	22	24	22	22	34	31	-	Oct 2017	14.0	0.0	5.0	7.0	31.00	184.00	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0																			Nov 2017	80.2	0	67.7	78.3	78.1	72.2	
Workforce	Mandatory Training	=> %	95.0	95.0																			Nov 2017	82.6	91.8	90.3	95.4		86.7	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-		-	
Workforce	New Investigations in Month	No			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	Nov 2017					0		
Workforce	Your Voice - Response Rate	No			-->	-->	-->	-->	-->	-->	-->	20	-->	-->	-->	-->	-->	24	-->	-->	-->	-->	Jul 2017	20	10	52	23	23.8		
Workforce	Your Voice - Overall Score	No			-->	-->	-->	-->	-->	-->	-->	3.58	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	Jan 2017	3.4	0	4.1	4.2	3.58		
Imaging Group Only	Unreported Tests / Scans	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-								
Imaging Group Only	Outsourced Reporting	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-								
Imaging Group Only	IRMA Instances	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-								

Primary Care, Community & Therapies Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	Data Period	Directorate AT	Directorate IB	Directorate IC	Month	Year To Date	Trend
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80.0	80.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Nov 2017	50	0	0	50		
Patient Safety - Harm Free Care	Number of DOLS raised	No			-	-	-	-	-	2	2	1	0	5	4	4	1	3	2	5	14	4	Nov 2017	0	4	0	4	37	
Patient Safety - Harm Free Care	Number of DOLS which are 7 day urgent	No			-	-	-	-	-	2	2	2	0	5	4	4	1	3	2	5	14	4	Nov 2017	0	4	0	4	37	
Patient Safety - Harm Free Care	Number of delays with LA in assessing for standard DOLS application	No			-	-	-	-	-	2	0	0	0	0	0	0	0	2	0	0	0	0	Nov 2017	0	0	0	0	2	
Patient Safety - Harm Free Care	Number DOLs rolled over from previous month	No			-	-	-	-	-	1	1	2	0	0	3	2	3	0	3	0	2	1	Nov 2017	0	1	0	1	14	
Patient Safety - Harm Free Care	Number patients discharged prior to LA assessment targets	No			-	-	-	-	-	1	0	0	0	0	2	2	4	0	1	2	3	3	Nov 2017	0	3	0	3	17	
Patient Safety - Harm Free Care	Number of DOLs applications the LA disagreed with	No			-	-	-	-	-	0	0	0	0	0	0	0	0	0	0	1	0	0	Nov 2017	0	0	0	0	1	
Patient Safety - Harm Free Care	Number patients cognitively improved regained capacity did not require LA assessment	No			-	-	-	-	-	0	0	0	0	0	2	0	0	0	0	0	0	0	Nov 2017	0	0	0	0	2	
Patient Safety - Harm Free Care	Falls	<= No	0	0	31	29	31	29	33	30	27	20	19	31	23	21	36	36	38	30	33	32	Nov 2017	0	32	0	32	249	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	1	2	1	0	1	Nov 2017	0	1	0	1	5	
Patient Safety - Harm Free Care	Grade 3 or 4 Pressure Ulcers (avoidable)	<= No	0	0	2	3	1	1	0	1	3	2	2	1	5	1	1	1	0	3	1	2	Nov 2017	0	2	0	2	14	
Patient Safety - Harm Free Care	Never Events	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Nov 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Nov 2017	0	0	0	0	1	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Nov 2017	0	1	0	1	8	
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	Nov 2017	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			5	4	5	4	3	8	4	6	1	1	4	3	8	4	10	2	7	6	Nov 2017	2	2	2	6	44	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			9	8	9	7	5	5	6	6	6	6	9	10	12	9	11	8	8	8	Nov 2017	3	3	2	8		

Primary Care, Community & Therapies Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	Data Period	Directorate AT	IB	IC	Month	Year To Date	
Workforce	WTE - Actual versus Plan	No			128	154	152	135	104	109	122	115	112	118	128	130	131	132	136	130	112	97.9	Nov 2017	36.9	34.6	26.4	97.85		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			Nov 2017	83.9	91	87.7		91.0	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			Nov 2017	3.2	4.96	3.82	4.07	4.03	
Workforce	Sickness Absence - in month	<= %	3.15	3.15																			Nov 2017	3.3	4.18	4.52	4.09	3.94	
Workforce	Sickness Absence - Long Term - in month	No			26	24	27	29	22	23	29	32	24	24	24	19	19	15	24	21	26	-	Oct 2017	6	-	-	26	148	
Workforce	Sickness Absence - Short Term - in month	No			81	80	83	53	74	104	101	102	93	82	57	60	57	78	84	76	121	-	Oct 2017	22	52	47	121	533	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0																			Nov 2017	74	83.9	82.4	81.3	78.98	
Workforce	Mandatory Training	=> %	95.0	95.0																			Nov 2017	0	89	0		90.0	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-		-	
Workforce	New Investigations in Month	No			2	0	1	0	0	0	1	0	0	0	0	0	1	0	0	0	1	0	Nov 2017				0		
Workforce	Nurse Bank Fill Rate	=> %	100	100	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016	-	-	-	87.87	87.87	
Workforce	Nurse Bank Shifts Not Filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Apr 2016	-	-	-	87	87	
Workforce	Your Voice - Response Rate	No			-->	-->	-->	-->	-->	-->	-->	29	-->	-->	-->	-->	-->	29	-->	-->	-->	-->	Jul 2017	31.1	24.1	31.1	29		
Workforce	Your Voice - Overall Score	No			-->	-->	-->	-->	-->	-->	-->	3.83	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	Jan 2017	3.72	3.72	3.96	3.83		

Primary Care, Community & Therapies Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate			Month	Year To Date	
			Year	Month	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N		AT	IB	IC			
Community & Therapies Group Only	DVT numbers	=> No	730	61	74	-	-	-	-	-	-	-	-	-	41	54	59	70	54	56	55	55	Nov 2017				55	444	
Community & Therapies Group Only	Adults Therapy DNA rate OP services	<= %	9	9	9.6	8.85	9.01	9.22	7.88	7.37	12.2	12.2	8.97	8.04	8.47	8.18	8.5	7.79	8.04	-	-	-	Aug 2017				8.0	8.2	
Community & Therapies Group Only	Therapy DNA rate Paediatric Therapy services	<= %	9	9	1.58	1.58	1.58	1.29	0	1.42	0.87	3.94	1.15	-	-	-	-	-	14.3	10.2	8.91	-	Oct 2017				8.9	10.1	
Community & Therapies Group Only	Therapy DNA rate S1 based OP Therapy services	<= %	9	9	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	11.5	Nov 2017				11.5	11.5	
Community & Therapies Group Only	STEIS	<= No	0	0	2	0	0	2	1	1	0	0	0	0	0	0	-	1	2	3	0	-	Oct 2017				0	6	
Community & Therapies Group Only	Green Stream Community Rehab response time for treatment (days)	<= No	11.0	11.0	17	-	-	-	-	-	-	-	-	-	15.5	16.7	18.3	18.5	19.4	15.5	14.7	12.4	Nov 2017				12.4	130.81	
Community & Therapies Group Only	DNA/No Access Visits	%			2	3	2	2	2	2	2	1	2	-	-	-	1	1	1	1	1	-	Oct 2017				0.66		
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	58.2	51.8	56.3	56.1	52.4	52	61.7	Nov 2017				61.7	56.53	
Community & Therapies Group Only	Falls Assessments - DN Intial Assessments only	%			70	61	55	65	42	77	69	60	62	58	69	63	57	58	57	54	50	60	Nov 2017				60.26		
Community & Therapies Group Only	Pressure Ulcer Assessment - DN Intial Assessments only	%			75	65	63	71	47	80	71	63	65	63	77	68	63	65	66	62	59	72	Nov 2017				71.96		
Community & Therapies Group Only	MUST Assessments - DN Intial Assessments only	%			40	36	32	37	26	52	46	48	36	46	58	52	46	49	49	49	43	54	Nov 2017				54.01		
Community & Therapies Group Only	Dementia Assessments - DN Intial Assessments only	%			11	30	37	45	14	53	53	52	62	44	55	-	-	60	38	63	41	50	Nov 2017				50		
Community & Therapies Group Only	48 hour inputting rate - DN Service Only	%			90	90	92	86	94	93	93	69	93	94	92	-	93	92	93	93	94	-	Oct 2017				94.34		
Community & Therapies Group Only	Making Every Contact (MECC) - DN Intial Assessments only	%			200	222	222	270	177	251	369	308	382	460	488	467	453	428	420	369	556	398	Nov 2017				63.78	57.77	
Community & Therapies Group Only	Avoidable Grade 2,3 or 4 Pressure Ulcers (DN Caseload acquired)	No			1	4	3	2	0	2	5	6	8	6	5	8	4	8	4	4	6	4	Nov 2017				4	43	
Community & Therapies Group Only	Avoidable Grade 2 Pressure Ulcers (DN caseload acquired)	No			1	3	1	1	0	2	2	4	6	3	5	8	4	5	2	3	3	4	Nov 2017				4	34	
Community & Therapies Group Only	Avoidable Grade 3 Pressure Ulcers (DN caseload acquired)	No			0	1	1	1	0	0	3	2	2	2	0	0	0	3	2	0	1	0	Nov 2017				0	6	
Community & Therapies Group Only	Avoidable Grade 4 Pressure Ulcers (DN caseload acquired)	No			0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	1	2	0	Nov 2017				0	3	

Corporate Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate							Month	Year To Date	Trend
			Year	Month	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N		SG	F	W	M	E	N	O			
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			12	4	13	8	13	11	12	11	11	14	3	9	5	10	2	8	4	9	Nov 2017	3	0	0	0	2	3	1	9	50	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			12	9	17	10	13	18	13	12	17	19	16	17	10	13	5	10	7	11	Nov 2017	2	0	0	0	2	6	1	11		
Workforce	WTE - Actual versus Plan	No			101	106	130	146	123	118	133	98.6	94.5	105	99.5	103	102	102	107	123	114	111	Nov 2017	6.48	1.96	0.04	19.7	-2.04	38.8	46.4	111.29		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			Nov 2017	78	81	70	84	89	88	84		88.3	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0																			Nov 2017			95					66.7	60	
Workforce	Sickness Absence - 12 month rolling	<= %	3.15	3.15																			Nov 2017	2.55	2.99	3.92	2.90	4.16	5.84	4.88	4.76	4.66	
Workforce	Sickness Absence - in month	<= %	3.15	3.15																			Nov 2017	3.32	1.37	2.21	2.64	6.68	6.45	4.40	4.84	4.57	
Workforce	Sickness Absence - Long Term - in month	No			52	59	62	65	64	64	79	0	1	0	2	1	2	2	2	2	1	-	Oct 2017	1.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	12.00	
Workforce	Sickness Absence - Short Term - in month	No			173	153	160	181	203	224	191	7	8	8	3	2	3	1	4	10	4	-	Oct 2017	4.00	0.00	0.00	0.00	0.00	0.00	0.00	4.00	27.00	
Workforce	Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0																			Nov 2017	89.2	75.8	71.8	74.7	79.8	83.7	80.8	80.9	80.3	
Workforce	Mandatory Training	=> %	95.0	95.0																			Nov 2017	0	93	95	85	98	92	92	91.9	90	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-	-	-	-	-	
Workforce	New Investigations in Month	No			1	4	1	1	0	0	2	1	1	4	6	0	2	1	1	0	0	1	Nov 2017	0	0	0	1	0	0	0	1		
Workforce	Your Voice - Response Rate	No			-->	-->	-->	-->	-->	-->	-->	18	-->	-->	-->	-->	-->	21	-->	-->	-->	-->	Jul 2017	67.7	41.5	42.9	30.4	30.3	6.6	21.9	21.2		
Workforce	Your Voice - Overall Score	No			-->	-->	-->	-->	-->	-->	-->	3.64	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	Jan 2017	3.83	3.61	3.98	3.55	3.52	3.62	3.37	3.64		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	IPR Persistent Reds – P08 November 2017
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Finance & Performance Director
AUTHOR:	Yasmina Gainer, Head Performance Management & Costing
DATE OF MEETING:	4 January 2018

EXECUTIVE SUMMARY:

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

Progress in the last month was not sufficient and prospective improvement should be accelerated.

In order to expedite this and to better secure improvement delivery respective executive leads are setting specific milestones actions across Q4 together with an expected trajectory for measured improvement.

These remedial action plans shall be reviewed at the January executive PMC and Board Q&S Committee.

Attached to this report is a work-in-progress note for key operational standards. Similar shall be produced for all other persistent red KPIs.

As reported previously this paper shows :

1. Progress against June (Q1) delivery.
   - Only one indicator was due in Q1; Early Booking Assessments. Whilst there has been investigation, this is incomplete and should be expedited to confirm issues and actions necessary to remedy. As part of this, the Trust may consider a tolerance to be applied to this indicator based on 'what is in the trust's control or reasonable influence'. Indicator performance impacted by 'out of area' women.

2. Results for the September (Q2) indicators which were due to improve by end of that period.
   - There is a stubborn marginal underperformance on Patient Safety Thermometer and which has previously been determined as deferred for remediation in Q3.
   - Other KPIs due in Q2 require discipline in day to day delivery to close out a residual small number of breaches. This is the subject of routine management attention and does not require a RAP.

3. KPIs due for remediation becoming due by end Q3 [P09 December]
   - Attention is drawn to elective cancellations, Hip Fractures, Patient Safety Thermometer and Return to Work Interviews where extant performance is inconsistent with remediation in Q3.
   - Neutropenic Sepsis performance is due by end of Q3 and currently there are still breaches observed which are consistent.
   - Who Safer Surgery has also been postponed to Q3, but fails to improve

KPI	Due	Achieved Now?	Revised target date	RAP
Early Booking Assessment [90% within 12 weeks]	Q1	NO ▪ 78% Q1 ▪ 76% P05 ▪ 76% P06 ▪ 75% P07 ▪ 78% P08	Q3 ▪ patient level review underway to identify performance issues; improving GP liaison ▪ A tolerance may need to be considered as delivery is not entirely within the Trust's control (out of area women)	YES

Patient Safety Thermometer – Overall Harm Free Care [95%]	Q2	NO ▪ 93.9% P05 ▪ 94.8% P06 ▪ 94.5% P07 ▪ 94.5% P08	Q3 ▪ Stubborn marginal under-performance ▪ Delivery unlikely for Q3	Reqd & TBC
WHO safer surgery checklist – brief & debrief [100%]	Q2	NO ▪ 98% Q1 ▪ 99.2% P05 ▪ 98.7% P06 ▪ 98.7% P07 ▪ 97.9% P08	Q3 ▪ Small residual # breaches being monitored & followed up at specific clinician / operating list level. ▪ Key issue are lists in Cardiology & BMEC	YES
Neutropenic sepsis – treatment within 1 hour	Q2	NO # breaches: ▪ 21 Q1 ▪ 10 P04 ▪ 3 P05 ▪ 7 P06 ▪ 8 P07 ▪ 7 P08	Q3 ▪ Small residual # breaches being monitored & followed up at specific patient / clinician level. ▪ Performance for some weeks at 100% suggesting embedded performance with sporadic non-compliance	YES
ED timeliness to initial assessment – 95th %ile within 15 minutes	Q2	YES ▪ Delivered P01-P06	N/A	N/A
Elective Cancellations at last minute for non-clinical reasons (as a percentage of elective admissions) (tolerance 0.8%)	Q3	NO ▪ 1.3% P05 ▪ 0.9% P05 ▪ 1.1% P06 ▪ 1.1% P07 ▪ 1.0% P08	Delivery unlikely for Q3 Agree change and focus Static cancellations with c30% avoidable still presenting Dependent on bed capacity	Reqd & TBC
Hip Fractures	Q3	NO ▪ 70% P08	Unlikely to deliver to the 85% standard by end of December	Reqd & TBC
Patient Bed Moves (10pm - 6am) (No.) – ALL	Q3	NO ▪ 674 P07 ▪ 657 P08	Q4 Agreed at November Board	N/A
Patient Bed Moves (10pm - 6am) (No.) - exc. Assessment Units (tolerance tbc – clinical moves)	Q3	NO ▪ 231 P07 ▪ 268 P08	Q4 Agreed at November Board	N/A
Medical Appraisal (target 95%)	Q3	NO ▪ consistent 82%-88% p.m. YTD ▪ 71.5% P08	Change Q4 – March Revised approach considered at November Q&S Cttee	N/A

Return to Work Interviews following Sickness Absence (target 100%)	Q3	NO ▪ 79.6% mnth P07 ▪	November Delivery unlikely	N/A
RTT - Admittted Care (18-weeks) (standard 90%)	Q3	NO ▪ 77.7% mnth P07	Q4 – March	Reqd & TBC
RTT – Non - Admittted Care (18-weeks) (standard 95%)	Q3	NO ▪ 91.4% mnth P07	Q4 – March	Reqd & TBC
Treatment Functions Underperforming (Incomplete) (tolerance None)	Q3	NO ▪ 4 mnth P07	Q4 – March - Oral and T&O No change – December – all other	Reqd & TBC

4. KPIs due for remediation becoming due by end Q4 [P12 March]

Caesarean Section Rate – Total	Q4	26% P08	Close to target of 25%	
Weekday Theatre Utilisation	Q4	72.3% P08	Unlikely to close gap to 85% in-session utilisation target	
Emergency 4 hour waits & breaches	Q4			
Sickness Absence	Q4			
Mandatory Training	Q4			
Workforce Turnover	Q4			
RTT	Q4			
Open Referrals	Q4		IT development not progressed, backlog clearance an issue for the workforce	
Friends & Family	Q4		Response & Scores – work ongoing	
LD – Access to Healthcare for Patients with Learning Disabilities	Q4		Trust Nurse appointed.	

4.1 In addition to the Q4 due indicators above, a number of Q3 deliverables have now been moved to Q4 eg.:

- Patient Bed Moves – exclusions are being considered to ensure that 'clinical reasons for bed moves' are fully excluded
- Medical Appraisal
- Question over Elective Cancellations change as Q3 delivery unlikely
- Question over Hip Fractures as Q3 delivery unlikely
- Question over Return to Work Interviews as delivery in Q3 unlikely
- Friends & Family – good progress being made towards delivery – update on plans would be helpful
- Open Referrals – unlikely for Q4 to deliver without a) IT development to remove new issues being created in the system to sustainably remove the issue for good and b) additional resource to clear current backlog

Oversight and assurance shall continue to be provided through routine consideration at the executive PMC and non-executive Q&S Committee. Recommendations to the PMC have been summarised below.

REPORT RECOMMENDATION:

The Board is recommended to:

1. Require necessary and effective remedial action plans in respect of all indicators not confirmed as prospectively delivering to standard.
2. Require at its next meeting a prospective assessment of all indicators for end Q4

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	**x**
Clinical	**x**	Equality and Diversity		Workforce	
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, Q&S Committee

Persistent red KPI	Due	Revised target date	Lead (if changed from previous board report)
Neutropenic sepsis	Q2	Single figure breaches monthly. Root cause themes: In hours root cause is time to administer treatment; OOH is time to be seen by doctor. Milestones to deliver 100% compliance: 1. Patients carry ID card to present to ED when booking which will trigger pathway – process live in December 2. From January 1st the consultant will be alerted 24/7 for all neutropenic sepsis patients to oversee complaint pathway Forecast 100 % throughout Q4	
Elective cancelations	Originally Q3 but this was approved to move with a delivery trajectory to Q4 in August.	Theatre improvement programme has underpinning key milestones to address booking, pre theatres checks and consultant list sign off. Priority improvement areas oral, ENT, ophthalmology and general surgery, Forecast trajectory of number of patient level late cancellations: December 29 January 27 February 23 March 20	
Bed move Change indicator to non-clinical bed moves only between 10 pm and 6am	Originally Q3 but agreed to defer delivery to end Q4 in October.	Key milestones 1. Establish bench mark for Q3 performance 2. Improve by 25% in Q4 3. Eliminate non clinical transfers in Q1	Rachel Barlow
RTT – admitted	Q4	[DN: to insert monthly milestones]	
RTT – non admitted	Q4	[DN: to insert monthly milestones]	
RTT incomplete all treatment functions performing	Q4	[DN: to insert monthly milestones]	
ED 4 hour wait %	Q4	Milestones outline in Trust Board paper related to ED improvement plan and patient flow improvement plan. Forecast trajectory:	Rachel Barlow

		January 85% February 87% March 90%	
ED 4 hour breach numbers	Q4	Daily breach numbers correlated to above Forecast trajectory January 82 February 71 March 55	Rachel Barlow
Unplanned re-attendance	Q3	Audit completed in December and themes for improvement include in Q4: • Gynae pathway straight to EGAU • Did not wait patients– book to GP pathway on arrival • Patients with re-current catheter problems- review of pathways with Surgical Assessment Unit and community services • Review of access GPs have to acute service- single point of access/admissions hub which will divert patients who would normally attend ED for re-admission • ED frequent re-attendance multi provider review in place Forecast trajectory: December 6% January 5.5% February 5.25% March 5%	Michelle Harris
DTOC bed days	Q4	[DN: to insert monthly milestones]	Caroline Rennalls
DTC attributed to NHS	Q4	[DN: to insert monthly milestones]	Caroline Rennalls
Hip fracture	Q4	Improvement milestones include : • Review trauma planning meeting for improvement opportunity in January Review of effectiveness of snow and bad weather response in imaging and theatre team planning Forecast trajectory: January 75% February 80% March 85%	

Persistent Red Recovery Plan

	Indicator	Measure	2016-2017		Directors' Priority Assessment			Lead	Plan In Place	Delivery Trajectory			
			Year	Month	NOW	SOON	LATER		Yes / No	Q1	Q2	Q3	Q4
Obstetric	Caesarean Section Rate - Total	<= %	25	25			√	Amanda Geary	Yes				x
	Early Booking Assessment (<12 + 6 weeks) - SWBH Specific	=> %	90	90	√			Amanda Geary	Yes			x	
Harm Free Care	Patient Safety Thermometer - Overall Harm Free Care	=> %	95	95	√			Debbie Talbot	Yes			x	
	Falls	<= No	804	67			√	Paul Hooton	Yes				Align to Quality Plan
	WHO Safer Surgery - Audit - brief and debrief (% lists where complete)	=> %	100	100	√			Ajai Tyagi	Yes			x	
	Mortality Reviews within 42 working days	=> %	90	90		√		David Carruthers	Yes			x	
	Neutropenia Sepsis Door to Needle Time Greater Than 1 Hour	=> No	0	0	√			Michelle Harris	Yes			x	
Cancelled Operations	Elective Cancellations at last minute for non-clinical reasons (as a percentage of elective admissions)	<= %	1	1	√			Tina Robinson	Yes	Scoping Theatre Improvement Programme		x	
	No. of Sitrep Declared Late Cancellations - Total	<= No	320	27	√				Yes			x	
	Weekday Theatre Utilisation (as % of scheduled)	=> %	85	85	√			Liam Kennedy	Yes				x
Access To Emergency Care & Patient Flow	Emergency Care 4-hour waits	=> %	95	95	√			Rachel Barlow	Yes				x
	Emergency Care 4-hour breach (numbers)	No	0	0	√			Rachel Barlow	Yes				x
	Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15	15	√			Michelle Harris	Yes	x			
	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5	5	√			Michelle Harris	Yes			x	
	Delayed Transfers of Care (Acute) - Total Bed Days (All Local Authorities)	<= No	0	0		√		Caroline Rennalls	No				x
	Delayed Transfers of Care (Acute) (Av./Week) attributable to NHS	<= No	0	0		√		Caroline Rennalls	No				x
	Patient Bed Moves (10pm - 6am) (No.) -ALL	No				√		Rachel Barlow	Yes				x
	Patient Bed Moves (10pm - 6am) (No.) - exc. Assessment Units	No				√		Rachel Barlow	Yes				x
	Hip Fractures - Best Practice Tarriff - Operation < 36 hours of admission (%)	=> %	85	85	√			Tina Robinson	Yes				x
	PDRs - 12 month rolling	=> %	95	95	√			Raffaela Goodby	Yes	Implementation of new PDR programme			Q4 for 2018/19
	Medical Appraisal	=> %	95	95	√			David Carruthers	Yes				x
	Sickness Absence (Rolling 12 Months)	<= %	3.15	3.15	√			Raffaela Goodby	Yes	On-going programme of actions			x
	Sickness Absence (Monthly)	<= %	3.15	3.15	√			Raffaela Goodby	Yes	On-going programme of actions			x

Persistent Red Recovery Plan

	Indicator	Measure	2016-2017		Directors' Priority Assessment			Lead	Plan In Place	Delivery Trajectory			
			Year	Month	NOW	SOON	LATER		Yes / No	Q1	Q2	Q3	Q4
Workforce	Sickness Absence - Long Term (Monthly)	No	0	0	√			Raffaela Goodby	Yes	On-going programme of actions			x
	Sickness Absence - Short Term (Monthly)	No	0	0	√			Raffaela Goodby	Yes	On-going programme of actions			x
	Return to Work Interviews following Sickness Absence	=> %	100	100	√			Raffaela Goodby	Yes	On-going programme of actions		x	
	Mandatory Training	=> %	95	95	√			Raffaela Goodby	Yes	On-going programme of actions			x
	Mandatory Training - Health & Safety (% staff)	=> %	95	95	√			Raffaela Goodby	Yes	On-going programme of actions			x
	Employee Turnover (rolling 12 months)	<= %	10	10	√			Raffaela Goodby	Yes	On-going programme of actions			x
	Nursing Turnover	%	0	0	√			Raffaela Goodby	Yes	On-going programme of actions			x
Referral to Treatment (RTT)	RTT - Admittted Care (18-weeks)	=> %	90	90		√		Liam Kennedy	No				x
	RTT - Non Admittted Care (18-weeks)	=> %	95	95		√		Liam Kennedy	No				x
	Patients Waiting >52 weeks	<= No	0	0	√			Liam Kennedy	No				x
	Treatment Functions Underperforming (Admitted, Non-Admitted, Incomplete)	<= No	0	0	√			Liam Kennedy	Yes				x
Open Referrals	Open Referrals without Future Activity/ Waiting List: Requiring Validation	No			√			Liam Kennedy	Yes	Resume project plan; progressed as part of planned care initiatives such as FUP waiting list review; IT dependency			x
Friends and Family	FFT Response Rate - Adult and Children Inpatients (including day cases and community)	=> %	50	50			√	Elaine Newell	No	Good progress already made towards a credible plan and ward roll out			Q4 for 2018/19
	FFT Score - Adult and Children Inpatients (including day cases and community)	=> No	95	95			√		No				
	FFT Response Rate: Type 1 and 2 Emergency Department	=> %	50	50			√		No				
	FFT Score - Adult and Children Emergency Department (type 1 and type 2)	=> No	95	95			√		No				
	FFT Response Rate: Type 3 WiU Emergency Department	=> %	50	50			√		No				
	FFT Score - Outpatients	=> No	95	95			√		No				
	FFT Score - Maternity Birth	=> No	95	95			√		No				
	FFT Response Rate - Maternity Birth	=> %	50	50			√		No				
LD	Access to healthcare for people with Learning Disability (full compliance)	Yes / No	Yes	Yes		√		Elaine Newell	No				Q4 for 2018/19

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Financial performance – P08 November 2017**
SPONSOR (EXECUTIVE DIRECTOR):	**Tony Waite – Finance Director**
AUTHOR:	**Tim Reardon – Associate Director of Finance (Compliance)** **Dinah McLannahan – Deputy Director of Finance**
DATE OF MEETING:	**4 January 2018**

EXECUTIVE SUMMARY:

Headlines

This report deals with the financial performance for P08 November 2017/18 and indications for the performance in relation to statutory duties for the full year.

Year to date the trust is reporting a surplus and a significant positive variance from plan. This is achieved through the use of non-recurrent technical items. A recovery plan has been developed by the Trust executive that is designed to address both the underlying position and deliver headline break even performance having accounted for STF.

Based on this recovery plan the likely out-turn is a headline £1m (post-STF) surplus being consistent with a (pre-STF) deficit of £3.953m. This out-turn is not compliant with the trust's accepted control total.
That out-look includes key assumptions as follows and the report contains further detail on each;

- £264.5m SWB CCG Income, secured
- £17.4m CIP delivery - £963k off track ytd at Month 8
- Production plan delivery of £110m – on track at Month 8 – but the projection looks challenging
- £4m additional CIP+ stretch delivery – identified, mostly non-recurrently

A CIP board sub-group (Financial Recovery Project Steering Group) with clear ownership and roles is driving the management of risk inherent within the above assumptions, and delivery of "CIP+", through 3 key work-streams; pay, non-pay and income. This work is likely to culminate in confirmation of the revised forecast outturn position of the Trust with NHSI in Month 9 reporting. The Trust attempted to reflect a revised forecast outturn with NHSI at Month 8, but this was rejected as the forecast outturn protocol requires quarter end movements only.

The aim remains to secure the best out-turn position possible for 2017/18 and to make a step reduction in operating costs consistent with necessary run rate to secure recurrent balance going into 2018/19.

The executive team continue to monitor and manage the above risks, alongside possible opportunities to mitigate, as well as requiring recovery plans from those areas not delivering their financial plans, through group finance reviews, and the Clinical Leadership Executive meetings.
Taper relief of £7m has been secured and received in cash from NHSE.

The impact of the above outlined underlying deficit position combined with planned capital expenditure means that the Trust may need to secure future cash borrowing to support operating costs. Based on assumptions in relation to CCG payments, taper relief, capital phasing and winter pressures this requirement is not now likely to crystallise in this financial year.

Key actions:

- Remedy production plan to meet target including income CIPs & CIP stretch.
- Remedy ED 4hr performance to 90% by P06 to secure Q3/Q4 STF.
- Resolution of 2017.18 contract year end settlement with SWBCCG.
- Accelerate CIP delivery, and identification and delivery through implementation of FIP2 next steps plan, and 10 key actions, "CIP+".
- Confirm and monitor expedient measures and technical opportunity.
- Begin scenario planning on key variables in preparation for year end.

Key numbers:

- Headline year to date surplus £5.423m being £12.062m ahead of plan due to profit of land sale.
- Underlying YTD deficit -£20.5m being £6.1m adverse to plan.
- STF of £4.3m assumed earned for year to date.
- Pay bill £25.5m (vs. £26.4m previous month); Agency spend £0.725m (vs. £1.4m in P6 – but technical improvement went against the agency line, so effectively flat).
- Capital spend at £15.4m is £10.1m behind plan to date.
- Cash at 31st October £3.366m being above plan by £2.114m.

REPORT RECOMMENDATION:

The Committee is recommended to

- NOTE the report and specifically the remedial actions proposed to improve the forecast outturn to the "best possible" for 2017/18 and address 2018/19 run rate issues.
- 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 08 2017/18
November 2017

Trust Board
4th January 2018

Contents

Page Title

Finance Report

Summary & Recommendations

Period 08 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	£92.3m	√	3

1. **Forecast surplus £8.1m formally reported. Downside risk with pre-STF £4m deficit [£1m surplus post-STF] likely & advised to NHSi. To be reviewed & confirmed on back of P09 results.**
2. **CRL remains to be confirmed by NHSI. Plan capex £46.6m under review with likely revision to £28m due to timing variations.**
3. **EFL compliance risk from P&L downside & any consequent loss of STF funds. Asset disposal proceeds provide mitigation.**

Outlook

- NHSI P08 return reports forecast surplus £8.1m, £1.8m below control total due to A&E STF failure to P09.
- Likely out-turn surplus £1m with £4m deficit pre-STF.
- Step reduction in exit run rate costs required to avoid compounding scale of 2018.19 financial challenge.
- Expedient CIP+ measures have been initiated during Q3.
- Capacity & capability build on-going through implementation of Board agreed FIP2 action plan.

P08 key issues & remedial actions

- P08 YTD headline surplus £5.4m being £12.1m ahead of plan due to profit on land sale.
- Position is reliant on significant technical support and looking forward requires remediation through P&L improvement, both to achieve the best possible 17/18 outturn and to meet 18/19 ask.
- Planned care income significantly off NHSI plan target ytd. Delivery of revised H2 plan on track in P07 & P08. Winter pressures risk to P09 & Q4 delivery. Requires remedy to secure 2018.19 plan run rate assumptions.
- Pre-STF £4m deficit forecast. Assumes delivery of production plan (£110m) and CIP delivery (£17.4m), plus £4m expedient CIP+ measures.
- CIP+ measures largely identified – albeit most non-recurrently.
- Remediation plan requires accelerated step cost reduction in pay, which remains stubborn.
- Capex programme has been revised to £27.9m. CRL remains to be confirmed by NHSI. Dialogue on-going.
- Resulting impact on cash has been communicated to NHSI.
- No loan is anticipated as required until Q1 2018/19.

Recommendation

- Challenge and confirm:
  - Reported P08 position and the current assumptions relating to the £4m deficit forecast
  - Actions necessary & sufficient to secure likely out-turn and required exit run-rate reduced Opex costs

Finance Report

Performance to date – I&E and cash

Period 08 2017/18

Financial Performance to Date

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

- P08 year to date reported ahead of plan excluding STF
- Headline I&E surplus of £5.4m, exceeds NHSI plan by £12.m as a result of £16.3m land sale profit, offsetting STF A&E failure and operational performance.
- Underlying I&E deficit £20.5m being £6.1m adverse to plan
- Capital spend of £15.4m being £10.1m behind plan;
- Cash at 30th November £3.4m being £2.1m more than plan.
- Use of resources rating at 3 year to date.

I&E

P08 year to date reported as ahead of plan due to profit on sale of land. A&E waiting time performance failure reported at £1,494k .

The reported delivery is dependent on the benefits from £20.9m of contingencies and flexibility. This includes the land sale which was intended to provide the mitigation against the £13m ask included in P12. At current run rates the benefit is likely to be utilised by P09.

Patient related income, and pay are the main drivers of underlying I&E underperformance. Planned Care is significantly behind internal plan to date and faces a step up which remains to be fully secured.

Savings

Savings required in 2017/18 are now £37.8m. Of this total £26.3m have been delivered to date. This includes the £16.3m N/R profit on disposal of surplus assets. Not counting this disposal £10.0m CIP delivery has been achieved to date. This is 50% of the full year operational CIP required. There is a significant step up in CIP delivery required in H2 2017/18. This is being heavily scrutinised as part of the financial recovery work.

Capital

Capital expenditure to date stands at £15.4m against a full year plan of £46.7m. Key variance to date is in respect of timing of EPR and MMH. The full year programme will likely be revised to £27.9m and the application for CRL to NHSI will reflect this number. The impact of this together with cost pressures on future years is being assessed.

Cash

The cash position is £2.1m above plan at 30th November. This is due to deferred capex spend and asset disposal proceeds.

Based on a revised capital forecast for 2017/18 the earliest revenue borrowing requirement anticipated for January is now expected to crystallise in Q1 2018/19. This has been communicated to NHSI.

EFL compliance at risk from P&L downside and any under-recovery of STF funds. Asset disposal proceeds provide potential mitigation.

Better Payments Practice Code

Performance in November improved when measured by value while volume deteriorated, and both continue 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.

Finance Report

I&E Performance – Full Year – As reported

Period 08 2017/18

Period 8	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	36,306	970	282,962	276,176	(6,786)	424,405	424,405	0
Other Income	4,406	5,159	753	32,646	38,120	5,474	59,706	57,898	(1,808)
Income total	**39,742**	**41,466**	**1,724**	**315,608**	**314,296**	**(1,312)**	**484,111**	**482,303**	**(1,808)**
Pay	(25,048)	(25,515)	(467)	(204,988)	(209,107)	(4,119)	(300,666)	(300,666)	0
Non-Pay	(12,398)	(13,033)	(635)	(100,651)	(99,516)	1,135	(155,280)	(155,280)	0
Expenditure total	**(37,446)**	**(38,549)**	**(1,102)**	**(305,639)**	**(308,623)**	**(2,984)**	**(455,946)**	**(455,946)**	**0**
EBITDA	**2,296**	**2,917**	**621**	**9,969**	**5,673**	**(4,296)**	**28,165**	**26,357**	**(1,808)**
Non-Operating Expenditure	(2,099)	(2,066)	33	(16,748)	(335)	16,413	(9,271)	(9,271)	0
Technical Adjustments	18	19	1	140	85	(55)	(8,961)	(8,961)	0
DH Surplus/(Deficit)	**215**	**870**	**655**	**(6,639)**	**5,423**	**12,062**	**9,933**	**8,125**	**(1,808)**
Add back STF	*(1,048)*	*(734)*	*314*	*(5,766)*	*(4,272)*	*1,494*	*(10,483)*	*(8,675)*	*1,808*
Adjusted position	***(834)***	***136***	***969***	***(12,405)***	***1,151***	***13,556***	***(550)***	***(550)***	***0***
Technical Support (inc. Taper Relief)	*(250)*	*(1,631)*	*(1,381)*	*(2,000)*	*(21,655)*	*(19,655)*	*(3,000)*	*(3,000)*	*0*
Underlying position	***(1,084)***	***(1,495)***	***(411)***	***(14,405)***	***(20,504)***	***(6,099)***	***(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 underlying deficit for P08 YTD is therefore recorded as £20.5m. This is £6.1m adverse compared with the plan underlying deficit of £14.4m.

In terms of the forecast – this slide reflects the NHSI return. The Trust is not permitted to make any formal changes to forecast until the end of Q3. As a result the forecast reflects the Trust's control total, and receipt of STF. The likely scenario will be a variance to control total and less STF as a result, detailed on the following slides in this report.

The trust reported a headline surplus for P08 YTD of £5.4m being £12.1m ahead of plan having taken account of the STF failure related to A&E 4hr waiting times performance.

This surplus continues to be driven by the land sale in P05. This generated a £16.3m I&E surplus.

