Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD – PUBLIC SESSION AGENDA

Venue: Anne Gibson Boardroom, City Hospital **Date:** 1st February 2018, 0930h – 1230h

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 People & OD
Miss K Dhami	(RG)	Director of Governance

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.	**Questions from members of the public**	Verbal	**Chair**
0955h	4.	**Chair's opening comments**	Verbal	**Chair**
		UPDATES FROM THE BOARD COMMITTEES		
1000h	6a	To: (a) receive the update from the Audit and Risk Management Committee meeting held on 24th January 2018 (b) receive the minutes from Audit and Risk Management Committee meeting held on 18th October 2017	SWBTB (02/18) 001 *to follow* SWBTB (02/18) 002	**MP** **MP**
1005h	6b	To: (a) receive the update from the Quality and Safety Committee held on 26th January 2018 (b) receive the minutes from the Quality and Safety Committee held on 22nd December 2017	SWBTB (02/18) 003 *to follow* SWBTB (02/18) 004	**OD** **OD**

Time	Item	Title	Reference Number	Lead
1010h	6c	To: (a) receive the update from the Finance and Investment Committee held on 26th January 2018 (b) receive the minutes from the Finance and Investment Committee held on 22nd December 2017	SWBTB (01/18) 005 *to follow* SWBTB (01/18) 006	**MH** **MH**
1015h	6d	To: (c) receive the update from the People and OD Committee held on 26th January 2018 (d) receive the minutes from the People and OD Committee held on 25th September 2018	SWBTB (01/18) 007 *to follow* SWBTB (01/18) 008	**HK** **HK**
	MATTERS FOR APPROVAL OR DISCUSSION			
1020h	**7.**	**Chief Executive's Report**	SWBTB (02/18) 009	**TL**
1035h	**8.**	**Strategic Board Assurance Framework**	SWBTB (02/18) 010	**KD**
1045h	**9.**	**Trust Risk Register**	SWBTB (02/18) 011	**KD**
1050h	**10.**	**Perinatal Mortality Review Update**	SWBTB (02/18) 012	**EN**
1105h	**11.**	**Integrated Quality & Performance Report**	SWBTB (02/18) 013	**TW**
	11.1	**IPR Persistent Reds – P09 December 2017**	SWBTB (02/18) 014	**TW**
	11.2	**52 Week RTT Breach Analysis**	SWBTB (02/18) 015	**RB**
1120h	**12.**	**Financial Performance - P09 December 2017**	SWBTB (02/18) 016	**TW**
1135h	**13.**	**Winter Plan**	SWBTB (02/18) 017	**RB**
1150h	**14.**	**Trust Evacuation and Shelter Proposal**	SWBTB (02/18) 018	**RB**
1205h	**15.**	**Purple Phone Points**	SWBTB (02/18) 019	**KD**
	UPDATE ON ACTIONS ARISING FROM PREVIOUS MEETINGS			
1215h	**16.**	**Minutes of the previous meeting and action log** (a) To approve the minutes of the meeting held on 4th January 2018 as a true/accurate record of discussions (b) Update on actions from previous meetings (action log)	SWBTB (02/18) 020 SWBTB (02/18) 021	**Chair** **Chair**
	17.	**Matters arising**	Verbal	**Chair**
	MATTERS FOR INFORMATION			
1220h	**18.**	**Q3 Complaints Report**	SWBTB (02/18) 022	**KD**
1225h	**19.**	**Any other business**	Verbal	
	20.	**Details of next meeting** The next public Trust Board meeting will be held on **Thursday 1st March 2018 at 09:30am in The Cap Centre, Windmill Lane, Smethwick B66 3LX**		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Audit and Risk Committee

Venue Anne Gibson Committee Room, City Hospital **Date** 18th October 2017; 1000h – 1200h

Present

Members Present		**In Attendance**
Ms M Perry	Chair	Miss K Dhami
Mr H Kang	Non-Executive Director	Mr T Waite
		Mr T Reardon
		Ms C Dooley
		Ms N Coombe
		Mr A Hussain
		Mr B Vaughan
		Ms L Goodwin
		Mrs E Quinn

Minutes	**Paper Reference**
1 Welcome, apologies and declarations of interest	**Verbal**
Ms Perry welcomed all present to the meeting. Apologies had been received from Olwen Dutton, Waseem Zaffar, Elaine Newell and Mark Stocks.	
2 Minutes of the previous meeting held on 19th July 2017	**SWBAR (10/17) 002**
The minutes of the previous meeting held on 19th July 2017 were agreed as a true record.	
3 Matters and actions arising from previous meetings	**SWBAR (10/17) 003**
Declaration of interest returns Miss Dhami reported that the 2017/18 process for declarations of interest will be to focus on the Trust's top leaders (around 180 staff members), to ensure a more manageable process. The declarations of interest policy will be reviewed and updated to ensure that staff are aware of the expectation of them. This will be presented at the next Committee meeting in January 2018. The Committee noted that all other actions arising were to be discussed as part of the agenda.	
4 Strategic Board Assurance Framework: Q2 Update	**SWBAR (10/17) 004**

The Committee received the updated Q2 position on the Board Assurance Framework (BAF), which was noted to have been reviewed and updated by Executive leads. The Committee is to have oversight of the BAF; the various Board sub-committees will be required to own/pick up relevant risks – agendas will need to include strategic BAF risks and report to the Board bi-monthly. Ms Dooley is to ensure that agendas are reflected accordingly and will establish a process to monitor compliance. An internal audit review of the BAF will take place later in 2017/18.

Ms Perry thanked those involved for the improved arrangements.

5 Governance Pack	**SWBAR (10/17) 005**

Mr Reardon presented the Governance Pack that outlines the Trust's performance in relation to aged debt, losses and special payments, salary overpayments and single tender waivers (STW).

In terms of aged debt, Mr Reardon highlighted the on-going issue with the CCG, which had compacted the position by approximately £400k and had not been expected. A revenue loan was being considered, with a view to it being drawn in January 2018 however, this may need to be brought forward if the position with the CCG does not improve.

In terms of losses and special payments, the Committee noted the proposed write-offs. Overseas debt continues to be subject to the Trust's dunning cycle, to include escalation to debt recovery firms. Resolution is anticipated by taking payment upfront, which will become a requirement in most circumstances from 23rd October 2017. The Trust will be putting its own team in place to take payments on-site later in the year.

6 Legal Services: Q2 Update	**SWBAR (10/17) 006**

The Committee received the Quarter 2 update that provides an overview of the number and type of clinical and non-clinical claims that have been made against the Trust, together with an update on the identification and charging of overseas visitors. Miss Dhami highlighted negligence claims in relation to slips, trips and falls that were noted to be clustered to Facilities and Estates staff. A piece of work is to be undertaken with the relevant Heads of Department around staff awareness/compliance/mandatory training in this respect. Mr Kang, in his role as Chair of the Workforce Committee, is to follow-up the issues in relation to Mandatory training.

Further work will also be undertaken in relation to learning from table-top reviews to understand the reasons why lessons are not being learned/actions implemented.

7 External Audit – Progress report and emerging issues and developments	**SWBAR (10/17) 007**

The Committee received the progress report. Ms Coombe reported that the quality accounts report will be brought to the next Committee meeting in January. She highlighted that the Committee would be asked to challenge and confirm the Trust's year end accounting treatment in relation to the land disposal.

The Trust's statutory financial obligations/break even duty was highlighted. Ms Perry asked that this data/forecast is periodically included within the finance reporting pack to the Board.

8 Internal Audit Progress Report	**SWBAR (10/17) 008**

Mr Hussain presented the progress report and summarised that seven reports had been finalised since the date of the last meeting. These were noted to be: General Ledger, Cash Management, Accounts Receivable, Charitable Funds, Payroll, Accounts Payable and Compliance with Overseas Visitors Charging Policy. In terms of the latter, internal Audit colleagues are to provide support in relation to ensuring the systems the Trust has in place for collecting payments for Overseas visitors are effective.

The Committee noted that the position in terms of closed audit recommendations was much improved. Ms Perry congratulated those involved who helped to ensure this improved reporting/position.

An Information Governance (I.G.) review is to be undertaken by internal audit colleagues in advance of the national GDPR changes in May 2018. This will be organised via the newly appointed Head of I.G. once she has commenced in post.

9 Data Quality Progress Report	**SWBAR (10/17) 009**

Mr Hussain updated the Committee on the work that had been undertaken as part of the data quality assurance plan 2017/18. Analysis of the Integrated Performance Report (IPR) highlighted that:

- There were 61 new key performance indicators (KPIs) with Kitemarks shown on the IPR which required the completion of a data quality Kitemark;
- 48 Kitemarks recorded against KPIs that had one or more Red Segments highlighting an area of weakness;
- 7 Previously identified KPIs which had Kitemarks that had one or more Red segments that are now showing Green on the IPR; and
- 9 Kitemarks that had no Executive Sign-off.

The data quality Kitemarks have since been re-visited, refreshed and updated to ensure that they reflect current practice.

The Committee noted there was a need to ensure that the data quality work stream picks up the work on kitemark indicators, and is aligned with the Trust's IPR reporting.

10 Local Counter Fraud Specialist (LCFS) Progress Report	**SWBAR (10/17) 010**

The Committee received and noted the update on progress against the 2017/18 counter fraud work plan. Mr Vaughan highlighted the reactive cases that had been received and progresses by the LCFS, together with details of the activities scheduled to be undertaken prior to the next Committee meeting in January 2018.

The Committee noted that LCF processes will need to align to GDPR prior to April 2018 and be reported at the Committee.

11 Committee effectiveness: self-assessment	**SWBAR (10/17) 011**

Based on national best practice formats, a questionnaire will be circulated to all Committee members for completion/return to the Head of Corporate Governance to ascertain Committee effectiveness. The results from this review will be reported to the Committee in January 2018.