In addition the position has also utilised the benefit of £9.6m of contingency and support of which £3.4m was unplanned.

This includes taper relief funding which has now been agreed. Costs are accruing against this funding stream.

Finance Report

I&E Performance – Revised Plan delivery

Period 08 2017/18

	Actual								Revised Plan				
Revised Plan [Pre-STF]	**Apr-17 £000's**	**May-17 £000's**	**Jun-17 £000's**	**Jul-17 £000's**	**Aug-17 £000's**	**Sep-17 £000's**	**Oct-17 £000's**	**Nov-17 £000's**	**Dec-17 £000's**	**Jan-18 £000's**	**Feb-18 £000's**	**Mar-18 £000's**	**2017.18 £000's**
Patient Related Income	31,894	34,323	35,389	35,057	34,557	33,409	35,491	35,975	34,633	35,450	34,248	34,982	415,407
Other Income	4,445	3,996	4,184	4,853	3,529	4,091	4,078	4,132	4,132	4,101	4,121	4,121	49,784
Pay	(26,452)	(26,375)	(26,431)	(26,188)	(26,218)	(25,511)	(26,247)	(25,506)	(25,643)	(25,480)	(25,366)	(25,555)	(310,973)
Non Pay	(9,871)	(12,495)	(12,903)	(13,057)	(12,849)	(12,083)	(13,083)	(12,791)	(12,735)	(12,711)	(12,662)	(12,557)	(149,798)
Non Operational Costs	(2,064)	(2,098)	(2,037)	(2,079)	14,235	(2,038)	(2,049)	(2,049)	(2,049)	(2,049)	(2,049)	(2,049)	(8,372)
Revised Plan [Pre-STF]	**(2,048)**	**(2,650)**	**(1,799)**	**(1,414)**	**13,254**	**(2,131)**	**(1,809)**	**(238)**	**(1,661)**	**(688)**	**(1,708)**	**(1,058)**	**(3,951)**
Actual							**(2,197)**	**136**					
Variance - month							**(388)**	**374**					
Variance - cumulative							**(388)**	**(13)**					

Notes

- The above table reflects delivery against the revised plan pre-STF out-turn deficit of £3.9m.
- The reported variance in October was caused by a retrospective correction to the phasing of the trust's production plan. November actual performance records the recovery of that adverse variance.
- November's I&E performance was supported by £1.631m of non-recurrent items in month. These are detailed in Appendix 1 to this report.
- The forecast out-turn is an expected delivery of the revised plan deficit.

Finance Report

I&E Performance – Forecast and remediation plans - Pay

Period 08 2017/18

	Year to date								Forecast					
	Apr-17 £000's	May-17 £000's	Jun-17 £000's	Jul-17 £000's	Aug-17 £000's	Sep-17 £000's	Oct-17 £000's	Nov-17 £000's	Dec-17 £000's	Jan-18 £000's	Feb-18 £000's	Mar-18 £000's	Total Expected £000's	Apr-18
Pay - original £8m forecast	(26,452)	(26,375)	(26,431)	(26,188)	(26,218)	(25,511)	(26,267)	(26,086)	(26,243)	(26,080)	(25,966)	(26,155)	(313,973)	(26,155)
Required improvement	0	0	0	0	0	0	0	600	600	600	600	600	3,000	0
Target for Pay	**(26,452)**	**(26,375)**	**(26,431)**	**(26,188)**	**(26,218)**	**(25,511)**	**(26,267)**	**(25,486)**	**(25,643)**	**(25,480)**	**(25,366)**	**(25,555)**	**(310,973)**	**(26,155)**
ACTUALS against forecast							**(26,416)**	**(25,515)**						
Variance - actuals to forecast							**(149)**	**(29)**						
April 2018 target run rate														**(24,076)**
Gap to close														**(2,079)**

Key messages

- Previous reports have indicated the intended route to provide required mitigation to reach the revised target for pay. In reality this represents a menu of opportunity that will be chosen from as required, dependent on performance pre-mitigation.
- For month 8, the pay number was £25.5m. This was after non-recurrent mitigation of £871k. The underlying pay position, therefore, is £26.4m, £300k over revised plan. This variance was driven mainly by CIP non-delivery relating to the deferred closure of beds, medical agency expenditure in Paediatrics and Gynaecology, and recruitment to established midwifery posts.
- The mitigations identified for future months are mainly non-recurrent and low risk in nature; work is ongoing to determine any recurrent impact.
- Managing the avoidance of future costs currently in the forecast is the subject of routine scrutiny & challenge. It is likely that the factors that impacted on increasing the pay bill above forecast in November will continue into December.
- Forecast monthly pay costs significantly exceed that run rate necessary to secure recurrent balance by £2m.

Finance Report

Pay bill & Workforce

Period 08 2017/18

Pay and Workforce	Current Period	Previous Period	Change between periods	%	Plan YTD	Actual YTD	Variance YTD
Pay - total spend	£25,515k	£26,416k	-£901k	-3%	£204,988k	£209,107k	£4,119k
Pay - substantive	£22,337k	£22,153k	£184k	1%	£177,931k	£176,240k	-£1,691k
Pay - agency spend	£725k	£1,401k	-£676k	-48%	£9,403k	£10,748k	£1,345k
Pay - bank (inc. locum) spend	£2,454k	£2,862k	-£409k	-14%	£17,654k	£22,119k	£4,465k
WTE - total	6,903	6,923	-20	0%	6,764	6,903	139
WTE - substantive	6,099	6,071	28	0%	5,977	6,099	122
WTE - agency	156	191	-35	-18%	199	156	-43
WTE - bank (inc. locum)	647	660	-13	-2%	588	647	60
Memo: locum spend	£687k	£769k	-£82k	-11%	£337k	£5,867k	£5,529k
Memo: locum WTE	62	60	1	2%	4	62	58

NHSI locum spend target	£6,307k

Paybill & Workforce – key messages

- Total workforce at the end of November of 6,903 WTE [being 139 higher than plan] and including 156 WTE of agency staff.
- Total pay costs (including agency workers) were £25.5m in November. Reported agency costs are moderated by £0.8m of written back accruals.
- 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 November. Shifts procured outside of this are subject to COO approval and is driven by strict commitment to maintaining safe staffing.
- The Trust's agency cap for 2017/18 is £11,672k. At the end of P08 the Trust had spent £10,748k on agency. Forecast full year agency spend at £16m represents an £8m reduction compared to 2016/17.

Finance Report

I&E Performance – Forecast and remediation plans – Non Pay

Period 08 2017/18

	Year to date								Revised Plan					
	Apr-17 £000's	May-17 £000's	Jun-17 £000's	Jul-17 £000's	Aug-17 £000's	Sep-17 £000's	Oct-17 £000's	Nov-17 £000's	Dec-17 £000's	Jan-18 £000's	Feb-18 £000's	Mar-18 £000's	Total Expected £000's	Apr-18 £000's
Non Pay original £8m deficit forecast	(9,871)	(12,495)	(12,903)	(13,057)	(12,849)	(12,083)	(13,043)	(13,051)	(12,955)	(12,931)	(12,882)	(12,777)	(150,899)	(12,777)
Required improvement	0	0	0	0	0	0	220	220	220	220	220	220	1,320	
Revised non-pay	**(9,871)**	**(12,495)**	**(12,903)**	**(13,057)**	**(12,849)**	**(12,083)**	**(12,823)**	**(12,831)**	**(12,735)**	**(12,711)**	**(12,662)**	**(12,557)**	**(149,579)**	**(12,777)**
ACTUAL against Forecast							**(13,224)**	**(13,033)**						
Variance to forecast							**(401)**	**(202)**						**(11,300)**
Gap to close - current M13 view versus required														**(1,477)**

Key messages

- Previous reports have indicated the intended route to provide required mitigation to reach the revised target for non-pay. In reality this represents a menu of opportunity that will be chosen from as required, dependent on performance pre-mitigation.
- The underlying non-pay result for Month 8 was £13.7m, against a forecast of £13.1m. Over-performance on pass through drugs was a driver for this, offset by over-performance on income. Ante Natal pathway charges were also above forecast, the trust continues to recognise these costs in full whilst it pursues an SLA with moderated costs.
- £743k was released in relation to an EPR reserve now not required in this financial year against non-pay in Month 8. This was to ensure that the Trust remained on revised plan trajectory, to align with accurate production plan phasing.

Finance Report

I&E Performance – Forecast and remediation plans – Income

Period 08 2017/18

	Apr-17 £'000	May-17 £'000	Jun-17 £'000	Jul-17 £'000	Aug-17 £'000	Sep-17 £'000	Oct-17 £'000	Nov-17 £'000	Dec-17 £'000	Jan-18 £'000	Feb-18 £'000	Mar-18 £'000	Total £'000
Income: NHS Trusts	124	104	142	140	121	141	122	122	122	122	122	122	1,508
Income: Other NHS Bodies	229	156	37	172	82	167	140	140	140	140	140	140	1,684
Other Non Protected Income	132	(38)	115	102	72	(7)	66	66	66	66	66	66	775
Private Patients Income	8	50	118	261	365	269	184	184	184	184	184	184	2,173
SLAs: Main Healthcare Contracts	31,401	34,051	34,976	34,381	33,916	32,838	34,978	35,462	34,120	34,938	33,735	34,469	409,266
Grand Total - PRI target	**31,894**	**34,323**	**35,389**	**35,057**	**34,557**	**33,409**	**35,491**	**35,975**	**34,633**	**35,451**	**34,248**	**34,982**	**415,406**
Actuals against forecast							35,241	36,306					
Variance to forecast							(250)	331					

Key messages

- The SLA income assumed in the forecast is matched back monthly to the SLA monitoring (SLAM) system to ensure movements are tracked. The comparable final month 7 view (final month 8 not yet available) of the forecast outturn in relation to main healthcare contracts remains in line with this forecast.
- The key assumptions within this is receipt of £264.5m from SWBCCG, and delivery of a production plan of £110m (below).
- The Trust has shared a schedule with the CCG that would justify this amount from the CCG, and discussions are progressing well.
- The Trust and CCG are actively going through a process to resolve differences of opinion on data challenges.
- Below a forecast of the expected performance in Month 9 – reflecting poor weather conditions, emergency bed pressures and consultant leave. This variance will be largely mitigated by a year end agreement with SWBCCG.

Production Plan – on plan year to date but a large ask ahead over winter

Agreed Production Plan Forecast by Group	Apr-17 Actual	May-17 Actual	Jun-17 Actual	Jul-17 Actual	Aug-17 Actual	Sep-17 Actual	Oct-17 Actual	Nov-17 Actual	Dec-17 F'cast	Jan-18 F'cast	Feb-18 F'cast	Mar-18 F'cast	TOTAL
Imaging	20,838	25,617	23,978	20,880	38,828	22,254	23,545	23,545	20,334	23,545	21,405	22,475	287,245
Medicine & Emergency Care	1,463,665	1,882,696	1,841,314	1,875,841	1,906,101	1,764,047	1,950,522	1,950,522	1,696,011	1,950,522	1,780,848	1,865,685	21,927,774
Pathology	290,059	301,184	350,350	391,554	356,141	318,155	341,618	341,618	295,716	341,618	311,017	326,317	3,965,347
Primary Care, Community and Therapies	707,734	859,777	936,096	869,734	781,111	847,712	896,907	896,907	774,601	896,907	815,370	856,138	10,138,995
Surgical Services	4,382,067	5,333,964	5,503,529	5,226,160	5,278,775	5,227,395	5,777,991	5,884,322	5,134,324	5,884,322	5,384,323	5,634,323	64,651,495
Women's & Child Health	739,860	709,615	860,632	853,920	744,144	748,604	792,047	792,047	684,041	792,047	720,043	756,045	9,193,045
TOTAL	**7,604,224**	**9,112,853**	**9,515,898**	**9,238,089**	**9,105,100**	**8,928,166**	**9,782,630**	**9,888,962**	**8,605,027**	**9,888,962**	**9,033,005**	**9,460,984**	**110,163,900**
ACTUALS ACHIEVED						**8,987,531**	**9,843,516**	**9,950,136**	**7,905,027**				
VARIANCE TO PLAN						**59,365**	**60,886**	**61,174**	**-700,000**				
	£53.504m						£56.659m						

Finance Report

Income Analysis

Period 08 2017/18

Performance Against SLA by Patient Type	Activity					Finance			
	Annual Plan	Planned	Actual	Variance		Annual Plan £000	Planned £000	Actual £000	Variance £000
A&E	226,873	151,931	148,244	-3,687		£24,194	£16,202	£16,828	£626
Emergencies	45,400	29,810	30,382	572		£85,899	£56,490	£60,524	£4,033
Emergency Short Stay	10,217	7,090	4,860	-2,230		£7,536	£5,234	£3,656	-£1,577
Excess bed days	10,495	6,565	9,514	2,949		£2,906	£1,818	£2,503	£685
Urgent Care						**£120,535**	**£79,744**	**£83,511**	**£3,767**
OP New	169,764	115,337	127,696	12,359		£25,597	£17,395	£18,679	£1,284
OP Procedures	61,597	41,852	48,981	7,129		£10,487	£7,125	£7,975	£850
OP Review	387,088	262,972	229,969	-33,003		£27,394	£18,607	£16,824	-£1,783
OP Telephone	12,965	8,803	10,061	1,258		£298	£202	£214	£12
DC	39,887	27,098	23,939	-3,159		£32,844	£22,313	£19,199	-£3,114
EL	6,408	4,353	4,357	3		£16,430	£11,155	£10,574	-£581
Planned Care - production plan						**£113,049**	**£76,796**	**£73,465**	**-£3,332**
Planned care outside production plan	24,234	18,294	25,456	7,163		£4,114	3,017	£3,569	£552
Maternity	20,284	13,467	13,423	-44		£19,193	£12,744	£12,780	£37
Renal dialysis	565	383	435	52		£68	£46	£52	£6
Community	619,003	419,490	427,516	8,027		£36,658	£24,739	£24,864	£125
Cot days	12,932	8,708	10,373	1,666		£6,782	£4,567	£4,803	£236
Other contract lines	3,624,354	2,418,036	2,767,077	349,041		£94,066	£63,353	£65,594	£2,241
Unbundled activity	68,721	48,223	49,667	1,445		£7,629	£5,534	£6,051	£518
Other						**£168,511**	**£113,999**	**£117,714**	**£3,715**
Sub-Total: Main SLA income (excl fines)						**£402,096**	**£270,539**	**£274,689**	**£4,150**
Year to date refresh of prior months' data						£0	-£10	£0	£10
Income adjustment - pass through drugs						-£156	-£473	-£944	-£471
Fines and penalties						-£600	-£310	-£2,133	-£1,824
Cancer Drugs Fund						£2,636	£1,758	£555	-£1,203
Pass Through Drugs Accrual						£902	£902	£317	-£584
NHSE Oncology top up						£567	£0	£0	£0
UHB Oncology						£2,269	£0	£0	£0
National Poisons						£734	£489	£485	-£4
SLA income -interpreting						£255	£170	£173	£3
SLA income -Neurophys / Maternity etc						£1,735	£1,157	£1,024	-£133
Mental Health Trust SLA						£29	£19	£22	£3
Individual funding requests						£0	£0	£23	£23
Private patients						£236	£158	£84	-£73
Overseas patients						£768	£512	£1,078	£566
Overseas patients Non EEA						£0	£0	£408	£408
Prescription Charges Income						£39	£26	£27	£1
Injury cost recovery						£1,249	£832	£395	-£437
NHSI Plan phasing adjustment						£4	-£710	£0	£710
Other adjustments						£2,323	£2,341	-£28	-£2,369
GRAND TOTAL patient related income						**£415,085**	**£277,400**	**£276,176**	**-£1,223**

Key messages

This table shows the Trust's year to date patient related income including SLA income performance by point of delivery as measured against the contract price & activity schedule.

Planned care within the production plan is behind by £3.3m for the year to date as measured against the [CCG] contract plan profile. This contract plan is different from the internal production plan.
A revised H2 production plan profile has been established & was delivered for P07 & P08. Winter pressures risk P09 & Q4 delivery.

- The trust & SWBCCG have agreed a full year contract sum at £264.5m.
- The impact of any over-performance on pass through drug costs assumed within that sum shall be monitored.
- Work is ongoing to resolve residual data challenges to establish a PbR baseline.
- The residual risk arising from that baseline work is the recovery of income from associate CCGs where no similar fixed sum deals are in place. That risk is assessed at c£250k.

Finance Report

CIP achievement

Period 08 2017/18

Cost Improvement Programmes	Annual Plan £'000	CIP Delivery Achieved YTD £000	CIP Delivery Forecast £000	Likely Achievement (excl. mitigations) £'000	Variance from plan £'000
Medicine and Emergency Care	6,862	2,744	2,170	4,914	-1,948
Surgical Services	3,343	1,269	1,187	2,456	-887
Women and Child Health	909	419	596	1,015	106
Primary Care, Community and Therapies	2,485	1,474	1,040	2,514	29
Pathology	1,321	848	494	1,342	21
Imaging	1,807	747	862	1,609	-198
Sub-total Clinical groups	**16,727**	**7,501**	**6,349**	**13,850**	**-2,877**
Strategy and Governance	170	113	57	170	0
Finance	289	193	96	289	0
Medical Director	403	269	134	403	0
Operations	711	315	362	677	-34
Organisational Development	162	34	127	161	-1
Estates and NHP	562	349	173	522	-40
Corporate Nursing and Facilities	682	317	259	576	-106
Sub-total Corporate	**2,979**	**1,590**	**1,208**	**2,798**	**-181**
Central	13,294	17,914	0	21,194	7,900
Total CIPs	33,000	27,005	7,557	37,842	4,842
Annual Target 17/18	33,000			33,000	0
(Deficit) / Excess of Schemes Above Plan	0			4,842	4,842

Key messages

- The above table demonstrates the back ended improvement requirement to CIP delivery, across the Trust.
- This is as well as CIP+ required to improve the forecast deficit from £8m to £3.953m.
- During November there was £781k under-performance against CIP. This was mainly in relation to bed closure plans not achieved, and income CIP not recognised year to date. The income CIP totals £460k, and although not recognised ytd, is likely to be achieved.
- Various smaller schemes made up the balance of non-delivery. This is to be managed by a formal request to the groups for recovery and mitigation plans, and through a revised approach to group finance review meetings.

Finance Report

Capital

Period 08 2017/18

Programme	Year to Date Plan £'000s	Year to Date Actual £'000s	Year to Date Gap £'000s	*Orders Placed £'000s*	Full Year NHSI Plan £'000s	Full Year Forecast £'000s	Full Year Variance £'000s
Estates	14,344	10,389	(3,955)	*3,055*	20,624	16,340	4,284
Information	8,841	3,784	(5,057)	*5,347*	10,572	7,719	2,853
Medical equipment / Imaging	1,771	478	(1,293)	*991*	5,006	2,791	2,215
Contingency	0	0	0	*0*	0	0	0
Sub-Total	**24,956**	**14,652**	**(10,304)**	*9,393*	**36,202**	**26,850**	**9,352**
Technical schemes	504	690	186	*0*	10,386	986	9,400
Donated assets	56	66	10	*58*	84	78	6
Total Programme	**25,516**	**15,408**	**(10,108)**	*9,451*	**46,672**	**27,914**	**18,758**

The table shows the status of the capital programme, analysed by category, at the end of period 8.
Spending is £9.5m behind plan year to date due to delays on the major projects within Information and Estates. The impact of this delay on the unplanned balance of PDC funding at 31st March 2018 is being assessed.

In line with good practice a stock take of the capital programme has been undertaken. The initial out-come is a reduction in forecast for the current financial year. The impact on spend in future years is now under review in order to understand the cost pressures and profile over the 2018/19 and 2019/20 financial years. There is little meaningful prospect of significant additional capital resources and as such mitigation of those pressures within the extant capital programme resources shall be necessary. This will include a review of specification, scope and re-prioritisation as necessary.

On the basis of this reduced in year capital programme the anticipated loan requirement will not crystallise until Q1 2018/19. NHSI have been notified of this revised expectation. It is possible that borrowing may not be required if the Trust achieves its I&E surplus control totals.

Finance Report

SOFP

Period 08 2017/18

Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION 2017/18

	Balance as at 31st March 2017	Balance as at 30th November 2017	NHSI Planned Balance as at 30th November 2017	Variance to plan as at 30th November 2017	NHSI 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	209,407	222,431	(13,024)	242,166	242,166
Intangible Assets	166	723	239	484	239	239
Trade and Other Receivables	43,017	58,231	76,323	(18,092)	92,045	92,045
Current Assets						
Inventories	5,268	5,559	4,179	1,380	4,177	4,177
Trade and Other Receivables	25,151	59,201	20,946	38,255	20,946	20,946
Cash and Cash Equivalents	23,902	3,366	1,252	2,114	309	309
Current Liabilities						
Trade and Other Payables	(68,516)	(74,395)	(57,375)	(17,020)	(38,646)	(38,646)
Provisions	(1,138)	(912)	(1,196)	284	(1,196)	(1,196)
Borrowings	(903)	(1,306)	(1,903)	597	(3,353)	(3,353)
DH Capital Loan	0	0	0	0	0	0
Non Current Liabilities						
Provisions	(3,404)	(3,301)	(2,955)	(346)	(3,012)	(3,012)
Borrowings	(33,954)	(38,313)	(38,816)	503	(50,077)	(50,077)
DH Capital Loan	0	0	0	0	0	0
	197,023	**218,260**	**223,125**	**(4,865)**	**263,598**	**263,598**
Financed By						
Taxpayers Equity						
Public Dividend Capital	205,362	221,050	238,417	(17,367)	252,540	252,540
Retained Earnings reserve	(24,972)	(19,633)	(31,495)	11,862	(5,822)	(5,822)
Revaluation Reserve	7,575	7,785	7,145	640	7,822	7,822
Other Reserves	9,058	9,058	9,058	0	9,058	9,058
	197,023	**218,260**	**223,125**	**(4,865)**	**263,598**	**263,598**

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

Capital Receipts, slippage on capital expenditure 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 and the recent invoice raised for Taper Relief (£7m). 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 08 2017/18

CASH FLOW 2017/18

PLAN, ACTUAL AND YEAR END FORECAST 2017-18

ACTUAL/FORECAST	April Actual £000s	May Actual £000s	June Actual £000s	July Actual £000s	August Actual £000s	September Actual £000s	October Actual £000s	November Actual £000s	December Forecast £000s	January Forecast £000s	February Forecast £000s	March Forecast £000s
Receipts												
SLAs: SWB CCG	22,627	22,930	22,303	22,269	22,216	22,327	22,372	22,556	22,361	22,361	22,361	22,361
Associates	6,278	6,675	6,356	6,393	6,500	6,418	6,509	6,176	6,466	6,466	6,466	6,466
Other NHS	1,980	750	646	1,151	1,204	856	487	925	795	1,161	1,428	1,772
Specialised Services	3,583	3,374	3,838	6,668	4,327	3,373	3,536	3,787	4,094	3,858	4,520	5,420
STF Funding and Taper Relief	0	0	0	0	0	1,337	0	0	0	8,467	0	1,259
Over Performance	0	0	0	0	0	0	0	0	0	0	0	0
Education & Training - HEE	353	0	4,353	0	4,352	0	0	0	4,405	0	0	4,405
Public Dividend Capital	5,050	5,138	0	5,500	0	0	0	0	3,290	2,220	2,800	2,700
Loans	0	0	0	0	0	0	0	0	0	0	0	0
Other Receipts	1,769	4,237	2,759	2,770	3,138	2,661	2,413	2,737	2,075	2,075	2,075	2,075
Land Sale Receipt					18,800							
Total Receipts	41,641	43,105	40,255	44,751	60,538	36,973	35,318	36,181	43,487	46,608	39,651	46,459
Payments												
Payroll	13,431	13,789	14,017	13,567	14,042	14,023	13,877	13,627	13,853	13,804	13,804	13,804
Tax, NI and Pensions	9,910	10,133	10,202	10,047	10,062	9,867	9,789	10,232	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	10991	15,389	11,205	14,664	9,959	11,198	10,300	10,800	10,810
Non Pay - Capital	11,368	4,422	1,720	1,645	1,179	3,155	2,244	2,600	3,391	2,989	2,068	1,811
MMH PFI	3,397	2,055	2,552	2,022	1,587	735	630	2,549	2,075	4,724	2,824	2,699
PDC Dividend	0	2	0	0	3	3,447	0	2	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	186	133	464	285	117	138	180	240	240	240
Total Payments	45,595	48,442	45,544	41,487	45,809	45,799	44,402	42,190	43,709	45,069	41,656	44,921
Cash Brought Forward	23,873	19,919	14,582	9,292	12,556	27,285	18,459	9,375	3,366	3,144	4,683	2,678
Net Receipts/(Payments)	(3,954)	(5,337)	(5,290)	3,264	14,729	(8,826)	(9,084)	(6,009)	(222)	1,539	(2,005)	1,538
Cash Carried Forward	19,919	14,582	9,292	12,556	27,285	18,459	9,375	3,366	3,144	4,683	2,678	4,215

Key Messages

This cash flow statement reflects the latest collective view of cash flows and incorporates the land sale. It can be seen that the Trust is no longer expecting a cash shortage as Taper Relief funding is now forecast to be received in January 2018. (and was actually received on December 15th).

The cash flow is based on actual cash flows for April to November. The future months forecast incorporates intelligence from the following teams:

- Capital planning
- Income and contracting
- Exchequer services
- Estates

STF is forecast for receipt at the end of the following quarter in which it is earned.

Finance Report

Use of Resources Rating

Period 07 2017/18

Finance and use of resources rating	Expected Sign	03PLANYTD Plan 30/11/2017 YTD £'000	03ACTYTD Actual 30/11/2017 YTD £'000	03VARYTD Variance 30/11/2017 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	Maincode / Subcode
Capital service cover rating	+	3	4		1	4		PRR0160
Liquidity rating	+	4	3		4	4		PRR0170
I&E margin rating	+	4	1		1	2		PRR0180
I&E margin: distance from financial plan	+		1			3		PRR0190
Agency rating	+	2	3		2	2		PRR0200

Overall finance and use of resources risk rating	Expected Sign	03PLANYTD Plan 30/11/2017 YTD £'000	03ACTYTD Actual 30/11/2017 YTD £'000	03VARYTD Variance 30/11/2017 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	Maincode / Subcode
Overall rating unrounded	+		2.40			3.00		PRR0202
If unrounded score ends in 0.5	+		0.00			0.00		PRR0204
Plan risk ratings before overrides	+		2			3		PRR0206
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		PRR0208
Any ratings in table 6 with a score of 4 override - maximum score override of 3 if any rating in table 6 scored as a 4	+		3			3		PRR0210
Control total override - Control total accepted	+		YES			YES		PRR0212
Control total override - Planned or Forecast deficit	Text		No			No		PRR0214
Control total override - Maximum score (0 = N/A)	+		0			0		PRR0216
Is Trust under financial special measures	Text		No			No		PRR0218
Risk ratings after overrides	+		3			3		PRR0220

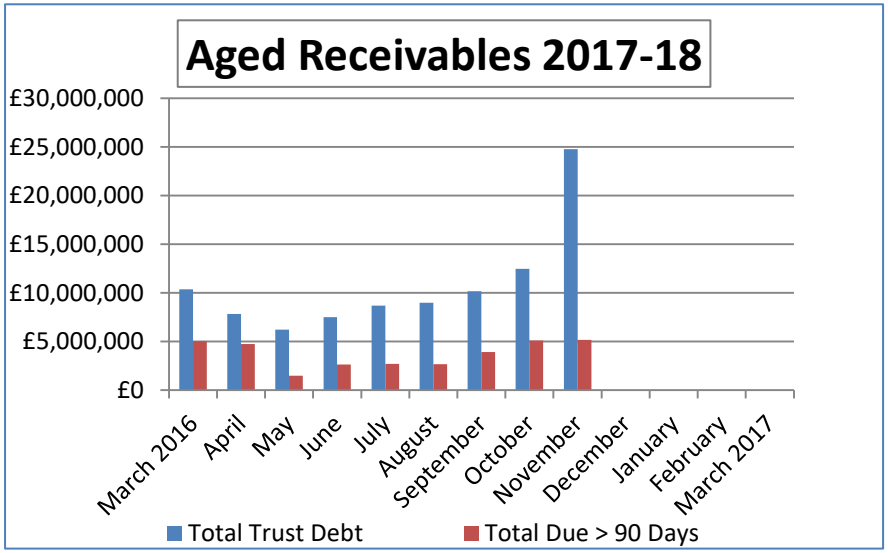
The Trust use of resources rating year to date is 3 (amber) with a number of metrics showing 1 or 2 rather than the 4 previously reported. This is related to the profit generated on land which has been reported in August and so will be temporary. However, not all metrics are affected:

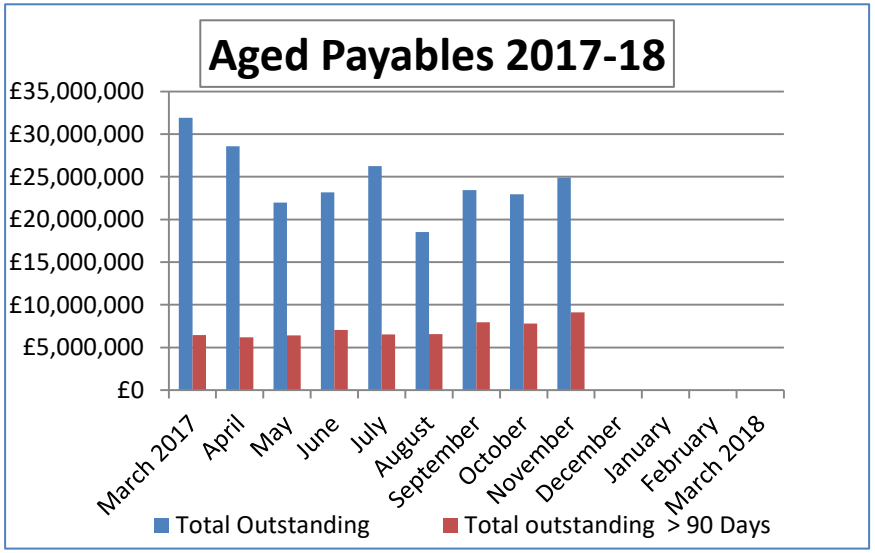
- Capital service cover is calculated using margin before profit on sale and so is unaffected and consequently remains red;
- Agency spend remains more than plan resulting in a score of 3.

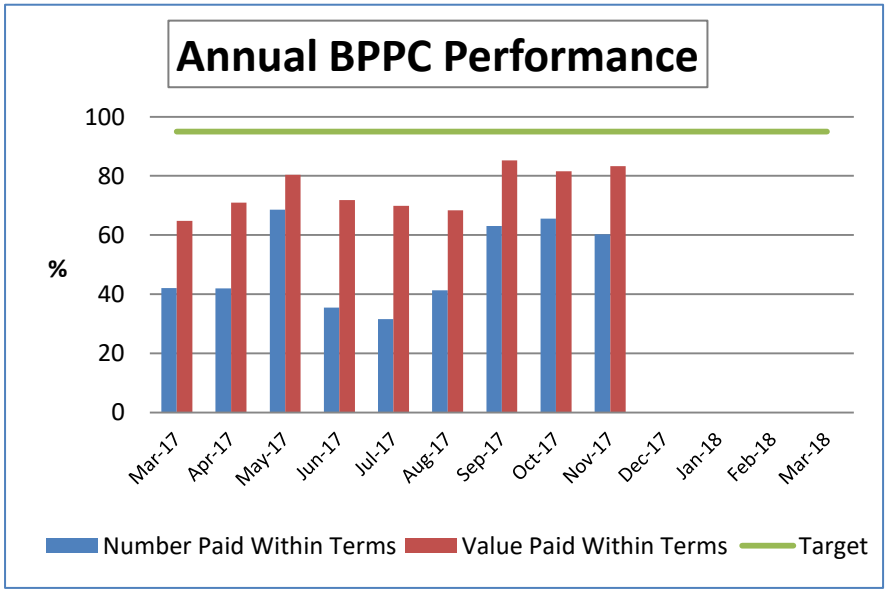
Finance Report

Aged Receivables, Aged Payables, BPPC and Cash Forecast

Period 08 2017/18







Key messages

- The November debtor position increased due to -
  - Invoice for Taper relief £7m raised in month (paid in December)
  - Invoices were raised in advance for the Q3 L&D (£4.7m in month)
  - Payment withheld in relation to CQUIN and performance challenges – all commissioners. (£3.5m ytd)
- The Trust finance team is working on a debtor recovery strategy to drastically reduce the receivables balance by 31st March 2018.
- The overall Payables position has increased in November as the Trust balances the utilisation of cash to reduce working capital pressures against the requirements to maintain minimum cash balances to NHSI expected levels. Forecasts for the remainder of 2017/18 however will reflect a cash pressure and the requirement to increase the Payables balances to minimise future borrowing requirements. The overall level of over 90 days liability has increased as some historical NHS invoices aged further.
- BPPC is below target of 95% by volume and value as the Trust looks to effectively manage cash. Underlying performance remains the subject of improvement work with finance and procurement teams.

Appendices

Finance Report

Appendix 1 - Technical support

Period 08 2017/18

Contingency & flexibility utilised in delivering actual performance to date

	P08 Month	P08 YTD
Unplanned contingency & flexibility	**£k**	**£k**
GRNI accrual released from balance sheet		808
Relase of pay accrual for Medical staffing	480	480
Relase of pay accrual for Admin, Nursing and Scientific staff groups	391	391
EPR accrual released from balance sheet	743	743
Taper relief - timing - income excess over costs accrued	(233)	933
Other contingency & flexibilities utilised	0	0
Profit on sale	0	2,744
	1,381	6,099
Planned contingency & flexibility		
Taper relief - income used to fund planned capex	250	2,000
Other contingency & flexibilities utilised	0	0
	250	2,000
Contingency & flexibility required to delivered YTD plan	**1,631**	**8,099**
Residual profit on sale currently available for £13m risk mitigation in March		13,556
Total contingency & flexibility utilised	**1,631**	**21,655**

*2

*1

It is considered that, taking the high risk and lower risk technical support in the round that the assumptions made are reasonable.

Crucially management contend that the treatment does not mis-inform decisions and triggers in relation to STF monies.

This details the non-operational support that has been utilised to achieved the reported month & YTD I&E positions*1. Also shown is the support required to maintain alignment with pre-STF plan *2 and is subject to the following risks:

- Taper relief income is being fully accrued at the previously agreed £5.8m. Costs have been accrued in the P07 & P08 position. Plan anticipates £2m of costs would have incurred by the end of P06.
- GRNI of £808k has been assumed. The Trust is working through the balance sheet including 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.
- The release of old pay accruals was agreed to support the pay position to reach the required pay figure towards a revised £3.95m deficit position.
- The EPR accrual was released to smooth the impact against plan of the revised production plan phasings.

Finance Report

Appendix 2 - Group I&E Performance

Period 08 2017/18

Period 8	Current Period			Run rate change	Year to Date			Full Year
	Plan	Actual	Variance	since P7	Plan	Actual	Variance	Plan
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Medicine & Emergency Care	1,808	1,620	(188)	(3)	13,182	10,211	(2,971)	20,485
Surgical Services	1,954	1,581	(373)	471	12,421	7,093	(5,327)	18,572
Women's & Child Health	2,014	1,924	(90)	212	15,390	12,339	(3,051)	23,377
Primary Care, Community and Therapies	736	361	(375)	(313)	7,162	4,289	(2,873)	10,862
Pathology	362	432	70	1	2,817	2,925	108	4,338
Imaging	316	235	(81)	36	2,271	1,388	(883)	3,593
Clinical Groups	**7,190**	**6,153**	**(1,037)**	**404**	**53,242**	**38,244**	**(14,998)**	**81,227**
Strategy and Governance	(1,313)	(1,250)	63	288	(10,613)	(10,273)	339	(15,831)
Performance & Insight	(108)	(99)	9		(865)	(816)	49	(1,298)
Finance	(324)	(360)	(36)	10	(2,681)	(2,711)	(30)	(3,947)
Medical Director	(987)	(1,034)	(46)	178	(6,407)	(6,539)	(132)	(9,494)
Operations	(1,128)	(1,085)	43	202	(9,233)	(9,254)	(20)	(13,709)
Workforce & Organisation Development	(475)	(484)	(10)	99	(3,922)	(3,888)	34	(5,776)
Estates & New Hospital Project	(1,028)	(1,134)	(105)	11	(8,474)	(8,392)	82	(12,496)
Corporate Nursing & Facilities	(1,419)	(1,587)	(168)	(69)	(11,772)	(12,561)	(788)	(17,285)
Corporate Directorates	**(6,783)**	**(7,033)**	**(249)**	**718**	**(53,967)**	**(54,434)**	**(467)**	**(79,836)**
Central	(3)	(177)	(174)	(373)	(947)	12,973	13,920	683
Income	1,430	1,427	(3)	1,231	10,060	9,360	(699)	16,007
Reserves	(1,636)	(263)	1,373	(499)	(15,164)	(1,549)	13,616	(8,356)
Technical Adjustments	17	19	2	0	139	85	(53)	208
DH Surplus/(Deficit)	**215**	**127**	**(88)**	**1,481**	**(6,639)**	**4,680**	**11,319**	**9,933**

While the bottom line Trust variance year to date is £11.3k favourable related to land sale, the underlying Group variance of £15.0m adverse is highlighted as being offset by central items and release of reserves.

Forecast scenarios based on P06 YTD performance indicate that achievement of breakeven will require achievement of stretch targets and use of STF.