12 Draft Committee 2018/19 work plan and meeting dates	**SWBAR (10/17) 012**

The Committee received the draft work plan and noted this will need to be reviewed to ensure it dovetails with year-end/ external obligations for 2017/18.

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

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

a) Positive update from internal audit in terms of completed actions/recommendations;
b) Positive feedback from the Local Counter Fraud Specialist (LCFS) in terms of reactive reporting.
(a) Break even duty to be included in the finance reporting/pack;
(b) Challenge on 'red' segments in IPR and actions to close off;
(c) GDPR assessment process/alignment of internal audit to Governance team.

14 Any other business	**Verbal**

There was no other business.

Details of the next meeting

The next meeting will be held on 24th January 2018 at 1000 – 1200h in the Anne Gibson Committee Room, City Hospital.

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUALITY AND SAFETY COMMITTEE MINUTES

Venue Anne Gibson Committee Room, City Hospital **Date** 22nd December 2017; 1030 - 1200

Members attending:		**In attendance:**	
Ms. O. Dutton	Non-Executive Director & Chair	Mrs. S. Cattermole	Executive Assistant
Mrs. E. Newell	Chief Nurse		
Mr. T. Waite	Executive Director of Finance		
Miss K. Dhami	Director of Governance		
Ms. R. Barlow	Chief Operating Officer		
Ms. C. Parker	SWBH CCG		

Minutes	**Paper Reference**
1. Welcome, apologies for absence and declarations of interest	**Verbal**
Apologies were received from Mr. R. Samuda and Ms. M. Perry. The members present did not have any interests to declare.	
2. Minutes of the previous meeting	**SWBQS (12/17) 002**
The minutes of the previous meeting held on the 24th November 2017 were approved as a correct record. Ms. Dutton said that she was more than happy to attend a QIHD session.	
3. Matters and actions arising from previous meetings	**SWBQS (12/17) 003**
The matters and actions from previous meetings were agenda items.	
4. Patient story for the January Trust Board	***Verbal***
Ms. Newell informed members that the Patient Story at the January Board is a video 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. Board members will also be able to take part in a walkabout of the Rowley Regis wards after the meeting.	
5. Integrated Quality and Performance Report and Persistent Reds	***SWBQS (12/17) 004 & 005***
Mr. Waite summarised the IPR and Persistent Reds. Members were informed that progress in the last month was not sufficient and prospective improvement should be accelerated. It was agreed that the Trust needs a different approach 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. Following a query from Ms. Dutton, Mr. Waite explained that N/A relates to where we are down to last percentage point of improvement. 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** x 46 incurred in October mainly due to capacity pressures, but also due to a slow discharge flow. A walk about is taking place later in the day. **Neutropenic Sepsis** - Shows improvement but stubborn to further reduction to secure 100% local 'always event' compliance standard. Leadership team look at solutions to improve. 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

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. October performance now validated as compliant; November delivery at risk. Impact of prospective changes to oncology services on measured performance being assessed & could risk future compliance.

NHSI – Miss Dhami informed members that as part of the transfer of the 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.

6. Perinatal Mortality Progress Report	***Verbal***

Ms. Newell gave an update 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.

7. CQC Improvement Plan : December Deliverables (EQC)	**SWBQS (12/17) 006**

Miss Dhami informed members that at the end of October, 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 were then 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. An extract of the Improvement Plan which pulls out the actions to be delivered by the end of December was circulated prior to the meeting. Miss Dhami will circulate a reporting template to GDoPs so that they can give an update on progress to the Executive Quality Committee by the end of December. The Board in January will receive a report on achievements against the December delivery deadlines.

Following a query on how we will know that actions have been completed; Miss Dhami informed members that they will be monitored by the Clinical Audit Plan, Internal Audit Plan, Dashboards, KPI's and mock inspections. Ms. Parker asked if she can be involved with the mock inspections, Miss Dhami will send the details to her once completed.

8. Safety Plan Progress Report	***Verbal***

Ms. Newell informed members that 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 are also sighted on the 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.

Ms. Dutton asked what would happen to the corporate nursing team now that the management of the safely plan has gone to the groups to manage and was informed that they will be using their skills on other projects such as the shared learning from the Consistency of Care and Safety Plan Projects.

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

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.	
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: 26th January 2018 at 10.30h in the Anne Gibson Committee Room at City Hospital.	

Signed ……
Print ……
Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

FINANCE & INVESTMENT COMMITTEE MINUTES

Venue: Anne Gibson Committee Room, City Hospital

Date: 22 December 2017, 0830h – 1000h

Members present:		**In attendance:**	
Mr Mike Hoare	Chair	Ms Dinah McLannahan	Deputy Finance Director
Mr Richard Samuda	Non-Executive Director	Mrs Lesley Barnett	Deputy Director – Human Resources
Mr Harjinder Kang	Non-Executive Director		
Mr Tony Waite	Director of Finance		
Ms Rachel Barlow	Chief Operating Officer	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 Mrs Marie Perry and Mrs Raffaela Goodby. The members present did not have any interests to declare.	
2. Minutes of the previous meeting held on 24 November 2017	**SWBFI (12/17) 002**
The minutes were agreed as a true record.	
2.1. Matters arising and update on actions from the previous meetings	SWBFI (12/17) 002(a)
The Committee noted that there were no on-going actions.	
3. Financial Performance – P08 November 2017	**SWBFI (12/17) 003**

The Committee noted that the 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 year to date 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 NHS England. 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.

4. Strategic Board Assurance Framework Q2 – For Information	**SWBFI (12/17) 004**
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.	
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 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;
- Key matters of accounting judgement: taper relief/all accruals;
- Annual review of SWBH Trust as a going concern.

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 26th January 2018 at 0830h – 1000h in the Anne Gibson Committee Room, City Hospital.	

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PEOPLE & ORGANISATIONAL DEVELOPMENT COMMITTEE MINUTES

Venue: Anne Gibson Committee Room, City Hospital

Date: 25th September 2017, 1530h – 1700h

Members Present:

Mr Harjinder Kang, Chair (HK)
Mr Richard Samuda, Non-Executive Director (RS)
Mr Toby Lewis, Chief Executive (TL)
Mrs Elaine Newell, Chief Nurse (EN)
Ms Rachel Barlow, Chief Operating Officer (RB)

In Attendance:

Mrs Lesley Barnett, Deputy Director of Workforce (*representing R Goodby*) (LB)
Miss Yulander Charles – Executive Assistant (YC)

Minutes	**Paper Reference**
1. Welcome, apologies and declarations of interest	**Verbal**
Apology was received from Mrs Raffaela Goodby, Director of People & OD	
2. Minutes of the previous meeting	**SWBPOD (06/17) 007**
The minutes of the meeting held on 2017 was agreed as a true record.	
3. Matters arising from previous meeting, 17th March	**Verbal**

Meeting schedule/time - Mr Lewis noted that his previous request to have this meeting rescheduled so as to not interfere with the executives attending other meetings occurring on the same day had not be addressed. The committee was made aware that on this occasion the committee times clash with the Directors meeting at 1600 which has had to be cancelled due to the lack of numbers of core executives. Mr Lewis asked for assurance that the times of this committee meeting will be altered as a matter of urgency to ensure no future clashes. The committee agreed for this to be done.

Guardian of Safe working - Mr Lewis raised concerns as to the viability in the Junior doctor rotas. Particularly as the number of vacancies in some rotas are making them unsafe. Ms Barnett responded that due to the terms and conditions within the new Junior doctors' contracts we are not able to ascertain this level of information. Mr Lewis asked for a review of compliancy of the junior doctors' rota against the terms and conditions of their contracts.

ACTIONS:

- ***Meeting schedule/time*** - **Miss Charles to reschedule the times of this meeting ensuring there are no further clashes and email the core members with the revised schedule.**
- ***Guardian of Safe working*** - **Ms Barnett to review the junior doctors to ensure we are compliant with the terms and conditions. This is to be circulated to the Trust board, although not as part of the TB papers.**

4. Workforce Consultation 16-18 Outstanding redeployees	**Verbal**

Ms Barnett provided a summarised update on the two outstanding redeployees. Mr Lewis asked whether

the cost of the scheme was within the financial boundary set aside to cover any redundancies. The committee was assured that the scheme was within the pre-determined financial boundary. Mr Lewis reminded the committee of the need for HR to track whether the redeployment move would actually save money. Mr Lewis also requested assurance for further clarity as to what financial head room we have.

The Chair complimented Ms Barnett and her team on their efforts in the redeployment successes to-date. The Chair commented on issues raised at the JCNC meeting attended earlier that day on the timing of the next round of final consultations which will be launched earlier than anticipated. Mr Lewis stipulated that the timings of the consultation had not been finalised at the executive committee level and could impact on the level of monies allocated for the scheme. Ms Barnett explained at length the nature of the schemes.

Mr Lewis emphasised the need to be able to track our finances going forward and the need for clarity on the posts available for redeployment. The Chair agreed and added that such issues had been discussed at the recent JCNC meeting where it was resolute that new posts were not to be created but post were to be back-filled.

It was noted that this was the case i.e. posts were backfilled during the redeployment of staff with Health care group. This needed to be continued through to the forward schemes. Mr Lewis stressed that teams should not be using Agency as a means to backfill post. It has been a growing awareness that some teams are still employing this as a measure. He added that it is imperative this message is clear to teams and the use of concise rotas is to be employed. Mr Lewis acknowledged that there is much work to be done in this area and added the need for a stronger message on creating a more fluid workforce along with the need to have a clear policy around staff holding several posts of employment e.g. external roles as well as internal job role.