Finance Report

Appendix 3 - Group I&E Variances

Period 08 2017/18

Period 8	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	4,709	886	0	(305)		(88)	6,267	(6,283)	(6,029)	3	(886)	(1,245)	0	(2,971)
Surgical Services	(3,883)	(69)	(74)	337		113	4,174	(2,981)	(1,624)	(418)	144	(1,046)	0	(5,327)
Women's & Child Health	(221)	84	0	(1,037)		(311)	3,219	(1,429)	(718)	(1,800)	(84)	(753)	0	(3,051)
Primary Care, Community and Therapie	1,370	1,479	(1,203)	(2,253)		5	3,068	(2,025)	(1,011)	(1,760)	(276)	(267)	0	(2,873)
Pathology	167	0	0	(81)		395	994	(214)	0	(901)	(0)	(252)	0	108
Imaging	(249)	0	0	23		(141)	611	(556)	(330)	118	0	(359)	0	(883)
Clinical Groups	**1,893**	**2,379**	**(1,277)**	**(3,318)**	**0**	**(27)**	**18,333**	**(13,488)**	**(9,711)**	**(4,758)**	**(1,102)**	**(3,923)**	**0**	**(14,998)**
Strategy and Governance	0	0	0	978		359	1	(105)	(98)	103	0	(898)	0	339
Performance & Insight	0	0	0	0		0	123	(7)	(77)	1	0	9	0	49
Finance	0	0	0	0		19	266	(123)	(152)	26	0	(66)	0	(30)
Medical Director	0	0	0	0		(462)	692	(236)	(2)	58	0	(183)	0	(132)
Operations	0	7	(237)	254		327	1,286	(464)	(376)	(49)	230	(998)	0	(21)
Workforce & Organisation Developmer	0	0	0	0		198	(128)	(140)	12	123	0	(31)	0	34
Estates & New Hospital Project	0	0	0	0		108	19	(33)	(35)	31	0	(9)	0	82
Corporate Nursing & Facilities	(0)	0	0	(7)		67	1,381	(1,298)	(89)	(483)	0	(359)	0	(788)
Corporate Directorates	**(0)**	**7**	**(237)**	**1,226**	**0**	**616**	**3,641**	**(2,406)**	**(818)**	**(190)**	**230**	**(2,535)**	**0**	**(467)**
Central	(126)	0	0	(644)	(1,494)	(655)	44	244	527	0	0	(412)	16,436	13,920
Income	(4,381)		0	3,254		386	63	0	0	0	0	0	(22)	(699)
Reserves	0	0	0	0		1	0	0	0	4,788	0	8,828	0	13,616
Technical Adjustments	0	0	0	0		0	0	0	0	0	0	0	(53)	(53)
DH Surplus/(Deficit)	**(2,614)**	**2,386**	**(1,513)**	**518**	**(1,494)**	**320**	**22,082**	**(15,650)**	**(10,003)**	**(160)**	**(873)**	**1,958**	**16,361**	**11,318**

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 net impact of STF failure and profit on sale driving the bottom line variance is seen in Central.

The significant reliance on bank and agency staff is shown. Work streams to tackle pay are improving rostering, waiting list initiative and recruitment practices. Any non-recurrent benefit seen in November's pay bill is offset by the additional beds compared to forecast. 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.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Decreasing Sickness Absence and Improving Employee Mental Well Being
SPONSOR (EXECUTIVE DIRECTOR):	Raffaela Goodby, Director of People and Organisation Development
AUTHOR:	Dr Tamsin Radford – Consultant and Head of Occupational Health and Wellbeing service Sarah Towe – Human Resources Business Partner
DATE OF MEETING:	4th January 2018

EXECUTIVE SUMMARY:

Further to the November 2017 Public Trust Board paper, this paper sets out the planned actions and areas of focus for 2018 to achieve the required improvement in attendance. The report is structured in to seven sections, and the board are invited to comment on each.

1. Mental health and well being
2. Early intervention service
3. Musculoskeletal absence
4. Time to be Well
5. Policy Review and revised training
6. Communications and engagement
7. Attendance Recognition Scheme

The Board are asked to note the support offered from NHSI of £15k to pilot interventions in A&E, Maternity and in holistic health across the workforce, and our commitment to be a pilot site during 2018 and asked to support point 6 in particular on showing Board support for mental health and well being during 2018.

REPORT RECOMMENDATION:

Note the planned actions
Feedback is invited on the seven main action points as detailed in the report, in particular 'time to be well' and communications and engagement and attendance recognition scheme.

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

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

Good use of resources

PREVIOUS CONSIDERATION:

FOCUS FOR 2018

INVESTMENT IN THE PREVENTION OF THE KEY CAUSES OF SICKNESS ABSENCE:

1. Mental Health

1.1 Review of the mental health need assessment

The final comprehensive mental health needs assessment for the Trust is due at the end of February 2018, and will be delivered by Dr Liz Griffiths, a public health registrar on secondment at the Trust. This is also due for discussion in the Public Health, Community development and Equality Committee in January 18. This will propose strategy changes as it compares SWBH's current "offer" to the needs identified through the independent assessment. For the purpose of this report we have taken initial findings from the work done so far with suggested actions. These are a natural progression from the suggested actions in the November Board report section 2.2.

1.2 Background

The needs assessment looked at data from ESR over the last 5 years on mental health recorded absence, and the last 3 years of Occupational Health data on cases of mental ill health cases.
It also used a stakeholder questionnaire which was distributed electronically and via paper copy and promoted by employee representatives and through internal communications. This compared SWBH employees' responses with the Public Health England Healthy Working Futures Workplace health needs assessment survey (2017) which is national data.

Two areas were looked at – mental illness and stress. We note that "stress" is highly subjective and whilst it is NOT a medical condition, can adversely affect wellbeing or lead to mental illness if sustained.

Mental illness or stress is the second biggest cause of sickness absence in this Trust and most organisations (after combined musculoskeletal problems). Data from MIND, a mental health charity, shows that there is still much under-reporting to work by employees with 95% of those employees they studied stating a physical reason for absence to their manager when in fact they had mental health symptoms or stress.

1.3 Key findings so far:

- Absences due to mental ill health have not increased annually in the last five years but have remained consistent. This is also shown in the data from Occupational Health.
- Where an employee reports an absence due to mental ill health the cause (e.g. anxiety, stress, depression) it is not recorded on ESR in up to 2/3 of cases, making it difficult to obtain a true picture from these figures on which problems are prevalent when and in which areas of the Trust.
- Work relatedness is even less commonly recorded in ESR (in fewer than 20% of cases) making targeted intervention difficult using ESR data. Referral to Occupational Health is also under reported in ESR as it suggests only 50% of those reporting absence with these issues are referred to Occupational Health. However, experience of running long term absence case conferences suggests that management of long term absence has improved significantly during 2017.

- Occupational health (OH) data shows anxiety >stress >depression > other as diagnoses made at consultation by specialist nurses and doctors in OH. Anxiety and stress are more often than not, diagnosed as related to work (either caused by it or made worse by it) Depression tends to be much less often work related but accounts for longer periods of absence, partly because treatment takes longer to take effect (usually a minimum of 4-6 weeks)
- Absence recorded as being due to mental ill health or stress is most prevalent in lower banded employees, with an inverse relationship between "psychiatric" absences on ESR with pay band.
- The groups recording more psychiatric absence than the Trust average are: Surgical Services, Women's and Child Health and Corporate.
- The staff groups most affected by mental health absence episodes per WTE are administration and clerical, nursing and midwifery and additional clinical services – these are the categories that nearly 4500 of our employees fall into.
- The self-reported health status of SWBH respondents is lower than the national average. The General Lifestyle Survey 2011 found that 34% of respondents reported their health status as Very Good vs. only 3% of respondents reported this level to the SWBH questionnaire.
- Anxiety is higher in SWBH respondents than nationally. When asked "how anxious they felt yesterday" 40.9% of SWBH respondents reported a high score compared to the national figure of 63.1%.
- Sleep appears to be a problem in SWBH employees. 18.5% of respondents reported having a problem with sleep 7 days a week. This was slightly higher in the lower pay grades (1-4) at 23.7% compared to higher grades (5-8) at 17.7%.

The statements which received the most positive agreement in SWBH employee respondents were those around autonomy:

- There is good cooperation between colleagues (77% positive)
- I can decide on the order in which I do things (74% positive)
- I can have 1:1 meetings with my manager (70% positive).
- I can use personal initiative or judgement (68% positive)
- I can adapt my role according to the workplace needs (68% positive)

The statements which received the most negative agreement in SWBH employee respondents were those around the relationship between employees and managers:

- Communication is good (34% negative)
- I feel listened to (33% negative)
- Negative feedback is provided in a constructive way (30% negative)
- Management show that they have confidence in the people who work for them (29% negative)

1.4 Agreed actions for 2018 – Mental Health Tender for Service

1) There has been a mental health invitation to tender (ITT) devised in response to the above data and based on other detailed data points (as examined by the board in November 17). The ITT has been widely consulted on via the group managers, Workforce Delivery Committee and directly with Deputy HR and the Exec People & OD director.
2) The aim will be to have this new service in place by April 2018 with the procurement having been slightly delayed due to operational procurement capacity but commencing in January 2018.
3) There are two "lots" in the ITT –
   a) "treatment" – this aims to procure:
      1. 24/7 telephone counselling support
      2. Face to face counselling options with different recognised therapeutic techniques
      3. Close KPI and quality monitoring required, including data which can be used by the Trust (anonymised) relating to reasons for access, groups and staff groups that clients present from
      4. Response to serious and distressing incidents, to support employees as requested
      5. Onward specialist referral pathways especially in the area of autistic spectrum conditions, bereavement and post-traumatic stress (we already have OH specific psychiatric access)

   b) "prevention and training" –
      1. Requesting sessions in issues of concern to our employees including – stress management, change, sleep issues, assertiveness training, manager training for helping employees with stress or mental health issues, debt management, grief /loss, mindfulness / meditation /autism awareness.
      2. We are also asking for the bid to include suggestions for a mental health first aid for colleagues including suicide awareness
      3. Annual confidential stress / distress assessment as a voluntary support measure for those in identified high stress or absence areas.

There is a cost implication – while bids are not yet in, indicative costs show this comprehensive tender will require an additional £30k in comparison to previous year's provision but is much more extensive and prevention and specialist focused.

1.5 In addition, the following actions are planned

a) Introduction of a new Attendance Policy and associated training to replace the current Sickness Absence Policy. The new policy will include an expectation that employees with mental health issues are referred immediately to Occupational Health and will also contain guidance on the accurate completion of the ESR absence fields so that "hot spot" areas of particular conditions or high absence can be identified for specific intervention or training and assurance received that OH referral is in place. This is currently out for comments with Trade Unions and Managers.

b) In our current "start-up" offer, OH receives medical information from new employees and calls or sees those with active or previous mental health issues and gives advice to the employee and their manager. We cannot mandate that employees disclose their mental health background/issues, but the plan is to provide a framework that encourages disclosure. Additional health and wellbeing information to be included as part of the Trust induction process to introduce and highlight the organisation as a place that supports good mental health and to outline in more detail the offer for new employees.

c) c) A rolling communication programme detailing the help available for particular stressors or conditions. We would also propose a rolling programme of professional attendance at QIHDs to present on Mindfulness, meditation and other stress reducing techniques, subject to funding. Linking Trust communications with national mental health campaigns, e.g. Time To Talk and Diversity Days.

d) Implementing a pilot (funded by NHSI) on holistic interventions in A&E and Maternity based on the evidence based approach to mindfulness in a busy front line environment. Full details of the scope of the pilot will be available in early February 2018. NHSI have allocated £15k to supporting SWBH with piloting these interventions including offering free yoga, pilates and meditation classes across the Trust.

2. Early Intervention service for Employees

Occupational Health data has shown that many employees absent from work or on restricted duties because they are waiting for investigation or an appointment at SWBH. Informal expediting of appointments was in place but not equitable across the Trust.

The Executive team agreed with the Early Intervention service being introduced. This has "gone live" with a trial group of employees who have attended Occupational Health in December, to test the IT and procedures before a planned launch in January with a Heartbeat feature.

Employees will have the opportunity to fill in an online form (or paper version will also be explored) which will then be sent to Occupational Health who will RAG rate the health issue in terms of its effect on attendance work. Employees will still be required to have a GP referral to use SWBH services and are free to use other Trusts without prejudice. On receipt of the form, the bookings team will use last minute cancellations and extra slots to expedite the appointment for employees, ensuring that this does NOT displace patients with more urgent needs. All cases sent on by Occupational Health will be followed up to assess the usefulness of the service after 6 months' use (July 2018).

Long term the aim would be to extend this scheme to our partner Trusts on a quid pro quo basis, ideally to include the mental health trusts.

This strategy aims to impact sickness absence, presenteeism and wellbeing for employees as well as reducing cost to the Trust and reducing use of temporary workers. It will also create more transparency of barriers that may be affecting an individual's return to work. These factors are known to impact on patient morbidity and mortality.

3 Musculoskeletal absence

The Musculoskeletal Occupational Physiotherapy Service (MOPS) has been run separately from main Occupational Health services for over 18 months now. This service can be directly accessed by employees. They report their data via their Group Director. Where useful, they liaise with Occupational Health on difficult mutual cases and refer employees on to Trust extended physiotherapy services as patients. Employees with musculoskeletal issues will also be able to use the early Intervention service as above.

3.1 The Trust Board is asked to consider:

As combined musculoskeletal causes form the biggest group of sickness absence in the Trust, and occupational Health figures suggest that the majority of these cases are either caused or made worse by work, –

a) That the MOPS service regularly present their data with agreed Key Performance Indicators to the Workforce delivery Committee so that this data is joined up with other workforce health related data.
b) Inviting a service profile presentation and results so far / plan for tackling occupational musculoskeletal issues at a future Trust Board meeting
c) Inviting a Health and Safety Committee update on work related injury and related policies and scope whether they wish to invest in some more full time SWBH bespoke ergonomic support after a discussion and a cost evaluation.

4 "Time to be well"

The Occupational Health and MOPS service recommend employees attend certain exercise and other wellbeing classes or services for positively managing physical and mental health conditions. We welcome comments on the proposal for colleagues to attend these classes / sessions in "work time", with sensible rules, audits and limitations built in for operating this approach. This reflects and would support the primary care focus on 'social prescribing' where exercise, weight management, stopping smoking, mindfulness or holistic well-being interventions are prescribed instead of traditional medicine.

FOCUS FROM SICKNESS ABSENCE TO EMPLOYEE ATTENDANCE AND POSITIVE WELL BEING

5. Policy review

Consultation on the proposed changes to the Sickness Absence Management Policy has commenced, with a planned implementation date of April 2018. A programme of retraining / briefing for managers of the revised policy and processes is also planned to be implemented at this time to ensure confidence and compliance.

6. Communications and engagement on positive well-being:

Effective from January 2018 onwards:

- The rolling programme of corporate sickness absence training for managers will focus on improving attendance and employee health and wellbeing. This is also incorporated within the mandatory modules of the SWBH Accredited Manager Programme, which launches in January 2018.
- Bi-monthly meetings will be held to identify 'hotspot' areas for sickness absence, whereby targeted health and wellbeing interventions will be discussed and actioned.
- Manager's factsheet to include revised focus on improving attendance and employee health and wellbeing and the crucial roles of managers for achieving this.

7. Attendance incentive scheme:

We will be undertaking a scoping exercise to consider the introduction of an 'Attendance Incentive Scheme'. Attendance incentives come in many forms, including (for example) additional annual leave or vouchers, gifts/prizes and are essentially designed both as an incentive for future attendance and to reward good attendance. Other organisations across public and private sector offer incentives of this type, including the Black Country Trusts.

Part of the scoping exercise will consider financial, employee relations (any potential demotivating factors) and any discriminatory implications.

Dr Tamsin Radford – Consultant and Head of Occupational Health and Wellbeing service
Sarah Towe – Human Resources Business Partner
21st December 2017

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Nursing Career Escalator
SPONSOR (EXECUTIVE DIRECTOR):	Elaine Newell, Chief Nurse
AUTHOR:	Elaine Newell - Chief Nurse
DATE OF MEETING:	4th January 2018

EXECUTIVE SUMMARY:

This paper responds to the 'turnover in years 2-5' issue. It sets out an approach for bands 4/5/6 nursing colleagues, with a clear focus on performance and development related progression. Comments are welcomed from the Trust Board on the ambition and scope of this programme.

REPORT RECOMMENDATION:

Discuss Nursing Career escalator and comment on the scope of the proposal.

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 Diversity		Workforce	X

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

Career Escalator for Nursing Careers at SWBH – bringing your AMBITION to life

Nursing Bands 4, 5 and 6 Escalator–Novice to expert programme launching 1st April 2018

Introduction

During December 2017 Trust Board we considered the nursing turnover data, which demonstrated that nurses leave SWBH in their first year (preceptor) and then in years 2-5.The Trust Board asked for consideration to be given to the career opportunities and development available to retain those nurses within our Trust, and avoid the £32-42k recruitment cost per head that recruiting a band 5 or band 6 nurse generates.

Response

We already have an existing theoretical route for B4 – 5, via the nurse apprenticeship and nursing associate programmes. Currently B4 via nurse associate routes, exit with a foundation degree. There is currently no identified funding to support via 'secondment' those staff who wish to pursue a nursing career and this is a limiting factor for many staff – we need to agree the funding streams for those associates who wish to continue onto nurse training programmes. This will be evaluated and agreed when HEE fully launch the Nursing Apprenticeship Standards in Q4.

Band 5 nurses currently commence at spinal column point (scp)16 (£22,128). They are mandated to access our preceptorship programme, which the December Trust Board heard in has been refreshed by the Deputy Chief Nurse and colleagues. This takes approximately 12-18 months to complete.

We would expect every new starter to have a PDR (as detailed in the induction changes set out above) setting objectives for the year ahead by month 3 of employment at the latest, with a further review and new objectives at 12 months of employment. This escalator proposal identifies high achievers through the PDR process and then maps them to an appropriate development programme (management and leadership or clinical expert) at that point. NB the two are not mutually exclusive.

Action – ensure all PDR's are completed with new nurses within 3 months in their new role.

At end of 2 years from the start date, following completion of the preceptorship programme and a 6 – 12 month period of consolidation) there will be a full review of the objectives from previous 12 months. Those staff who score **4A or similar –** will have a structured development conversation with their line manager which focusses on their escalated development via either management or clinical expert route. OD and Nursing are working together on a robust competency based package which will be delivered over a 12 month period. This may be developed internally or procured.

Action – Nursing and OD to develop or procure a structured 12 month programme of learning to be undertaken for management route and clinical expert route.

At this point, we would uplift the nurse's basic salary to SCP 19 (£24,574). A fair and consistent recruitment process would also be developed, that would give priority access to interviews for more senior posts to nurses on the career escalator.

Action – after two years since start date, those nurses undertaking the career escalator route will be uplifted to SCP 19 whilst they undertake their development.

Action – internal recruitment first process to be designed to give access to interviews for substantive posts for colleagues on career escalator programme.

Following successful completion of the 12 month development programme, their subsequent year of embedding in and learning (3 years since starting with the Trust), and consistently achieving a 4A in the PDR, the Trust would uplift the nurse to point scp 21 £26,565 (entry point to B6). This would mean that a newly qualified nurse could graduate and be operating with development at a band 6 level within 3 years of qualifying. Subsequent annual uplift will be dependent upon sustained delivery against objectives at 4A or similar high levels of performance. This approach is outlined in the table below:

Scp16	First preceptorship 12-18 months (mandated)	£22,128	Start point – PDR at 3 months Commence on preceptor programme for completion within 12 - 18 months. PDR at 12 months to evaluate performance
Scp 17	Development year with career choices and advice communicated throughout	£22,683	Year 2- consolidation year. PDR at end year 2 – those staff assessed at 4a – discussion / assessment whether to progress via management or clinical expert route. Programme to be developed for each route during Q4. As an **Opt in**, staff who meet 4a criteria, skip to salary point 19 whilst undertaking a suite of competencies appropriate to the career pathway of choice – completion approx. 1 year.
Scp18		23,597	
Scp19	Career escalator accelerated banding	£24,547	Year 3 – completion of development programme / objectives. At end year 3 - PDR to assess progress. If all competencies achieved and objectives met or exceeded then skip to salary point 21 for exceptional performers. Preferential access to interviews for more senior roles
Scp20		£25,551	
Scp 21	Band 6 entry point	£26,565	Year 4 Ongoing salary uplift linked to PDR and performance against set objectives.

Key questions to consider before launch:

1) **Where the decision making and budgeting will sit?** In order for the career escalator to be fairly and consistently applied, the Trust will need to take a Trust wide approach to ensure equity of opportunity across the clinical groups. However, it is suggested that individual budgets should be managed at a directorate level, with oversight by the clinical group board.
2) **How we will recruit to higher banded positions.** E.g. the nurses on a career escalator should be considered / guaranteed interviews for more highly banded positions. This will require a rethink of the internal recruitment process to ensure that we are prioritising our internal talent pool (i.e. those on the career escalator programme) and gaining return on investment. This will be redesigned during Jan and Feb 18 and ensure it is fair and equitable.
3) **Career escalation for bands 3 and 4?** More will be known about the access to opportunities for Band 3 and 4 staff in Q4. This will be aligned to the launch of nursing apprenticeships (due to start in Jan 18 but not ready) and our utilisation of the new nursing associate role. SWBH are part of the Black Country pilot on nursing apprenticeships, being led by Walsall currently.
4) **How will this be paid for?** This will be modelled in more detail as the process is refined. However, it is assumed that the resulting reduction in turnover will more than comfortably pay for the career escalator increase in salary. The increases are within the agenda for change banding and small increases when you consider the cost of replacing band 5 and band 6 nurses. This will be modelled during January 2018.
5) **Are the skills and capacity in place to build competency packages for the development needed?** OD and Nursing are working together on either Building a learning package internally or commissioning an accredited package from external providers. There will be a cost to this – which will be provided for in next year's training budget allocation.
6) **Are the skills and capacity in place for line managers to have development conversations and set SMART objectives?** Each manager should have undertaken the foundation modules of the Accredited Manager programme, which sets out how to set SMART objectives. However, a manager coaching pack will be developed to sit alongside the Career Escalator Programme.
7) **How can we be sure this will be fair and equitably applied?** Nursing and OD will work closely with clinical group leaders to ensure that the process is fair and equitable, in terms of those who can opt in to the career escalator. There is also a moderator role already in place through the existing Performance and Development Review Process. The Trust will monitor applications in terms of its equality reporting objectives (WRES and others).
8) **Is it just for newly qualified staff?** No, the career escalator will be available to all staff who wish to develop their skills within the organisation. Consideration on pay will be given on an individual basis depending on where a nurse starts their journey (e.g. nurses may already be at the top of band 5 but wish to undertake the development programme and have access to the development and interviews. This will be considered with nursing leaders in January 2018.
9) **When will this launch?** The aim is to launch the programme on 1st April 2018 and use to enhance our recruitment offer.

Elaine Newell – Chief Nurse
December 2017

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Trust Risk Register
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Refeth Mirza, Head of Risk Management
DATE OF MEETING:	4 January 2018

EXECUTIVE SUMMARY:

The Trust Risk Register (TRR) provides the Board with details on all identified operational risk exposures across Sandwell and West Birmingham Hospitals NHS Trust. The Trust has identified a range of significant risks, which are currently being mitigated, whose impact could have a direct bearing on the achievement of Trust Plans and priorities and requirements within the NHSI Accountability Framework or CQC registration should the mitigation plans be ineffective.

There are currently four areas where, having implemented the planned mitigating actions, the potential of an adverse impact on the Trust remains significant. These relate to the introduction of a new EPR, unfunded beds and Delayed Transfers of Care, and merit a Board discussion on further actions planned and/ or required to reduce the probability or severity of the risks materialising.

REPORT RECOMMENDATION:

Trust Board is recommended to:

a) consider, challenge and confirm the correct strategy has been adopted to keep potential significant risks under prudent control; and
b) advise on any further risk treatment required

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:

Risk Management Committee and Clinical Leadership Executive

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Trust Board: 4 January 2018

Trust Risk Register

1. Introduction

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

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

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

2. Discussion points

2.1 Since the TRR was reported to the Board at its December 2017 meeting the Head of Risk Management has supported risk owners in further reviewing their risks and updated each risk assessment to provide an accurate position against the progress of mitigating actions.

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

2.3 Apart from the addition of the risk approved by the Board in December (impact of continued spend on unfunded beds, **Risk 2849)** there are no changes to the TRR being put forward.

2.4 There are currently four areas where, having implemented the planned mitigating actions, the potential of an adverse impact on the Trust remains significant. **<u>These are shown below and merit a Board discussion on further actions planned and/ or required to reduce the probability or severity of the risks materialising</u>.**

Risk No. 271	Risk No. 1643	Risk No. 215	Risk No. 2849
There is a risk of failure of a Trust wide implementation of a new EPR. Failure of the EPR to go-live in the timescale specified will impact on cost and lost benefits resulting in an inability to meet strategic objectives.	Unfunded beds with inconsistent nursing and medical rotas are reliant on temporary staff to support rotas and carry an unfilled rate against establishment. This could result in underperformance of the safety plan, poor documentation and inconsistency of care standards.	There are high Delayed Transfers of Care (DTOC) patients remaining in acute beds due to a lack of EAB beds in nursing and residential care placements and social services. This results in an increased demand on acute beds.	Continued spend on unfunded beds will impact on the financial delivery of CIP and the overall Trust forecast for year end. Deviation from the financial plan will impact on STF which is assumed in the financial outturn forecast. This could result in a significant financial deficit year end.

3. Recommendations

Trust Board is recommended to:

c) consider, challenge and confirm the correct strategy has been adopted to keep potential significant risks under prudent control; and
d) advise on any further risk treatment required

Refeth Mirza
Head of Risk Management

29 December 2017

TRUST RISK REGISTER - January 2018

Risk No.	Clinical Group	Department	Risk	Initial Risk Rating (LxS)	Existing controls	Owner *Executive Lead*	Review Date	Current Risk Rating (LxS)	Gaps in control and planned actions	Target Risk Rating Score (LxS)	Completion date for actions	Status
121 24/01/2017	Women And Child Health	Maternity 1	There is a risk that due to the unpredictable birth activity and the impact of cross charging from other providers against the AN / PN tariff is significantly affecting the financial position of the service impacting on the affordability and quality provision of the service.	4x4=16	1- Maximisation of tariff income through robust electronic data capture and validation of cross charges from secondary providers.	Amanda Geary ***Rachel Barlow***	29/12/2017	3x4=12	**Cross charging tariff affecting financial position.** **1**-Options for management of maternity pathways payment between primary and secondary provider for AN/PN care in progress by the Finance Director - with cross provider SLA planned. Risk proposed for removal from TRR when 2016-17 SLA is signed. **(29/12/2017))** **2**-Options appraisal from finance in progress which will be discussed between the Clinical Group Director of Operations and Director of Finance. **(29/12/2017)**	2x4=8	29/12/2017	Live (With Actions)
221 22/09/2015	Medical Director Office	Informatics(C)	There is a risk of failure of a trust wide implementation of a new EPR. Failure of the EPR to go-live in the timescale specified will impact on cost and lost benefits resulting in an inability to meet strategic objectives.	4x4=16	1-Recruitment of suitably skilled specialist resources for EPR Programme and Infrastructure Stabilisation 2-Funding allocated to LTFM 3-Delivery risk shared with supplier through contract 4-Project prioritised by Board and management. 5-Project governance including development, approval and tracking to plan. 6-Focus on resources to deliver the implementation including business change, training and champions.	Kulvinder Kalsi ***Mark Reynolds***	16/12/2017	5x4=20	**Insufficient skilled resources within the Trust to deliver the EPR system.** **1**-Develop and publish implementation checklists and timescales for EPR. Report progress at Digital PMO and Committee **(30/11/2017)** **2**-Agree and implement super user and business change approaches and review and re-establish project governance. **(30/11/2017)** **3**-Embed Informatics implementation and change activities in Group PMOs and production planning **(31/12/2017)** **4**-Agree and implement super user and business change approaches and review and re-establish project governance **(30/11/2017)**	1x2=2	31/12/2017	Live (With Actions)
1643 11/02/2016	Corporate Operation	__	Unfunded beds with inconsistent nursing and medical rotas are reliant on temporary staff to support rotas and carry an unfilled rate against establishment. This could result in underperformance of the safety plan, poor documentation and inconsistency of care standards.	4x4=16	1-Use of bank staff including block bookings 2-Close working with partners in relation to DTOCs 3-Close monitoring and response as required. 4-Partial control - Bed programme did initially ease the situation but different ways of working not fully implemented as planned.	***Rachel Barlow***	31/12/2017	4x4=16	**Unfunded beds - insufficient staff capacity.** **1**-Contingency bed plan is agreed in October for winter - L5 to be opened in November.**(31/12/2017)** **2**-Bed programme to ensure robust implementation of EDD planning on admission and implementation of red/green working on wards. **(31/12/2017)** **3**-Overseas recruitment drive **(pending)**	1x4=4	31/12/2017	Live (With Actions)
228 22/09/2015	Medical Director Office	Informatics(C)	There is a risk that a not fit for purpose IT infrastructure as current systems are not flexible to support clinical activity redesign. This will result in a failure to achieve strategic objectives and significantly diminishes the ability to realise benefits from related capital investments.	3x4=12	1-Approved Business Case in place for Infrastructure Stabilisation programme (approved by Trust Board June 2015) 2-Specialist technical resources engaged (both direct and via supplier model) to deliver key activities 3-Informatics has undergone organisational review and restructure to support delivery of key transformational activities 4-Informatics governance structures and delivery mechanisms have been initiated to support of transformational activities	Dean Harris ***Mark Reynolds***	14/02/2018	3x3=9	**IT infrastructure not fit for purpose.** **1**-Complete network and desktops refresh. **(31/12/2017)** **2**-Stabilisation of all aspects of the local IT infrastructure to be completed. The replacement of PCs, printers, monitors, etc., and upgrade of the network is conducted in parallel. **(31/12/2017)** **3**-Establish infrastructure plan and track progress. **(31/12/2017)**	1x1=1	31/12/2017	Live (With Actions)
325 12/05/2015	Medical Director Office	Informatics(C)	There is a risk of a breach of patient or staff confidentiality due to cyber attack which could result in loss of data and/or serious disruption to the operational running of the Trust.	4x4=16	1-Prioritised and protected investment for security infrastructure via Infrastructure Stabilisation approved Business Case 2-Information security assessment completed and actions underway.	Mark Reynolds ***Mark Reynolds***	15/12/2017	2x4=8	**Sytems in place to prevent cyber attack.** **1**- Upgrade servers from version 2003. **(31/12/2017)** **2**-Restricted Devices Security Controls **(31/12/2017)** **3**-Implement security controls (VLAN, IPSEC) to stop access to and from restricted devices. Over time this should harden the Trust infrastructure against attack, recognising that securing the physical network is a challenge on the estate. **(31/03/2018)** **4**-Achieve Cyber Security Essentials **(31/12/2017)** **5**-The Trust must achieve cyber-security essentials as part of the minimum commitment to security. This will likely form part of our CQC inspections. **(31/12/2017)** **6**-Complete rollout of Windows 7. **(15/12/2017)**	1x4=4	31/12/2017	Live (With Actions)
2642 20/06/2017	Medical Director Office	Medical Director's Office	There is a risk that results not being seen and acknowledged due to I.T. systems having no mechanism for acknowledgment will lead to patients having treatment delayed or omitted.	3x5=15	1-There is results acknowledgment available in CDA only for certain types of investigation. 2-Results acknowledgement is routinely monitored and shows a range of compliance from very poor, in emergency areas, to good in outpatient areas. 3-Policy: Validation Of Imaging Results That Require Skilled Interpretation Policy SWBH/Pt Care/025 4-Clinical staff are require to keep HCR up to date - Actions related to results are updated in HCR 5-SOP - Results from Pathology by Telephone (attached)	***Roger Stedman***	31/12/2017	2x5=10	**Multiple IT systems some of which have no mechanism for acknowledgment or audit trail.** **1**-Implementation of EPR in order to allow single point of access for results and audit **(30/03/2018)** **2**-All staff to comply with the updated Management of Clinical Diagnostic Tests policy **31/12/2017)** **3**-To review and update Management of Clinical Diagnostic Tests **(31/12/2017)**	1x5=5	31/12/2017	Live (With Actions)
1738 15/04/2016	Surgery	BMEC Outpatients - Eye Centre	There is a risk that children under 3 years of age, who attend the ED at BMEC, do not receive either timely or appropriate treatment, due to limited availability OOH of specialist paediatric ophthalmologists and/or the availability of a paediatric anaesthetist. This could potentially result in severe harm to the patient.	3x4=12	1-Contingency arrangement is for a general ophthalmologist to deal with OOH emergency cases. 2-Agreement with BCH to access paediatric specialists advice. 3-There is a cohort of anaesthetists who are capable of anaesthetising children under 3 who can provide back-up anaesthetic services when required. 4-Where required patients can be transferred to alternative paediatric ophthalmology services beyond the local area - potentially Great Ormond Street Hospital 5-The expectation of the department is that a general ophthalmologist should be able to treat to the level of a general ophthalmologist and will be able to deal competently with the majority of cases that present at BMEC ED.	Bushra Mushtaq ***Roger Stedman***	15/12/2017	2x4=8	**Limited access to OOH service.** 1-Engage with ophthalmology clinical lead at BCH and agree a plan for delivering an on call service. **(15/12/2017)** 2-Liaise with commissioners over the funding model for the Paediatric OOH service. **(15/12/2017)** 3-Paediatric ophthalmologists from around the region to participate in OOH service (for discussion and agreement at a paediatric ophthalmology summit meeting).**(22/12/2017)** 4-Clarify with Surgery Group leads what the paediatric anaesthetic resourcing capacity is. **(22/12/2017)**	1x4=4	31/12/2017	Live (With Actions)
215 16/09/2016	Corporate Operations	Waiting List Management (S)	There is high Delayed Transfers of Care (DTOC) patients remaining in acute beds, due to a lack of EAB beds in nursing and residential care placements and social services. This results in an increased demand on acute beds.	4x5=20	New joint team with Sandwell is in implementation phase.	Phil Holland ***Rachel Barlow***	31/12/2017	4x4=16	**Lack of EAB beds in nursing and residential care placements and social services.** **1**- The System Resilience plan awaits clarification from Birmingham City Council. The system resilience partners are considering risk and mitigation as part of A&E delivery group. **(31/12/2017)** **2**- To review and update the ADAPT pathway, with a management data set and KPI standards. The new process to be implemented in September to provide more focused assessments and care planning. **(31/12/2017)**	3x4=12	31/12/2017	Live (With Actions)