ACTIONS:

- **Ms Barnett to provide assurances on redundancy headroom for the forecasted redundancies in 16-18**
- **HR to implement a new process for recording whether redeployment actually saves money i.e. whether the vacancy they are being moved into has been backfilled with bank or agency**.
- **Paul Stanaway to track the savings associated with the redeployment of the Medical Records clerks.**

5. 2017 Winter Consultation planning	**SWBPOD (09/17) 004**

Ms Barnett sought to assure the committee of the steps that have been taken to date to ensure that the small number of schemes planned for this additional round of consultation have been subject to thorough and robust scrutiny with regards to safety and quality before being put forward for consultation with staff.

The assurances were challenged by Mr Lewis as the decision to proceed had not been discussed with the Exec's nor had been approved. He advised the committee that there may be a need for more schemes involving redundancies if we are unable to find the necessary savings from bank and agency reduction given the Trust's current pay spend.

It was noted that there could be some service implications around gynae-oncolgy service. Mr Lewis noted his agreement for its inclusion within the system and advised the committee that the commissioners 'may' appoint a provider in mid-October 2017, which 'may' end up being collaboration between the Women's and UHB. Ms Barnett confirmed that we could easily switch to TUPE consultation if necessary.

The implications of a TUPE consultation were discussed at length.

ACTIONS:

- **Mr Lewis asked that the Groups (mainly T&O) come up with a plan B to ascertain where we have rota's with Long Term vacancies that we cannot fill as a cost saving measure**

6. Nurse Recruitment Trajectory	Verbal

Mrs Newell updated the committee on the process made around the recent Nurse recruitment drive.
It was highlighted there has been positive outcomes particularly during September 2017 which has put us back on track as a Trust with the planned trajectory for overall staff nurse recruitment.

Despite this however the turnover of staff nurses proved to be higher in September 2017 than we had predicted. The committee discussed at length possible ways of improving this, primarily on increasing the number of ward based specialist Band 6's in order to give them a clear career pathway.
Suggestions were discussed such as providing Mentors; easier ability to transfer from one speciality to another.

ACTIONS:

- **Mrs Newell to include community nursing in next months' recruitment trajectory**
- **Mrs Newell to scope out potential to introduce more band 6's; ward based nurses, to help improve retention of band 5's at the next meeting in November 2017. This will encompass the TU concern around HCA's and consider developing an automatic progression from bands 2 - 3.**

7. Aspiring for Excellence Update	SWBPOD (09/17) 005

Ms Barnett updated the committee on the roll-out of the programme to date. The 4 month focus on PDR training has now concluded, the business as usual model for the Manager training will be provided through 2 sessions per month facilitated internally. There is a rolling training programme and communications strategy for new managers, new staff, with updates for those who need further support. To date 614 Managers attended PDR for Managers Training leaving a total of 86 Managers yet to receive training.

A lengthy discussion followed around the proposed reward and sanctions. Mr Lewis challenged the proposal as felt that the incremental progression to go through for a score of 2 didn't reward 'excellence'. Ms Barnett advised of the limitations of AfC which basically allows for annual increments unless staff are in a performance management process, this would not be the case if they are receiving a scoring of 2.

The committee went on to discuss the impact on recruitment and retention after a lengthy discussion the following suggestions was put to the committee by Mr Lewis; option one- AFC plus bonus or option 2 - Withhold AFC however it was agreed that probably the best solution would be to have annual increments at score 2, then rewarding excellence via a bonus i.e. £1000 (one year only, non-pensionable)

Re the Moderator Process. Mr Lewis expressed his concerns on what is proposed in the paper i.e. the 1st level of moderation will be provided by the Manager's Manager followed by a final moderation that will be reviewed within Groups and Corporate Directorates of the range of scores within the Group, and identification of 1's and 4's to enable Group leaders to be assure around management plans for talent and poor performance. Mr Lewis viewed this as a secondary marking process and suggested a tighter process which allows for oversight by a multi professional panel.

ACTION:

- **Both the moderation process, and sanctions and rewards will be further developed during October and November (inclusive of Board feedback on the Chief Executive Consequences Paper in October) and come back to the People & Organisation Development Board Committee in December 2017.**

8. Accredited Manager Programme and revised launch dates	SWBPOD (09/17) 006

This was presented to the committee by Ms Barnett. The Accredited Manager programme was recently discussed at the Major Projects Authority committee where concerns were raised regarding the dates along with impact on the organisation. The original proposal suggested that the Accredited Manager programme was mandated for the Trust's 600 Line Managers in 2017/18. Following assessment of the EPR training requirements, the Accredited Manager modules will be offered during 2017/18, and targeted to particular areas but will not be mandated during the time of the EPR training and roll-out.

Ms Barnett highlighted the roll out of the pilot scheme to be in November 2017, however the committee felt that this was a big ask concerning the current work around EPR.

Ms Barlow asked that additional training be added around operational requirements.

It was noted that around 80+ managers are yet to receive training. Mr Lewis felt that this was unacceptable and that if training is not complete then individuals should face disciplinary action and requested a mandate attendance in Jan/Feb 2018. Mr Lewis asked that the diversity element of the programme be made more explicit in the titles of the modules.

ACTION:

- **By 1st November to confirm the list of managers that have not yet been trained.**
- **Advise all outstanding Managers that they need to attend (by a given date) or face disciplinary proceedings.**
- **Amend titles of modules to make the inclusion of diversity more visible.**

9. Matters to raise to the Board and Audit & Risk Management Committee	Verbal

The key items to share at the next Trust Board meeting are;

- 2017 Winter Consultation planning
- Nurse Recruitment Trajectory
- Aspiring for Excellence Update

10. Any other business	Verbal

There were no items of any other business.

11. Date and time of next meeting	Verbal

The next meeting will be held on Monday 11th December 2017; 1030-1200. Meeting room 1, Trust Headquarters, Sandwell Hospital.

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Chief Executive's Report to Trust Board

February 2018

Quite understandably the liquidation of Carillion is a dominant consideration in the work of the Trust's leadership in recent weeks. I cover some of the key issues below and we will return to the latest updated material orally. Notwithstanding that, the Board will consider progress on digital improvement, readiness to deploy our appraisal solution from April, the management of winter pressures, and our ongoing financial recovery programme. We meet against the background of continued recruitment success, with every prospect of reaching our milestone of fewer than forty nurse vacancies in medicine this month – against a year ago when the figure exceeded 160.

It is now probable that we will meet our financial obligations in 2017-18. This is an immense achievement, which reflects dedicated work across clinical groups and the executive, as well as good work with partners. There remain issues to tackle, around the antenatal pathway funding model, oncology, and CQUINs, but our expectation is of resolution. As such, whilst our underlying finances remain in deficit, we are able to support our initial capital programme for 2018-19. That is important because we are committed to investing in our IT to improve care and release staff time to do so, and investing in our 'retained' estate – in other words building at City (Sheldon) and at Sandwell, which are intrinsic to the Midland Met care model, and which need in part to be completed before relocation. There are a small number of similar dependencies beyond the Trust's control, of which the material one is the expansion of Walsall A&E to accommodate the changes at Sandwell A&E in 2019. It remains possible that this can be accomplished in time, and we continue to work with partners to achieve that. Likewise we are working with the CCG to understand urgent care changes at locations like Parsonage Street, which could create pressure in the emergency care system. The CCG is in process of engaging local residents on some of these matters.

1. Our patients

This last week marks the 19th week in a row when we will have fallen below 90% performance in our emergency care system. The last six weeks has seen consistent return to the eighties (from below that), and stronger performance on our city site. We will review and present at the next Board meeting the very long wait position for 2017-18. Our focus since 2013-14 was on reducing long waits from arrival (and within that so-called trolley waits). The last few months have seen a relative deterioration after the considerable improvement of 2014-16 and we need to take evident action on the key pathways. These appear to be mental health waits, monitored beds, neurosurgical consideration, inter-site transfer and overnight medical beds. Three of these five areas are wholly or largely in our control. As the Board is aware from public papers, since Q3 we intended to later our reporting in line with revised national guidance. In the event this was not enacted because comparison with neighbouring Birmingham hospitals suggested that we should consider incorporating far more ambulatory activity, as they have done. As such our resubmission, alongside the CCG, was stayed and is pending and will now take place under amended revised national

guidance. The transparency of the discussion in prior Board meetings underscores our transparency about our approach.

We continue to operate with more beds open in Q4 that our original winter plan. The revised winter plan (with the funding granted nationally in late December) maintains those beds until the start of April. Our intention remains to reduce our bed base from spring, and the papers standing in Rachel Barlow's name outline how that will be safely achieved. Length of stay improvements to patient experience remain to be made in ambulatory care, for intermediate acute stays, and for very long stay patients. Our key interventions remain the programme of work set out in our Patient Journey project. The safety of our approach is being examined once again through the Board's Quality and Safety Committee. Most crucially we need to consider how we safely staff beds. Given the outlier position for February we have stood down some further elective work in order to ensure sufficient doctor cover is in place, and a single senior manager is available to respond and coordinate support for individual patients with excessive red days.

During February we will see the launch of our Purple Point project to support easier routes for patients or relatives to raise concerns during their care, in the first instance focused on hospital based inpatient care. Alongside this, the Chief Nurse is overseeing revisions to our Family and Friends programme to incorporate best practice from elsewhere, and examining how we introduce a more proactive feedback system for patients receiving one to one community based care. Purple Point does not replace our complaints process, which is showing continued signs of improvement as the Board discussed in late 2017. It does create real-time opportunity to address in particular communication issues for families, and David Carruthers will take the lead in making sure that there is no implication that raising concerns will in any way adversely 'impact' on the way a patient is looked after. As a seven day service the project in particular will offer us all an insight into some of the challenges of care over weekends.

The Board's papers contain further feedback on the perinatal mortality investigation that we undertook. The Safety Summit will take place in early February. Progress continues to next month's deadline for Trauma and Orthopaedics and implementation of the improvement plan. We expect to receive a feedback report in coming weeks on the incident reporting approach as applied to oncology, which will consider in due course. All of which brings again into view the necessity to look across Serious Incidents, incidents, the risk register, audit, complaints, and other indicators and ensure implementation grip around our action plans. I have asked Kam Dhami to revisit the system for doing that and report to the April Board on how we will operate in 2018-19. Plans are already in train to create Governance business partners, alongside the extant HR and finance business partners, to ensure that local management teams have some resource to support devolved delivery of improvement on specific quality issues.