TRUST RISK REGISTER - January 2018

Risk No.	Clinical Group	Department	Risk	Initial Risk Rating (LxS)	Existing controls	Owner *Executive Lead*	Review Date	Current Risk Rating (LxS)	Gaps in control and planned actions	Target Risk Rating Score (LxS)	Completion date for actions	Status
2849 28/11/2017	Corporate Operations	Medical Surgical Team	Continued spend on unfunded beds will impact on the financial delivery of CIP and the overall Trust forecast for year end. Deviation from the financial plan will impact on STF which is assumed in the financial outturn forecast. This could result in a significant financial deficit year end.	5x4=20	Design and implementation of improvement initiatives to reduce LOS and EDD variation through establishing consistency in medical presence and leadership at ward level - consultant of the week	Rachel Barlow ***Rachel Barlow***	22/12/2017	5x4=20	**1-** To reduce number of patients staying over 7 days **(31/12/2017)** **2-** Implement at pace the improvement programme to reduce LOS and improve EDD compliance **(31/12/2017)** **3-** Ensure business intelligence available to mange at ward, group and corporate level in real time **(09/12/2017)**	4x3=12	31/12/2017	Live (With Actions)
214 18/03/2016	Corporate Operations	Waiting List Management (S)	The lack of assurance of the 18 week data quality process, has an impact on patient treatment plans which results in poor patient outcomes/experience and financial implications for the Trust as it results in 52 weeks breaches. There is a risk delay in treatment for individual patients due to the lack of assurance of the 18 week data quality process which will result in poor patient outcome and financial implications for the trust as a result of 52 week breaches	4x3=12	1- SOP in place 2-Improvement plan in place for elective access with training being progressed. 3-following a bout of 52 week breach patients in Dermatology a process has been implemented where by all clock stops following theatre are automatically removed and a clock stop has to be added following close validation 4-The 52 week review was completed with TDA input. The action plan is focused on prospective data quality check points in the RTT pathway, competency and training.	Liam Kennedy ***Rachel Barlow***	15/12/2017	3x3=9	**Lack of assurance on 18 week process.** **1**-Data quality process to be audited - Monthly audits **(31/03/2018)** **2**- E-learning module for RTT with a competency sign off for all staff in delivery chain - to b e rolled out to all staff from October. **(01/12/2017)** **3**-Bespoke training platform for 18 weeks and pathway management for all staff groups developed in line with accredited managers programme. **(31/10/2017) - COMPLETED**	2x2=4	11/02/2018	Live (With Actions)
533 29/12/2015	Primary Care And Community Therapies	Oncology Medical	There is a risk of negative impact to cancer waiting times, caused the withdrawal of oncology consultants and transfer of patients to other providers, which may lead to longer waits for oncology treatment.	3x5=15	1- Use of locums to fill staffing gaps. 2- NHS Improvement-seconded UHB manager on site at SWBH to try and facilitate communication with UHB clinical team and improve perception of performance.	Stephen Hildrew ***Roger Stedman***	22/02/2018	3x5=15	**Staffing gaps due to non replacement UHB roles.** **1-** Recruitment halted by UHB. Notification of withdrawal not rescinded. Service due to cease **28/02/2018**	1x5=3	28/02/2018	Live (With Actions)
1603 22/01?2016	Finance	Financial Management (S)	The Trust's recent financial performance has significantly eroded cash balances and which were underpinning future investment plans. There is a risk that our future necessary level of cost reduction and cash remediation is not achieved in full or on time and which compromises our ability to invest in essential revenue developments and inter-dependent capital projects	5x5=25	1-Routine & timely financial planning, reporting and forecasting including fit for purpose cash flow forecasting. 2-Routine five year capital programme review & forecast 3-Routine medium term financial plan update 4-PMO infrastructure and service innovation & improvement infrastructure in place & effective Independent controls / assurance 1- Internal audit review of core financial controls 2-External audit review of trust Use of Resources including financial sustainability 3-Regulator scrutiny of financial plans 4-Routine scrutiny of delivery by FIC	Timothy Reardon ***Tony Waite***	31/12/2017	4x5=20	**Lack of assurance on the sufficiency of our plans to achieve cost reduction and cash remediation** **1**- Deliver operational performance consistent with delivery of financial plan to mitigate further cash erosion -Use relevant benchmarks to underpin multi-year & specific CIP plans -Align trust CIP to commissioner QIPP to secure collective system cost reduction -Secure market opportunities to drive financial margin gain **2**- Ensure necessary & sufficient capacity & capability to deliver scale of improvement required **3**- Develop and secure alternative funding and contracting mechanisms with commissioners to secure income recovery and to drive the right long term system behaviours **4**- Refresh LTFM to confirm scale of cash remediation required consistent with level 2 SOF financial sustainability rating **5**- Secure borrowing necessary to bridge any financial gap	2x5=10	31/03/2018	Live (With Actions)
534 29/12/2015	Primary Care & Community Therapies	Oncology Medical	There is a risk of Trust non-compliance with some peer review standards and impact on effectiveness of tumour site MDTs due to withdrawal of UHB consultant oncologists, which may lead to lack of oncologist attendance at MDTs	3x4=12	Oncology recruitment ongoing. Withdrawal of UHB oncologists confirmed, however assurance given around attendance at MDT meetings. Gaps remain due to simultaneous MDT meetings.	Jennifer Donovan ***Roger Stedman***	11/02/2018	3x4=12	**Lack of Oncologist attendance at MDTs.** **1-** Review of MDT attendance underway as part of NHS Improvement/ NHS England oversight arrangements for oncology transfer. **31/03/2018**	1x4=4	31/03/2018	Live (With Actions)
666 20/07/2017	Women and Child Health	Lyndon 1	Children-Young people with mental health conditions are being admitted to the paediatric ward due to lack of Tier 4 bed facilities. Therefore therapeutic care is compromised and there can be an impact on other children and parents.	4x4=16	1- Mental health agency nursing staff utilised to provide care 1:1 2- All admissions are monitored for internal and external monitoring purposes. 3-Awareness training for Trust staff to support management of these patients. 4-Children are managed in a paediatric environment.	Heather Bennett ***Rachel Barlow***	30/01/2018	4x4=16	**There is no specialist medical or nursing MH team to care for their needs with limited access to in/OOH CAMHS support.** **1**- The LA and CCG are looking to develop a Tier 3+ service. An update has been requested through the CCG and a response is awaited. Tier 4 beds are being reviewed nationally. **(31/03/2018)**	3x4=12	31/03/2018	Monitor (Tolerate)
566 17/10/2017	Medicine And Emergency Care	Accident & Emergency (S)	There is a risk that further reduction or failure to recruit senior medical staff in ED will lead to an inability to provide a viable rota at consultant level. This will impact on delays in assessment, treatment and will compromise patient safety.	4x5=20	1- Recruitment campaign in place through local networks, national adverts, head-hunters and international recruitment expertise. 2- Leadership development and mentorship programme in place to support staff development. 3-Robust forward look on rotas are being monitored through leadership team reliance on locums and shifts are filled with locums.	Michelle Harris ***Rachel Barlow***	30/01/2018	3x4=12	**Vacancies in senior medical staff in ED.** **1**- Recruitment ongoing with marketing of new hospital. **(31/03/2018)** **2**- CESR middle grade training programme to be implemented as a "grow your own" workforce strategy. **(31/03/2018)** **3**- Development of recruitment strategy **(31/03/2018)**	4x3=12	31/03/2018	Live (With Actions)
114 04/04/2016	Workforce And Organisational D	Human Resources	Insufficient policy levers to ensure effective delivery of Trust workforce plan establishment due to a reduction of 1400 WTEs, leading to excess pay costs.	4x5=20	1-The Executive led delivery plan is progressing the reduction of WTEs alongside a change management programme and formal consultation, including TUPE or other statutory requirements. 2- Learning from previous workforce change is factored in to the delivery plan, inclusive of legislative changes and joint working with Staffside	***Raffaela Goodby***	31/12/2017	3x4=12	**Delivery of Workforce Plan.** **1-**Implementation of 2nd year of the 16-18 Transformation Plan monitored via TPRS and People Plan Scorecard. **(31/03/2018)** **2-**Groups required to develop workforce plans/ associated savings plans for 18-19 ensuring effective and affordable reconfiguration of services in 2019. Plans to be developed through Group Leadership, with a view to commencing an open and transparent workforce consultation process in the spring of 2018. **3-**Groups required to develop and implement additional CIP plans to address identified CIP shortfall. **(31/12/2017)**	3x3=9	31/07/2018	Live (With Actions)

TRUST RISK REGISTER - January 2018

Risk No.	Clinical Group	Department	Risk	Initial Risk Rating (LxS)	Existing controls	Owner *Executive Lead*	Review Date	Current Risk Rating (LxS)	Gaps in control and planned actions	Target Risk Rating Score (LxS)	Completion date for actions	Status
410 04/10/2016	Surgery	Outpatients - EYE (S)	Risk of Breach of Privacy and Dignity Standard, Information Governance Risk and Infection Control Risk at SGH Opthalmology Outpatient Department as a consequence of poor building design which can result in financial penalties and poor patient outcomes.	5x4=20	Staff trained in Information Governance and mindful of conversations being overheard by nearby patients / staff / visitors	Laura Young ***Rachel Barlow***	30/01/2018	3x4=12	**Poor building design of SGH Ophthamology OPD** **1**-Review of moving the community dental rooms. Plans being drawn up - should be available for consultation mid Sept 2017 - potential for renovation around mid 2018. **(31/07/2018)** **2**-Review plans in line with STC retained estate **(31/07/2018)**	2x2=4	29/09/2018	Live (With Actions)
2272 13/01/2017	Medicine and Emergency Care	Accident and Emergency	The Trust has un-substantiated beds open due to admissions above plan, extended Length of Stay (LOS) above bed plan assumptions and too many Delayed Transfers of Care bed days (DTOC). This could result in overcrowding in ED undoubtedly adversely impact on patient outcomes.	5x5=25	Business continuity inplace for upto 20 additional patients in ED	Michelle Harris ***Rachel Barlow***	31/12/2017	4x5=20	**Existing bed reduction programme insufficient** **1**. Support from On call manager and capacity to support ED cohorting patients in corridor = x1 crew 4 pts **(31/12/2017)** **2.** To obtain social care business continuity response to eradicate all acute delayed transfer of care patients. **(31/01/2018)** **3.** Command and control structure to be put in place if business plan activated to support ED and live assessment of risk **(31/01/2018)**	1x5=5	31/12/2018	Live with Actions

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Building Sustainable Finances – Outline Financial Plan 2018.19
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance
AUTHOR:	Dinah McLannahan, Deputy Director of Finance
DATE OF MEETING:	4th January 2018

EXECUTIVE SUMMARY:

The principal governance matter for the Board in respect of the financial plan for 2018.19 is its acceptance or otherwise of the trust's notified Control Total.

That declaration shall be required when making the formal plan submission to NHSI. That is currently anticipated to be at the end of February 2018.

This report provides an initial view of the financial plan for 2018.19.

The Board has previously seen the rationale for the total ask, being the current underlying position of the Trust, the impact of the transfer out of Oncology services, and incremental costs for 2018/19, driven by achieving the 2018/19 control total of a pre-STF surplus of £791k, which the Trust has previously accepted.

After removing non-recurrent items that have improved the headline position of the Trust, the underlying deficit is measured at £22.676m.

The current view of the impact of Oncology services transferring out is £3.45m. The Trust is expecting that it will not suffer financial detriment as a result of this decision, and will be putting a proposal to commissioners for compensation for stranded costs, over a reasonable taper period, to allow the Trust to absorb the impact. The view on incremental cost for 2018/19 remains at just over £17m.

The Board will be aware of the significant amount of work ongoing in the Trust to improve the monthly run rate by £3.5m, which if achieved on a full year effect basis, would meet the required ask and mean that the Trust achieves the current control total ask.

The report sets out the key variables to the current view, all of which should be confirmed for the final plan submission. A timetable for future Board and Committee review of the plans is also included. Dates for plan submission to NHSI are yet to be confirmed, as is reconfirmation of the control total (expected to remain the same as previously advised).

The report also contains a five year view on the capital programme, outlining a forward look of c£101m (including 2017/18). There is also a slide on a five year cash plan, to determine the likely funding source of the capital programme.

Assuming the Trust continues to break even and receive a similar level of STF, the capital programme as it is currently set out can plausibly be internally funded from cash and depreciation.

That plan is, however, sensitive to the achievement of year on year P&L targets and the consequent recovery in full of anticipated STF incentive funds.

REPORT RECOMMENDATION:

The Board is recommended to:

1. confirm and challenge the assumptions in the plan that form the £43m estimated ask, and note the potential upside and downside risks to it.
2. having regard to extant and prospective savings plans consider the plausibility of achieving the scale & pace of necessary financial improvement consistent with delivery of the notified Control Total
3. consider the matters consequent on any compromise to that achievement and / or notification to NHSI of a proposed amendment to the notified Control Total
4. routinely consider these matters at subsequent meetings in advance of any formal submission to NHSI

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	
Clinical		Equality and Diversity		Workforce	x

Comments:

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

PREVIOUS CONSIDERATION:

Building Sustainable Finances
Outline financial plan 2018/19

Contents

Recommendation

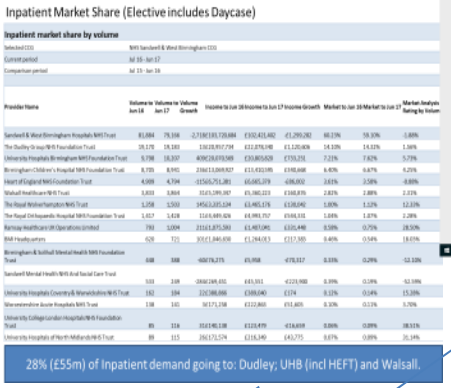
The principal governance matter for the Board in respect of the financial plan for 2018.19 is its acceptance or otherwise of the trust's notified Control Total.

That declaration shall be required when making the formal plan submission to NHSI. That is currently anticipated to be at the end of February 2018.

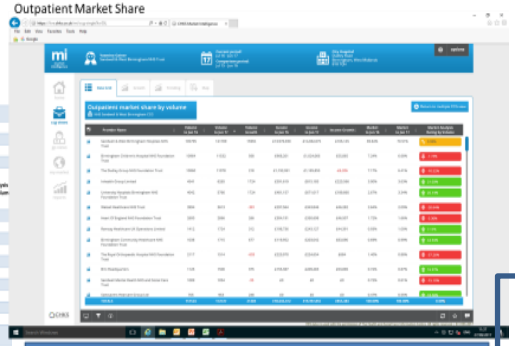
Having regard to that obligation and in consideration of this initial outline financial plan, the Board is recommended to:

- ❑ confirm and challenge the assumptions in the plan that form the £43m estimated ask, and note the potential upside and downside risks to it.
- ❑ having regard to extant and prospective savings plans consider the plausibility of achieving the scale & pace of necessary financial improvement consistent with delivery of the notified Control Total
- ❑ consider the matters consequent on any compromise to that achievement and / or notification to NHSI of a proposed amendment to the notified Control Total
- ❑ routinely consider these matters at subsequent meetings in advance of any formal submission to NHSI

Fulfilling our promise to local people – care without boundaries



28% (£55m) of Inpatient demand going to: Dudley; UHB (incl HEFT) and Walsall.



13% (£2.5m) of outpatient demand going to: Dudley; UHB (incl HEFT) and Walsall.

Purpose and Vision

Resilient place based integrated care pathways
Delivery of Midland Met as a cornerstone to the delivery of the system plans
Effective deployment of the joint system workforce models to underpin future care provision without destabilising delivery.
Improved clinical outcomes through effective investments
Clinically engaged and connected

Comms and processes to implement POLCV Phase 2. Ongoing review. Biosimilars.

Goals

Grow the SWB Business

Driving £5-7m margin from additional work undertaken in Sandwell for Sandwell residents, while reducing pressure on neighbouring hospitals:

Look analytically at £57m of out of area secondary care and cross border community services to see where there is margin benefit and patient gain in a local service instead

Reducing wait time pressures on neighbouring providers by utilising capacity within the two treatment centres as part of an electronically enabled care referral system

Confirm what we will Stop doing

Confirming what we will stop doing locally in order to fund that investment plan at a value of £8m per annum:

Develop a clear list of FYE changes we can make together which either migrate work to cheaper delivery models which are mutually cash releasing or which stop types of care

Agree mutual responsibility for 'policing' those changes such that the provider does not seek to undertake work that is not commissioned, without imposing costly burdens of administration on either GPs or other service providers.

Start with a fixed point of what we need to achieve in the future

Finalise the Investment Plans to improve Outcomes and deliver the Midland Met operating model

We will develop **place based investment plans which serve the strategic commissioning plans for the local population**, and incorporate enhanced out of hospital care sufficient to reduce emergency and elective demand to expected FBC levels or STP projections, whichever is lower.

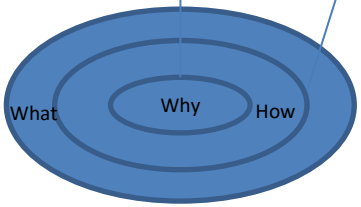
In making those investment decisions we will seek to achieve the revenue and margin aims in the FBC, and cap provider CIP levels at 4% in each of the next three years – this may be based on alliance or lead provider delivery models

Influencing the plans of non patch commissioners

Influencing **the plans of non-patch commissioners**, and the referral behaviour of GPs, to ensure that the FBC is delivered or transitional relief arranged with regulators

Closing the gap between the expected FBC Birmingham and western Sandwell referral patterns and those seen in 2016-17 (£10m)

Through the STP organise a managed strategy for changes in commissioning models for specialised services such that no unintended surcharges are applied to secondary care providers (2% per annum)



Key Considerations
Focus on acute and community but where margin exists
Achieve and market competitive waiting times including 2 week waits – Brand SWBH
SWBH plan to deliver increased volumes
Investments to underpin change workstreams first. Dependent on QIPP/CIP
Maintain some of right care, right place and right time but have enhanced focus on the route to value
Recognising Western Birmingham as a place
Helping partners to keep their promises
Making sure our plans add up before we commit the resource
Shared story on the money through to 2020

- Joint leadership team development – values and design principles
- Operational team development and approach
- Governance and Issue Resolution
- Capacity and Capability
- Shared Data
- Incentives
- Enabling Financial Framework
- Very Focussed Portfolio
- One team working together through co-design and delivery with focus on the right metrics – joint machinery
- Recognising the broader role and business of the CCG
- Clarity of role for the independent Chair

Each work-stream will be led jointly by a GP and Trust clinician, supported by an executive director drawn from across the two Boards, with relevant finance support and HR support where required. All four workstreams report fortnightly to a weekly meeting of Chairs, AOs, and directors. That meeting will report to an independently chaired oversight body.

What has the Board seen before?

Building a sustainable [clinical, operational &] financial future

SWBH	2017.18	2018.19	2019.20
CIP	£21m (4.7%)	£23m non recurrent in 17/18 New £18m 18/19 CIP	£29m (6.1%)
QIPP		£8m	£8m
SWBCCG	£264.5m	£267m (+1%) £273m (+3%)	£275m (+3%) £280m (+3%)
Pre –STF out-turn	£(4)m	£Nil	£Nil
Post STF out-turn	£1m	£11m	£11m

- Setting 2018.19 in the context of an system-led recurrent solution to 2019.20
- A necessary transformational 2019.20 plan built now [ACS; response to GE report]
- CIP driven 2018.19 plan but which will likely require accelerated ACS impact too
  - Grow the SWBH business & margin through repatriation & routing local spend through the trust
  - Influencing the plans of non-SWB commissioners and referral behaviour of GPs
  - CCG investment plans finalised to underscore Midland Met operating model
  - Confirm what we stop doing

2017/18 into 2018/19

Narrative	£'000
Headline revised plan FOT	**1,053**
Remove 2017/18 non-recurrent items	
Forecast STF	(5,006)
Profit on Land Sale, July 2017	(16,300)
Other non-recurrent items (net)	(2,423)
Underlying position – forecast outturn	**(22,676)**

Key messages

- The Trust has necessarily relied on non-recurrent, non-cash measures to optimise its reported financial position. This has been transparent and is in the national context of significant financial pressures.
- The impact of this has been to mitigate the underlying recurrent position of the Trust and having regard to the STF incentive regime.
- The reliance on such measures is by definition time limited and sustainable finances requires real & sustainable [recurrent] solutions to that underlying position.

What big things do we know are changing in 2018/19?

Item	Impact £000s	Mitigation
Assumed starting point	(22,676)	The extant focus on reducing run rate operating costs as very best possible between now and 31st March 2018 should improve this number
Net impact of transfer of Oncology services	(3,450)	This represents an assessment of stranded costs consequent on the prospective changes to the provision of oncology services. To ensure that the trust suffers no financial detriment consequent on those changes it will be necessary to secure income from commissioners to cover those costs. That income remains to be secured.
Revised starting point	**(26,126)**	

2018.19 Financial Plan [Draft]	Annual sum £000s	Notes
Revised starting point	**(26,126)**	
National Inflation	£10.175m	1% pay award + 1% local increments 2.1% non-pay + 2.9% non-opex 0.1% tariff inflation [implies 2% CIP] Assume £3.8m CNST step cost funded through tariff
Local inflation	£1.727m	£350k Living wage + £250k CEAs £1m PDC dividends re MMH investment
Investments	£2.950m	£1.050m EPR £0.900m Imaging MES BTC £1.000m 24/7 ward clerks & other developments
Reserves	£Nil	No provision for restructuring / cost of change No build up of reserve to fund MMH UP in 2019.20
Planning contingency	£2.000m	Provision to cover omission & risk e.g. QIPP erodes flat real assumption on PRI Cost pressures in groups on bottom up budgeting
Allowance for other items	£0.432m	£332k Other service stranded costs £100k Reduction in net taper relief contribution
SUB-TOTAL – TOTAL ASK – deals with underlying 2017/18 position, and "new incremental cost" above	**(43,410)**	**Slightly higher than previously understood due to impact of Oncology – if this ask is met, gets the Trust to Break Even.**
Step up in control total surplus required	791	£791k surplus pre-STF for 2018/19
STF	10,483	As advised
Current Control Total 2018/19, as advised	**11,274**	**NHSI expected to reconfirm this imminently**

What might change this ask?

- Any change from the current Month 8 forecast position would either reduce or increase the ask depending on whether the movement was favourable or adverse.
- Reserves for incremental drift not sufficient
- Pay awards being in excess of current provision for 1%
- Bottom up budget setting process completed. This has identified cost pressures, risks and service developments. The finance team are currently assessing this list in detail, to ascertain
  - How much is already wrapped up in the forecast outturn, and therefore not an incremental ask?
  - What the true cost pressures that are a call against the £2m planning variance?
- CNST – possible cost pressure if no step change in tariff to compensate
- At present the plan assumes only tariff inflation on income. Any increases over and above this would reduce the ask
- The extent to which the impact of Oncology can be mitigated

The above issues are being monitored and tracked closely and implications will be fed in to the planning process as they are confirmed.

Business rules

- The detail of the business rules for the organisation is being worked through, but will require groups to achieve financial balance, the savings targets being built into budgets.
- The apportionment of savings targets will need to be joined up and balanced with
  - CIP exclusions (£70m quantum)
  - Fair shares approach – on operating expenditure
  - Extant savings plans and opportunity
- The budget setting practicalities will also need to be determined in the above context – i.e. budgets set at normalised forecast outturn, or a more traditional approach. This will be confirmed imminently. It is important that budget managers have meaningful budgets that they can be held to account to managing within. This is a key part of the training to be provided as part of the Trust's new accredited manager programme.

Capital forward look

	2017/18 £000s	2018/19 £000s	2019/20 £000s	2020/21 £000s	2021/22 £000s
Capital Expenditure (RK Issued 10/11/17)					
Estates	16,190	11,486	8,904	1,050	1,754
IM&T Programme	8,120	7,962	1,666	575	1,413
Equipment	2,791	3,008	5,989	1,772	4,122
MES, BTC and Donated Assets	1,064	4,361	10,565	1,714	2,136
GP Practice at SGH	150	4,850	0	0	0
MMH Construction Cost	0	0	323,638	0	0
	28,315	**31,666**	**350,762**	**5,111**	**9,425**
Indexation	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**
Total Capital	**28,315**	**31,666**	**350,762**	**5,111**	**9,425**

- The above reflects the latest iteration of the capital programme, which remains to be confirmed by the Board
- The next slide sets out the proposed source of funds for the programme.
- It is assumed that alternative financing is sourced to cover the capex costs associated with the GP practice development at SGH and as such is not a draw on internally generated funds.

Cash – forward look

	2017/18 £000s	2018/19 £000s	2019/20 £000s	2020/21 £000s	2021/22 £000s
Opening Cash Balance	**23,902**	**5,000**	**7,500**	**12,364**	**28,818**
Planned Surplus/(deficit) - Excluding STF/land Sale Contribution of £16.2m	(20,200)	791	0	0	0
STF Income	5,005	10,483	10,483	10,483	10,483
Land Sale Proceeds	18,800	0	0	0	0
Add Back Depreciation	14,998	17,097	21,966	19,511	19,552
Movement in Working Capital	(7,026)	0	0	0	0
MMH PDC Received	26,938	24,084	2,376	0	0
MMH Payments	(26,938)	(24,084)	(2,376)	0	0
MMH Prepayment Unwinding	0	0	94,674	0	0
Funding for GP Practice (Source TBC)	0	4,650	0	0	0
Less Loss of Car Parking Income		0	0	0	0
Non cash adjustments	0	0	0	0	0
Increase/(Decrease) in Non Current provisions	0	0	0	0	0
Cash Available to Fund Capex	**35,479**	**38,021**	**134,623**	**42,358**	**58,853**
Capital Programme, excluding MES, BTC, MMH	(27,317)	(27,305)	(16,559)	(3,397)	(7,289)
BTC/MES Capital Repayment/Lifecycle	(3,228)	(3,215)	(2,982)	(3,493)	(3,724)
MMH Capital Repayment	0	0	(5,668)	(6,650)	(6,650)
MMH Recognition of Asset (PDC)	0	0	(97,050)	0	0
Plus Donated Assets	66	0	0	0	0
Movement in Capital Payables	0	0	0	0	0
	(30,480)	**(30,521)**	**(122,259)**	**(13,540)**	**(17,663)**
Closing Cash Balance	**5,000**	**7,500**	**12,364**	**28,818**	**41,190**

- Assumes the Trust ends the year with £5m cash balance – realistic based on current projections. Dependent on phasing of the 18/19 plan, the Trust is likely to require revenue borrowing during 2018/19.
- Demonstrates that funding of the capital programme forward look from internal funding sources is plausible – IF the Trust continues to earn STF and deliver control total / break even
- 18/19 is a KEY YEAR. If the STF is not earned in full, the trust may require borrowing for capital (assuming other assumptions hold true)

Next steps and timetable

- Draft plan to FIC, January 2018
- Confirm budget setting methodology, January 2018
- Possible draft plan submission to NHSI, early February 2018 (not yet confirmed)
- Final plan to FIC, February 2018
- Final plan and budgets to Trust Board, March 2018
- Final plan submission to NHSI, to be confirmed, likely April 2018.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD PUBLIC MEETING MINUTES

Venue: The Education Centre, Sandwell General Hospital **Date:** 7th December 2017

Members Present:

Mr R Samuda, Chair	(RS)	**In Attendance:**	
Ms O Dutton, Vice Chair	(OD)		
Mr H Kang, Non-Executive Director	(HK)	Mr D Baker, Director of Partnership and Innovations	(DB)
Cllr W Zaffar, Non-Executive Director	(WZ)	Mrs C Rickards, Trust Convenor	(CR)
Mrs M Perry, Non-Executive Director	(MP)	Mrs R Wilkin, Director of Communications	(RW)
Ms M Hoare, Non-Executive Director	(MH)	Dr D Carruthers, Medical Director designate	(CD)
Mr T Lewis, Chief Executive	(TL)	Mr P Hooton, Deputy Chief Nurse	(PH)
Mr T Waite, Finance Director	(TW)		
Mrs R Goodby, Director of OD	(RG)	**Board Support**	
Ms R Barlow, Chief Operating Officer	(RB)	Miss R Fuller, Executive Assistant	(RF)
Miss K Dhami, Director of Governance	(KD)		
Mr. Nigel Trudgill, Acting Medical Director	(NT)		

Minutes	**Reference**
1. Welcome, apologies and declaration of interests	**Verbal**

Apologies were received from Prof Thomas and Mrs Newell.

Declaration of Interests - No declarations of interests were received.

2. Patient Story	**Presentation**

The patient story was presented by Ruth Morrey and Cathy Carmody-Heaton who provide the Fatigue, Anxiety and Breathlessness Clinic (FAB Clinic) service, which has been running since 2014. The clinic is primarily linked to the respiratory function for heart, lung and cancer patients to provide patients with coping and self-managing techniques in relation to their condition. Each patient is given a 6 week, 2 hour per week, programme which they attend once and the service is currently provide on the Rowley Regis Hospital site.

A video was presented highlighting how patients learn techniques to deal with panic attacks, anxiety, and anger. It was advised that all patients are clinically triaged to ensure they are suitable for the programme, which could also include meeting patients with possible mental health issues, and these are then referred on to other wellbeing services.

Ms Morrey informed the Trust Board members that the team require administrative support to ensure data is recorded effectively, as some results have an impact on reduction of patient readmission numbers. It was also confirmed that once patients are discharged they are monitored through a referral service such as iCares and palliative services. However, promotion with GP services would provide additional benefit as patients are discharged with discharge summary notes and it is unclear if GPs have an awareness of the service provided by the Trust.

The Trust Board discussed the financial cost of the service and asked for the recharging costs be checked to ensure the Trust is receiving correct payments from external suppliers.

ACTION:

- The recharging mechanism to be checked to ensure the Trust is receiving correct financial costs external suppliers for this (FAB clinic) service.

3. Questions from the public	**Verbal**

The following questions were asked by the public.

An update on the completion of Midland Metropolitan Hospital was requested. It was noted there is currently a media focus on Carillion in relation to their refinancing. However, the Midland Metropolitan hospital construction is not affected. The current completion date of Midland Metropolitan Hospital is just off Spring 2019 and work is underway with Carillion to confirm a date before formal announcement.

Mr Hodgetts of Healthwatch expressed disappointment on losing the oncology outpatient services at the Trust. Mr Lewis thanked Mr Hodgetts for the continued support of Healthwatch and confirmed a meeting took place at the end of November of the Health Scrutiny Board about the future of oncology services. The Trust is remaining open to suggestions of restoring a local service with another partner, and Mr Lewis confirmed the commissioning decision to have all solid tumour services and chemotherapy services delivered from a location in Edgbaston from February 2018. It is proposed that blood based cancers will, after consultation, be based on one site. The Chief Executive was asked to present the outstanding quality impact assessment and equality impact assessments for solid tumour oncology at the next Trust Board meeting.

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

Mr Samuda reported on the following:

The Trust was involved in a recent summit lead by NHS Improvement on our recent Care Quality Commission inspection/report. The summit was well attended and was supported by our health economy partners at a senior level. The Trust were able to present progress from the previous inspection and confirm we are on track to achieve a "Good" rating from the next annual inspection. Mr Samuda confirmed the Care Quality Commission Improvement Plan is an item on today's agenda and would be discussed further at that point in the meeting. Mr Samuda thanked colleagues in the Trust for the improvements made to date and for the continued support of our partners.

The weekly meetings with Sandwell and West Birmingham Clinical Commissioning Group are continuing with a focus on an improved joint financial position to ensure the Sandwell health pound is spent to support primary and community care for our patients. The weekly meetings have been expanded to include clinical and finance colleagues and from January 2018 more time will be spent on whole health system finances and how a collaborative approach will ensure our funding allocations are utilised to maximum benefit.

5a. Charitable Funds Committee – 16th November 2017	**SWBTB (12/17) 001**

Cllr Zaffar highlighted the Committee discussed a major grant secured for domestic violence. This is a vital grant as many similar services across the patch have been decommissioned.

The minutes of the meeting on the 14th September were noted.

5c. Sandwell & West Birmingham Hospitals NHS Trust Charities – Annual Report and Accounts 2016/17	**SWBTB (12/17) 002**

Cllr Zaffar presented the Charities annual report and accounts for the year ended 31st March 2017 along with the auditor's letter and letter of recommendation. The Charitable Funds Committee have received the reports and now recommend the Trust Board as Trustees agree the accounts, following Trust Board challenge. Mr Waite confirmed the recommendations have been discussed at various meetings between auditors and the finance team and also supported the proposal for the Trust Board to adopt the annual report and accounts.

Mr Lewis queried the amount of pre commitments of funding in relation to grants. Mr Waite recognised that commitments shown are at the end of contract and have no effect on investments. The commitments in the accounts are not liabilities and have no effect on the closing balance sheet.

There were no further comments. The Trust Board agreed to approve the Charities Annual Report and Accounts for 2016/17 and the Chairman signed the Letter of Representation on behalf of the Charities Trustees.

AGREEMENT:

- The Trust Board agreed to approve the Charities Annual Report and Accounts for 2016/17.
- Mr Samuda, as Trust Chair, was authorised to sign the Letter of Representation as a Charities Trustee.

5b. Public Health, Community Development and Equality Committee – 16th November 2107	**TABLED SWBTB (12/17) 003**

Mr Lewis, on behalf of the Chair of the Committee, Prof Thomas, highlighted discussions from the meeting, which focused on public health and patient elements of diversity pledges, including disability. The Committee also discussed work on community development and requested additional work be undertaken on mapping the need of the Birmingham resident. It was also reported the data on female leadership is a positive position, including how distinctive the executive team is with a 50/50 gender split.

The minutes of the meeting dated 4th October 2017 were noted, following a point of reference made on page 3 of 4. The focus on increasing the number of women in band 8 and above roles to 25% by 2020 and not 29%.

5c. Quality and Safety Committee – 24th November 2017	**TABLED SWBTB (12/17) 004**

Ms Perry, on behalf of the Chair of the Committee, Ms. Dutton, highlighted to the Trust Board the Committee's discussion on the trauma and orthopaedic safety summit noting progress on sepsis by ensuring the governance of working practices are embedded into the service. The Committee also discussed the integrated performance report on persistent reds, and noted the Committee should receive, by the end of the January 2017, the delayed report on the desk top review into perinatal mortality.

The minutes of the meeting held on the 27th October 2017 were noted.

5d. Finance & Investment Committee – 27th October 2017	**TABLED SWBTB (12/17) 005**

Mr Hoare reported on the financial outcome for the year which stood at a deficit of £4m pre STF. Pay income was reported as off track by £3m and there is a focus by the Committee on enhanced scrutiny of the delivery expectation of Cost Improvement Plans. It was noted the Cost Improvement Plans will be discussed in detail at the Private Trust Board meeting later today.

6. Chief Executive's Report	**SWBTB (00/17) 010**

Mr Lewis highlighted the following from his report:

A Birmingham system wide Care Quality Commission review commences on the 19th December 2017, which will form part of how the CQC review process is evaluating particular systems, and will provide an extra layer of inspection. Ms Barlow and her team will be working with Social Services colleagues on our ADOPT pathway which was highlighted to the inspectors.

Safe Staffing - the position on outstanding nursing vacancies has improved leading to reduced reliance on agency staff. Mrs Newell will be undertaking a routine acuity review for discussion at the February Trust Board meeting, following presentation at the Clinical Leadership Executive in January 2018.

Following the Trust's first annual Speak Up Day, staff who attended the Hot Topic session were asked to raise any concerns about safety and behaviour that they wished to be addressed. The executive team will follow up on issues raised and report on these to the Trust Board meeting early in 2018.

T&O Safety Summit - Mr. Lewis will be responding to the Coroner's deadlines of concerns by end of December 2017. It was stated that during 2018 the medical and chief nurse directors will be focusing on patient reported outcome measures (PROMs) which asses the quality of care delivered to NHS patients from the patient's perspective and a paper will be provided to the Trust Board at the January 2018 meeting.

Oncology - following previous updates on gynaecological oncology Mr Lewis confirmed that notice has been given to NHS England in relation to this service. However, it is unlikely a successor provider will be in place by the end of our contract and discussions continue about how the Trust can best sustain services while NHS England obtain a new provider. Clarity should be emerging on the transfer of staff (TUPE), as they are currently under formal notice of redundancy, which is expected in the next few weeks.

A Care Quality Commission system review is being undertaken in Birmingham which links into the STP process. The launch event for this work takes place on the 19th December 2017, and there will be further events taking place in January 2018, with an expected report to be available by early Summer 2018. The team will look at clinical collaboration which may be difficult to resolve, but current collaborations on interventional radiology and atrial fibrillation will continue.

ACTION:

- Mr Lewis to provide an update paper of PROMs for the Trust Board's attention.

7. Winter Plan: Performance v Expectations	**SWBTB (12/17) 007**

Mrs Barlow reported on A&E performance following deterioration in the latter half of November 2017 and the actions to improve performance to 90% against the 4-hour target standard. Currently the Trust has 40 unfunded beds, of which 10 are due to delayed transfers of care, resulting in a cost pressure of £180k per month to the Trust. A number of key performance indicator measures on staff work practices, including a consultant of the week model, which goes live this week and is expected to provide a positive impact to services. However, the risk of breaches is during out of hours and while Rapid Assessment and Treatment Systems (RATS) has become normal procedure during daytime hours, the ED leadership team are reviewing the ability to run RATS during out of hours.

Mrs Barlow explained how the clinical pathway will commence at hour 1 rather than hour 3 of a patients assessment in ED which have a greater impact of ensuring breaches are not occurring and diagnoses are phased during the 4 hours.

Mr Lewis commented reducing length of stay for medical patients will have a measurable effect on improved ED performance. Mrs Barlow felt that freeing beds and using the consultant of the week model, where consultants are based on wards and have dedicated time to get to know patients, would ensure consultants are making the accurate decisions quicker for patients, leading to an earlier safe discharge. Mrs Barlow advised that she is meeting with the Medicine team to consider a structure redesign to ensure that specialties are focused in achieving targets.

Responding to a query, Mrs Barlow confirmed junior doctors will be able to have coaching from a consultant and receive supervision. There will also be opportunity for nursing staff to expand their skills as the consultant of the week will be ward based. Dr Carruthers stated with the consultant of the week this will give trainees further opportunities for direct/timely feedback, to add to their training portfolio.

Miss Dhami queried, as part of the consultant of the week, would consultants be responsible for a number of discharges and if they did not meet the target what the consequences might be. Mrs Barlow recognised that consultants need to be part of how patients flow through the Trust and it is vital that each day at 11.30am the patient meeting is hosted by an acute physician who will determinate admissions and discharges over the next 24 hours. There will be an expectation that 44 discharges will take place from wards across the site per day. This will be measurable and support of teams will be available as the consultant of the week model will be a development challenge for some clinicians.

It was confirmed there has been a delay in obtaining transport and moving some patients. However, a new out of hours contract is in place and patients will be booked for transport if known 24 hours prior to discharge. Mr Lewis reminded the Trust Board the issues on delivery of the 4 hour target standard are internal and the Trust will not gain benefit of support from external suppliers. He also confirmed there will be a league table on individual ED performance commencing from 4th January 2018.

Following a further discussion Mr Lewis informed the Trust Board the decision to open/close beds across the Trust is his responsibility and accountability, with decisions made on the grounds of safety following advice.

8. Integrated Quality & Performance Report: P07 October 2017	**SWBTB (12/17) 008**

Mr Waite reported a breach on mixed sex accommodation which was reported to the Commissioners and they confirmed it was considered appropriate. Performance on planned care remains on track. The following was highlighted through discussion:

Cancer – Mrs Barlow informed the Trust Board a forecast on 62 day cancer performance compliance from April 2018 will look at the pathway management of patients mid-way through their treatment and she will circulate a matrix on this management for the Trust Board to review. Work to ensure the target reached in Q2 is maintained throughout the year.

Sickness – Mrs Goodby informed the Trust Board that sickness levels increased in October 2017 and an instruction will be provided to all line managers who are not completing return to work interviews to ensure they are completed, as these reports provide vital information to support reducing sickness rates across the Trust. During 2018/19 the next round of group review meetings will focus on sickness and groups will be asked to provide a forward trajectory to review how to support staff to return to work sooner.

November Paybill – reported performance is in line with the revised financial plan trajectory and currently viewed as a success. There is a reported reduction in the medical agency bill by £200k.

Neutropenic Sepsis – A letter has been sent to the clinical director of the ED and he will be overseeing this standard and ensuring consultants are following policy.

Theatre booking cancellations – Mrs Barlow reported support has been provided to clinical and theatre teams. The results for November 2017 show a slight improvement and continues to be reported to the Quality and Safety Committee for detailed discussion. Mr Lewis commented that from early 2018 Group Directors will be invited to the Private Trust Board meetings as assurance will be required from them in relation to booked procedures taking place unless patients become unfit for treatment.