2. Our workforce

Recruitment progress is considered in the attachments elsewhere in this report. We have now costed the approach to our nurse escalator, and we will progress to Q1 implementation this exciting project. Our aim remains to make it straightforward for individuals at band 2,3,4,5 and 6 to progress their career inside the Trust, with support linked to high potential. Within that there are really three changes – a single spine approach to the difference between bands 2 and 3 linked to skill development, the rapid introduction of band 4 roles, and the escalator which permits promotion to

band 6 more rapidly. Elaine Newell will chair a project group overseeing these changes, reporting to me, and will be report progress to the Board through my monthly report. This reflects the importance the Board places on solving nurse recruitment in our organisation as a key enabler to quality improvement.

The annual review of dependency and acuity of ward staffing has been completed and will be reported to the next meeting. Professional advice suggests that we may be able to alter some of our establishments. The working paper attached outlines some of the specific issues under consideration. My expectation is that the changes create a savings dividend, and we will need to then consider the balance between reinvestment and cost improvement. Distinct from this work, but related to it, we are moving to implement a seven day ward clerk model to relieve administrative pressure from ward nursing teams. This is also crucial to the implementation of our Unity EPR, which depends very directly on real time accuracy in the identification of, for example, the supervising team for each inpatient.

The Board has been concerned for some time about the bandwidth and capability issues faced by the wider senior leadership of the organisation. A variety of projects were agreed to address this. We will discuss progress with that work within the upcoming Board retreat, which colleagues will recall also incorporates over twenty clinical leaders who are members of the Clinical Leadership Executive. The vacancy position is now largely addressed at band 8d and above. A meaningful succession planning model will be put into deployment, taking lessons from system wide approaches of that kind being run both on a regulator regional basis and an STP basis. The upcoming retirements of both Amanda Geary and Fiona Shorney should be marked by our thanks as a Board, in my view, and we welcome Claire Hubbard and Diane Ettringham into group director of nursing roles over the next two months. I would not expect to see any wider restructure of the organisation in 2018-19, beyond the realignment of "performance" to fit within Dave Baker's brief and release finance capacity to support the FRP, and the previously discussed disestablishment of a single facilities structure, which will migrate to operations, estates, and for most patient facing roles, remain within corporate nursing. An evaluation of that change post implementation will come to the Board in September/October 2018.

At our last meeting we agreed the sickness action plan for the coming few months. Work continues to ensure that that plan is quantified by impact and time-lined, such that we can establish a sickness trajectory for the next fiscal year. That will be reflected in both days lost and cover expenditure, aligned to our FRP.

During Q1, everyone working inside the Trust will undertake their appraisal using the new Aspiring to Excellence model. That means that by the mid-summer all employees will have a moderated performance and potential score. We will consider through the Board's workforce committee how that is best scrutinised to ensure fairness but also to oversee concerted action in response. Prior to go-live all of our managers will have completed the Accredited Manager programme.

3. Our partners (including Unity and Midland Met)

The Trust continues to work with commissioners to establish activity and funding plans for 2018-19. As a general rule we do not expect to quite hit the national timeframes for agreement, as discussion on issues in relation to complex surgery and neonatology continue, and we are working alongside

our host CCG to create a different contractual arrangement for the next two years. We are optimistic of reaching agreement over the course of coming weeks.

We expect to deploy our Unity EPR towards the end of Q1 2018-19. This requires very considerable technical and people mobilisation work in coming months. We will take deployed technical downloads on March 12th and at the end of April. These will be used in training arrangements with firstly our Digital Champions (February and March) and then will all relevant employees (April and May). The full dress rehearsal for go live is scheduled for week beginning April 16th. Our present anticipated go live date is in June. During February we will establish final criteria for deployment, assuming that by the week of February 12th we achieve clinical sponsor support for progression. This is a by domain approval for each part of the product, but also satisfaction that the product as a whole is operationally fit for purpose. To the same timetable we need to conclude our work on reporting to ensure that the product can meet national reporting specifications, which have changed since the procurement, and can substitute for internal reporting that is necessary to complete operational management of the organisation as well as support strategic plans such as the safety plan. Finally our intent is to assertively manage the use of the product through deployment of mobilisation data through the Cerner product Lights On. Training to support managers in this endeavour is ongoing. As this implies the success criteria for deployment is set for three months after Go Live, with a level of utilisation sufficient to deliver our benefits plan.

The deeply regrettable collapse of Carillion occasions the potential for significant delay to the opening of the new hospital. A series of other Carillion companies are following into liquidation, which impact both the financing model and the provision of hard Facilities Management services. Under the terms of our contract, Hospital Co have a responsibility for creating a timely solution to this circumstance. The cost of the new hospital may be judged to exceed the bid made by Carillion, and contracted by the Trust, and as such funding parties will need to cover this provision, which was £75m in Carillion's accounts and may exceed that in practice. We need to be explicit that this does reflect remotely on the Trust or public services as we have sought the same outcome and hospital from contract to now. Finding the funding model and contractor go hand in hand, and Hospital Co are working with others to succeed with our support. It is probable that the time taken to do will extend beyond the period when we could, in theory, terminate our contract, and the Board will establish governance to support the Chairman and myself in making decisions around the balance between contractual implementation and operational necessity. Our aim must be to get the right hospital in rapid time, and we should support the present contractual model if it offers the better prospect of meeting that aim. Impacting time and cost will be the retention of key staff involved to date in the construction. Arrangements to early March are made, and in very rapid time this needs to be extended into the spring. The Trust continues to work to ensure all involved know what is required and what is being done. A running commentary is probably unhelpful, as is blithe reassurance. However, as Ministers made clear in the House of Commons on Monday 15th and Wednesday 24th the governmental position is for completion of the hospital as the right strategy for both healthcare and public health. That clear endorsement is enormously important and welcome.

4. **Our regulators**

The Trust has contributed to the Birmingham CQC System Wide Review. It was notable that during the City Council overview presentation considerable emphasis was placed on the intended locality/constituency model. There was also much made of the innovation taking place with our ADAPT model and via our modality collaboration. This reflects a desire to establish as routine more subsidiarity across such a large conurbation. The methodology for the review was challenged by the idea of twin STPs for the city, and it will be interesting to see how much of the output focuses on care pathways and how much on organisational systems. The former is clearly where the gain for patients lies.

The Trust remains outside the NHS Improvement quarterly review process presently, because of our relative performance being considered acceptable. That said, like all other NHS Trusts, we are due to complete an undertakings process with the regulator – in our case specific to our CQC RI rating, 52 week wait breaches, four hour standard performance, agency cap and forward financial stability. Board members comments on the draft document are presently being considered and I would expect to make a formal proposal for approval when the Board next meets.

5. Black Country Sustainability and Transformation Plan

Proposals to conclude discussions on general pathology, under the Black Country Pathology model, are discussed within the private board papers. Excellent progress has been made to secure capital investment, and to create a commercial partnership agreement. The change envisaged is significant, and is driven by an intention to create a long term model for pathology services which can endure. The proposal has the support the executive, but it is right to reflect continued diverse views inside the organisation.

The STP leadership continues to examine how best to develop a shared implementation plan. Time has been set aside in February and March to seek to align three facets which are all necessary to success, those being: Developing primary care at scale, supporting social care models which work, and aligning statutory health providers. Increasingly, with changes in the Birmingham commissioning landscape, we will need to align plans across STP boundaries.

Attached to this report are our standard papers on recruitment trajectories for hard to fill roles and on nurse safe staffing. Also appended are working papers on nurse establishments discussed above, and on the nurse escalator financial model likewise. The matter arising on hard FM is obviated by the Carillion position.

The CLE update will be tabled, because the meeting takes place on Tuesday January 30th. The focus of the meeting is on safety and quality, cost improvement, and the revised out of hours management system we are implementing for the Trusts' sites from February 1st.

Toby Lewis, Chief Executive
January 26th 2018

Annex A – Speak Up Actions
Annex B – Trust Board Nursing Career Escalator
Annex C – Safe Staffing Summary
Annex D – Recruitment Scorecard
Annex E – Nurse Establishment Review

Speak Up Day: Listening and taking action, Ruth Wilkin, Director of Communications

Our first Speak Up Day took place in September 2017 where over 1000 colleagues made a promise to speak up if they saw an issue of concern relating to safety at work. Teams were asked via our Hot Topics feedback system to share any issues of concern that had been raised and not yet resolved. Executive Directors took ownership over each issue and contacted the teams to discuss their concerns and the actions they would expect. Some issues raised were handled locally by the team and their managers as reported in the Hot Topics feedback. The outcomes of concerns raised are reported in the table below and will be published internally. Full details are not always given due to the confidentiality of teams who submitted the concerns. The items are coded Red / Green depending on whether the action has been closed. Progress has been made on all actions. We will repeat Speak Up Day during 2018.

Issue raised	Outcome
Effectiveness of case note scanning	**G: Most issues now resolved**
Incomplete and inaccurate coding	**R: Corrections made and coding audit to be carried out in T&O**
Faxing of prescriptions – can lead to error	**R: Electronic prescribing will resolve the concern**
Unfair annual leave processes in department	**G: Arrangements reviewed openly and new process in place from 1 January 2018**
Uncertainty over oncology changes impacting on staffing	**G: Oncology changes are now clear and patients for solid tumour oncology care are being transitioned to UHB or RWT up to end of February 2018. Regular communication with staff and patients.**
Falls not being appropriately documented reported as incidents	**G: Issue raised at senior nurse forum**
Lack of feedback relating to incidents raised	**G: Improved feedback mechanism to be in place locally**
Inappropriate and unprofessional behaviour within a team	**G: Chief Nurse meeting with team leader**
Effective communication and engagement about decisions affecting teams and individuals	**R: Hot Topics feedback for January includes suggestions for how to improve communications between teams and senior managers**
Availability of the right equipment for moving patients	**R: Audit carried out in January 2018 to assess availability and identify requirements**
Policies out of date or needing review on Connect	**R: Stocktake of all policies with plan to review out of date documents. Policy approval process will be revised and relaunched**
Monitoring system for mandatory training	**G: Mandatory training can be accepted from other organisations, new mandatory training system will be introduced in 2018 , CDA is being updated quickly reducing time delay in registering compliance.**
Telephony outages	**G: Telephone issues now resolved with ongoing monitoring**
Concern about Unity in light of existing IT issues	**G: Reassured and new urgent response service for callers if with patient**
Use of IT system for respiratory patients	**R: N3 issue that is being resolved through installation of Trust line**
IT support for Mac-based service	**R: Outstanding but issue recognised**
Buildings security	**R: Meeting with NHS Property Services to resolve**
Catering facilities	**G: New suppliers in place and click and collect service launching at City Hospital in January 2018**
Parking issues at Sandwell	**G: More spaces now that Education Centre refurbishment is complete**
Kitchen facilities	**R: New microwave in place and old microwave removed. Meeting with NHS Property Services to identify scope for improvement.**
IT system for wheelchair services	**G: Discussed with CIO and reassured that right actions being progressed.**
Pathology changes and staff communications	**G: Communications shared with affected teams, via Pathology news and on Connect pages**
Confidentiality of concerns / complaints	**G: Reassurance that concerns raised are treated in confidence. We welcome people speaking up and respect right to anonymity.**
Community continence support for paediatric patients	**R: Business case has been developed and is being reviewed with decision to be made by end of March 2018.**
Infection control over supply cages	**G: Confirmed that NHS Supply Chain cages are single use and returned daily to NHS Supplies for industrial cleaning before re-use**

Nursing Career Escalator

Elaine Newell – Chief Nurse

During January 2018, the Trust Board discussed high level recommendations for an accelerated development model for Band 5 nurses. The recommendations were targeted towards retaining nurses in year two to five of their employment, and avoid the £32-42k cost per head incurred with the recruitment and development of a band 5 or band 6 nurse (as per December board paper). This paper sets out more detail on the financial modelling associated with that proposal.
In applying the principles of the average organisation / normal distribution performance curve, one might safely assume the percentage of staff accessing this programme (PDR 4a/b) to be around 10 – 15% of Band 5 staff.

In determining financial modelling the following points have been considered

- There are currently 158 nurses at the bottom of Band 5. We have assumed 30 staff in year 1 will take up the programme with approx. 24 per year thereafter.
- Upon achieving the core skills of the desired development framework, the nurse will be given priority consideration for any B6 opportunities which arise but will not automatically progress through the remainder of the B6 pay scale without being appointed to a vacant post.
- Backfill for release into classroom based training is assumed at approx. 10 days per person.

Financial Modelling:

1) The career escalator pulls forward by 3 years, salary costs which would otherwise be accrued in 6 years – i.e. an extra £1.5k in year 3, and an extra £3k in year 4 (and 5/6) compared to a normal progression through the band.
2) Backfill costs for an assumed average of 10 days training per nurse with backfill equates to 1.5k per employee
3) In the 12 month preceding Nov 2017, 25 Band 6 staff left the Trust (exc W & CH). Assuming this is a typical pattern of B6 leavers, some of the costs associated with this programme will be offset by Band 5 escalator staff progressing into these funded roles at around year 4 – 6, or before for exceptional colleagues.

Table 1 below demonstrates the costs required over 2 years assuming 54 staff enter the escalator programme and are retained within the Trust.

	Cost per person	Year 1 (30)	Year 2 (24)	Total
Escalator cost	£4.5k	£135k	£108k	243k
Backfill	£1.5k	£45k	£36k	£81k
				£324k
Costs associated with 33 x B5 leavers at year 2 – 5 (2017 data)	Av 38k			33 leavers per year - Cost per 12 months = £1,254,000
Attrition reduced by 50% plus escalator costs				£303k saving

4) In the 12 month period preceding November 2017, 33 Band 5 staff left the organisation after 2 -5 years of employment. Assuming an average recruitment and development cost of £38k, this equates to £1,254,000 in turnover costs. The cost reduction per nurse leaver retained, inclusive of escalator costs therefore equates to approximately £32k.
5) If only 50% of our Band 5 nurse leavers at year 2 – 5 were retained, this equates to a saving of around £303k inclusive of the investment in the nursing escalator programme

Summary
In summary, funding which is currently being directed towards recruitment of staff can comfortably cover the costs associated with the career escalator programme with an average of £5k investment per person saving £32k per post retained. The overall savings potential equates to approximately £303k. This saving will reduce if the board supports creating additional band 6 posts on each ward.

Annex C

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
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	285	315	225	210	555	527	0	27	110.5%	93.3%	95.0%	#DIV/0!	142	5.9	1.7	7.6
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Nov-17	RXK02	CITY HOSPITAL	29837	29413	14421	13001	27261	26670	9670	9875	98.6%	90.2%	97.8%	102.1%	9713	5.8	2.4	8.1
	RXK10	ROWLEY REGIS HOSPITAL	3951	3772	5319	5175	2698	2686	3687	3675	95.5%	97.3%	99.6%	99.7%	2495	2.6	3.5	6.1
	RXK01	SANDWELL GENERAL HOSPITAL	26841	25880	16620	16475	21943	21656	15566	16284	96.4%	99.1%	98.7%	104.6%	11132	4.3	2.9	7.2
			60914	59380	36585	34861	52457	51539	28923	29861	97.5%	95.3%	98.2%	103.2%	23482	19	11	29
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	322	367	232	210	573	545	0	27	114.0%	90.5%	95.1%	#DIV/0!	167	5.5	1.4	6.9
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0			
Dec-17	RXK02	CITY HOSPITAL	30881	29460	14839	13013	28229	27029	10254	9650	95.4%	87.7%	95.7%	94.1%	9260	6.1	2.4	8.5
	RXK10	ROWLEY REGIS HOSPITAL	4203	3700	5700	5371	2883	2859	3951	3849	88.0%	94.2%	99.2%	97.4%	2419	2.7	3.8	6.5
	RXK01	SANDWELL GENERAL HOSPITAL	28278	26344	17809	16640	26185	22192	17449	16449	93.2%	93.4%	84.8%	94.3%	11549	4.2	2.9	7.1
			63684	59871	38580	35234	57870	52625	31654	29975	94.0%	91.3%	90.9%	94.7%	23395	18	11	29
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	302	330	230	212	567	536	0	36	109.0%	92.5%	94.5%	#DIV/0!	161	5.4	1.5	6.9
3-month	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!
Avges	RXK02	CITY HOSPITAL	30528	29556	14563	13083	27879	26919	9822	9899	96.8%	89.8%	96.6%	100.8%	9679	5.8	2.4	8.2
	RXK10	ROWLEY REGIS HOSPITAL	4123	3842	5571	5288	2821	2813	3863	3802	93.2%	94.9%	99.7%	98.4%	2509	2.7	3.6	6.3
	RXK01	SANDWELL GENERAL HOSPITAL	27430	26303	16930	16491	23331	22038	15956	16290	95.9%	97.4%	94.5%	102.1%	11270	4.3	2.9	7.2
	Total	*Latest 3 month average====>*	62383	60030	37294	35074	54598	52306	29640	30028	96.2%	94.0%	95.8%	101.3%	23619	4.8	2.8	7.5