8.1 IPR Persistent Reds	**SWBTB (12/17) 009**

The Trust Board commented that progress on tackling persistent reds and other key indicators was not moving swiftly enough. Mr Lewis confirmed the focus was on the persistent reds and once they were competed and back on track, the executive team would review other key indicators.

8.2 P07 Finance Report	**SWBTB (12/17) 010**

Mr Waite presented the revised financial plan for the remainder of 2017/18 that provides a route to close the year at £1m surplus, which includes the expected recovery of £5m of STF, giving a pre STF financial total of -£4m. It was noted October performance is in line with the trajectory and the November pay bill is also in line with trajectory, which includes the reduction in medical agency spend and the continued delivery of the production plan.

The revised plan includes key assumptions of £264.5m clinical commissioning group income and negotiations are currently ongoing, as there is a difference of reported position by £3m. £17.4m cost improvement plans delivery and £1.7m of red rated schemes from the production plan, and £4m of additional cost improvement plan stretch has been identified as mostly non recurrent.

Mr Waite continued to report that capital spend has reduced with the 5 year outline plan being revised. The effect this has on the digital programme, i.e. Cerner and Unity, would need to be refreshed following a meeting Mr Lewis has with Unity on 11th December 2017. Mr Lewis agreed to provide an update on this issue in his next Trust Board paper. Tapper relief will be secured from NHS England and the Department of Health in Q4. The Trust Board were concerned about the £180k of lost income on the opening of unfunded beds and the significant cost improvement plans pay costs associated with that risk.

Mr Lewis stated there would be a modest financial impact next year of approximately £1m+ which is approximately £800k income and £400k of real costs, this would need to be resolved with the regulator and the Trust Board will be updated once the income stream has been confirmed. Mr Lewis also stated the potential of material risk (of £000k's) due to the payment in Q4 of premium rate working for gynaecological oncology services which, if received, could help with the I&E and cash position.

Mr Samuda stated the Private Trust Board will review the financial position further at their meeting later today.

ACTION:

- An update on capital spend and the impact of the digital programme to be provided to the Trust Board.

9. Service profile: Occupational Health	**Presentation**

Dr Tamsin Radford, Head of Service, assisted by her team presented to the Trust Board a service lead by 2 consultants, 8 specialist nurses, 3 screening nurses and 7 administration staff. The service performs a number of roles including screening of new staff, advice to employees on making work place adjustments and statutory requests on health surveillance. The team also administer flu vaccines noting 75% of patient facing staff have been vaccinated this year.

The team have been successful in securing a £500k tender with 2 mental health trusts, as well as providing contracted services to a number of local trusts, schools and the Sandwell Council taxis service; this provides a more rapid service to employees than if they had to wait for a community appointment.

The team have input into the Trust's sickness absence procedures by providing staff and wellbeing support services to staff. From 2018 staff who require early intervention programmes with waiting times will be seen at the earliest opportunity (not to the detriment of patient focus), with staff utilising cancelled appointments etc.

Dr Radford continued to inform the Trust Board that the Department of Health will visit the department in 2018 to discuss forming/developing good quality Occupational Health services across the Country. The public health plan objectives are also considered including support on smoking, weight management and providing counselling services. The team would like to support staff in high stress environments and provide services on a preventative basis.

Dr Radford informed the Trust Board of the vision of the department to be a "centre of excellence" by 2020.

Mr Kang queried how the team balanced the needs of the employee with the needs of the employer. Dr Radford agreed it could be difficult but the team have specialist staff who are well trained and are able to strike the right balance, which is measured by the renewal of contracts the department have received this year. The accredited manager training scheme will have a section on sickness management that should assist the Trust's middle managers to be able to manage sickness more effectively and prevent episodes of sickness before they occur.

Dr Radford informed the Trust Board about barriers the team face. An issue the team experienced was a lack of expertise in the Trust regarding the tendering process to help the team turn round tenders in a more efficient way. Similarly, the department wish to expand, which has been discussed with Mr Lewis.

Mr Samuda thanked Dr Radford and her team for attending the Trust Board.

10. Trust Risk Register	**SWBTB (12/17) 011**

Miss Dhami informed the Trust Board of the following risks for discussion.

Risk No. 325 – The Trust Board asked for this risk to be discussed at the Digital Committee following the current IT system vulnerabilities such as cyber-attacks. The recommendation from the Digital Committee is for the risk to be removed and monitored at a local level but for the Digital Committee to monitor its score. The Trust Board were informed of a national accreditation on cyber security noting roll out is not until Q1 in 2018. Mr Hoare and Mr Lewis would discuss this accreditation outside of this meeting. The Trust Board agreed for Risk 325 to be removed from the Trust Risk Register.

Risk 1643 – Operations Management. The Risk Management Committee agreed for the Chief Operating Officer and Head of Risk Management to refresh the risk but asked for the risk to remain due to its high impact on the business of the Trust.

New Risk 2849 – Unfunded Beds. This has a financial impact on the delivery of the cost improvement plans and overall Trust forecast for year end. The Trust Board agreed for this risk to be added to the Trust Risk Register.

The Trust Board discussed the risk on data quality in relation to 18 week performance. Performance issues in relation to patients waiting more than 52 weeks was noted and Trust Board members requested internal assurance on 52 week waiters before this risk was removed.

Mr Lewis noted 7 risks were scheduled to be delivered by the end of December 2017 but reflected 5 would miss that deadline. Miss Dhami commented that those 7 risks will be discussed at the Risk Management Committee on 11th December 2017, noting improvement is taking happening. However, the Trust Board asked for those 7 risks to be discussed at the next Trust Board meeting.

ACTION:

- Internal assurance on 52 week patient waits before risk is removed
- 7 risks to be presented at the next Trust Board for discussion

11. Care Quality Commission Improvement Plan | **SWBTB (12/17) 012**

Miss Dhami reported on the Care Quality Commission inspection which took place in March 2017. The majority of the actions set out in the report will be closed out by December 2017 with a small number being closed by March 2018. A mock inspection flagged up issues that are already known and there will be a refresh of training for teams. There is a still a governance issue with completing documentation for the improvement plan but this is being addressed.

The delivery of the actions will be monitored by the Executive Quality Committee, Quality and Safety Committee and Clinical Leadership Executive, as the inspectors are now planned to visit/inspect the Trust annually. There is a sub group which meets bi-monthly led by Miss Dhami which undertakes self assessments against the 5 domains which will be background evidence when the inspectors revisit.

Mr Lewis informed the Trust Board the recent Quality Summit was successful and he suggested in February 2018 the Trust looks at further improvements on DoLS and neutropenic sepsis to assure ourselves we are travelling in the right direction. Mr Lewis will also focus on the journey to a "Good" rating as part of the Executive Directors Awaydays planned in Q4.

The non executives expressed disappointment and surprise at the Rowley rating, which Mr Lewis totally disagreed that the service at Rowley was unsafe. Mr Lewis continued to inform the Trust Board that he suspected the inspectors did not understand the model of care undertaken at Rowley and would look to improve how that is communicated by staff. Nevertheless there is an issue with bank/agency staff and from April the supervising staff member on shift will complete a quick personal competency assessment on the bank/agency staff documenting if they would be asked to return again to that ward.

Miss Dhami agreed to circulate the presentation and notes used at the Quality Summit to members of the Trust Board.

ACTION:

- Trust Board members to have a copy of the presentation and notes from the Quality summit.

12. Safety Plan progress update and close out plan	SWBTB (12/17) 013

Mr Hooton reported against the progress against the Safety Plan and conditions that must be met before the project can be considered closed and part of core business. Over the last 12 months the safety plan has been deployed to a total of 43 clinical areas. During that time the majority of wards are consistently recording over 98% and work is currently taking place to bring the remaining ward over the line.

The safety plan is being monitored at the Quality and Safety Committee and they have requested continued sight of reports for a further 6 months to ensure there is no slippage. This information will be easy to provide as there is a mechanism for daily reports that are fed to the group director of nursing and matrons showing real time data. Mr Lewis stated the safety plan will be monitored by the Executive Quality Committee to build on the group level of quality and safety in governance hubs as the data is not the management of quality but part of a national standard. There are approximately 18 smaller safety plans that need various timescales and approaches but by the time the Care Quality Commission revisit the quality narrative needs to be visible across the organisation.

ACTION:

- Monitoring of reports to be presented to the Quality and Safety Committee on a monthly basis for the next 6 months.

13. Reducing Nursing Turnover – increasing retention of key skills and knowledge	SWBTB (12/17) 014

Mrs Goodby reported the retention of band 5 nurses deteriorated in September 2017, where 17 WTE nurses left the Trust. This position is above plan and out of the ordinary. In October 2017 the number has decreased to 12.9WTE and the plan is on trajectory to be met by end of November 2017.

Mr Hooton informed the Trust Board of a programme to support newly qualified nurses both in a classroom environment and support from experienced practice nurses with clinical tasks.

Ms Dutton asked if there was a finite breakdown at 3, 6 and 9 months to pinpoint when nurses decided to leave as it would be useful to know when staff became unsettled in their role. Mr Lewis reflected the paper did not include what the first 100 days would look like including pre-engagement keeping in touch time for successful nurses.

The Trust Board queried a career escalation for healthcare assistants and nurses whereby Mrs Goodby stated the Trust can use agenda for change to flex financial escalatory roles or convert band 5 roles into band 6 roles.

It was agreed a staff retention paper would be provided to the next Trust Board meeting in January fully costed and reflecting today's discussion.

ACTION:

- Staff retention to be presented to the January Trust Board.

14. Minutes of last meeting	SWBTB (12/17) 015

The following comments were made on the minutes of the last meeting. Ms Perry commented the update from the Audit Committee on fraud instances was a positive report and no problems were reported.

An amendment to the title of Mrs Rickards to state Trust Convenor.

Following these comments the minutes of the meeting held on the 2nd November 2017 were agreed as an accurate record.

15. Update on actions from previous meetings (action log)	SWBTB (12/17) 016

The following comments were recorded:

13 – Financial Performance. The outstanding debt with Birmingham City Council will be closed out by February 2018 or the debt may be written off. Patient Story - communication and reasonable adjustments to take place. The Trust Board were updated that a reengineered approach will take place making large scale changes by altering administrative systems following engagement with the patient who was featured in the video. This will also be discussed at the executive team meeting and a further update will be provided in February.

16. Complaints Report: 2017/17 Q2	**SWBTB (12/17) 017**
Ms Dhami reported complaint activity has decreased slightly with 97% of complaints received being managed within the target date. Ms Dhami also recognised the success of the department to reaching enhanced performance levels from the position reported 2 years ago.	
17. General Data Protection Regulation (GDPR)	**SWBTB (12/17) 018**
The Trust Board noted the report would be discussed in detail at the Trust Board Development Session on 13th December 2017.	
18. Application of the Trust Seal – Chair's Action	**SWBTB (12/17) 019**
Mr Lewis informed the Trust Board of the application of the Trust Seal by Chair's approval to license works on Hallam Phase 2 development and the contract between Sandwell and West Birmingham Hospitals and Sandwell Metropolitan Borough Council on the Co-operative working in the delivery of Public health Services. The Trust Board approved Chair's action in applying the seal.	
19. Any other business	**Verbal**
No other business was discussed.	
20. Date and time of next meeting	**Verbal**
The next public Trust Board will be held 4th January 2018 starting at 09:30am in Rowley Regis Hospital.	

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Public Trust Board Action Log

	Action	Assigned to	Due Date	Status
From Meeting held on 7th December 2017				
1)	Chief Executive's Report. An update to be provided on PROMs for the Trust Boards attention.	Toby Lewis	January 2018	Closed – appendix to CEO report
2)	P07 Finance Report. Details on the capital spend and the impact on the digital programme	Tony Waite	January 2018	Closed – on agenda
3)	Reducing Nursing Turnover. Staff retention paper to be presented to January Trust Board.	Raffaela Goodby/Elaine Newell	January 2018	Closed – on agenda
4)	Trust Risk Register. Internal assurance on 52 week waits required before this risk is removed.	Kam Dhami	January 2018	Closed – on agenda
5)	Care Quality Commission Summit – presentation and notes to be circulated to Trust Board Members.	Kam Dhami	January 2018	Closed
6)	Safety plan close out – monitoring to continue to be presented to the Quality and Safety Committee	Elaine Newell	May 2018	Open
7)	Reducing Nursing Turnover - Staff retention to be presented to the January Trust Board.	Elaine Newell	January 2018	Closed – on agenda
From Meeting held on 2nd November 2017				
1)	Charitable Funds Committee - 14.9.17: The Trust Board to receive on a quarterly basis detailed financial reports of the business of the Charity	Ruth Wilkin	Quarterly	Open
2)	Accountable Care System: The Trust Board would receive regular updates on ACS	Toby Lewis	Monthly	Open

	Action	Assigned to	Due Date	Status
3)	Perinatal Mortality Review: • Dr. Roger Stedman to review CESDI 0 – 1 cases not reviewed in Peer Review • The action plan to have all recommendations completed by 1.2.18 • Mr Lewis to Chair a safety summit and advise Trust board on cultural maturity	Elaine Newell	February 2018	Open
4)	IPR – P06 September 2017: Underperformance of Neutropenic Sepsis to be discussed as a matter arising at the January 2018 Trust Board	Rachel Barlow	January 2018	Open
From Meeting held on 5th October 2017				
1)	Patient Story: The patient to be contacted in 3 months time with an update and this also be provided back to the Trust Board.	Elaine Newell/ Ruth Wilkin	January 2018	Closed – on agenda
2)	Patient Story: Work with this patient on testing systems for the benefit of all patients.	Elaine Newell	January 2018	Closed – on agenda
3)	Patient Story: Executive Directors will reflect on the staff perspective/ behaviours (for staff in bands 2 – 4) on how confident they are to communicate with patients who require reasonable adjustments to attend	Elaine Newell	January 2018	Closed – on agenda
4)	Chair's Opening Comments: Review the membership of MLG with a view to widening the membership to include partner organisations.	Kam Dhami	January 2018	Open
5)	People and OD Committee: Pursue accuracy/assurance on junior doctor hours / fully employed status and report back to the Trust Board.	Toby Lewis/ Raffaela Goodby	January 2018	Open
6)	Perinatal Mortality Peer Review: Provide an update to the Trust Board in 6 months to highlight improvements actions which have taken place	Elaine Newell	April 2018	Open
7)	Financial performance: P05. Outstanding debt of Birmingham City Council to be progressed with Graham Betts.	Toby Lewis	~~November 2017~~ February 2018	Open
From Meeting held on 6th July 2017:				
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.	Raffaela Goodby	~~November 2017~~ January 2018	Open

	Action	Assigned to	Due Date	Status
2)	Smoking cessation: matter to be resolved and reported to Trust Board. This will be discussed at the Public Health, Community Development and Equality Committee	Toby Lewis	~~December 2017~~ February 2018	Open

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PUBLIC TRUST BOARD

DOCUMENT TITLE:	**Equality & Inclusion Report 2017**
SPONSOR (EXECUTIVE DIRECTOR):	**Raffaela Goodby – Director of People and Organisation Development**
AUTHOR:	**Stuart Young – Head of Equality and Inclusion** **Estelle Hickman – Equality and Diversity Advisor**
DATE OF MEETING:	**4th January 2018**

EXECUTIVE SUMMARY:

The Trust Board are asked to receive and formally approve the 2017 Equality and Inclusion Report.. This is an essential part of our annual reporting and is inclusive of WRES obligations, EDS 2 obligations and our other national reporting. Following approval the report will uploaded to the SWBH website before the end of January 2018

The Public Health Board committee considered the report on 20th December in some detail, and make the recommendation for full approval to the Trust Board.

REPORT RECOMMENDATION:

Note the contents of the report and approve to be uploaded to the Trust 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		Environmental		Communications & Media	X
Business and market share		Legal & Policy		Patient Experience	X
Clinical		Equality and Diversity	X	Workforce	X

Comments:

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

BAF, Trust Objective

PREVIOUS CONSIDERATION:

Trust Board every month.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

EQUALITY and INCLUSION REPORT
Published January 2018

Where EVERYONE Matters

Contents

Executive Summary

This document is the Trust response to the Public Sector Equality Duty requirement to publish Equality monitoring data of our workforce and service users and to clearly show how we are:

- Eliminating unlawful discrimination, harassment and victimisation and any other conduct prohibited by the Equality Act.
- Advancing equality of opportunity between people who share a protected characteristic and those who do not.
- Fostering good relations between people who share a protected characteristic and those who do not.
- Delivering on our Trust values and promises to be a more inclusive employer

The new equality regulations require us to publish 'relevant, proportionate information demonstrating our compliance' annually and to set and publish 'specific, measurable equality objectives' every 4 years.

Equality and Inclusion is a board responsibility and sits within the portfolio of the Executive Director of People and Organisation Development. It remains a key priority of the Trust that we are compliant with the Care Quality Commission, the Equality, Diversity and Human Rights (EDHR) Public Sector Duties in line with the Equality Act 2010.

Our Trust Board takes a very proactive role in the Diversity and Inclusion Agenda, they are kept informed of all developments and the work of the three staff networks through our Public Health Sub Committee. Members of the board also attend our staff network events and inclusion celebrations across the trust.

The board have approved the appointment of a Head of Diversity and Inclusion for the trust to ensure that we as an organisation reflect the values of our local community and allow everyone to be bring their whole selves to work or as a patient be able to be themselves without fear of judgement or discrimination.

The Trust has made significant progress over the past 2 years in ensuring that the well-being of patients, visitors and staff remains central to all of it functions, achieving 70% of Good or Outstanding ratings during the 2017 CQC Inspection. We aim to consistently provide quality health care that meets the needs of our local communities and make sure that the services we offer are inclusive. Our 7000 colleagues work hard to create an environment which ensures equality regardless of age, disability, gender, religion or belief, ethnic background, sexual orientation, gender reassignment, or socio-economic status.

As an employer, we ensure that our staff are kept informed, involved and are competent and confident in delivering the services we provide. Through proactive leadership right across the clinical and non-clinical bodies, we support and promote equality and diversity to ensure that our staff can work in environments free from discrimination.

As a service provider, we ensure that the needs of our patients inform the provision and delivery of our services, with the adoption of the equality delivery system2 template. Our engagement agenda provides us with the opportunity to listen, act and learn whilst enabling our service users to be involved and have confidence in what we do. We have fully involved ourselves in the launch and reporting of the Workforce Race Equality Standard (WRES) and will respond to any new national reporting to demonstrate our commitment to inclusion and share our learning with others.

Whilst we have been able to demonstrate compliance through our achievements and ongoing progress with the equality agenda, we cannot become complacent. We have a number of ambitious projects and future actions to undertake that will ensure we remain steadfast in our resolve to achieve better health outcomes for all and reducing the health inequalities experienced by many groups within our communities.

The Trust Board is committed to developing ever more consistent links into our local communities, working with voluntary sector, faith, and grassroots organisations. The development of our governing body and the expansion plans we have for our Trust Charity will also reinforce this work.

Public Sector Publishing Obligations

The aim of the Public Sector Equality Duty is to embed equality considerations in the day-to-day work of public bodies. It requires us to consider how our activities as an employer and our decision making as provider of services, affect the people we sreve.

In accordance with Public Sector Equality Duty requirements we have to provide information on our workforce and patients around the following protected characteristics:

- Ethnicity [Race]
- Disability
- Age
- Religion or belief
- Sex
- Sexual Orientation
- Gender Reassignment
- Pregnancy & maternity
- Marriage & Civil Partnership

Currently all areas of the Trust record some data on protected characteristics. It is a key priority for 2018 for all 9 of the characteristics to be recorded.

Public Sector Equality Duty
Equality Report

Section one: Overview

1.1 Introduction

The Trust is committed to achieving equality and inclusivity both as an employer and as a provider of services. We are determined to ensure that our policies and practices meet the needs of all service users as well as those of our 7000 staff. We will publish our equality assurance and objectives on our websites and in print format on request.

Organisation Profile

Sandwell and West Birmingham Hospitals NHS Trust is an integrated care organisation. We are dedicated to improving the lives of local people, to maintaining an outstanding reputation for teaching and education, and to embedding innovation and research. We employ around 7,000 people and spend around £430m of public money, largely drawn from our local Clinical Commissioning Group.

This Trust is responsible for the care of 530,000 local people from across North-West Birmingham and all the towns within Sandwell. Our teams are committed to providing compassionate, high quality care from City Hospital on Birmingham's Dudley Road, from Sandwell General Hospital in West Bromwich, and from our intermediate care hubs at Rowley Regis and at Leasowes in Smethwick (which is also our stand-alone Birth Centre's base). Our Trust received an 'Outstanding for Care' rating in the 2017 CQC Inspection.

The Trust includes the Birmingham and Midland Eye Centre (a supra-regional eye hospital), as well as our Sickle Cell and Thalassaemia Centre, and the regional base for the National Poisons Information Service – all based at City Hospital. Inpatient paediatrics, most general surgery, and our stroke specialist centre are located at Sandwell.

We have significant academic departments in cardiology, rheumatology, ophthalmology, and neurology. Our community teams deliver care across Sandwell providing integrated services for children in schools, GP practices and at home, and offering both general and specialist home care for adults, in nursing homes and hospice locations.

Committed to public health and local regeneration

We are a key partner in efforts to change the shape of care in our area. Our intention is to provide substantially more care at home and rely less on acute hospitals. We aim to move 350,000 appointments out of traditional settings and close a further 20% of our hospital beds, as we have safely closed 25% over the last ten years. Whilst most of the programme involves investment in GP surgeries and health centres, we still plan to relocate our acute care into a single purpose built hospital. Our vision is to be the best integrated care organisation in the NHS by 2020.

Midland Metropolitan Hospital

A site on Grove Lane in Smethwick has been purchased for this purpose, following public consultation in 2006. Our plans were approved in 15 and we will open our new facility in 2019. The new hospital will act as a major employment opportunity for local people , including apprentices employed directly by Carillion and the Trust, and is part of a wider scheme to develop the area adjacent to the site including economic improvements for local people. Carillion are sourcing local materials, labour and resources, and it is envisaged this will have a significant impact on the local population.

Our training and education team are outward facing in sourcing the workforce we need for the long-term. We have a very active programme of apprentices and school work experience joint working. We are partners in the Sandwell College, within the Black Country STP and University Technical College

development. More widely we work closely with Birmingham City University, Wolverhampton University, Birmingham and Aston Universities. The Learning Works is our community-based recruitment and training resource who lead on our 'Use It' programme that places qualified health care refugees in to work placements in our Trust.

Investing in the future

Each year we spend approximately £25m on new equipment and expanding services. This is generated by the savings we make in how we provide care. This includes consistently meeting NHS-wide efficiency requirements. We report financial results annually and typically target a surplus of around 1.5% of turnover, which we re-invest in patient care. Over the next decade we will make major investments in three areas: In the skills and training or our workforce; in the technology we use to both care for and communicate with patients and partners; and in our estate – in part through our plan to build the Midland Metropolitan Hospital to rationalise acute care.

Over the last year:

• 5,954 babies were born at our Trust.
• There were 199,437 patient attendances plus 33,265 attendances seen under GP triage at our emergency departments with over 38,994 people admitted for a hospital stay.
• 45,950 day case procedures were carried out.
• 526,945 patients were seen in our outpatient departments.
• Over 650,000 patients were seen by community staff.

Trust Vision

Sandwell and West Birmingham Hospitals NHS Trust provides care to over half a million local residents. One and a half million times each year someone has contact with one of our 7,000 staff.

National Voices, a national coalition of health and social care charities in England, were tasked with developing a definition for person-centred coordinated care in 2013. This definition has been developed to take away the jargon of integration, and describe what this really means, feels and looks like from a patient's point of view. It is this definition we adopted in 2014 to set the direction for our organisation. This definition clearly puts patients, their families and carers in the driving seat when it comes to their care.

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me"

Skilled, motivated people provide the best care. Teamwork is always at the heart of what we do, and good integrated care relies on inter-disciplinary working. We need to involve people, be clear with them, and support them in making the changes that we know need to be made. This is a Trust "where everyone matters".

Trust Values

The Trust vision is underpinned by its values and as an employer and provider of services we pride ourselves in being;

- Caring and Compassionate
- Accessible and Responsive
- Professional and Knowledgeable
- Open and Accountable
- Engaging and Empowering

The Trust annual report published in 2017 set out our priorities and our achievements to date. For more information about our Trust please view a copy of our annual report and annual plan at: https://www.swbh.nhs.uk/about-us/trust-publications/2017-2/

1.2 Demography of Local Population

- Both Sandwell and West Birmingham are considered to be parts of the most diverse urban areas of Britain.

- The population of Sandwell is approximately 308,063. The population of West Birmingham is 435,577.

- There are more females (50.8%) than males (49.2%) within Birmingham as a whole. West Birmingham also has more females (50.2%) than males (49.8%) although the ratio is slightly closer than Birmingham. Sandwell also has more females (50.8%) than males (49.2%).

- Both Sandwell and Birmingham have a youthful population.

- In England, more than 81,000 households were found to be homeless during 2012, which is an increase of 7% from 2011.

- The percentage of residents from the major religions within Sandwell are –Christian (55.2%), Sikh (8.7%), Muslim (8.2%), Hindu (2.2%), Buddhist (0.2%) Those with no Religion are 18.7%). The figures for West Birmingham are Christian (41.8%) Muslim (24.2%), Sikh (5.0%), Hindu (3.0%), Buddhist (0.6%), Jewish (0.2%). Those with no religion (17.7%).

- It is estimated that the current Lesbian, Gay, Bisexual (LGB) and Transgender population of Birmingham stands at 6 - 10%.

- Both Sandwell and Birmingham are ranked within the top twelve most deprived areas in the country.

1.3 Public Sector Duty

On 5 April 2011, the public sector equality duty (the equality duty) came into force. The equality duty was created under the Equality Act 2010.
The equality duty was developed in order to harmonise the equality duties and to extend it across the protected characteristics. It consists of a general equality duty, supported by specific duties which are imposed by secondary legislation. In summary, those subject to the equality duty must, in the exercise of their functions, have due regard to the need to:

The Equality Duty has three main aims which are to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.

- Advance equality of opportunity between people who share a protected characteristic and those who do not.

- Foster good relations between people who share a protected characteristic and those who do not.

Regulations came into effect in September 2011 requiring all public sector bodies to publish 'relevant, proportionate information demonstrating compliance' and to set 'specific, measurable equality objectives'. As an NHS organisation we are required to:

- Publish a report annually which explains how we achieved the general duty and provide information about people who share a 'protected characteristic'.

- Publish our Equality Objectives which will include a plan of what we intend every four years.

1.3.1 **Purpose of the duty**

The broad purpose of the equality duty is to integrate consideration of equality and good relations into the day-to-day business of public authorities. If you do not consider how a function can affect different groups in different ways, it is unlikely to have the intended effect. This can contribute to greater inequality and poor outcomes. The general equality duty therefore requires organisations to consider how they could positively contribute to the advancement of equality and good relations. It requires equality considerations to be reflected into the design of policies and the delivery of services, including internal policies, and for these issues to be kept under review.

Compliance with the general equality duty is a legal obligation, but it also makes good business sense. An organisation that is able to provide services to meet the diverse needs of its users should find that it carries out its core business more efficiently. A workforce that has a supportive working environment is more productive. Many organisations have also found it beneficial to draw on a broader range of talent and to better represent the community that they serve. It should also result in better informed decision-making and policy development. Overall, it can lead to services that are more appropriate to the user, and services that are more effective and cost-effective. This can lead to increased satisfaction with public services.

1.4 **Key Achievements**

Over the last year we have introduced a number of initiatives and measures to improve the experiences and outcomes for our patients and staff. These include:

- Been recognised as a Disability Confident employer

- Won the national ENEI Inclusive Culture award

- Winner of the Sandwell and West Birmingham CCG partnership award for Excellence in Equality

- BME, Disability and LGBT Staff networks highly commended for Star Awards Public Health and Equalities Award

- Piloting Deaf Awareness training session for all levels of colleagues

- Introduced designated Gender Neutral toilet facilities

- Introduction of 6 Learning Disability pledges – update below;

Promise	Current Position
'I will find out the best way to make sure that people with a LD are flagged when in hospital and put this in place' **Linked to CIPOLD** (Confidential inquiry into the premature deaths of people with learning disabilities) **1** A copy of the report can be found at; http://www.bristol.ac.uk/media-library/sites/cipold/migrated/documents/fullfinalreport.pdf	Patients are flagged on admission to the trust GP's have agreed information sharing with the trust to ensure patients are flagged so staff are aware on admission that a patient has an LD All flags are recorded on LD Dashboard
'I will ensure that reasonable adjustments are put in place for individuals in hospital and work with others including outside organisations to find ways for this to be audited referencing the Quality of Health Principles' **Linked to CIPOLD 2, 7**	Trust leaflets have been developed to inform staff of reasonable adjustments Reasonable adjustments are discussed and outlined on trust induction LD training No current record is kept to identify reasonable adjustments Awaiting to commence LD Nurse, reasonable adjustments will be monitored audited and recorded on LD dashboard.
I will put in place actions to increase the awareness and competency of staff working positively with people with LD and using reasonable adjustments.' **Links to CIPOLD 12**	Trust achieved target of 400 staff within emergency portals received LD awareness training LD awareness on trust induction When LD Nurse is in post further work will be done to provide training within clinical areas to increase awareness and competence when working with patients with LD.
Hand Held Records : **All flagged patients have hand held record, preferably with an electronic option** **Links to CIPOLD 5.**	Clinical areas have been provided with hospital passports EPR in development to support this Increased support to facilitate hospital passports and monitoring will be provided when LD nurse in post
Not employing less than 40 staff with a learning Disability within SWBH's	Target achieved
Positive confirmations that deaths among LD patients were not amenable to better care from January 2017. **Linked to CIPOLD 2, 7, 13, 14, 15.**	Mortality reviews are completed for any LD death 4 staff members have received LeDeR (The Learning Disabilities Mortality Review) training. Trust will contribute to the national LeDeR program

To ensure that the diverse needs of our patients and staff are integrated into our work at all times we have in place:

- The full commitment of the Trust Board.
- Continuous improvement of policies and practices.
- Effective community engagement activities.
- Equality Impact assessments of our policies, services and functions.
- Corporate Equality Delivery System (EDS2).
- WRES (Workforce Race Equality Standard) reporting framework.

Section Two – Equality Activities

The Trust supports its local communities by providing quality health care that meets their needs, and ensuring that the services we offer are inclusive. We work hard to create an environment which ensures equal access regardless of age, disability, gender, religion or belief, ethnic background, sexual orientation, gender reassignment or socio-economic status.

The NHS England report 'Action Plan on Hearing Loss' (2015) states that there are over 45,000 children with long term hearing loss and over 10 million adults who are either deaf or have some degree of hearing impairment in the United Kingdom. This number they say is predicted to rise to over 14.5 million by 2031 (20% of the population). Hearing loss affects both those born deaf and those who acquire it later in life, and whilst there has been substantial progress made in improving the health services available, significant challenges remain. More needs to be done on prevention, early diagnosis and support for those who have permanent hearing loss. The reasons for this increase they suggest are from the effects of increasing exposure to social noise i.e. use of personal music devices and workplace noise. They go on to say that more than 80,000 people are registered as being either severely or profoundly deaf with 840 babies being born with significant hearing impairment every year.
The Trust serves a population of approx. 530,000. The figures from the report suggest that up to one in seven people are affected with some kind of hearing impairment. For the Trust, that equates to 75,714 people or 14.2% of its population.

What we have done

- Achieved Level 2 Disability Confident employer status.
- Commenced work with Stonewall to enter the Trust onto the Top 100 Stonewall Equality Index by 2019.
- Launched staff network groups for BME (Black and Minority Ethnic), LGBT (Lesbian, Gay, Bisexual the Transgender) and Disability and Long Term Conditions staff networks groups, with Executive Director sponsorship for each group.
- Working with the Patient Experience manager jointly submitted a bid for Charitable Funds for monies to support the training of 360 front line staff.
- Liaised with the Charity 'Action on Hearing Loss' and on their recommendation, included in the charity bid money to buy each ward and department an amplifier to reduce the background noise for those patients who are hard of hearing.
- We have been assured by the New Hospital Project team that hearing loops will be available within Midland Metropolitan Hospital (MMH).

What we still need to do

- For the future, the new hospital project team are working with Carillion to develop downloadable apps that provide directions around the Midland Met site and they are exploring the use of visual patient call notifications in outpatients.

- Patients have requested 2 way text messaging. This Trust already has a contract with (Communication+) who provide a relay message service. This would allow patients to book, cancel and change appointments and to check if an interpreter has been booked thus reducing the number of wasted appointments and improving the patient experience.

- Consider the use of 'Face time' for non-medical discussions. Communication+ provides a 'Face Time' service for Deaf patients who have this facility. If ward devices enabled the app, this could be used for non – medical communication e.g. discussions with the Nursing staff about comfort, pain management and care needs on a 24/7 basis.

2.1 Equality Delivery System (EDS2)

In April 2010 the Equality Act was published with a phased implementation to commence in October 2010. Sandwell and West Birmingham Hospital Trust adopted EDS2 as a framework to deliver better outcomes for both staff and service users and embed equality into our mainstream activities. The EDS2 is intended to help us with the analysis of our equality performance that is required by section 149 of the Equality Act 2010 (the public sector equality duty), in a way that promotes localism, whilst helping us to deliver on the NHS Outcomes Framework, the NHS Constitution and the Human Resources Transition Framework. It also will help the Trust to continue meeting the Care Quality Commission's (CQC) 'Essential Standards of Quality and Safety'.
The Equality Delivery System2 (EDS2) is a set of nationally agreed objectives and outcomes comprising of 18 outcomes grouped under the following 4 goals:

- Better health outcomes
- Improved patient access and experience
- A representative and supported workforce
- Inclusive leadership

We grade our equality performance against the EDS goals Red, Amber, Green and purple rating below:

- Excelling - Purple
- Achieving - Green
- Developing - Amber
- Undeveloped - Red

2.1.1 Implementation

Effective implementation is vital to the success of the EDS2 and the Trust is committed to achieving positive outcomes through this process. As part of the implementing and embedding the EDS2, we have developed our own Trust 'Local Interest Group' comprising of local people representing the majority of the Protected Characteristics.

In partnership with our Local Interest Group we undertake assessments with service leads and staff members as part of the Trust initial equality performance analysis.

A great deal of activity is taking place to support the implementation of EDS2 within the organisation.

2.1.2 Equality Performance Assessments

In the current phase of the Trust EDS2 rollout programme we have successfully completed a corporate assessment which has been fully rag rated in accordance with the EDS2 toolkit.

2.1.3 Grading Outcome

The Sandwell and West Birmingham Hospitals (SWBH) EDS2 has been graded Green (Achieving). An action plan has been developed to address issues/concerns. This rating illustrates that compliance within the equalities agenda is visible however there is no room for complacency as there is much work to be done.

Our Equality delivery Framework is monitored by a sub-committee of the Trust Board, the Public Health, Community Development and Equality Committee chaired by the one of the non executive Directors, Prof Kate Thomas. There are three subgroups, each chaired by a senior manager, reporting into the Public Health, Community Development and Equality Committee;

This structure provides leadership, monitoring and reporting functions to give assurances to Trust Board. It also supports the organisation in the development and promotion of good practice in equality and diversity as a service provider and employer.

To see a copy of the SWBH EDS2 2017 see Appendix 3.

2.2 SWBH Colleague and Patient Diversity Pledges

The Trust is committed to being an inclusive and diverse organisation. The People Plan has a key focus on inclusion and diversity under 'theme 2' and to delivering on a series of ambitious targets to increase the diversity of our workforce and knowledge and understanding of equality issues, by 2020.

A key part of delivering on this ambition is the Trust 'Inclusion and Diversity Pledges' which will be monitored regularly by relevant Board Committees and through the public Trust board. Although there is a relevant executive director, inclusion involves every director executive and non-executive and every member of staff.

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 Accredited 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
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 • 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
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 Staff-side, to support LGBT staff at work • Celebrate LGBT History Month with events and support in Feb 2018 • 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 2019
5	**To ensure a safe and inclusive environment for transgender staff.** • 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
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 • 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 2016/7 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 • Develop a personalised leadership programme in the Black Country by delivery 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% • Develop BME Panellists on interview panels across the Trust

	• Develop mentoring and coaching schemes targeted at BME staff • 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 • Deliver extra training for chaplains, in particular develop a female Imam. • Attend recruitment events with a focus on BME inclusive staff
8	**To transform the opinion of our disabled employees about management's commitment to disability in the workplace** **Our promises** 1) To be positive about disability in our Trust 2) To create environments that work for disabled staff 3) To actively promote staff with disabilities into senior roles 4) To make reasonable adjustments for employees who acquire a disability 5) To train and develop staff with a disability **The Trust will adopt the following principles:** • **Equal Employment Opportunity Policy and Procedures:** Employment of people with disability will form an integral part of all Equal Employment Opportunity policies and practices. • **Staff Training and Disability Awareness:** Specific steps will be taken to raise awareness of disability throughout the organisation. • **The Working Environment:** Specific steps will be taken to ensure that the working environment does not prevent people with disability from taking up positions for which they are suitably qualified. • **Recruitment Commitment:** Recruitment procedures will be reviewed and developed to encourage applications from, and the employment of, people with disability.
9.	**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

PATIENT PLEDGES

- **Career Development:** Specific steps will be taken to ensure that employees with disability have the same opportunity as others to develop their full potential within the organisation.
- **Retention, Retraining and Redeployment:** Full support will be given to any employees who acquire disability, enabling them to maintain or return to a role appropriate to their experience and abilities within the organisation.
- **Training and Work Experience:** People with disability will be involved in work experience, training and education.
- **People with disability in the wider community:** The organisation will recognise and respond to people with disability as clients, suppliers, and members of the community at large.
- **Involvement of People with Disability:** Employees will be involved in implementing this agenda to ensure that wherever possible, employment practices recognise and meet their needs.
- **Monitoring Performance**: The organisation will monitor its progress in implementing the key points. There will be an annual audit of performance reviewed at Board level. Achievements and objectives will be published to employees and in the annual report.