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

Ward name	Main 2 Specialties on each ward	Main 2 Specialties on each ward	Day Registered midwives/nurses	Day Registered midwives/nurses	Day Care Staff	Day Care Staff	Night Registered midwives/nurses	Night Registered midwives/nurses	Night Care Staff	Night Care Staff	Day	Day	Night	Night	Care Hours Per Patient Day (CHPPD)				Note
	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall	
Critical Care - Sandwell	300 - GENERAL MEDICINE	100 - GENERAL SURGERY	3184	2952	392	336	5704	2739	0	33	92.7%	85.7%	48.0%	#DIV/0!	195	29.2	1.9	31.1	
AMU A - Sandwell	300 - GENERAL MEDICINE	320 - CARDIOLOGY	3565	3214	1426	1466	3565	3139	1426	1552	90.2%	102.8%	88.1%	108.8%	1357	4.7	2.2	6.9	
Older Persons Assessment Unit (OPAU) -	430 - GERIATRIC MEDICINE	430 - GERIATRIC MEDICINE	1426	1380	1069	1098	1069	1069	1069	1150	96.8%	102.7%	100.0%	107.6%	607	4.0	3.7	7.7	New Oct 16
Lyndon 1 - Paediatrics	420 - PAEDIATRICS	110 - TRAUMA & ORTHOPAEDICS	930	696	372	348	1705	1023	341	209	74.8%	93.5%	60.0%	61.3%	489	3.5	1.1	4.7	
Lyndon 2 - Surgery	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS	1782	1644	1736	1615	1069	1046	1633	1506	92.3%	93.0%	97.8%	92.2%	819	3.3	3.8	7.1	
Lyndon 3 - T&O/Stepdown	110 - TRAUMA & ORTHOPAEDICS	160 - PLASTIC SURGERY	1661	1558	1782	1633	1069	1012	1782	1633	93.8%	91.6%	94.7%	91.6%	787	3.3	4.1	7.4	
Lyndon 4	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1782	1661	1782	1725	1426	1391	1782	1702	93.2%	96.8%	97.5%	95.5%	962	3.2	3.6	6.7	
Lyndon 5 - Acute Medicine	100 - GENERAL SURGERY	300 - GENERAL MEDICINE	1782	1719	1782	1362	1426	1771	1782	1380	96.5%	76.4%	124.2%	77.4%	1014	3.4	2.7	6.1	Data from 25/9/2017
Lyndon Ground - PAU/Adolescents	420 - PAEDIATRICS	110 - TRAUMA & ORTHOPAEDICS	1116	1098	341	170	0	0	1254	616	98.4%	49.9%	#DIV/0!	49.1%	367	3.0	2.1	5.1	
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	1782	1742	1782	1621	1069	1046	1782	1702	97.8%	91.0%	97.8%	95.5%	860	3.2	3.9	7.1	
Newton 4 - Stepdown/Stroke/Neurology	314 - REHABILITATION	300 - GENERAL MEDICINE	1426	1339	1069	1035	1426	1299	1069	1012	93.9%	96.8%	91.1%	94.7%	864	3.1	2.4	5.4	
Newton 5 - Haematology	304 - CLINICAL PHYSIOLOGY	300 - GENERAL MEDICINE	713	753	356	299	713	713	356	333	105.6%	84.0%	100.0%	93.5%	418	3.5	1.5	5.0	
Priory 2 - Colorectal/General Surgery	100 - GENERAL SURGERY	100 - GENERAL SURGERY	1782	1702	1069	1138	1391	1345	1035	1161	95.5%	106.5%	96.7%	112.2%	732	4.2	3.1	7.3	
Priory 4 - Stroke/Neurology	300 - GENERAL MEDICINE	400 - NEUROLOGY	2139	1719	1069	1104	1782	1805	1069	1081	80.4%	103.3%	101.3%	101.1%	728	4.8	3.0	7.8	
Priory 5 - Gastro/Resp	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1426	1414	1069	1069	1345	1414	713	1069	99.2%	100.0%	105.1%	149.9%	933	3.0	2.3	5.3	
SAU - Sandwell	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS	1782	1753	713	621	1426	1380	356	310	98.4%	87.1%	96.8%	87.1%	417	7.5	2.2	9.7	See N2
CCS - Critical Care Services - City	300 - GENERAL MEDICINE	301 - GASTROENTEROLOGY	2976	3276	372	318	2728	2948	0	0	110.1%	85.5%	108.1%	#DIV/0!	262	23.8	1.2	25.0	
D5/D7 - Cardiology (Female)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	3565	3438	713	782	2852	2990	0	0	96.4%	109.7%	104.8%	#DIV/0!	438	14.7	1.8	16.5	Merged with D5/D7
D11 - Male Older Adult	430 - GERIATRIC MEDICINE	430 - GERIATRIC MEDICINE	1069	1058	1069	1029	1069	1069	713	690	99.0%	96.3%	100.0%	96.8%	621	3.4	2.8	6.2	
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	1069	1063	989	695	1069	1046	632	655	99.4%	70.3%	97.8%	103.6%	665	3.2	2.0	5.2	
D16 - (Female)	301 - GASTROENTEROLOGY	340 - RESPIRATORY MEDICINE	1069	1046	989	707	1069	1023	632	644	97.8%	71.5%	95.7%	101.9%	617	3.4	2.2	5.5	
D19 - Paediatric Medicine	420 - PAEDIATRICS	120 - ENT	837	831	100	87	682	638	341	77	99.3%	87.0%	93.5%	22.6%	298	4.9	0.6	5.5	
D21 - Male Urology / ENT	101 - UROLOGY	120 - ENT	1184	1127	713	580	828	851	713	678	95.2%	81.3%	102.8%	95.1%	465	4.3	2.7	7.0	
D26 - Female Older Adult	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1069	1052	1150	902	1069	1035	713	655	98.4%	78.4%	96.8%	91.9%	637	3.3	2.4	5.7	
D27 - Oncology	502 - GYNAECOLOGY		579	427	408	276	744	492	372	228	73.7%	67.6%	66.1%	61.3%	339	2.7	1.5	4.2	
AMU 2 & West Midlands Poisons Unit - C	300 - GENERAL MEDICINE	305 - CLINICAL PHARMACOLOGY	1782	1730	356	391	1782	1426	356	356	97.1%	109.8%	80.0%	100.0%	506	6.2	1.5	7.7	
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	1426	1207	1426	1316	1069	1023	1069	1023	84.6%	92.3%	95.7%	95.7%	761	2.9	3.1	6.0	
D47 - Geriatric MEDICAL			1069	879	1247	1173	713	632	713	713	82.2%	94.1%	88.6%	100.0%	538	2.8	3.5	6.3	
D7 - Cardiology (Male)	320 - CARDIOLOGY	300 - GENERAL MEDICINE									#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	552	0.0	0.0	0.0	Merged with D5
Female Surgical (D17)	101 - UROLOGY	120 - ENT	1069	977	713	626	471	713	437	448	91.4%	87.8%	151.4%	102.5%	327	5.2	3.3	8.5	
Labour Ward - City	501 - OBSTETRICS	501 - OBSTETRICS	3921	3141	713	592	3887	3197	713	678	80.1%	83.0%	82.2%	95.1%	274	23.1	4.6	27.8	
City Maternity - M1	501 - OBSTETRICS	424- WELL BABIES	1069	1109	713	753	1069	1035	356	356	103.7%	105.6%	96.8%	100.0%	479	4.5	2.3	6.8	
City Maternity - M2	501 - OBSTETRICS	424- WELL BABIES	1069	1086	673	655	1069	1023	356	322	101.6%	97.3%	95.7%	90.4%	524	4.0	1.9	5.9	
AMU 1 - City	300 - GENERAL MEDICINE	320 - CARDIOLOGY	2495	2443	1069	1086	2495	2484	1069	1104	97.9%	101.6%	99.6%	103.3%	751	6.6	2.9	9.5	
Neonatal			2495	2420	713	534	2495	2346	713	540	97.0%	74.9%	94.0%	75.7%	693	6.9	1.5	8.4	
Serenity Birth Centre - City	501 - OBSTETRICS	501 - OBSTETRICS	1069	1150	713	511	1069	1058	356	483	107.6%	71.7%	99.0%	135.7%	65	34.0	15.3	49.3	
Ophthalmology Main Ward - City	130 - OPHTHALMOLOGY	180 - ACCIDENT & EMERGENCY	322	367	232	210	573	545	0	27	114.0%	90.5%	95.1%	#DIV/0!	167	5.5	1.4	6.9	
Eliza Tinsley Ward - Community RTG	318- INTERMEDIATE CARE	300 - GENERAL MEDICINE	1069	856	1426	1351	713	713	1069	1035	80.1%	94.7%	100.0%	96.8%	641	2.4	3.7	6.2	
Henderson	318- INTERMEDIATE CARE		1069	960	1546	1391	713	701	1069	1035	89.8%	90.0%	98.3%	96.8%	615	2.7	3.9	6.6	
Leasowes	318- INTERMEDIATE CARE		996	936	1302	1284	744	732	744	744	94.0%	98.6%	98.4%	100.0%	540	3.1	3.8	6.8	
MCCarthy	318- INTERMEDIATE CARE		1069	948	1426	1345	713	713	1069	1035	1	94.3%	100.0%	96.8%	623	2.7	3.8	6.5	
	Trust Totals		**63684**	**59871**	**38580**	**35234**	**57870**	**52625**	**31654**	**29975**	1	91.3%	90.9%	94.7%	**23947**	**4.7**	**2.7**	**7.4**	

Fill rate indicator return
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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		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	3184	2952	392	336	5704	2739	0	33	92.7%	85.7%
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	AMU A - Sandwell	300 - GENERAL MEDICINE	320 - CARDIOLOGY	3565	3214	1426	1466	3565	3139	1426	1552	90.2%	102.8%
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Older Persons Assessment U	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1426	1380	1069	1098	1069	1069	1069	1150	96.8%	102.7%
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 1 - Paediatrics	420 - PAEDIATRICS	110 - TRAUMA & ORTHOPAEDICS	930	696	372	348	1705	1023	341	209	74.8%	93.5%
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 2 - Surgery	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS	1782	1644	1736	1615	1069	1046	1633	1506	92.3%	93.0%
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 3 - T&O/Stepdown	110 - TRAUMA & ORTHOPAEDICS	160 - PLASTIC SURGERY	1661	1558	1782	1633	1069	1012	1782	1633	93.8%	91.6%
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 4	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1782	1661	1782	1725	1426	1391	1782	1702	93.2%	96.8%
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon 5	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1782	1719	1782	1362	1426	1771	1782	1380	96.5%	76.4%
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Lyndon Ground - PAU/Adoles	420 - PAEDIATRICS	110 - TRAUMA & ORTHOPAEDICS	1116	1098	341	170	0	0	1254	616	98.4%	49.9%
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Newton 3 - T&O	110 - TRAUMA & ORTHOPAEDICS	430 - GERIATRIC MEDICINE	1782	1742	1782	1621	1069	1046	1782	1702	97.8%	91.0%
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Newton 4 - Stepdown/Stroke/N	314 - REHABILITATION	300 - GENERAL MEDICINE	1426	1339	1069	1035	1426	1299	1069	1012	93.9%	96.8%
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Newton 5 - Haematology	304 - CLINICAL PHYSIOLOGY	300 - GENERAL MEDICINE	713	753	356	299	713	713	356	333	105.6%	84.0%
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Priory 2 - Colorectal/General S	100 - GENERAL SURGERY	100 - GENERAL SURGERY	1782	1702	1069	1138	1391	1345	1035	1161	95.5%	106.5%
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Priory 4 - Stroke/Neurology	300 - GENERAL MEDICINE	400 - NEUROLOGY	2139	1719	1069	1104	1782	1805	1069	1081	80.4%	103.3%
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	Priory 5 - Gastro/Resp	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1426	1414	1069	1069	1345	1414	713	1069	99.2%	100.0%
	RXK01	SANDWELL GENERAL HOSPITAL - RXK01	SAU - Sandwell	100 - GENERAL SURGERY	110 - TRAUMA & ORTHOPAEDICS	1782	1753	713	621	1426	1380	356	310	98.4%	87.1%
	RXK02	CITY HOSPITAL - RXK02	CCS - Critical Care Services	300 - GENERAL MEDICINE	301 - GASTROENTEROLOGY	2976	3276	372	318	2728	2948	0	0	110.1%	85.5%
	RXK02	CITY HOSPITAL - RXK02	D5/D7 - Cardiology (Female/M	320 - CARDIOLOGY	300 - GENERAL MEDICINE	3565	3438	713	782	2852	2990	0	0	96.4%	109.7%
	RXK02	CITY HOSPITAL - RXK02	D11 - Male Older Adult	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1069	1058	1069	1029	1069	1069	713	690	99.0%	96.3%
	RXK02	CITY HOSPITAL - RXK02	D15 - Gastro/Resp/Haem (Ma	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1069	1063	989	695	1069	1046	632	655	99.4%	70.3%
	RXK02	CITY HOSPITAL - RXK02	D16 - (Female)	301 - GASTROENTEROLOGY	340 - RESPIRATORY MEDICINE	1069	1046	989	707	1069	1023	632	644	97.8%	71.5%
	RXK02	CITY HOSPITAL - RXK02	D19 - Paediatric Medicine	420 - PAEDIATRICS	120 - ENT	837	831	100	87	682	638	341	77	99.3%	87.0%
	RXK02	CITY HOSPITAL - RXK02	D21 - Male Urology / ENT	101 - UROLOGY	120 - ENT	1184	1127	713	580	828	851	713	678	95.2%	81.3%

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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		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	3184	2952	392	336	5704	2739	0	33	92.7%	85.7%
	RXK02	CITY HOSPITAL - RXK02	D26 - Female Older Adult	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1069	1052	1150	902	1069	1035	713	655	98.4%	78.4%
	RXK02	CITY HOSPITAL - RXK02	D27 - Oncology	502 - GYNAECOLOGY		579	427	408	276	744	492	372	228	73.7%	67.6%
	RXK02	CITY HOSPITAL - RXK02	AMU 2 & West Midlands Pois	300 - GENERAL MEDICINE	305 - CLINICAL PHARMACOLOGY	1782	1730	356	391	1782	1426	356	356	97.1%	109.8%
	RXK02	CITY HOSPITAL - RXK02	D43 - Community RTG	318- INTERMEDIATE CARE	430 - GERIATRIC MEDICINE	1426	1207	1426	1316	1069	1023	1069	1023	84.6%	92.3%
	RXK02	CITY HOSPITAL - RXK02	D47 - Geriatric MEDICAL	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1069	879	1247	1173	713	632	713	713	82.2%	94.1%
	RXK02	CITY HOSPITAL - RXK02	Female Surgical Ward	101 - UROLOGY	120 - ENT	1069	977	713	626	471	713	437	448	91.4%	87.8%
	RXK02	CITY HOSPITAL - RXK02	Labour Ward - City	501 - OBSTETRICS	501 - OBSTETRICS	3921	3141	713	592	3887	3197	713	678	80.1%	83.0%
	RXK02	CITY HOSPITAL - RXK02	City Maternity - 1	501 - OBSTETRICS	424- WELL BABIES	1069	1109	713	753	1069	1035	356	356	103.7%	105.6%
	RXK02	CITY HOSPITAL - RXK02	City Maternity - 2	501 - OBSTETRICS	424- WELL BABIES	1069	1086	673	655	1069	1023	356	322	101.6%	97.3%
	RXK02	CITY HOSPITAL - RXK02	AMU 1 - City	300 - GENERAL MEDICINE	320 - CARDIOLOGY	2495	2443	1069	1086	2495	2484	1069	1104	97.9%	101.6%
	RXK02	CITY HOSPITAL - RXK02	Neonatal	422- NEONATOLOGY		2495	2420	713	534	2495	2346	713	540	97.0%	74.9%
	RXK02	CITY HOSPITAL - RXK02	Serenity Birth Centre - City	501 - OBSTETRICS	501 - OBSTETRICS	1069	1150	713	511	1069	1058	356	483	107.6%	71.7%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BM	Ophthalmology Main Ward - C	130 - OPHTHALMOLOGY	180 - ACCIDENT & EMERGENCY	322	367	232	210	573	545	0	27	114.0%	90.5%
	RXK10	ROWLEY REGIS HOSPITAL - RXK10	Eliza Tinsley Ward - Commun	318- INTERMEDIATE CARE	300 - GENERAL MEDICINE	1069	856	1426	1351	713	713	1069	1035	80.1%	94.7%
	RXK10	ROWLEY REGIS HOSPITAL - RXK10	Henderson	318- INTERMEDIATE CARE		1069	960	1546	1391	713	701	1069	1035	89.8%	90.0%
	RXK10	ROWLEY REGIS HOSPITAL - RXK10	Leasowes	318- INTERMEDIATE CARE		996	936	1302	1284	744	732	744	744	94.0%	98.6%
	RXK10	ROWLEY REGIS HOSPITAL - RXK10	McCarthy	318- INTERMEDIATE CARE		1069	948	1426	1345	713	713	1069	1035	88.7%	94.3%

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Validation alerts (see control panel)	Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day	
	Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
						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	3184	2952	392	336	5704	2739	0	33	92.7%	85.7%
			Total			63684	59871	38580	35234	57870	52625	31654	29975		
RXK01	SANDW	0	0	0	0	0	0	0	0	0	0	0	0	0	0
RXK01	SANDW	0	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	0	0	1
RXK01	SANDW	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Recruitment Activity Report

Report Date: 24/01/2018

Criteria		Measure/Month		Actual									Notified as at Report Date		Forecast
				Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Band 5 Nurses	SIP	FTE	Establishment	983.64	992.21	981.67	981.95	981.97	817.62	817.62	828.09	828.09	*822.64*	*822.64*	*822.64*
		FTE	FTE In Post	839.93	819.86	815.91	807.19	801.52	692.36	689.60	697.08	692.20	*687.07*	*711.66*	*708.93*
		FTE	New Starters	5.83	7.77	7.65	6.92	5.23	43.67	15.33	13.05	3.00	*34.94*	*7.62*	*7.62*
		FTE	Leavers	14.21	7.29	14.05	11.88	7.07	15.80	12.55	6.21	8.13	*10.35*	*10.35*	*10.35*
		FTE	Vacancies in month	143.71	172.35	165.76	174.76	180.45	125.26	128.02	131.01	135.89	*135.57*	*110.98*	*113.71*
	Offers External Applicants	FTE	Conditional offers (in month)	5.60	9.44	25.80	40.92	10.27	15.92	13.80	6.00	1.00	*8.88*		
		FTE	Offers Confirmed (in month)	3.00	11.54	5.33	15.55	16.74	16.74	8.00	8.41	15.00	*11.53*		
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*
		FTE	FTE In Post	531.19	538.07	536.75	539.65	546.48	400.83	399.81	403.91	401.47	*403.74*	*404.93*	*405.40*
		FTE	New Starters	2.40	2.45	5.50	1.80	3.56	7.00	7.33	8.80	6.00	*4.44*	*3.73*	*3.73*
		FTE	Leavers	2.80	1.92	2.68	4.43	4.20	5.61	4.57	3.93	3.73	*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	43.74	*41.47*	*40.28*	*39.81*
	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	3.93	*1.00*		
		FTE	Offers Confirmed (in month)	2.00	2.72	6.16	1.00	0.00	2.73	5.95	5.00	5.40	*1.00*		
Band 5 Community Nurses	SIP	FTE	Establishment						164.35	164.35	165.47	165.47	*165.47*	*165.47*	*165.47*
		FTE	FTE In Post						131.27	132.62	139.82	139.43	*139.43*	*139.43*	*139.43*
		FTE	New Starters						2.00	2.20	2.46	0.00	*2.00*	*2.00*	*2.00*
		FTE	Leavers						4.48	0.40	0.00	0.00	*0.40*	*0.40*	*0.40*
		FTE	Vacancies in month						33.08	33.08	25.65	26.04	*26.04*	*26.04*	*26.04*
	Offers External Applicants	FTE	Conditional offers (in month)						1.46	1.00	0.00	0.00	*1.00*		
		FTE	Offers Confirmed (in month)						1.46	1.00	2.00	1.00	*1.00*		
Band 6 Community Nurses	SIP	FTE	Establishment						143.55	143.55	150.15	150.15	*150.15*	*150.15*	*150.15*
		FTE	FTE In Post						133.94	136.02	140.32	139.41	*139.41*	*139.41*	*139.41*
		FTE	New Starters						0.00	1.36	2.60	1.00	*3.20*	*3.20*	*3.20*
		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	10.74	*10.74*	*10.74*	*10.74*
	Offers External Applicants	FTE	Conditional offers (in month)						2.00	2.36	0.00	0.00	**0.00**		
		FTE	Offers Confirmed (in month)						0.60	1.96	1.00	1.60	*1.00*		
Band 5 Midwives	SIP	FTE	Establishment	8.25	8.25	8.25	8.25	8.25	8.25	8.25	8.25	8.25	*8.25*	*8.25*	*8.25*
		FTE	FTE In Post	28.28	27.16	23.96	24.16	23.16	31.16	39.16	41.24	41.24	*41.24*	*39.56*	*39.97*
		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	-32.99	*-32.99*	*-31.31*	*-31.72*
	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	*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	*0.00*		
Band 6 Midwives	SIP	FTE	Establishment	208.10	208.10	184.30	184.30	184.30	184.30	184.30	184.14	184.14	*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	123.53	*120.69*	*121.03*	*120.82*
		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	3.44	*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	60.61	*63.11*	*62.77*	*62.98*
	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	**3.22**		
		FTE	Offers Confirmed (in month)	0.00	0.80	0.00	0.00	0.00	0.00	1.00	0.60	0.00	*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*
		FTE	FTE In Post	284.47	285.17	281.97	280.57	283.37	284.82	291.12	292.25	287.39	*284.39*	*283.85*	*283.70*
		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	32.71	*35.71*	*36.25*	*36.40*
	Offers External Applicants	FTE	Conditional offers (in month)	3.00	0.00	3.00	3.00	0.00	2.00	3.00	1.00	6.00	*1.00*		
		FTE	Offers Confirmed (in month)	0.00	0.00	1.00	0.00	5.00	5.00	0.00	1.00	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	520.70	*516.62*	*516.62*	*516.62*
		FTE	FTE In Post	437.09	442.07	454.05	445.58	445.64	463.12	478.00	484.14	486.32	*490.72*	*495.54*	*495.97*
		FTE	New Starters	2.53	10.41	2.00	10.00	13.61	31.80	15.00	15.80	5.40	*9.00*	*4.61*	*4.61*
		FTE	Leavers	3.92	1.40	3.00	5.25	8.51	9.13	4.51	4.60	1.00	*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	34.38	*25.90*	*21.08*	*20.65*
	Offers External Applicants	FTE	Conditional offers (in month)	11.61	10.16	28.41	58.00	19.00	14.41	4.60	1.60	4.53	*2.62*		
		FTE	Offers Confirmed (in month)	7.25	2.61	3.00	1.00	16.50	22.00	5.00	13.40	8.80	*7.00*		
Band 3 HCAs	SIP	FTE	Establishment	93.14	93.38	93.38	93.54	92.48	92.48	92.48	93.97	93.97	*93.97*	*93.97*	*93.97*
		FTE	FTE In Post	92.71	92.63	88.57	88.57	88.37	84.16	87.71	90.71	91.99	*92.99*	*95.39*	*94.97*
		FTE	New Starters	0.00	0.00	0.00	0.00	0.46	0.00	0.96	2.00	1.00	*3.00*	*0.18*	*0.18*
		FTE	Leavers	1.00	1.80	1.92	0.00	0.00	2.00	0.00	0.00	0.00	*0.60*	*0.60*	*0.60*
		FTE	Vacancies in month	0.43	0.75	4.81		4.11	8.32	4.77	3.26	1.98	*0.98*	*-1.42*	*-1.00*
	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	3.00	*0.00*		
		FTE	Offers Confirmed (in month)	0.00	5.21	1.80	0.00	0.00	0.00	0.00	1.00	0.00	*3.00*		