1	**To get serious about the quality and equality of care we provide to people with learning disabilities** • Being aware of missing serious illness. Important medical symptoms can be ignored because they are seen as part of someone's disability. • Being more suspicious that the patient may have a serious illness and take action quickly. • Finding out the best way to communicate. Asking family, friends or support workers for help. Remembering that some people use signs and symbols as well as speech. • Listening to parents and carers, especially when someone has difficulty communicating. They can tell which signs and behaviours indicate distress. • Not making assumptions about a person's quality of life. They are likely to be enjoying a fulfilling life. • Being clear on the law about capacity to consent. When people lack capacity you are required to act in their best interests. • Asking for help. Staff from the community learning disability and corporate LD teams can help. • Remembering the Disability Discrimination Act. It requires us to make 'reasonable adjustments' so staff may have to do some things differently to achieve the same health outcomes.
2	**Widening access to services for our transgender or transitioning patients.** • Identifying and improving 2 patient pathways for transitioned patients • Develop and relaunch transgender policy for patients • Develop a partnership with community to explore issues facing trans patients and their carers or families
3	**Widening offer for parents who are looking after their children in hospital** • Expand on work of 'John's Campaign' for parents • Offer food options and expand offer to parents who are looking after their child • Develop support for parents and overnight / morning support • Develop a partnership with charity or third sector • Develop onsite wellbeing activities for children and parents

4	**Review friends and family comments and complaints / compliments to identify trends or issues** • Explore issues raised by patients with protected characteristics • Review measures for improvements • Develop specific action plan to address key issues Develop action plan to address trends in complaints from Black patients • Work with local interest group to deliver on patient inclusion issues where relevant • Support Trust work on supporting mental health patients whilst in the hospital and training and developing staff to support mental health patients efficiently and effectively
5	**Enhance our offering to older people's patient experience in our hospital** • Launch 'end PJ Paralysis' campaign • Work with partners to offer support for stay in hospital e.g. Sandwell College on massage and therapies • Work with local interest group to focus on patient group issues that are under-represented.

2.3 Training

SWBH Trust firmly believes that effective education, learning and development makes a major contribution to the provision of a committed and competent workforce that are focused on delivering safe and effective patient care. The Trust takes learning seriously, clearly demonstrated by the protected investment in the development of our colleagues.

The Trust Board and senior leaders of this Trust understand that by investing in a high quality workforce, who live our values and demonstrate patient focused behaviours every day, we will enable high quality care to be delivered to our patients which; in its turn will positively affect health outcomes in our communities.

Board Training: Equality and Diversity awareness and training has been part of the Board's development program, including a specific session on LGBT by Ellie Barnes OBE in the past 12 months.

Staff Training: We have included Equality, Diversity and Human Rights training in the Trust Mandatory training programmes and it also forms part the Trust Personal Development Review (PDR). The programmes are designed in line the Knowledge and Skills framework (KSF) and delivered by the Equality and Diversity team. The content incorporates awareness of Dignity in the workplace, including the legal, moral and social duty to promote Fairness, Respect, Equality, Dignity and Autonomy (FREDA) in line with the Human Rights principles.

Other training such as Corporate Welcome, Conflict Resolution, and Customer Care also incorporate and discuss the principles of the equality duties in relation to behaviours and attitudes. The Training Focuses in particular on identification of discrimination, victimisation and harassment and the processes in place to support the elimination of such behaviours and practices in the workplace.

E&D provides individual advice and support to managers or staff members.

The E&D team are visible across the organisation providing support, advice and specialist information to staff. We provide team based training in clinical areas and departments, individual staff support as well as guidance to facilitate changes to improve the wellbeing of our patients and staff.

2.4 Equality Impact Assessments

We undertake Equality Impact Assessments (EIAs) on all new and reviewed policies, services, functions and financial savings schemes.

Some of the outcomes from our EIAs have been highlighted previously in our key achievements. These have resulted in improved access and experiences for our patients and staff.

Embedding the practice of conducting equality impact assessments is ongoing to ensure that we continue to provide services and practices that meet the needs of all patients and staff. It also enables us to continuously promote of equality and challenge discrimination both as an employer and as a service provider.

2.5 Patient Engagement

Along with our patient surveys this activity provides one of the most effective ways to capture genuine and meaningful information which is important to each community. It provides powerful feedback that can influence the way the Trust provides its services, interact with individuals and create environments where people feel valued, respected and at ease. It also helps to build staff confidence and competence when caring for their patients.

2.5.1 **Patients**

To support our engagement processes for patients, we have

- Patient Experience Surveys
- Patient Advisory Liaison Service (PALS)
- Equality & Diversity Local Interest Group
- Quality Improvement patient and carer steering group

Patient Experience Surveys

We seek feedback from our patients about their experiences of care by using various methods which include surveys on a tablet PC, paper-based surveys, large-font pictorial surveys, telephone feedback, phone, texts and staff directly talking and listening to patients and carers informally. The majority of our surveys are voluntary and anonymous. This provides us with a wealth of information on their experience in relation to privacy and dignity, our doctors, nurses and other staff, ward environment, treatment and care, food and drink and overall recommendation ratings. The information collected helps the wards and departments to identify areas for improvement and celebrate good practice.

Key Highlights from 2017:

- Corporate Nursing revised roles and strategy in approach to patient experience with a strong emphasis on patient centred care, carer involvement and staff engagement and an improvement plan around patient and carer feedback

- Ongoing work around John's Campaign roll out to all wards to promote partnership working with relatives/carers of vulnerable patients. A concept developed by relatives of a patient with dementia who received excellent care for his acute medical condition in an acute general hospital but little consideration to his personhood and important role of carers in knowing the patient and being in a position to positively support emotional, social and physical needs of the patient in partnership with health care professionals. Mobile beds were purchased to support overnight stays as required. Simple moves to provide drinks and snacks for these carers .

- Training of more than 50 volunteers to support patients with dementia, delirium and distress facilitated by the Dementia Lead Nurse

- Continued collection, collation, analysis and reporting of Friends & Family test in : inpatients, Emergency Department, maternity, Outpatients - results ranging from 62%- 98% in terms of recommendations and from 1 to 3-400 responses depending on the area . December results illustrates a response rate of 85% and negative comments included staff attitude and implementation of care

- Agreement to work in partnership with "Kissing it Better" to promote closer working with colleges to enable students to provide support to our patients under well controlled conditions.

- Purchasing or sleep packs in response to positive results from our campaign to facilitate patient's rest at night

- Promotion of more flexible visiting times to respond to family needs

- Commenced a Quality Improvement Patient and Carer Steering Group. This group provides a space for service users and carers to input into and influence quality improvements for carers and services within the trust. This forum ensures patients and carers voices and opinions are heard, to work collaboratively with the trust to review projects and scrutinise project outcomes.

- Commenced a monthly carer support group based at Rowley Regis to provide emotional and practical support for carers and families of patients requiring further care or 24 hour care on discharge

- Development of Carer's page on trust internet site for carers in the community to review the services we offer for carers and be signposted for support within our local community

Challenges for 2018

- Patient Experience strategy – co-ordination with other teams receiving intelligence regarding patient experience such as PALS, complaints etc
- Review of Staff and Patient Experience Committee
- Review and confirmation of metrics
- Patient engagement/ expert patient

2.5.2 Employees

Employee's at all levels within the Trust are responsible for ensuring that their behaviour is consistent with our values, customer care promises and associated Trust policies and guidance. All managers are responsible for maintaining the equality principles within their areas and ensuring all equality issues are effectively managed. Employees are made aware that it is the responsibility of all individuals to promote equality and avoid discrimination in their practices and behaviours.

Throughout the Trust there are a number of engagement methods used to ensure employees are informed, engaged, have their views heard and able to influence. These include initiatives such as daily electronic Staff bulletins, Monthly Hot Topic meetings chaired by the Chief Executive or other members of the Executive team, Staff Magazine, local departmental meetings. Staff views are also sought via staff surveys and other consultations taking place within the Trust.

2.6 Student Nurses

Sandwell and West Birmingham Hospitals NHS Trust offer clinical placements to students from various different healthcare programmes at local universities.

Student groups are varied and placements are offered regardless of:

- Age – Students' ages can vary from 18 years old up to the more mature student.
- Disability – we support students on placement who may have a physical disability or a learning disability. Reasonable adjustments can be made within practice areas.
- Gender Reassignment.
- Marriage and Civil Partnership.
- Pregnancy and Maternity – we support students on placement who are pregnant using risk assessment processes.
- Race, including ethnic or national origins, colour or nationality – our student groups are varied in relation to the above.
- Religion or belief – individual student religious needs or concerns are discussed and supported.
- Sex.
- Sexual orientation.

The trust have a practice placement team who provide support and advice to students on placement.

2.7 Community Engagement

During the year we have continued developing our partnerships with local community and voluntary organisations to further embed the Trust within the community that it serves. The internal community engagement network within the Trust has established a subgroup who reviewed our partnerships and set out the partnerships we seek to develop.

2.7.1 Launch of the Sapphire Service

Funded through a grant from Your Trust Charity, the Sapphire Service began in 2017 as a partnership between Agewell and the West Bromwich African Caribbean Resource Centre. The service aims to identify inpatients who are at risk of social isolation and to provide them with support on discharge and follow-up back in the community when they leave hospital. The service has already exceeded the expected number of patients it supports.

2.7.2 Sandwell CARES

The Trust has also welcomed the support of Sandwell CARES, again aided by funding from Your Trust Charity, who are supporting carers of relatives who are being cared for on our wards. Their work aims to provide the right assistance to unpaid carers and raise awareness of carers' needs.

2.7.3 Independent Domestic Violence Advisors

Our project provided in partnership with Black Country Women's Aid has progressed well throughout the year demonstrating the benefits of specialist advisors working within our emergency departments who are able to provide immediate help for people who have experienced domestic abuse or who are at risk. The advisors have also been able to support and train staff within the department so that there is greater awareness.

2.7.4 Engaging with our diverse community

During the year we worked in partnership with Birmingham City Council and the Birmingham and Solihull Mental Health NHS Trust on a listening event for Eastern European groups. We heard how we can become better engaged in that community and have committed to working with them on information to help explain how to access NHS care.

2.7.5 Volunteer Service

During the year, our 200th volunteer was placed into a volunteering role and we are now consistently meeting our targets to recruit and place 30 volunteers each month. We are able to report that our volunteer service is reflective of the community it serves with representation across age, gender and ethnic background. We continue to recruit from targeted communities to ensure we continue to reflect the Sandwell and West Birmingham population.

The Trust is one of five national pilot schemes in collaboration with national health care volunteering organisation, HelpForce, and we have received funding to appoint a project manager. Our aim with the pilot is to test out two or three new volunteering interventions that can demonstrate an impact on patient care as people access or are discharged from hospital. We will begin implementing the interventions in early 2018. **(For a copy of the Volunteer data see Appendix 4).**

2.7.6 Your Trust Charity

Your Trust Charity continues to work in partnership with the local community. We have had significant support from local schools who provide refreshments to patient and visitor areas at Rowley Regis Hospital and in our paediatric wards. They have continued to fundraise for the charity and are planning further events in 2018.

With the appointment of a Major Grants Manager, the charity is seeking further external funding to run schemes, as lead or support partner, to better support our local communities.

2.7.7 Midland Metropolitan Hospital

Making the most of the regeneration opportunities of the new hospital has led the Trust to work with a number of community groups in the surrounding areas. In partnership with Carillion we have held a number of community engagement events where members of the public and those who represent particular groups have been able to talk to Carillion and the Trust about opportunities within and around the new building. A programme of community engagement is in place.

Part of this engagement will lead to establishing a network of community ambassadors for the new hospital as well as a team of 80 volunteers who will be present as the hospital opens in 2019.

2.8 SWBH Learning Works

SWBH Learning Works aims to help and support local people to enhance their employability through a range of different pathways, work experience, apprenticeships, traineeships and volunteers.

Launched in 2013, The Learning Works has been a true example of local partnership, working closely with a number of local organisations in the West Midlands including Sandwell Council, Jobcentre Plus, Birmingham Youth promise, Brushstrokes and The Sandwell guarantee.

The Learning Works offers hundreds of Apprenticeships and Work Experience placements to local people and helps them get into jobs. People who are enrolled on these programmes have the opportunity to work in the Trust's hospitals and have a taste of what it is like to work in the NHS.

The Learning Works also signposts to other job related self-improvement locally, as well as offering support and direction on a range of work experience, apprenticeship, volunteering and adult learning opportunities in support of individual's aspirations to become a member of the Trust's workforce. To date, more than 70% of those undertaking work experience and pre-employment training with the project are now in full time employment and 95% of apprentices have gone on to gain employment. Many apprentices have said that the apprenticeships have boosted their confidence and inspired them to pursue careers in healthcare. **(Work Experience and Traineeship statistics can be found at Appendix 6 & 7).**

2.9 Apprenticeships

As an employer of choice for apprenticeships SWBH apprenticeship recruitment centre is embedded in the heart of our local diverse community. Our organisation is committed to making apprenticeships inclusive and accessible to all. We encourage applications from local people to join us and start their career journey in the NHS. Recruiting over 100 apprentices each year into a wide range of professions and job roles. We pride ourselves in providing excellent vocational education and functional skills in Maths, English and ICT.

As an organisation we are proud to encourage and attract a range of individuals who represent our local community and the diversity contained within it **(Apprenticeship stats can be found at Appendix 5).**

2.10 Live and Work Project

This innovative scheme helping homeless young people into employment by providing apprenticeships and accommodation commenced in 2014 and has gone from strength to strength. We are currently providing apprenticeships and accommodation for 20+ young people who were homeless or at risk of homelessness from across the Birmingham and Sandwell regions.

During the last 12 months the Live and Work programme have achieved 11 **full** Apprenticeship QCF completions, 7 Health and Social Care, 2 Customer Service and 2 Business Administration. After their Apprenticeships their destinations have been employment at out Trust, joined the Trust Bank or entered Higher education, which is a fantastic achievement.

We're working with St Basil's to improve our joint communications with new videos incorporate the local area and the attractions for young people in addition to the opportunity of living accommodation and an Apprenticeship. Over the next twelve months we will hope to have secured an additional accommodation block, to support a "move-on " strategy for the Apprentices at the end of their 12 month programme, which will also support the young workers to live independently and remain benefit free. This scheme was visited by HRH Duke of Cambridge in December 2016.

2.11 Community Greenhouses

The Trust, in partnership with Summerfield Residents Association last year brought back to life the greenhouses on the City Hospital site that had remained derelict for over 15 years.

In addition to the support from the residents association there has been involvement from The Princes Trust, Lloyds Banking Group and the Health Futures University Technical College. This has involved young school pupils as well as local residents of all ages.

New developments have seen the introduction of eco-friendly composting systems, bee hives and the sale of house plants alongside fresh fruit and vegetables. This scheme has encouraged people to change their lifestyles by eating more freshly grown fruit and vegetables, as well as being a therapeutic recreational activity for some patients.

Section Three – Monitoring

3.1 Workforce Equality Information and Analysis

The NHS is the largest employer within the United Kingdom it employs in the region of 1.4 million people. There is a plethora of evidence and data regarding the NHS workforce and the experiences of its staff. The NHS represents society at all levels because of the diversity of its workforce

3.2 Trust Workforce Equality Data

The Trust reports annually on its workforce disaggregated by Ethnicity, Gender, Age, Disability, Religion and belief and Sexual Orientation. With the introduction of the new equality legislation the number of protected characteristics has expanded to include Gender Reassignment, Pregnancy and Maternity and Marriage and Civil Partnership. The Trust is actively seeking to improve its workforce data, and our employees are encouraged to disclose equalities information.

Accompanying this report is a summary of the workforce data (Equality Report – Workforce Equality Data) for the period January 2017 – November 2017 (**Appendix 8**).

Key messages from the data

Staff in Post Scorecard - The figures are Full-Time Equivalent (FTE) values and headcount numbers as at the 1st of each month. The comparison column looks at the median values (expressed as a percentage), versus a comparator for local population figures, where available.

Of note:

- Local population figures for Disability & Sexual Orientation are not readily available.

- Gender – SWBH employs more female staff when compared to local population numbers. This is a well understood health sector bias.
- Religious Belief – A high proportion of SWBH staff are identified as 'I do not wish to disclose', therefore it is difficult to draw conclusions at this stage.

- **Leavers** - The figures do not suggest any untoward variances across the diversity strands.

- **Promotions** - Promotions are broadly defined as an increase in grade when comparing one month with the next. This can include permanent changes or acting up posts. In general terms the figures look similar to Staff in Post percentages.

- **Recruitment** –Our recruitment trends do not show any adverse trends across the protected characteristics.

- **Professional Development Review** – PDR figures show a good correlation with Staff in Post numbers across the diversity strands. PDRs are measured as to whether a member of staff has had a PDR/review within the last 12 months.

- **Cases in Formal Procedures** - Our Employee Casework activity is subject to close monitoring and monitoring data/trends is shared with our Staffside partners on a monthly basis at the JCNC.

3.3 Pay Gap Audit

The Trust undertook an equal pay audit in 2013 (and is in the process of carrying out another audit), to assess whether there was inequity in pay in relations to gender, ethnicity or disability and to fulfil a statutory requirement to comply with the Gender Equality Duty Code of Practice and the Trust Single Equality Scheme at that time.

The audit findings showed that there were no statistically significant variances in the Gender analysis of staff on AfC terms and conditions. Within the Gender analysis, no pay band showed a dual variance of greater than 5%. In fact, only one band (Band 9) showed a median variance of 6.82%, which is explained by the difference in length of time in post.

There were statistical variances in 3 pay bands within the AfC Ethnicity analysis, however upon further examination the variances are within the Mixed Heritage group, which constitute 1.87% of Trust employees. Therefore, the variances can be explained by the relatively small numbers within that Ethnic group, which, in turn, is more greatly affected by the length of time in post for staff (their current salary point), which affects their mean and median values.

Anomalies identified with doctors pay on the Associate Specialist or Specialty Doctor pay scales was due to the starting salary (or the salary they moved across to from the old contract), which was laid down in accordance with national terms and conditions of service. Progression is by increments on the new contracts (and a mixture of increments and discretionary point on the old Associate Specialist contract). The salary on the new contracts will also be dependent on the amount of out of hours work individuals undertake. In some (A&E, Trauma and Orthopaedics and Anaesthetics) it is great in others it is minimal or non-existent.

Executive salaries are determined by the Trust's remuneration committee. Salaries have not been uplifted since 01 April 2010, this is outside the norm for the region and nationally. Director's salaries are declared in detail within the Trust's Annual Report.

Based on the results of the latest audit, it was concluded that there were no equal pay concerns that required attention. Any disparities were explained by either the use of a generic pay code (as in the case of doctors) that covers a wide range of duties or a combination of service/incremental points progression, which is a consequence of national terms and conditions. This will be reviewed in early 2018.

3.4 NHS Workforce Race Equality Standard

Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS provider organisations.

The NHS Equality and Diversity Council announced on 31 July 2014 that it had agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

In April 2015, after engaging and consulting with key stakeholders including other NHS organisations across England, the WRES was made compulsory.

With over one million employees, the NHS is mandated to show progress against a number of indicators of workforce equality, including a specific indicator to address the low numbers of BME board members across the organisation.

NHS providers are expected to show progress against a number of indicators of workforce equality, including a specific indicator to address the low numbers of BME board members across the organisation.

The first phase of the WRES focused on supporting the system to understand the nature of the challenge of workforce race equality and for leaders to recognise that it was their responsibility to help make the necessary changes.

3.4.1 WRES Phase Two

The next phase of the WRES will focus on enabling people to work comfortably with race equality. Through communications and engagement we will work to change the deep rooted cultures of race inequality in the system, learn more about the importance of equity, to build capacity and capability on knowledge and expertise of race issues. The WRES will continue to work to evidence the outcomes of the work that is done, publishing data intelligence and supporting the system by sharing replicable good practice.

Alongside WRES, NHS organisations use the Equality and Diversity Systems (EDS2) to help in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS2 and the WRES, NHS organisations can also be helped to deliver on the Public Sector Equality Duty.

The main purpose of the WRES is to help local, and national, NHS organisations to review their data against the nine WRES indicators, to produce action plans to close the gaps in workplace experience between White and Black and Ethnic Minority (BME) staff, and to improve BME representation at the Board level of the organisation.

3.4.2 WRES reporting

Organisations use UNIFY 2, a system for sharing and reporting NHS and social care performance information should be used for the annual WRES returns. **(To see a copy of our latest WRES publication please see Appendix 1 and the update can be found at Appendix 2).**

3.5 NHS National Staff Survey 2017

1250 staff were randomly selected from across all professional groups and pay bands to participate in the NHS national staff survey for 2017. We expect our results to be published early in 2018 that will allow us to benchmark our scores against other NHS organisations.

3.6 Patient Data

Our patient information can be disaggregated based on sex, age, ethnicity, religion and marital status. Information on sexual orientation, disability and gender reassignment is not captured on a regular basis due to constraint on the current national Patient Administration System [PAS] and therefore the data is limited.
(A breakdown of our patient data can be seen in Appendix 9).

4.0 Concerns and Complaints

Complaints

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 recognised that for some complaints, a resolution meeting, as opposed to a written response can be more effective in addressing concerns. Some complainants will also express a preference to meet with the Trust, and it remains an important aspect of the complaints resolution process.

The monitoring system in place continues to ensure that meetings are promoted as an effective way of resolving complaints, and where this is the complainant's preference, this is offered. It is an essential part of the process to offer all complainants the opportunity to meet with the Trust and this message is reiterated to all involved in devolved complaints across the Trust.

Everyone who makes a complaint is given the opportunity to provide feedback on how they found their experience via completion of a questionnaire that is sent with the final response.

In order to check that our complaints process is accessible to all, it is important to understand the profile of complainants by certain protected characteristics. Gender, age and ethnicity are recorded and then compared to our hospital population and also the population of the geographic area that we serve **(Appendix 10)**

4.1 PALS (now referred to as informal complaints)

Informal complaints continue to play a vital role in providing patients with a local advocate who can investigate concerns, resolving concerns within the Clinical Group effectively without the need to log a formal complaint. This year, there has been a renewed emphasis on encouraging local resolution within the Clinical Group/ Corporate Directorate without the intervention of the complaints team, thus further promoting accountability and improving the 'customer service' experience.
The collection of compliments has been identified as challenging in terms of consistency of reporting, although some are collected by Clinical Groups. This is to ensure that there is a balance in reporting, in regard to patients expressing concern, as well as gratitude. A network of telephone access points will be launched in February 2018 and will aid in collecting compliments, as well as providing access for patients to contact the complaints team for support.

5.0 Conclusion

This report shows that the Trust is compliant with its equality duties but more importantly if shows that the Trust is committed to proactively meeting and exceeding the diverse needs of the people who use its services and those in its employment. Equality, Diversity, Inclusion and Human Rights is a golden thread of all activities and remains a key executive and board priority of the Trust.

There is a great deal of activity taking place across the Trust, in relation to embedding equality and embracing diversity and human rights. Some of these have been highlighted within this report. We recognise however the ongoing nature of this work and will continue to monitor and measure equality and quality based on the outcomes underpinned by the Workforce Race Equality Standard (WRES) and Equality Delivery System (EDS2) and aligned with the Care Quality Commissioners equality standards.

The actions identified including the outcome of the EDS equality performance analysis will enable us to forge ahead and establish our equality objectives and actions to address the gaps in data and service provision. We will consult with patients and staff to develop our Equality objectives in line with the EDS2, to ensure that our Equality, Diversity, Inclusion and Human Rights strategy and objectives, prioritise the areas we need to improve.

Appendix 1

WRES Report

For each of these four workforce indicators, compare the data for White and BME staff	Data for current year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
1 Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	Clinical Staff BME Under Band 1 - 0% Band 1 - 6% Band 2 - 18% Band 3 - 15% Band 4 - 10% Band 5 - 41% Band 6 - 31% Band 7 - 21% Band 8A - 16% Band 8B -12% Band 8C - 7% Band 8D - 5% Band 9 - 0% VSM - 0% Non Clinical Staff BME Under Band 1 - 0% Band 1 - 19% Band 2 - 17% Band 3 - 11% Band 4 - 16% Band 5 - 3% Band 6 - 2% Band 7 - 3% Band 8A - 8% Band 8B - 2% Band 8C - 7% Band 8D - 5% Band 9 - 0%	Clinical Staff BME Under Band 1 - 0% Band 1 - 6% Band 2 - 6% Band 3 - 25% Band 4 - 19% Band 5 - 45% Band 6 - 30% Band 7 - 21% Band 8A - 18% Band 8B -17% Band 8C - 13% Band 8D - 10% Band 9 - 0% VSM - 2% Non Clinical Staff BME Under Band 1 - 50% Band 1 - 29% Band 2 - 14% Band 3 - 9% Band 4 - 7% Band 5 - 3% Band 6 - 2% Band 7 - 2% Band 8A - 5% Band 8B - 0%	The data for this indicator shows that for Clinical BME staff there has been an increase in staffing levels at Bands 2 and 6 with a reduction across all other bandings. For Non Clinical BME staff there has been an increase in bands 2 - 4 and bands 7 - 8C. For White Clinical staff there has been a reduction across all bandings. Non Clinical White staff has seen a reduction at bands 2 and 6.	Review and redesign recruitment and selection processes to ensure that; • Inclusion and diversity is included as a key aspect of all recruitment and selection training • Unconscious bias training is delivered to all recruiting managers • CV and interview skills workshops are run 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 • Monitor protected characteristics data of PDR completion and scoring. 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 • 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%

	VSM - 11% Clinical Staff White - Under Band 1 - 0% Band 1 - 19% Band 2 - 28% Band 3 - 37% Band 4 - 19% Band 5 - 41% Band 6 - 58% Band 7 - 65% Band 8A - 52% Band 8B - 55% Band 8C - 30% Band 8D - 37% Band 9 - 31% VSM - 0% Non Clinical Staff White Under Band 1 - 0% Band 1 - 37% Band 2 - 25% Band 3 - 28% Band 4 - 49% Band 5 - 8% Band 6 - 4% Band 7 - 6% Band 8A - 21% Band 8B - 32% Band 8C - 57% Band 8D - 47% Band 9 - 61% VSM - 78%	Band 8C - 5% Band 8D - 0% Band 9 - 0% VSM - 11% Clinical Staff White - Under Band 1 - 3% Band 1 - 30% Band 2 - 36% Band 3 - 47% Band 4 - 55% Band 5 - 47% Band 6 - 63% Band 7 - 71% Band 8A - 58% Band 8B - 70% Band 8C - 43% Band 8D - 80% Band 9 - 50% Non Clinical Staff White Under Band 1 - 47% Band 1 - 35% Band 2 - 26% Band 3 - 24% Band 4 - 19% Band 5 - 6% Band 6 - 5% Band 7 - 6% Band 8A - 19% Band 8B - 13%		• 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

			Band 8C - 39% Band 8D - 10% Band 9 - 50% VSM - 76%		
2	Relative likelihood of staff being appointed from shortlisting across all posts.	Number of shortlisted applicants - White - 2657. BME - 3159. Number appointed White - 419 BME - 358. Therefore White candidates are 1.39 times more likely than BME candidates to be appointed.	Number of short-listed applicants - 680. Appointed BME 262 Appointed white - 401. Therefore white candidates are 1.55 times more likely to be appointed than BME candidates.	The data indicates that there has been a reduction in the likelihood of white candidates being appointed over BME by 0.16 times	Review and redesign recruitment and selection processes to ensure that; • Inclusion and diversity is included as a key aspect of all recruitment and selection training • Unconscious bias training to be delivered to all recruiting managers • CV and interview skills workshops to be run 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 • Monitor protected characteristics data of PDR completion and scoring
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.	Data for the current year shows that BME staff are 0.65 times more likely to enter the formal disciplinary process.	BME staff were 1.11 times more likely than white staff to enter the formal disciplinary process.	There has been a reduction of 0.45 in the likelihood of BME staff entering the formal disciplinary process.	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
4 Relative likelihood of staff accessing non-mandatory training and CPD.	Non-mandatory and CPD training attendance by ethnicity: White = 0.28% BME = 0.22% White staff were 1.25 times more likely than BME staff to attend non-mandatory and CPD training during this period.	Non-mandatory and CPD training attendance by ethnicity: White = 0.17% BME = 0.13%. White staff were 1.31 times more likely than BME staff to attend non-mandatory and CPD training during this period.	There has been a reduction of white staff accessing non mandatory training and CPD over BME staff by 0.06 times .	The Education Committee will oversee the analysis of training requests and training funds via ESR and consider against protected characteristics data – in particular BME colleagues • Annual review of access to training • 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
National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.				
5 KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White – 26% BME – 12%	White – 27% BME – 18%	Whilst there has been a 1% decrease in white staff experiencing bullying, harassment or abuse from patients, relatives or the public, there has been a much greater 6% reduction for BME staff members.	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.
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White – 22% BME 19%	White – 23% BME – 26%	As with the previous indicator again there is a 1% decrease in white staff experiencing harassment, bullying or abuse from staff but a 7% decrease in BME staff experience.	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.
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.	White – 85% BJME – 84%	White 92% BME – 79%	This indicator shows that there has been a marked decrease 7% in White staff believing the trust provides equal opportunities for career progression or promotion whilst there is a 5% increase in BME staff perception.	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

8 Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White 5% BME 7%	White – 6% BME – 8%	The data in this indicator shows a 1% decrease for both White and BME staff from mangers, team leaders or other colleagues.	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
Board representation indicator For this indicator, compare the difference for White and BME sta				
9 Percentage difference between the organisations' Board voting membership and its overall workforce.	Total workforce White - 57% BME - 36% Board Voting Membership White - 83% BME - 17% Board Executive Membership White - 90% BME - 10%	Whole workforce: White - 57.09%, BME - 34.94% Voting Membership: White - 61.54%, BME - 30.77% Therefore the percentage difference is a 4.17% for BME	The data shows that the Board Voting membership is over-represented by 26% for White staff and under-represented by 19% for BME staff. The Executive membership id over-represented by 33% for white staff and under-represented by 26% for BME staff	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 • Communication and engagement with EDS both internally and externally

		and 4.45% for white members		• 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

Sandwell & West Birmingham NHS Trust
Diversity & Inclusion
WRES Update

Recruitment

Shortlisting & Interviewing - Inclusion and diversity is being built in to our interview process, we have staff from a BME background on all interview panels within the trust. Being a part of the panel involves the shortlisting of candidates, reviewing applications on NHS Jobs along with other panel members for consideration by the Chair of the panel. They sense check interview questions, the assessment criteria against the person specification so that all criteria will have been tested at some point during the selection process. Once the interviews are completed in order to ensure that staff being appointed to posts meet the standard as laid out in the person specification, they must ensure that each criteria is given due consideration with candidates being fairly considered against each. If at any point during the interview / assessment or decision making, any panellist has cause for concern, including any feelings that their 'voice' as Independent member of the panel has not been heard, or that the broader interests have not been represented, their concern should be raised with the relevant HR Business Partner or Chair of the Panel.

The Chief Executive and People Director have emailed all managers and staff around the process and reasoning behind the BME Panellist and have produced a number of FAQ's in consultation with the Equality and Diversity Team.

Chief Nurse Recruitment – External advisors from the BAME Nursing Community have been asked for input into the information pack, the job description and to help promote the role with our recruitment partner TMP World Wide.

Direct Contact for Vacancies – The trust are ensuring that all middle management vacancies are well advertised and ensuring that BME Staff are being encouraged to apply.

Training

Unconscious Bias – there is a plan in place to ensure that this training is delivered to recruiting managers during the planned Inclusion Module of the SWBH Accredited Line Manager programme.

CV & Interview Skills Workshop – These are being resourced through Learning and Development and there are dates for the 2018 calendar for and there is a session planned for the April 2018 BME Staff Network meeting.

Equality and Diversity Training for all – Equality and Diversity are working in partnership with Learning and Development to source an interactive story telling approach that looks at inclusion and diversity including the nine protected characteristics and unconscious bias through an e-learning platform, a programme from E-Learning for Health has been identified and a pilot is being run during January and February 2018, aiming to go live across the trust in Quarter 1 next year.

Stepping Up Programme - The programme is being run in partnership with the NHS Leadership Academy, The Dudley Group NHS Foundation Trust, The Royal Wolverhampton NHS Trust, Sandwell & West Birmingham NHS Trust, & Walsall Healthcare NHS Trust is aimed at BAME leaders and aspiring BAME leaders across healthcare working in bands 5 to 7.

It's been designed for individuals who have an interest in developing their leadership abilities and want to be involved in creating a transformational change in equality and diversity across the healthcare sector.

The programme is spilt into two cohorts – one for bands 5 and 6 and another for people in band 7 roles. The programme has been designed specifically for these colleagues to help them progress further in their careers.

The Stepping Up programme aims to create greater levels of sustainable inclusion within the NHS by addressing the social, organisational and psychological barriers restricting BAME colleagues from progressing within the NHS.

The main objectives of the programme are to:

- Emphasise the importance of a diverse workforce and create leaders who can educate the healthcare system about the effect this is having on frontline patient care
- Recognise the potential of BAME leaders demonstrating the range and benefits of diverse talent
- Highlight the importance of having BAME leaders as role models to help inspire others to progress into more senior roles
- Raise awareness and understanding of inclusion by bringing it to the forefront of all Academy communications to ensure a positive impact on the healthcare system
- Develop senior leaders in the NHS who will lead effectively, creating and embedding organisational inclusive cultures
- Work on changing the racial dynamics of an organisation to create a deeper level of understanding to help change take place

The programme runs over five months. You'll benefit from a mix blend of learning, including face-to-face, self-directed and workplace-based. This includes two face to face workshop.

The programme will run with initially three cohorts of 40 participants each.

Organisational Development Team – All of our Workforce Business partners will be completing the Accredited Manager Programme (Year 1) by the end of quarter four. All staff will also be completing the Equality and Inclusion E-Learning package once it goes live in Quarter 1 2018.

The trust is sourcing specific training for complex race relations investigations as part of the Continual Professional Development of our Human Resources Business Partners.

Mentorship – The mentorship programme is being developed by Learning and Development and key members of the BME Staff Network this is aiming to go live in early 2018.

QIHD – There is a QIHD slot planned for February 2018 around Inclusion and Diversity with an LGBT focus, we are hoping to replicate this or utilise Hot Topics in October 2018 with a BAME focus. This will be a bite size (30 minute) presentation that will inform staff and we hope encourage a debate within teams.

Board Training – The Trust board has had a presentation from Dr Ellie Barns MBE who spoke eloquently around conscious and unconscious bias and challenged the board to think differently.

The board has heard several patient stories over the last twelve months that have highlighted areas of good practice and opportunities for the trust to improve.

The board have attended the Education and Celebration events run by both the LGBT Staff Network and the BME Staff Network. The launch event for Black History Month was well attended by members of the board as they listened to the inspiring personal stories of both BME staff and influential members of the local community.

The board hope to have the BME Staff Network present to them during Quarter One of 2018

Data

PDR Completion – the scores from the Ambition PDR's are being recorded and monitored for all staff and scores of staff who have declared a protected characteristic are being collated for us to use 2017/2018 as a base line for progression.

Recruitment data – is being collated and in the first six weeks of the BME Panellists, please see the chart below, we are unable to state how many staff have started as no one has cleared the recruitment process since the implementation at the start of October 2017.

Number of Candidates

	BME Grouping			
Pay Band/Scale	**BME**	**Not Stated**	**White**	**Grand Total**
Band 2	71		77	148
Band 3	26		20	46
Band 4	5	1	10	16
Band 5	73	10	66	149
Band 6	37	1	36	74
Band 7	11	2	18	31
Band 8a	3		2	5
Band 8b	4		6	10
Band 8c	1		4	5
Hospital Medical and Dental Staff - Doctor - Other	12	1	2	15
Hospital Medical and Dental Staff - Foundation Doctor	2		2	4
Hospital Medical and Dental Staff - Specialty Doctor	3			3
Other	1		2	3
VSM (Very Senior Manager)			2	2
Grand Total	**249**	**15**	**247**	**511**
%	**49%**	**3%**	**48%**	

Number of Positions Offered

Pay Band/Scale	BME	Not Stated	White	Grand Total
Band 2	4		10	14
Band 3	2		2	4
Band 4			3	3
Band 5	7	1	7	15
Band 6	4	1	7	12
Band 7	3		6	9
Band 8a	1			1
Grand Total	**21**	**2**	**35**	**58**
	36%	**3%**	**60%**	

BME Complaint

BME Representative on Panel	Yes	No	Unknown	Grand Total
	74	20	6	100

Yearly Data – the yearly WRES audit is due to be completed between July and August and the data and analysis then goes to Trust Board, a new action plan will then be formulated in partnership with the BME Staff Network, The Trust Board and Organisational Development Team.

Staff Network – BME Staff Network – The staff network is a self-managing group within the trust The Black Minority Ethnic (BME) Staff Network is a self-organised, staff group addressing BME staff issues feeding into the Trust's Equal Opportunities and managing Diversity agenda to improve the working lives of BME staff by empowering them and ensuring that their rights are respected.

The membership of the group is open to all permanent and temporary staff. A confidential list of members will be maintained by the Committee members of the group. An Invitation to join the Black BME Staff Network is extended to all Trust staff on a frequent basis, via recognised staff communication mechanisms.

The network currently meet evert month and have had a programme of external speakers in 2017.

BME Executive Sponsor – Toby Lewis (Chief Executive) is the Executive Sponsor of the BME Staff Network, he works in partnership with the Co-Chairs Leanne Burris and Anser Khan and the Vice Chair Donna Mighty to help support and develop the network, all four meet regularly. Alongside Toby other members of the trust executive have attended meetings.

Celebration Events – The BME Network have had organised and celebrated Black History Month within the organisation, celebrating the diverse culture within our organisation and community in which we serve. The month had key speakers, a celebration events and daily communications highlighting BME role models.

The network have attended and had a stall at recruitment events both internal and external to the trust, at International Nurses Day, at the Spring Wellness Event, the Winter Wellness Event, the Sustainability Garden Party and the trusts Annual General Meeting.

The network also had prominent stalls at both Fiesta in the Park and Jamaica in the Square, two high profile public events advertising the diversity and inclusion of the trust.

Members of the network also supported the LGBT Staff Network and marched in the Birmingham Pride Parade.

Religions Events – There have been a number of religious celebrations facilitated by both the trust chaplaincy service and external faith leaders, these have included, celebrating and issuing health guidance around Ramadan, celebrating Eid, Celebrating Diwali, Celebrating Vaisakhi and Rama Nabani, Celebrating Lent, Celebrating Easter and Celebrating Christmas.

There are early plans in place to hold an event to commemorate International Holocaust Memorial Day in January 2018.

Appendix 3

Equality Delivery System for the NHS
EDS2 Summary Report

Implementation of the Equality Delivery System – EDS2 is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS2 in accordance with the '9 Steps for EDS2 Implementation' as outlined in the 2013 EDS2 guidance document. The document can be found at: **http://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf**

This *EDS2 Summary Report* is designed to give an overview of the organisation's most recent EDS2 implementation. It is recommended that once completed, this Summary Report is published on the organisation's website.

NHS organisation name:
Sandwell and West Birmingham Hospitals NHS Trust

Organisation's Board lead for EDS2:
Raffaela Goodby - Director of People & Organisational Development

Organisation's EDS2 lead (name/email):
Stuart Young - Head of Diversity & Inclusion - stuartyoung1@nhs.net

Level of stakeholder involvement in EDS2 grading and subsequent actions:
SWBH Trust EDS2 rollout programme has successfully now been fully rag rated in accordance with the EDS2 toolkit. The assessments have been very successful in terms of local engagement - our last RAG rating panel (Local Interest Group) comprised of local people representing the majority of the Protected Characteristics.

Organisation's Equality Objectives (including duration period):
Diversity pledges 2017-2020 1. Increase recognition and knowledge of the value of inclusion within the leader and manager population. 2. Review and redesign recruitment and selection processes. 3. Develop and support Staff Network Groups. 4. Create a culture where it is safe to be 'out' at SWBH as a staff member or a patient. 5. To ensure a safe and inclusive environment for transgender staff. 6. Review the use of EDS 2 and develop and implement a 'Trust EDS' 7. To ensure a safe and inclusive working environment for BME Staff. 8. To transform the opinion of our disabled employees about management's commitment to disability in the workplace 9. Run communications campaigns each month with emphasis on protected characteristics (PC) based on CIPD Diversity Calendar and with visible support from employee network groups.

Headline good practice examples of EDS2 outcomes (for patients/community/workforce):
Live and Work Project Learning Works Community Greenhouses

Date of EDS2 grading December 2017			**Date of next EDS2 grading** December 2018
Goal 1	Outcome	Grade and reason for rating	**Outcome links to an Equality Objective**
Better health outcomes	1.1	**Services are commissioned, procured, designed and delivered to meet the health needs of local communities** **Grade** ☐ **Undeveloped** ☐ **Developing** ☑ **Achieving** ☐ **Excelling** **Which protected characteristics fare well** ☑ Age ☑ Disability ☐ Gender Reassignment ☑ Marriage and civil Partnership ☐ Pregnancy and Maternity ☑ Race ☑ Religion and Belief ☑ Sex ☑ Sexual Orientation **Evidence drawn upon for rating** We do not commission or procure services. We only design and deliver services which have previously been commissioned by the CCG. We deliver a range of services for all members of the community regardless of protected characteristics. Currently we only gather data for age, sex, marriage, ethnicity , and religion. Services are provided at Sandwell Hospital, City Hospital, Birmingham Treatment Centre and community services at Rowley Regis Hospital and various of community Health Centres. Patient Transport service is available to all outpatients and inpatients, subject to medical criteria guidelines which are issued by the department of health. Referrals are received from primary care.	☑

Better health outcomes	1.2	**Individual people's health needs are assessed and met in appropriate and effective ways** **Grade** ☐ **Undeveloped** ☑ **Developing** ☐ **Achieving** ☐ **Excelling** **Which protected characteristics fare well**: ☑ Age; ☑ Disability; ☐ Gender Reassignment; ☑ Marriage and civil Partnership; ☐ Pregnancy and Maternity; ☑ Race; ☑ Religion and Belief; ☑ Sex; ☑ Sexual Orientation **Evidence drawn upon for rating** The Trust delivers a range of services to members of the local community. Patients are seen at the Trust via either a visit to the Accident and Emergency department or via GP referral. Patients are individually assessed on admission using a physical /psychological and social needs approach . compliance with documentation is audited locally as part of ward dashboards. Personalised Care plans are used in order to record patient details. Patients are assessed for Mental capacity and the Trust use of safeguarding & deprivation of liberties. In the majority of cases, wider discussion of the treatment options will have taken place in outpatients prior to the patient being admitted. Informed consent is obtained when the patient arrives for a procedure. Some cases are reviewed beforehand in the multi-disciplinary team meetings, where the referring clinician has discussed and obtained and obtained consent from the patient before the procedure. We work very closely with the SEPSIS team and train all doctors in order to standardise the Trust procedures, blood culture stations and packs have been introduced. The Trust has a SEPSIS care pathway in place. Blood culture contaminants are monitored and variants investigated. All NICE guidance is adhered to or are worked at a higher level. Infection Control monthly reports are completed and shared with all areas. All patients receive a MUST assessment of nutrition in community bed bases and community. Where patients are incapable of informed consent, we use the Trust's procedure for recording this on the dedicated consent form. If necessary, the individual's treatment is discussed with the clinicians responsible for the overall care of the patient, and/or with the next of kin, as appropriate.	☑

Better health outcomes	1.3	**Transitions form one service to another, for people on care pathways, are made smoothly with everyone well informed.** **Grade** ☐ Undeveloped ☑ Developing ☐ Achieving ☐ Excelling **Which protected characteristics fare well** ☑ Age ☑ Disability ☐ Gender Reassignment ☑ Marriage and civil Partnership ☐ Pregnancy and Maternity ☑ Race ☑ Religion and Belief ☑ Sex ☑ Sexual Orientation **Evidence drawn upon for rating** The teams within SWBH have multiple pathways in place to ensure patients are handed over correctly and efficiently from all areas. There are referrals between multidisciplinary teams, and where necessary, inter Trust discussions. We are able to transfer Imaging electronically to specialist centres as and when required. For children transition may be between community and acute hospital care or at developmental stages as they grow up; for example transition into school, transition from primary to secondary school, transition to adult services. We have local agreements in place regarding cross boundary working with neighbouring authorities. End of life spiritual and religious care is discussed with the patient and/or family members, throughout the care pathway and provision is made through the Chaplaincy service if this is required. Pathways for vulnerable groups reviewed to try and reduce number of ward transfers (Dementia CQUIN) and patients with Learning Disability will have personal support across hospital and community pathways following introduction of flagging identification system Important information is recorded on Electronic Bed Management System. Attendance at year 5 Transition annual reviews –where secondary school placement planned with child & family.	☑

Better health outcomes	1.4	**When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse** **Grade** ☐ **Undeveloped** ☑ **Developing** ☑ **Achieving** ☐ **Excelling** ☑ **Which protected characteristics fare well** ☑ Age; ☑ Disability; ☐ Gender Reassignment; ☑ Marriage and civil Partnership; ☐ Pregnancy and Maternity; ☑ Race; ☑ Religion and Belief; ☑ Sex; ☑ Sexual Orientation **Evidence drawn upon for rating** There are systems in place within SWBH to ensure that the Trust, its staff and service users are safe and free from abuse, mistreatment and mistakes. All Trust staff and volunteers are referenced; DBS (CRB) checked, fully trained and wear clear photo identification and name badges. Training systems such as the Clinical MOT and Quest competency assessment tool are in place to ensure staff have knowledge to recognise an individual's health needs effectively. We also provide; • health and safety training within corporate induction, • health and safety risk assessments, • mentoring programmes for junior staff members • clinical supervision • clinical audits, • governance meetings to review any complaints/incidents/patterns and themes, • appropriate training sessions are in place to ensure staff are safe in practice and maintain patient safety. • Incident reporting, complaints management, • Duty of candour policy and professional guidance. • Whistle-blowing policy • Professional registration for all qualified staff • Competency programmes for qualified and non registered staff • Mandatory training for all staff If any abuse is suspected the service user would be referred onto the relevant services by the Safeguarding team, this would include social services and the police. • When concerns are raised regarding the Trust then table top reviews are carried out. • Presenting the Board members with monthly patient stories to highlight any issues and aspects of best practice.	☑

Better health outcomes	1.5	**Screening, vaccination and other health promotion services reach and benefit all local communities** **Grade** ☐ **Undeveloped** ☑ **Developing** ☐ **Achieving** ☐ **Excelling** **Which protected characteristics fare well** ☑ Age ☑ Disability ☐ Gender Reassignment ☑ Marriage and civil Partnership ☐ Pregnancy and Maternity ☑ Race ☑ Religion and Belief ☑ Sex ☑ Sexual Orientation **Evidence drawn upon for rating** All Trust service users have access to screening, vaccination, health promotion services, although some teams within SWBH are not directly involved with this. All admitted patients are screened for MRSA and DVT.	☑

Date of EDS2 grading December 2017		**Date of next EDS2 grading** December 2018	
Goal 2	Outcome	Grade and reason for rating	**Outcome links to an Equality Objective**
Improved patient access and experience	2.1	**People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds** **Grade** ☐ **Undeveloped** ☐ **Developing** ☑ **Achieving** ☐ **Excelling** **Which protected characteristics fare well** ☑ Age ☑ Disability ☐ Gender Reassignment ☑ Marriage and civil Partnership ☐ Pregnancy and Maternity ☑ Race ☑ Religion and Belief ☑ Sex ☑ Sexual Orientation **Evidence drawn upon for rating** SWBH includes a variety of services, some of these are available 7 days a week. Others have procedures to follow if they are needed out of hours, this ensures that no service user is denied access to Trust services. Disabled Go have been commissioned by the Trust to carry out accessibility audits of all trust premises and provide in depth details (via their web site) of all wards and department within the Trust to enable out disabled service users top pre plan routes etc around the sites.	☑

Improved patient access and experience	2.2	**People are informed and supported to be as involved as they wish to be in decisions about their care** **Grade** ☐ **Undeveloped** ☐ **Developing** ☑ **Achieving** ☐ **Excelling** **Which protected characteristics fare well** ☑ Age ☑ Disability ☐ Gender Reassignment ☑ Marriage and civil Partnership ☐ Pregnancy and Maternity ☑ Race ☑ Religion and Belief ☑ Sex ☑ Sexual Orientation **Evidence drawn upon for rating** Patients have the right to be as involved in their own care as much as they wish, and the clinical teams within SWBH recognise and action this by; • offering patient and carer support and also taking patients and carer (where appropriate) views and wishes into account. • Patients who lack capacity about their care will have family, friends, carers or IMCA (Independent Mental Capacity Advocate consulted. • Clinical MOT is open to both HCA's and registered nursing staff and identifies how they can promote choice and support patients to be involved in their care. • Patient surveys seek patient views on involvement with care decisions and is feedback to the different service areas. • Patients have the choice to accept or decline our services within their care. • Consent for patient decision making is gained as per Trust consent policy.	☑

<table>
<tr>
<td>Improved patient access and experience</td>
<td>2.3</td>
<td>
People report positive experiences of the NHS

Grade | Which protected characteristics fare well | Evidence drawn upon for rating

☐ Undeveloped
☐ Developing
☑ Achieving
☐ Excelling

☑ Age
☑ Disability
☐ Gender Reassignment
☑ Marriage and civil Partnership

☐ Pregnancy and Maternity
☑ Race
☑ Religion and Belief
☑ Sex
☑ Sexual Orientation

The Trust has a programme of surveys to measure patient experience and actively seek feedback.
• We are constantly improving ways of capturing this feedback by introducing multiple sources of giving feedback, for example, ipads, SMS texting and token box systems. The Friends and Family Test which patients can use to compare hospitals nationally has shown steady increase in participation and improvement in the FFT score. Patient are able to give names of staff members who gave them exceptional service.

Individual areas also regularly receive thank you cards and letters from patients or relatives.
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<tr>
<td>Improved patient access and experience</td>
<td>2.4</td>
<td>
People's complaints about services are handled respectfully and efficiently

Grade | Which protected characteristics fare well | Evidence drawn upon for rating

☐ Undeveloped
☐ Developing
☑ Achieving
☐ Excelling

☑ Age
☑ Disability
☐ Gender Reassignment
☑ Marriage and civil Partnership

☐ Pregnancy and Maternity
☑ Race
☑ Religion and Belief
☑ Sex
☑ Sexual Orientation

Any issues/complaints from service users, are aimed to be dealt with efficiently and effectively and in accordance with any Trust polices/guidelines.

• People can make an informal complaint through contacting the PALS service, or if they wish to do so, their concerns can be raised with individual service areas. If they wish to raised a formal complaint they contact the head of PALS and complaints either verbally or in writing in accordance with the Trust complaints policy.
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Date of EDS2 grading December 2017			**Date of next EDS2 grading** December 2018
Goal 3	Outcome	Grade and reason for rating	**Outcome links to an Equality Objective**
A representative and supported workforce	3.1	**Fair NHS recruitment and selection processes lead to a more representative workforce at all levels** **Grade** ☐ **Undeveloped** ☐ **Developing** ☑ **Achieving** ☐ **Excelling** **Which protected characteristics fare well** ☑ Age ☑ Disability ☐ Gender Reassignment ☑ Marriage and civil Partnership ☐ Pregnancy and Maternity ☑ Race ☑ Religion and Belief ☑ Sex ☑ Sexual Orientation **Evidence drawn upon for rating** All applications are processed through NHS jobs. All interview panels consist of various staff members from the recruiting area ensuring that the protected characteristics are represented.	☑

A representative and supported workforce	3.2	**The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations** **Grade** ☐ Undeveloped ☑ Developing ☐ Achieving ☐ Excelling **Which protected characteristics fare well** ☑ Age ☑ Disability ☐ Gender Reassignment ☑ Marriage and civil Partnership ☐ Pregnancy and Maternity ☑ Race ☑ Religion and Belief ☑ Sex ☑ Sexual Orientation **Evidence drawn upon for rating** The Trust undertook an equal pay audit in 2013, to assess whether there was inequity in pay in relations to gender, ethnicity or disability and to fulfil a statutory requirement to comply with the Gender Equality Duty Code of Practice and the Trust Single Equality Scheme at that time. The audit findings showed that there were no statistically significant variances in the Gender analysis of staff on AfC terms and conditions. Within the Gender analysis, no pay band showed a dual variance of greater than 5%. In fact, only one band (Band 9) showed a median variance of 6.82%, which is explained by the difference in length of time in post. There were statistical variances in 3 pay bands within the AfC Ethnicity analysis, however upon further examination the variances are within the Mixed Heritage group, which constitute 1.87% of Trust employees. Therefore, the variances can be explained by the relatively small numbers within that Ethnic group, which, in turn, is more greatly affected by the length of time in post for staff (their current salary point), which affects their mean and median values. Anomalies identified with doctors pay on the Associate Specialist or Specialty Doctor pay scales was due to the starting salary (or the salary they moved across to from the old contract), which was laid down in accordance with national terms and conditions of service. Progression is by increments on the new contracts (and a mixture of increments and discretionary point on the old Associate Specialist contract). The salary on the new contracts will also be dependent on the amount of out of hours work individuals undertake. In some (A&E, Trauma and Orthopaedics and Anaesthetics) it is great in others it is minimal or non-existent. Executive salaries are determined by the Trust's remuneration committee. Salaries have not been uplifted since 01 April 2010, in line with the national pay freeze. Based on the results of the latest audit, it was concluded that there were no equal pay concerns that required attention. Any disparities were explained by either the use of a generic pay code (as in the case of doctors) that covers a wide range of duties or a combination of service/incremental points progression, which is a consequence of national terms and conditions.	☑

A representative and supported workforce	3.3	**Training and development opportunities are taken up and positively evaluated by all staff** **Grade** ☐ Undeveloped ☑ Developing ☐ Achieving ☐ Excelling **Which protected characteristics fare well** ☑ Age ☑ Disability ☐ Gender Reassignment ☑ Marriage and civil Partnership ☐ Pregnancy and Maternity ☑ Race ☑ Religion and Belief ☑ Sex ☑ Sexual Orientation **Evidence drawn upon for rating** All training and development opportunities are made available to all staff. Each PDR also involves a thorough discussion with staff members on any training and development opportunities that might be helpful in assisting them in their role. The trust is launching a stepping up programme to encourage more of our BME staff to progress through the ranks of the organisation. The learning and development team monitor the application / attendance data of each of the programmes and study leave.	☑
A representative and supported workforce	3.4	**When at work, staff are free from abuse, harassment, bullying and violence from any source** **Grade** ☐ Undeveloped ☑ Developing ☐ Achieving ☐ Excelling **Which protected characteristics fare well** ☑ Age ☑ Disability ☐ Gender Reassignment ☑ Marriage and civil Partnership ☐ Pregnancy and Maternity ☑ Race ☑ Religion and Belief ☑ Sex ☑ Sexual Orientation **Evidence drawn upon for rating** Allegations of any bullying or harassment are investigated and action plans made . We have three staff networks who work to promote equality and inclusion within the trust and highlight areas of concern and good practice across the organisation. Along side both of theses we have ten speak up guardians who advice and support staff to raise concerns.	☑

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<td>A representative and supported workforce</td>
<td>3.5</td>
<td>
Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives

Grade | Which protected characteristics fare well | Evidence drawn upon for rating

☐ Undeveloped
☐ Developing
☑ Achieving
☐ Excelling

☑ Age
☑ Disability
☐ Gender Reassignment
☑ Marriage and civil Partnership
☐ Pregnancy and Maternity
☑ Race
☑ Religion and Belief
☑ Sex
Sexual Orientation

Staff can request flexible working options in accordance with the Trust flexible working policy. Each request is considered on its own merits to ensure that the requirements of the service as well as personal requirements/needs are met. Requests are considered both as part of the formal PDR process but also routinely through regular 1:1 meetings.

The trust also promotes job share opportunities for staff.
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<tr>
<td>A representative and supported workforce</td>
<td>3.6</td>
<td>
Staff report positive experiences of their membership of the workforce

Grade | Which protected characteristics fare well | Evidence drawn upon for rating

☐ Undeveloped
☐ Developing
☑ Achieving
☐ Excelling

☑ Age
☑ Disability
☐ Gender Reassignment
☑ Marriage and civil Partnership
☐ Pregnancy and Maternity
☑ Race
☑ Religion and Belief
☑ Sex
☑ Sexual Orientation

Throughout the Trust there are a number of engagement methods used to ensure employees are informed, engaged, have their views heard and able to influence. These include initiatives such as daily electronic Staff bulletins, Monthly Hot Topic meetings chaired by the Chief Executive or other members of the Executive team, Staff Magazine, local departmental meetings. Staff views are also sought via staff surveys and other consultations taking place within the Trust.
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Date of EDS2 grading December 2017			**Date of next EDS2 grading** December 2018
Goal 4	Outcome	Grade and reason for rating	**Outcome links to an Equality Objective**
Inclusive leadership	4.1	**Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations** **Grade** ☐ Undeveloped ☑ Developing ☐ Achieving ☐ Excelling **Which protected characteristics fare well** ☑ Age ☑ Disability ☐ Gender Reassignment ☐ Marriage and civil Partnership ☐ Pregnancy and Maternity ☑ Race ☑ Religion and Belief ☑ Sex ☑ Sexual Orientation **Evidence drawn upon for rating** The Trust, through the Chair and C.Exec, is heavily engaged in the homeless, getting unemployed back in to work projects and working with charitable trusts, Job Centre Plus and other agencies. They were the instigators of the Learning Works creation which is an innovative (and the first in the NHS) entity to transform recruitment and develop the local community into work ready recruits. The Learning Works is an HSJ award winner. The project has gained both regional and national recognition by winning regional awards and coming runner up in 4 national awards. This was been topped off by a visit to the scheme by HRH Prince William, Duke of Cambridge. The Trust, in partnership with Summerfield Residents Association has brought back to life the greenhouses on the City Hospital site that had remained derelict for over 15 years. In addition to the support from the residents association there has been involvement from The Princes Trust, Lloyds Banking Group and the Health Futures University Technical College. This has involved young school pupils as well as local residents of all ages.	☑

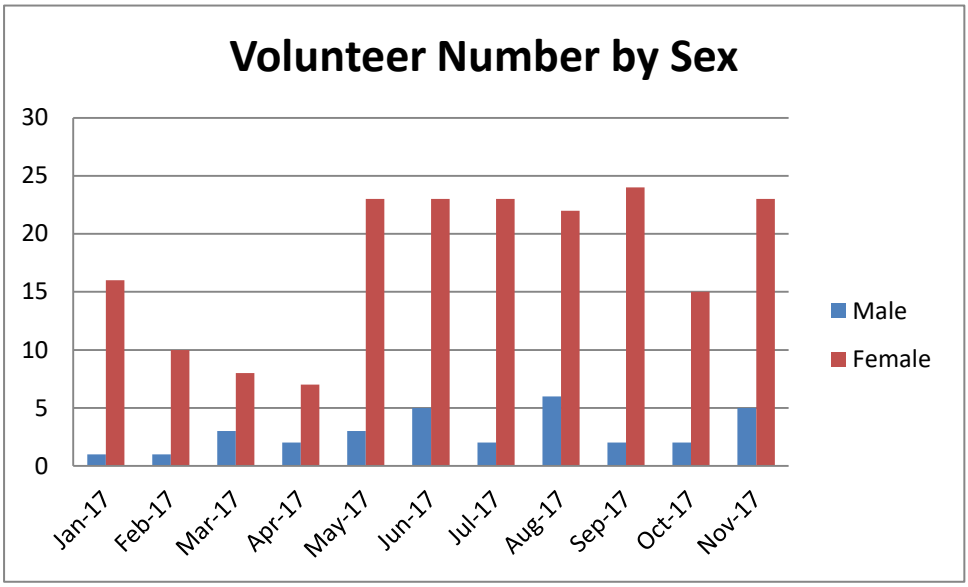
Inclusive leadership	4.2	**Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed** **Grade** ☐ Undeveloped ☑ Developing ☐ Achieving ☐ Excelling **Which protected characteristics fare well** ☑ Age ☑ Disability ☐ Gender Reassignment ☑ Marriage and civil Partnership ☐ Pregnancy and Maternity ☑ Race ☑ Religion and Belief ☑ Sex ☑ Sexual Orientation **Evidence drawn upon for rating** Papers that are developed and prepared for the Board and other Board committees follow the set templates agreed within the organisation. As part of this process key risks related to the contents of the paper are identified, however equality related impacts are not necessarily identified on each occasion. This is an area that requires development/improvement.	☑

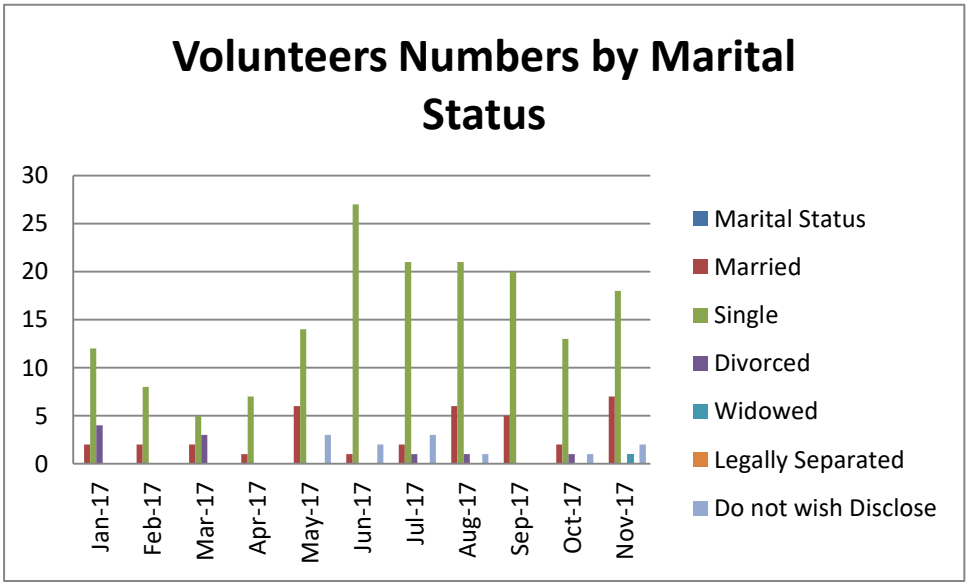
Inclusive leadership	4.3	**Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination** **Grade** ☐ **Undeveloped** ☐ **Developing** ☑ **Achieving** ☐ **Excelling** **Which protected characteristics fare well** ☑ Age ☐ Disability ☐ Gender Reassignment ☑ Marriage and civil Partnership ☐ Pregnancy and Maternity ☑ Race ☑ Religion and Belief ☑ Sex ☑ Sexual Orientation **Evidence drawn upon for rating** All staff have access to Mandatory Equality and Diversity training sessions and policies. All staff are given the opportunity to discuss any issues or concerns through the regular one to one meetings and annual PDR's, any concerns would be dealt with on an individual basis. The second year of the SWBH Accredited Manager programme has a dedicated Diversity and Inclusion Module	☑

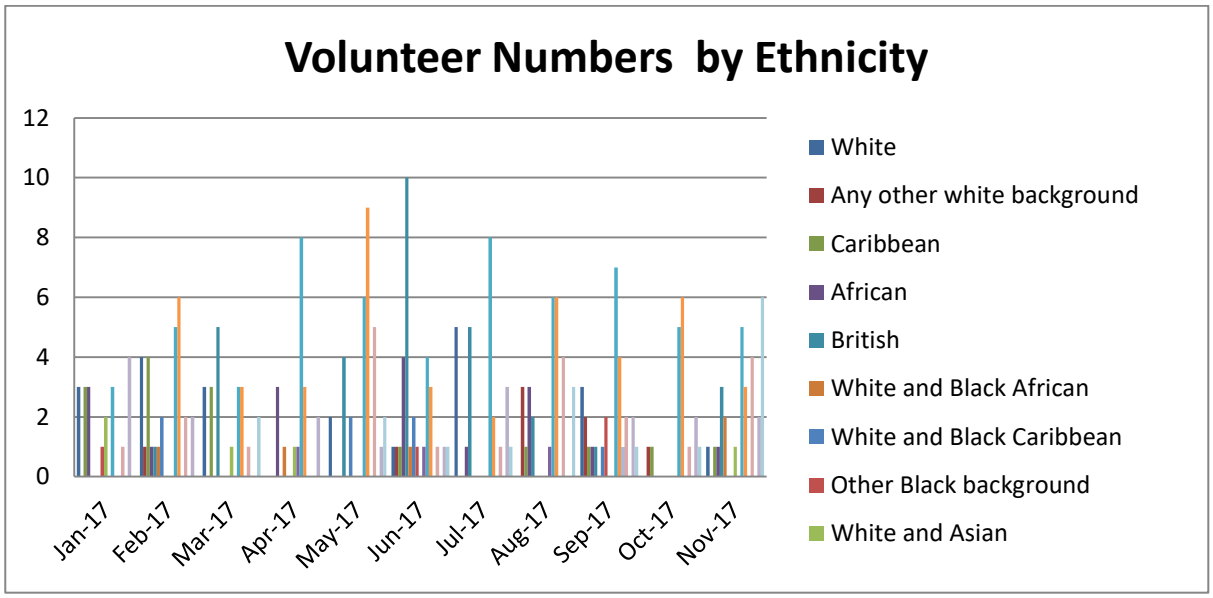
Volunteer Equality and Diversity Monitoring Information

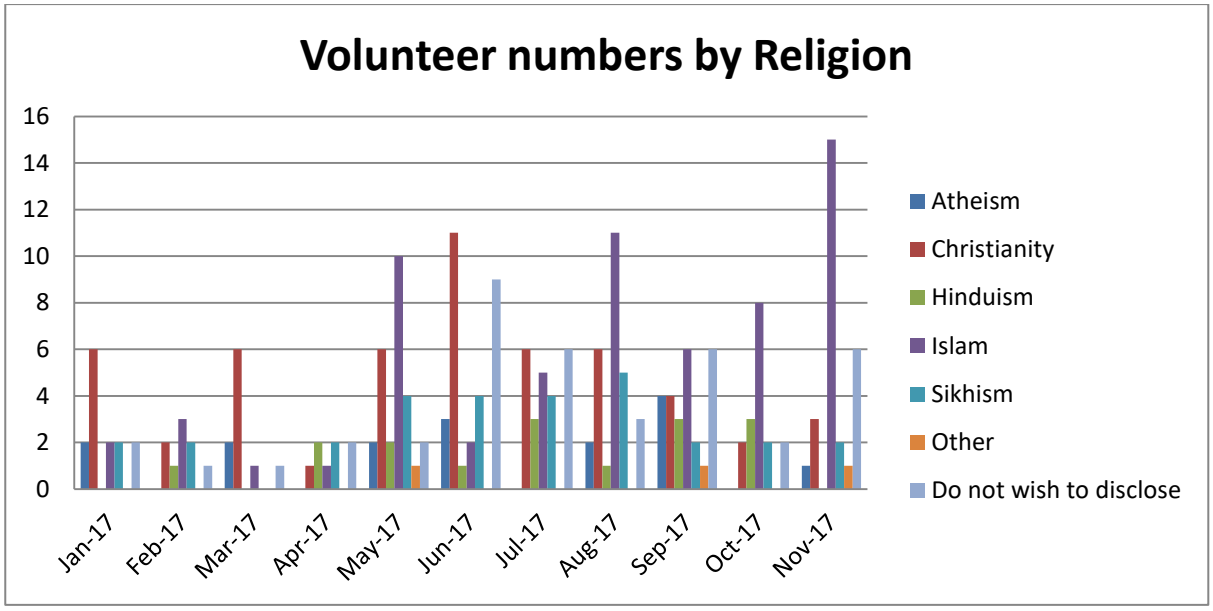
Equality Act 2010

The Equality Act 2010 protects people against discrimination on the grounds of age, sex, sexual orientation, religion and belief, ethnicity, disability, marriage and civil partnership, pregnancy and maternity and gender reassignment.







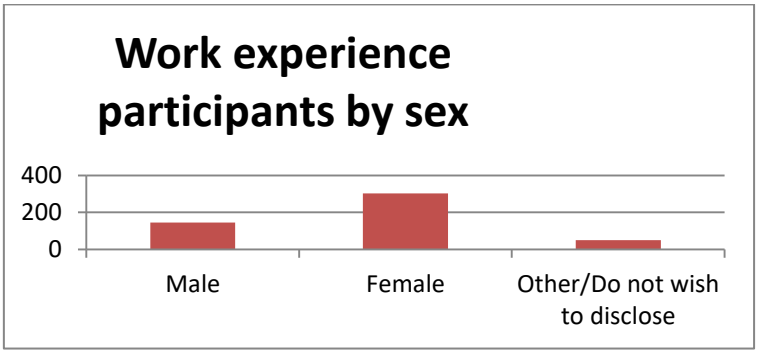


Apprentices – January 2017 – December 2017

Gender		Age		Religion		Ethnicity		Sexual Orientation		Marital Status		Disability	
Male	21	16-18	44	Atheist		Bangladeshi	0	Heterosexual		Married	8	Physical	0
Female	83	19-24	35	Christian		White British	70	Bisexual		Single	67	Mental Health	0
		25-30	5	Islam		Pakistani	7	Nondisclosure	104	Non-disclosure	29	Learning Difficulty	1
		30-40	6	Jain		British African	1					Unspecified	103
		40-50	9	Sikh		Irish	1						
		50-65	5	Hindu		Caribbean Black	6						
				Other		Black & White Caribbean	4						
				Non-disclosure	104	British Indian	6						
						White & Asian	1						
						Other Mixed	1						
						Non disclosure	7						
Totals	104		104		104		104		104		104		104

Work Experience participants, split by sex

Participant total	Male	%	Female	%	Other/Do not wish to disclose	%
497	145	29%	303	61%	49	10%

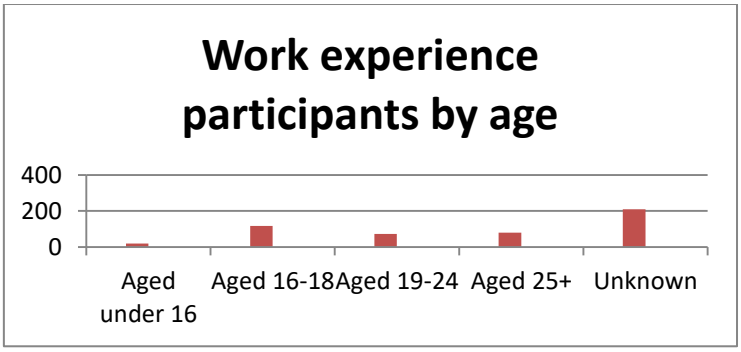


Work Experience participants with a declared disability

Total	Number of participants with declared disability	%
497	5	1

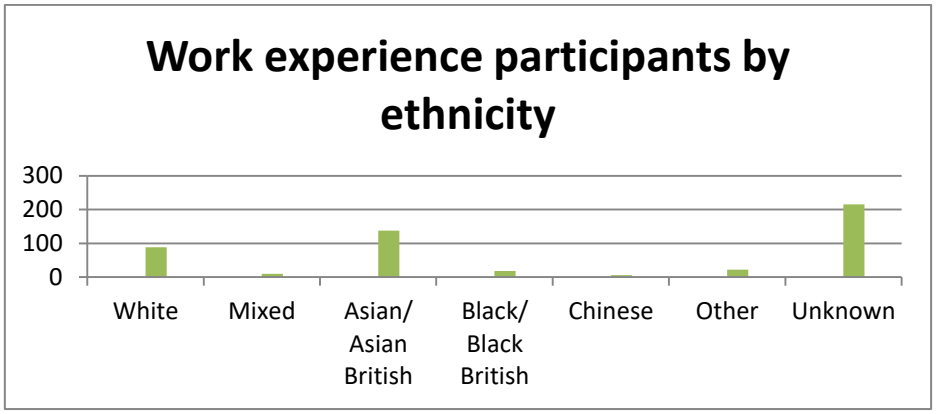
Work Experience participants, split by age

Participant total	Aged under 16	%	Aged 16-18	%	Aged 19-24	%	Aged 25+	%	Unknown	%
497	19	4%	117	23%	73	15%	79	16%	209	42%



Work Experience participants, split by ethnicity

Total	White	%	Mixed	%	Asian/ Asian British	%	Black/ Black British	%	Chinese	%	Other	%	Unknown	%
497	88	18 %	10	2%	138	28%	18	4%	6	1%	22	4%	215	43 %



Appendix 7

Traineeship participants, split by gender

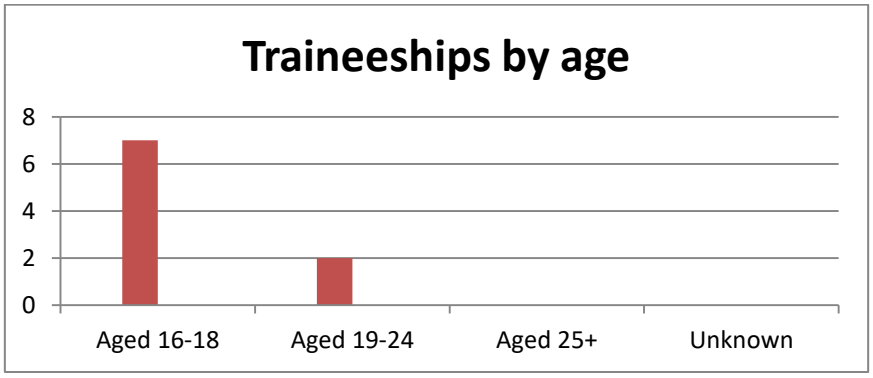
Participant total	Male	%	Female	%	Other/Do not wish to disclose	%
9	0	0%	9	100%	0	0%

Traineeship participants, split by disability

Total	Number of participants with declared disability	%
9	0	0%

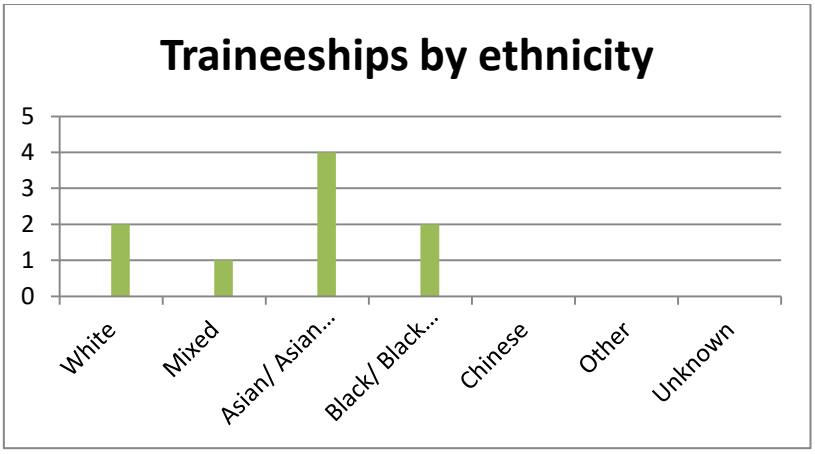
Traineeship participants, split by age

Participant total	Aged 16-18	%	Aged 19-24	%	Aged 25+	%	Unknown	%
9	7	78%	2	22%	0	0%	0	0%



Total	White	%	Mixed	%	Asian/ Asian British	%	Black/ Black British	%	Chinese	%	Other	%	Unknown	%
9	2	22%	1	11%	4	44%	2	22 %	0	0%	0	0%	0	0%

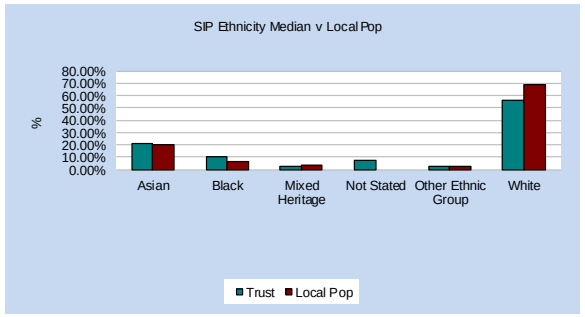
Traineeship participants, split by ethnicity

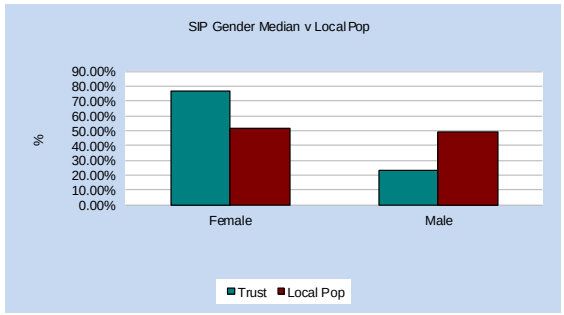


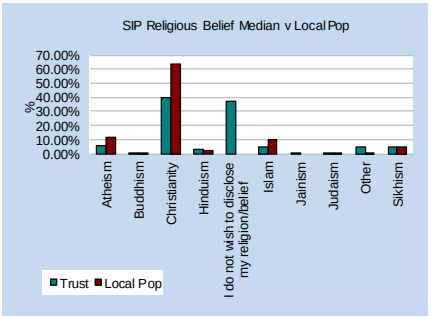
Diversity (SIP) Scorecard

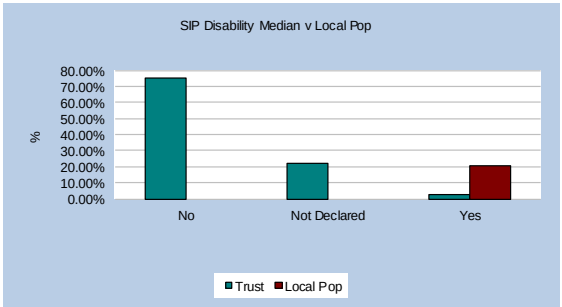
All Data from ESR, unless stated otherwise.

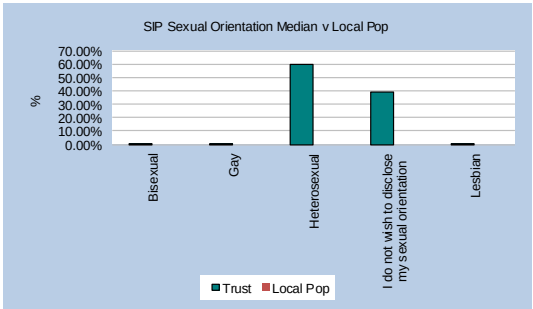
		Jan-17		Feb-17		Mar-17		Apr-17		May-17		Jun-17		Jul-17		Aug-17		Sep-17		Oct-17		Nov-17		Comparison	
Component	Category	FTE	HC	FTE	HC	FTE	HC	FTE	HC	FTE	HC	FTE	HC	FTE	HC	FTE	HC	FTE	HC	FTE	HC	FTE	HC	Trust	Local Pop
Ethnicity	Asian	1,264.54	1,407	1,287.73	1,431	1,289.75	1,433	1,287.51	1,435	1,290.31	1,439	1,286.16	1,438	1,277.56	1,431	1,278.15	1,431	1,279.64	1,435	1,269.08	1,425	1,291.34	1,448	**21.14%**	**19.69%**
	Black	629.32	720	643.51	739	646.39	741	648.95	741	647.64	739	653.42	746	658.81	750	652.80	745	643.92	736	665.67	758	679.51	771	**10.67%**	**6.16%**
	Mixed Heritage	146.19	166	142.20	162	140.88	161	142.28	163	143.01	164	146.63	168	146.25	168	152.30	173	158.67	180	169.82	193	170.90	194	**2.40%**	**3.08%**
	Not Stated	458.15	534	453.89	531	447.69	525	444.32	521	439.69	517	437.11	513	435.77	511	428.40	503	426.98	500	428.82	501	438.97	512	**7.22%**	**0.00%**
	Other Ethnic Group	152.75	163	152.48	163	152.48	163	153.26	164	153.90	165	154.08	166	155.08	167	155.65	167	156.24	169	158.03	171	158.98	172	**2.53%**	**2.07%**
	White	3,448.34	3,984	3,469.75	4,005	3,456.04	3,989	3,438.02	3,968	3,421.03	3,951	3,409.07	3,936	3,392.39	3,920	3,374.10	3,902	3,381.14	3,916	3,364.45	3,888	3,404.87	3,935	**56.04%**	**68.99%**
Gender	Female	4,652.60	5,454	4,699.10	5,506	4,690.13	5,496	4,673.67	5,479	4,663.07	5,469	4,658.08	5,465	4,645.14	5,451	4,625.55	5,431	4,642.63	5,456	4,670.41	5,476	4,736.74	5,549	**76.55%**	**51.10%**
	Male	1,446.69	1,520	1,450.44	1,525	1,443.08	1,516	1,440.67	1,513	1,432.51	1,506	1,428.39	1,502	1,420.71	1,496	1,415.85	1,490	1,403.96	1,480	1,385.45	1,460	1,407.82	1,483	**23.45%**	**48.90%**
Disability	No	4,537.63	5,144	4,588.98	5,201	4,583.96	5,196	4,573.85	5,186	4,578.58	5,195	4,582.61	5,202	4,575.95	5,198	4,569.38	5,189	4,578.95	5,208	4,594.04	5,220	4,665.27	5,298	**75.31%**	
	Not Declared	1,401.04	1,647	1,397.90	1,645	1,386.77	1,631	1,377.33	1,620	1,353.24	1,593	1,338.73	1,576	1,323.84	1,558	1,309.66	1,543	1,308.67	1,543	1,302.72	1,531	1,313.72	1,543	**22.02%**	
	Yes	160.61	183	162.67	185	162.48	185	163.16	186	163.77	187	165.13	189	166.06	191	162.36	189	158.97	185	159.10	185	165.57	191	**2.68%**	**20.69%**
Religious Belief	Atheism	350.58	381	354.62	384	351.64	381	351.15	379	348.59	377	349.60	377	350.77	379	354.57	382	350.54	379	359.74	389	369.77	401	**5.76%**	**11.44%**
	Buddhism	20.31	22	22.03	24	22.03	24	24.73	27	25.46	28	24.46	27	23.46	26	23.46	26	23.46	26	22.79	26	23.79	27	**0.39%**	**0.21%**
	Christianity	2,416.23	2,750	2,447.98	2,786	2,448.04	2,784	2,446.42	2,780	2,438.26	2,773	2,434.37	2,767	2,436.93	2,771	2,426.68	2,762	2,420.70	2,759	2,419.08	2,754	2,445.15	2,783	**39.99%**	**63.88%**
	Hinduism	159.59	176	168.35	185	170.05	187	167.27	184	167.43	183	168.30	185	169.90	187	171.56	189	163.56	182	159.76	179	162.12	181	**2.75%**	**1.98%**
	I do not wish to disclose	2,296.43	2,687	2,291.63	2,683	2,279.30	2,668	2,265.06	2,654	2,250.17	2,636	2,244.87	2,631	2,218.88	2,602	2,199.99	2,582	2,213.13	2,595	2,193.53	2,565	2,224.69	2,597	**36.84%**	**0.00%**
	Islam	283.42	317	289.88	324	288.20	323	283.17	319	285.19	323	284.68	324	285.98	325	287.51	326	290.96	331	305.22	345	315.29	355	**4.72%**	**9.47%**
	Jainism	3.00	3	3.00	3	2.00	2	2.00	2	2.00	2	2.00	2	2.00	2	2.00	2	2.00	2	3.00	3	3.00	3	**0.03%**	**0.00%**
	Judaism	3.00	3	3.00	3	3.00	3	4.00	4	4.00	4	4.00	4	4.00	4	4.00	4	6.70	7	6.42	7	6.42	7	**0.07%**	**0.14%**
	Other	295.38	327	298.66	332	299.42	334	301.71	337	306.49	343	307.29	344	308.29	346	308.99	346	307.08	348	317.08	359	321.42	365	**5.04%**	**0.21%**
	Sikhism	272.34	309	271.39	308	269.54	306	268.82	306	268.00	306	266.91	306	265.65	305	262.65	302	268.47	307	269.26	309	272.90	313	**4.41%**	**4.90%**
Sexual Orientation	Bisexual	16.39	19	18.31	21	18.16	21	17.36	20	17.77	21	18.41	22	18.21	22	18.21	22	19.21	23	18.37	22	18.37	22	**0.30%**	
	Gay	50.56	52	51.95	53	52.95	54	52.95	54	51.75	53	48.75	50	47.83	49	46.83	48	42.83	44	39.44	41	40.44	42	**0.80%**	
	Heterosexual	3,577.55	4,030	3,633.17	4,091	3,631.07	4,087	3,628.63	4,083	3,622.27	4,081	3,628.62	4,089	3,640.41	4,104	3,638.81	4,104	3,635.79	4,112	3,670.32	4,146	3,732.70	4,215	**59.65%**	
	I do not wish to disclose	2,436.05	2,854	2,426.39	2,846	2,410.50	2,829	2,396.88	2,816	2,385.25	2,801	2,372.16	2,787	2,341.87	2,754	2,319.82	2,729	2,330.03	2,738	2,309.89	2,709	2,334.32	2,734	**38.95%**	
	Lesbian	18.73	19	19.73	20	20.53	21	18.53	19	18.53	19	18.53	19	17.53	18	17.73	18	18.73	19	17.83	18	18.73	19	**0.30%**	





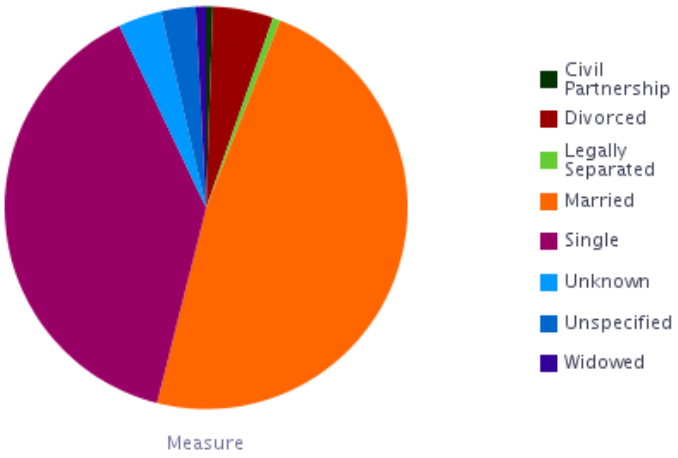






Marital Status

Marital Status	Headcount	%	FTE
Civil Partnership	45	0.64	40.03
Divorced	359	5.14	319.64
Legally Separated	42	0.60	35.64
Married	3,631	52.00	3118.48
Single	2,566	36.75	2315.63
Unknown	244	3.49	227.44
Unspecified	40	0.57	34.92
Widowed	56	0.80	48.43
Grand Total	**6,983**	**100.00**	**6140.20**



Patient Data Disaggregated by Sex

A&E	Count
BOTH	89
Female	87109
Male	92432
Total	179630
Inpatient	
BOTH	11
Female	74396
Male	59041
Not Known	1
Total	133449
Outpatient	
BOTH	2
Female	577432
Male	390562
Not Known	2
Total	967998
Grand Total	1281077

Patient Data Disaggregated by Age

A&E	Count
Age Between 00-12	25508
Age Between 13-18	11527
Age Between 19-40	62108
Age Between 41-60	42016
Age Between 61-80	26685
Age Between 81+	11786
Total	179630
Inpatient	
Age Between 00-12	15580
Age Between 13-18	3010
Age Between 19-40	27178
Age Between 41-60	29680
Age Between 61-80	38860
Age Between 81+	19141
Total	133449
Outpatient	
Age Between 00-12	57052
Age Between 13-18	26897
Age Between 19-40	267851
Age Between 41-60	260559
Age Between 61-80	274677
Age Between 81+	80962
Total	967998
Grand Total	1281077

Patient Data Disaggregated by Ethnicity

A&E	Count
Any Other Ethnic Group	7243
Asian/Asian Brit - Bangladeshi	4574
Asian/Asian Brit - Indian	19598
Asian/Asian Brit - Pakistani	14073
Asian/Asian Brit-any oth Asian b/g	5282
Black/Blk Brit-African	4025
Black/Blk Brit-Caribbean	11835
Not Stated	4204
Other	9788
Unknown	23164
White - any other White b/g	11482
White - British	64362
Total	179630
Inpatient	
Any Other Ethnic Group	3800
Asian/Asian Brit - Bangladeshi	3598
Asian/Asian Brit - Indian	14274
Asian/Asian Brit - Pakistani	8974
Asian/Asian Brit-any oth Asian b/g	2398
Black/Blk Brit-African	3048
Black/Blk Brit-Caribbean	9395
Not Stated	3472
Other	6516
Unknown	13277
White - any other White b/g	8763
White - British	55934
Total	133449
Outpatient	
Any Other Ethnic Group	24683
Asian/Asian Brit - Bangladeshi	27690
Asian/Asian Brit - Indian	116563
Asian/Asian Brit - Pakistani	72455
Asian/Asian Brit-any oth Asian b/g	19584
Black/Blk Brit-African	24226
Black/Blk Brit-Caribbean	65348
Not Stated	35448
Other	45446
Unknown	101599
White - any other White b/g	62906
White - British	372050
Total	967998
Grand Total	1281077

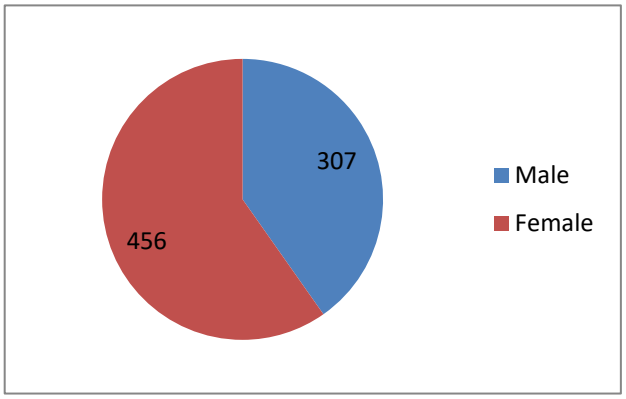
Patient Data Disaggregated by Religion

A&E	Count
Church of England	34427
Ismaili Muslim	365
Not Religious	2900
Other	23
Unknown	141832
Patient Religion Unknown	21
Buddhist	29
Religion (Other Not Listed)	5
Romanian Orthodox	7
Native American Religion	5
Old Catholic	4
Nonconformist	8
Reformed Christian	4
Total	179630
Inpatient	
Christian	8647
Church of England	36365
Hindu	3272
Ismaili Muslim	1326
Methodist	1827
Muslim	15564
Not Religious	4205
Other	5228
Religion not given - PATIENT refused	6004
Roman Catholic	7487
Sikh	9196
Unknown	34328
Total	133449
Outpatient	
Christian	46998
Church of England	192699
Hindu	21906
Ismaili Muslim	7262
Methodist	9632
Muslim	98312
Not Religious	22335
Other	29944
Religion not given - PATIENT refused	37317
Roman Catholic	41849
Sikh	56398
Unknown	403346
Total	967998
Grand Total	1281077

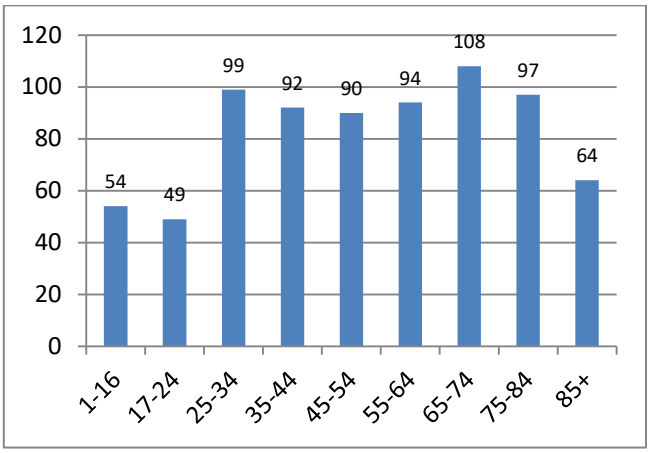
Patient Data Disaggregated by Marital Status

A&E	
Civil Partner	131
Divorced	1715
Married	21592
Not applicable	27
Not Disclosed	39
Other	129
Separated	464
Single	47297
Surviving Civil Partner	121
Unknown	105680
Widowed	2435
Total	179630
Inpatient	
Divorced	2169
Married	27611
Not Disclosed	77997
Separated	460
Single	20976
Unknown	68
Widowed	4168
Total	133449
Outpatient	
Civil Partner	915
Divorced	14083
Married	201246
Not Disclosed	279
Not Known	117
Other	789
Separated	2527
Single	160746
Surviving Civil Partner	597
Unknown	569838
Widowed	16861
Total	967998
Grand Total	1281077

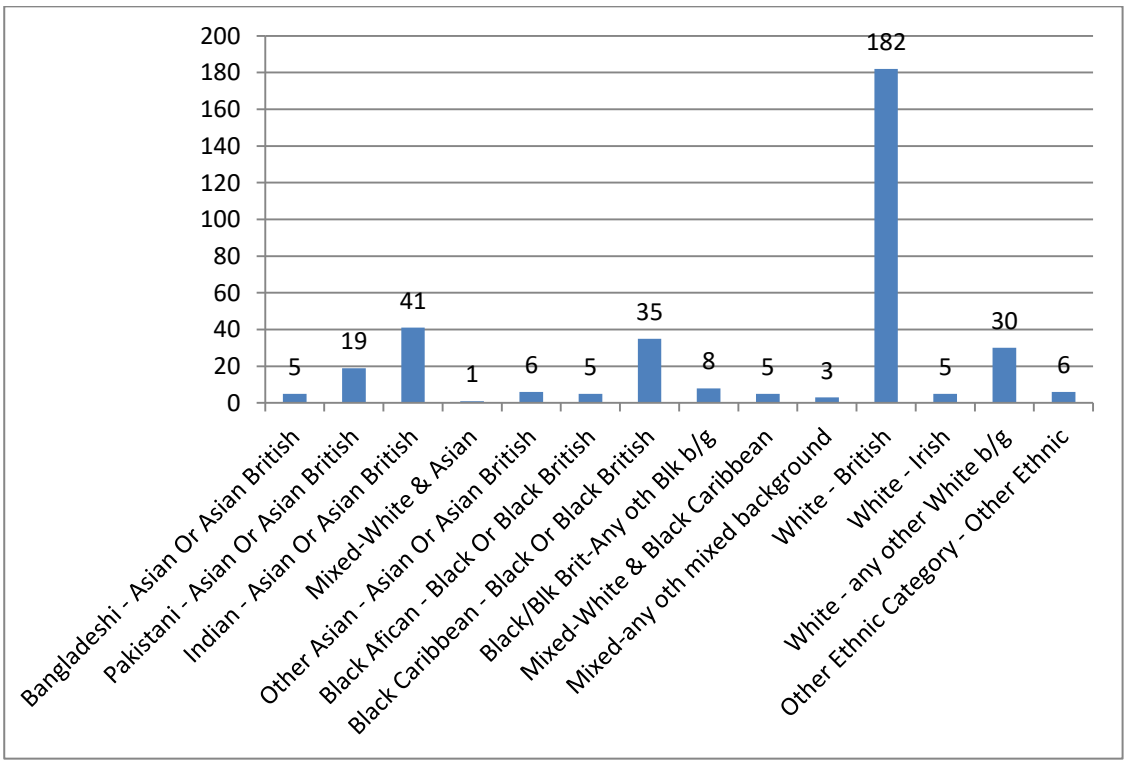
Subject of complaint – Gender
(excluding those complainants where gender not known)



Subject of complaint - Age
(excluding those complainants where age not known)



Subject of complaint – Ethnicity(excluded those complainants where ethnicity not known)



Appendix 11

Employer Evidence Template

You may use this template to record your evidence, further actions or comments for consideration as you go through your self-assessment. This will also help you if you want to become a Disability Confident Leader and have your self-assessment validated.

Employers name	**Sandwell and West Birmingham Hospitals NHS Trust**
Disability Confident Reference number	**DSC004486**
Date	**December 18th 2017**

Theme 1 – Getting the right people for your business
The employer must have agreed to all of the following actions.

Criteria **As a Disability Confident employer, my business is:**	**Evidence**	**Comments or further action required**
1. Actively looking to attract and recruit disabled people.	Attendance at the disability recruitment event hosted by Birmingham City council. Focused approach on selection on apprenticeships and paid internships	**Continue to attend these events, attendance planned in 2018** **Protected vacancies on both of these programmes in 2018/2019**
2. Providing a fully inclusive and accessible recruitment process.	On-line application process, support available from recruitment team for those who are unable to access online or computer.	**Restricted to NHS Jobs website, recruitment team offer support in uploading and completing applications forms if requested**

3. Offering an interview to disabled people who meet the minimum criteria for the job.	If this box is ticked and minimum criteria is met an interview is offered, this is monitored via central recruitment	**Reminder to all line managers from central recruitment of this policy January 2018**
4. Flexible when assessing people so disabled job applicants have the best opportunity to demonstrate that they can do the job.	Recruitment Panel Leads given guidance of locations to hold interviews, candidates given preference of site / location if access is an issue	**Variety of locations available across the site with the new Sandwell Education Centre having great disability access.**
Criteria **As a Disability Confident employer, my business is:**	**Evidence**	**Comments or further action required**
5. Proactively offering and making reasonable adjustments as required.	Any member of staff can request a reasonable adjustment to be implemented. The Trust works with Access to Work in order to ensure the correct adjustments are made for employees.	**Reasonable adjustments form part of the training package delivered to all managers within the Sickness & Absence Module**
6. Encouraging our suppliers and partner firms to be Disability Confident.	We are highlighting the Disability Confident to all of our suppliers and we will be sending a letter to all suppliers in early 2018.	**Letter being sent by the Head of Diversity and Inclusion, championing the positive impact being a disability confident employer can have**
7. Ensuring employees have sufficient disability equality awareness training.	Disability training is part of the Trust Induction process. All staff have a 1 hour induction presentation and also have a 20 minute video presentation regarding learning disability.	**The trust is launching a E-Learning module for all staff to complete in Quarter 1 2018/2019**

Theme 1 – Getting the right people for your business You must agree to at least one of the following activities.		
Activity	**Evidence (only for the activities you have agreed to in your self-assessment)**	**Comments or further action required**
1. Providing work experience.	N/A	**N/A**
2. Providing work trials.	N/A	**N/A**
3. Providing paid employment (permanent or fixed term).	N/A	**N/A**
4. Providing apprenticeships.	N/A	**N/A**
5. Providing a traineeship.	N/A	**N/A**
6. Providing paid internships or support internships (or both).	Three supported internships commenced in September 2017 in conjunction with Sandwell College.	**Currently two staff on the internship programme with a support package in place, the third is due to start in early 2018**
7. Advertising vacancies and other opportunities through organisations and media aimed particularly at	We publicise our vacancies and the trust at a variety of recruitment events including Birmingham City Council and the Department of	**We plan to advertise in Diversity Group Directory all vacancies from**

Theme 1 – Getting the right people for your business You must agree to at least one of the following activities.		
Activity	**Evidence (only for the activities you have agreed to in your self-assessment)**	**Comments or further action required**
disabled people.	work & Pensions looking at getting disabled people working within our organisation	**Quarter 1 2018/2019**
8. Engaging with Jobcentre Plus, Work Choice providers and local disabled people's user led organisations (DPULOs) to access support when required.	SWBH have a Learning Works centre and work with Job centre plus offering a variety of opportunities for local residents.	**We continue to meet with Job Centre Plus through our Learning Works Centre – finding talent to join our organisation**
9. Providing an environment that is inclusive and accessible for staff, clients and customer.	SWBH Trust has had a full Disabled Go access audit carried out and the results are available on the Disabled Go website for any disabled visitors to plan their visit.	**Disabled Go to re-visit all sites in early 2018**
10. Offering other innovative and effective approaches to encourage disabled people to apply for opportunities and supporting them when they do.	N/A	**N/A**

Theme 2 – Keeping and developing your people The employer must have agreed to all of the following actions.		
Criteria **As a Disability Confident employer, my business is:**	**Evidence**	**Comments or further action required**
1. Promoting a culture of being Disability Confident.	We have a Disability and Long Term Conditions Staff Network, who look at both patient and staff experience within our organisation and work with our Trust Board to implement change. Trust is part of MidlandsAbility	**Letters sent out on yellow paper for people with sight issues, disability access to public and staff areas within the trust, new education centre and new build Midland Metropolitan Hospital has disability access and resources as part of the implementation plan.** **Taking a more active role in Q1 2018/2019**
2. Supporting employees to manage their disabilities or health conditions.	We have a Disability and Long Term Conditions staff network for anyone with a disability or long term condition and their allies. Occupational Health (OH) have a supportive pathway to make reasonable adjustments for staff	**Network is currently working on the Trusts Patient Pledges and The Staff Pledges in regards to disability** **Recommendations are actioned by local managers both prior to and after assessment by OH**

	Ongoing training for all managers on the sickness and absence management policy – highlighting the sections on reasonable adjustments and supporting all staff to be in work	**Training forms part of the core competencies for all managers – part of the SWH Accredited Manager Scheme**
3. Ensuring there are no barriers to the development and progression of disabled staff.	All staff given access to development and annual PDR, enhanced training and roles are highlighted to all staff but in addition to this there is a focus through the Disability Staff Network to ensure that specific groups are effectively targeted	**The Trust is looking at an internal job advertising campaign in 2018 for the three staff networks – this will target email to all staff within these groups and encourage them to take the next rung on the ladder**
4. Ensuring managers are aware of how they can support staff who are sick or absent from work.	Ongoing training for all managers on the sickness and absence management policy – highlighting the sections on reasonable adjustments and supporting all staff to be in work	**Training forms part of the core competencies for all managers – part of the SWH Accredited Manager Scheme**
5. Valuing and listening to feedback from disabled staff.	We have a Disability and Long Term Conditions staff network for anyone with a disability or long term condition and their allies. This group and the Head of Diversity and Inclusion for the trust listen to staff and patient stories and look at how we as an organisation can support people into employment and how to retain staff. We also trouble shoot individual cases and facilitate them being resolved at a local level	**Network is currently working on the Trusts Patient Pledges and The Staff Pledges in regards to disability.** **Patient stories are presented to the Trust Board and ongoing action plans include:-** **Assistance Dog Policy** **Sign Language Training** **IT Software Implementation** **In Quarter 4 2017/2018 & Quarter 1**

		2018/2019 we are going to run a campaign to highlight the achievement of staff within the trust who are part of our three staff networks. LGBT, BME and Disability and Long Term Conditions
6. Reviewing this Disability Confident employer self-assessment regularly.	Initially part of the Disability Two Ticks Scheme, we are migrated across to Disability Confident and this was awarded 5th of June 2017. Reassessment completed in December 2017.	**Plan to review this assessment annually prior to the Publication of our annual report and enclose this document in the appendix**

Theme 2 – Keeping and developing your people. The employer must have agreed to take at least one of the following activities.		
Activity	**Evidence (only for the activities you have agreed to in your self-assessment)**	**Comments**
1. Providing mentoring, coaching, buddying and or other support networks for staff.	We have a staff network for anyone with a disability or long term condition and their allies.	**Network is currently working on the Trusts Patient Pledges and The Staff Pledges in regards to disability.** **There is a coaching and mentoring programme being launched in Quarter 1 2018/2019**
2. Including disability awareness equality training in our induction process.	Disability training is part of the Trust Induction process. All staff have a 1 hour induction presentation and also have a 20 minute video presentation regarding learning disability.	**There is an E-Learning platform being accessed by all staff – there will be a compulsory Diversity and Inclusion module for all staff launching Quarter 1 2018/2019**
3. Guiding staff to information and advice on mental health conditions.	Occupational Health have a specific pathway for this support that is outside the normal referral process, there is also counselling available through the trust.	**Ensure this this is highlighted in the Sickness and Absence Management training (Currently on the presentation – reassurance being sort that it is always delivered)**
4. Providing occupational health services if required.	The Trust has an Occupational Health department which staff can access on request.	**Staff have access to Occupational Health during the normal working week, outside**

		these hours there is an emergency protocol in place
5. Identifying and sharing good practice.	The Trust are actively part of the Black Country Sustainability and Transformation Partnership (STP) Equality Sub Group and we often discuss good practice Trust is part of MidlandsAbility	**Sharing of best practice and lead people is highlighted in our notes and circulated to all members of the STP** **Taking a more active role in Q1 2018/2019**
6. Providing human resource managers with specific Disability Confident training	Within the SWBH Accredited Managers scheme we have ensured that Diversity and Inclusion is a golden thread through out – there is focus on being Disability Confident	**As part of the E-Learning package there is a Module on Disability Confident which we are hoping to roll out to all manages in 2018/2019**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	On-Boarding New Colleagues
SPONSOR (EXECUTIVE DIRECTOR):	Raffaela Goodby, Director of People and Organisation Development
AUTHOR:	Raffaela Goodby – Director of People & OD Bethan Downing – Deputy Director of OD & Learning
DATE OF MEETING:	4th January 2018

EXECUTIVE SUMMARY:

The December 2017 Trust Board examined nursing turnover data, seeing a trend to nurses leaving in their first 12 months of employment, and subsequently in years 2-5. The Board asked for a specific approach to be developed for each respective issue.

This paper sets out the changes taking place across the whole of the Trust on Corporate Induction and the first 100 days on-boarding process, which will apply to, and impact upon our nursing family. This will significantly reduce the time and paperwork in becoming an employee of SWBH, including reducing form filling and making the majority of induction digital. It also introduces an independent intervention at 100 days, to ascertain how the employee is getting on in the post. Comments are welcomed from the Trust Board.

REPORT RECOMMENDATION:

Discuss on-boarding and corporate induction and comment on improvements.

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 Diversity		Workforce	X

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

New Induction Model at Sandwell and West Birmingham Hospitals NHS Trust

Launching February 2018

Summary

The purpose of this paper is to discuss the introduction of a new approach to Induction that ensures new employees to SWBH feel valued and see and feel that the induction pathway is adding value and feel supported throughout.

For the purpose of this paper, induction is categorised into four timeframes:

- Pre-start date
- First day
- First 4 weeks
- First 3 months

The proposal focuses on reducing form filling and duplication in process by ensuring that all information and training is available to access from the point of acceptance of the new role. This will be done through the exciting launch of our new Moodle website "SWBH New Employee Website" and "SWBH New Employee App". The Chief Executive had asked for these to be developed as an innovative solution and they have the benefit of reiterating that we are a Digital Trust from the start of the journey with SWBH.

The current lengthy (perceived low-value add) Corporate Induction days will be reduced significant, with all Mandatory Training porting across easily from previous NHS organisations where applicable. For those staff whom require training, this is available via the "SWBH New Employee Website/App".

Prior to starting, and during the first few months in employment, a new employee will obviously form a view about the organisation they work for. A large part of this view is determined by how supported they feel during a potentially vulnerable time in their new job. The new on-boarding process is described in detail within this paper, which will increase the support to a new employee via their line manager, new team and an additional independent process to ensure early intervention where required and learning (*both good and bad) shared across the organisation.

Background

There are many routes that a new employee can join the SWBH Family. A detailed process mapping exercise was undertaken with all teams involved in the new starter process. This included ESR, Recruitment, Information Team, IT, Volunteers, Comms, Employee Benefits and L&D and new starters. I have also carried out focus groups with employees new and existing. These interventions revealed the routes of entry as below:

- NHS jobs
- Junior Doctor Rotation
- Student Nurses
- Volunteers
- Apprenticeships

- Bank and Agency
- Contractors

There are currently 70 steps from launch of a vacant post, to a new employee undertaking their Corporate Induction at the Trust. The processes were mapped based on a new employee applying for a post via NHS jobs, the process was then reviewed against the other entry routes described above.

Assessment

A qualitative assessment then took place enabling discussion with new employees and how they felt about Induction to SWBH which has been considered within the new SWBH Induction.

No.	Issue
1	It takes too long – I want to get stuck in!
2	I didn't know anyone and found it difficult to fit straight in without any introduction to anyone.
3	The information that was important to them wasn't easy to find e.g. • How to book annual leave • How do I know what Mandatory Training I need to do
4	I kept hearing there is lots of information on "connect" but didn't know what Connect was and how to find it and knowing what is there now that would have been really useful to know on my first day
5	The time taken to get an IT account is too long and difficult
6	The process for getting badges/fobs/car parking/swipe card/smart card is disjointed and takes too long
7	It took a while to know "who is who" but I really like that on email you can see photos of staff (so you know what they look like before you meet them)
8	Staff benefits (including on-site gyms) are a great benefit but info about Staff Benefits was difficult to view on the induction slide and access to info before start date would be beneficial
9	I didn't always want to keep going to my Manager and having someone to contact more informally would have been
10	I'm up-to-date with Mandatory Training from my last Trust but I've had to do it all again
11	I wanted to get any elearning completed before I started but couldn't access

Recommendations for improvements

1. Digital Induction available from time employee accepts role at SWBH
    a. SWBH New Employee Website & App
        i. Welcome to SWBH
            1. What to expect as a new employee at SWBH (I.e this process to 3 months) Who to contact if you have any queries.
        ii. ONE form with upload your photo
            1. The information will be electronically disseminated to appropriate team for ID/Parking/OH etc

iii. Trust information (site maps, staff benefits, travel options, "How do I" FAQ's)
iv. Mandatory Training – Individualised plan with elearning and how to access non-elearning training
v. Change the 13 forms currently needed to ONE form

2. Corporate Induction (for substantive staff only)

Bank staff will have access to SWBH New Employee website but do not need to attend the Corporate Induction welcome session. This is a big change and saves time, energy and resources.

The Corporate Induction session will now include:

a. Tea/Coffee available
b. New Starter packs for all substantive employees (SWBH & Staff benefit bags/pens/paper/cups etc)
c. Executive Speaker to welcome
d. Facilitator to support session and resolve any individual queries. Preferably once per week. The size of group will be manageable to

- Distribute passes
- Demonstrate where and how to find "connect" and what sort of information is available via connect
- Check individuals MT is up-to-date and if not agree a plan and if any additional support is required
- Check all staff have an IT login and NHSmail (for staff who have had requested)

3. On-boarding – Support, Team integration & Feeling part of the SWBH Family

Pre-start date

An effective on-boarding process will reduce the likelihood of employees leaving in first few months which is important in any role but critical in hard to fill posts. On-boarding will include:

a. 1:1 with Manager prior to start date to:
    i. Meet the team
    ii. Local tour
    iii. Identify and Introduce to Buddy
    iv. Agree start date

On first day

1. Meeting with Line Manager
    a. Arrange any Local Training
    b. Appropriate Site(s) Tour with Manager or Buddy including:
        i. Costa(s), shops and restaurant
        ii. Any areas to relevant to their role

iii. Staff gyms
iv. Library

4 weeks

1. 4-week review meeting with line manager
    a. All MT has been completed
    b. First month feedback requested from new employee (and appropriate action taken)
    c. Issues and challenges discussed and a plan & support agreed

3 months

1. A three-month review will take place to objectively review the induction experience of every new substantive employee The proposal is in two parts :
    a. Firstly an anonymous survey that will enable us to identify and address any trends.
    b. Secondly in the form of a short meeting with a senior member of staff (possibly Deputy Directors). The purpose of this meeting is again for each individual to meet a senior member of the Trust demonstrating value of the new member of staff but also to gain qualitative with someone who can also sensitively probe into any concerns to ensure they are addressed.

2. PDR completed with Line Manager including objectives for remainder of PDR year.

Manager Training - Accredited Manager

The Accredited Manager modules for managing your employee's well-being and effective recruitment will be delivered during Quarter 4 of 2017/18. These modules will provide Managers with the skills to effectively recruit and ensure their staff are supported during the induction period (particularly the first 3 months in a new post). This will include training regarding effective on-boarding and also clarify expectations of the Line Managers role, pre and post day one.

Competency for all line managers will be assessed as part of the PDR via survey results and 1:1 interview outcomes where issues have arisen.

Bank Staff Bank staff will have all information provided to them via the SWBH new employee's website and are no longer required to attend Corporate Induction. The use of bank/agency staff and ensuring they are given the information is incorporated into the Accredited Manager training. This will help with Bank recruitment timings, as currently bank staff have to attend corporate induction in their own (unpaid) time.

Junior Doctors Will have access to the SWBH New Employees Website and App for information and training.

Bethan Downing – Deputy Director of OD & Learning.
28th December 2017