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: ESR and Recruitment data base

Nurse Establishment Review December 2017

Background

In July 2014, the final NICE guideline 'Safe staffing for nursing in adult inpatient wards in acute hospitals' was issued. This guidance focused on safe and sustainable staffing for nursing in adult inpatient care in acute wards. Part of that recommendation was for Trusts to undertake a yearly staffing review of their nurse establishment.

A ratio of one registered nurse to a maximum of eight patients during the day and (following revised guidance from NICE) one to ten or one to twelve at night is seen nationally as the threshold for provision of safe care. It is widely acknowledged that this ratio or better does not guarantee safe care, but evidence from the RCN, NQB and NICE all suggest that when that ratio is exceeded, additional pressures are experienced by the nursing staff and care standards as well as patient outcomes, may deteriorate. The National Quality Board in 2012 sets out an expectation that there will be a minimum of two registered nurses on duty on each shift, regardless of ward size or patient need. When setting safe staffing levels, it is important that the focus is not just on achieving a minimum registered nurse to patient ratio (1:8) but other factors such as ward layout/ general environment, patient presentation and specific care needs must also be considered alongside professional judgement. In keeping with NICE guidelines, a comprehensive review was undertaken of all inpatient and community wards in December 2017. The Safer Nursing Care Tool, developed by the Shelford Group was used. This is an evidence based tool that enables teams to assess patient acuity and dependency, whilst incorporating a staffing multiplier to ensure nursing establishments reflect patient needs. The tool has been endorsed by NICE, in line with the guidance for Acute Hospital Inpatient wards (2014) and includes twenty two percent uplift for planned leave (study and annual leave). The detail of this review can be made available upon request

Below is a summary analysis of findings:

- Based upon the current bed base, the majority of areas have staffing establishments and skill mix which is appropriate for the acuity and dependency of patients taking into account the current geography and bed numbers. Having determined acuity profiles for each ward, the same modelling can be applied to inform staffing requirements for the proposed bed reduction programme
- Some areas are shown to be working with higher nurse to patient ratios due to the geography and bed numbers on these wards. In the majority of general wards, a revised staffing model utilising Band 4 staff could be considered.
- There is a 2 year lead time to the Nursing Associate role (2 years training) and work is being undertaken in partnership with the BCA to develop these roles. By 2020 it is envisaged that all inpatient and community hospitals will have a nurse associate workforce within their establishment. The assumption being that wards providing care for dependant (rather than high acuity) patients can safely utilise such roles. Applied across 5 wards, the replacement of a Band 5 nurse per shift with a Band 4 would release circa £407,850.
- Given the revised NICE guidance which suggests that a ratio of 1:10 / 1:12 may be acceptable at night in areas of lower acuity and higher dependency, savings may safely be released by reducing the ratio of nurses and increasing the HCA ratio. High level costings suggest this could potentially yield savings of 352k plus enhancements. Skill mixing a reduction in the ratios, as described, supported by a group of nurses assigned to a cluster and deployed to the area of highest need

(similar to the hit team model), has been modelled but appears unlikely to release significant savings.

- There are nurse staffing savings associated with the proposed bed reduction programme. These need robust financial modelling and group consultation and will form part of the Group CIP programme. This work will be conducted over the next 3 weeks and will report to the March Board. This modelling will include the proposal for a safe reduction in nurse patient ratios at night supported by an uplift in HCA numbers where acuity profiles deem this to be appropriate.
- There has been some high level scoping relating to the potential for releasing costs associated with assumed higher sickness levels in permanent night staff. However the table shown in App 1 challenges these assumptions showing that those staff who currently work predominantly night shifts have lower sickness levels and higher mandatory training attendance.
- The cost of maternity leave is circa £860k (exclusive of backfill costs) per year. In agreeing a revised nurse staffing model, the Board may wish to consider ring-fencing a sum of money to cover the costs of maternity leave. This would be offset by any potential savings.

Summary:

The establishment review has demonstrated a number of opportunities for safely remodelling ward staffing. However the financial costing of these proposals needs to be conducted (at pace) alongside plans for bed reduction, ensuring group engagement and avoiding the potential for double counting. This work will be conducted with groups over the next 3 weeks, reporting a fully costed model to the Board in March

Elaine Newell
Chief Nurse
25th January 2018

Appendix 1

	Headcount		Sickness	Mandatory Training		
	Qualified/Unqualified	**Number**	**MT %**	**ST %**	**LT %**	**Total %**
Predominantly Days	Qualified	2339	91.05	2.30	2.70	5.00
	Unqualified	800	87.41	2.89	4.20	7.09
N Total		**3139**	**90.21**	**2.44**	**3.06**	**5.50**
Predominantly Nights	Qualified	62	92.62	1.80	1.36	3.16
	Unqualified	39	88.33	2.29	0.39	2.68
Days Total		**101**	**91.07**	**1.99**	**0.99**	**2.98**
Grand Total		**3240**	**90.24**	**2.42**	**2.99**	**5.42**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Strategic Board Assurance Framework: Q3 Update
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Clare Dooley, Head of Corporate Governance
DATE OF MEETING:	1st February 2017

EXECUTIVE SUMMARY:

The 2017/19 Strategic Board Assurance Framework has been reviewed and updated by Executive Leads (Trust risk owners) in December 2017. The report is provided to the Trust Board for review/scrutiny, in particular the actions that are overdue (rated red). In summary, the 2017/19 Strategic Board Assurance Framework, at Q3, has the following number of gaps in control and/or assurance:

Green: action completed	**3**
Amber: action on track and will be delivered by agreed date	**8**
Red: action off track and revised date set	**5**

REPORT RECOMMENDATION:

The Trust Board is asked to **REVIEW AND COMMENT ON ASSURANCE**, particularly on actions which are overdue (rated red) from the Q3 updates of the 2017/19 Strategic Board Assurance Framework.

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

Accept	Approve the recommendation	Discuss
X		X

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

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

Comments:

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

PREVIOUS CONSIDERATION:

Taken to Audit and Risk Management Committee, Finance and Investment Committee and Quality and Safety Committee in January 2018.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Strategic Board Assurance Framework: 2017/19

Progress report as at period ending December 2017

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	Deadline	Status
MR	BAF1	MPA	Digital Plan	There is a risk that our **infrastructure** does not support 365 day 24/7 uptime for key systems, resulting in a resort to paper back up, and a loss of confidence by users. This then reduces use and data completeness militating against the quality and efficiency gains we are seeking.	• The absence of an Infrastructure scorecard **Actions** 1. Include an infrastructure scorecard in the Informatics monthly report.	Added to infrastructure monthly report. The report is reviewed in the CEO Corporate Review for Informatics / MDO	-	G
EN	BAF2	Q&S	Safety Plan	There is a risk that we are unable to deliver consistent safety checks inside the first 24 hours because **staff turnover and temporary staffing** use mean that our wards are not staffed by individuals sufficiently familiar with our 'approach'. This exposes patients to risk of sub optimal care.	• External comparison • Assurance that data can be replicated in Cerner **Actions** 1. Gap analysis completed - Work with Cerner EPR team to ensure input data can be replicated and output / outcome reporting in place	Vacancy Gap is reducing significantly and the SP process is well embedded, such that the risk is minimal. This can be demonstrated by improving compliance rates. Project closure planned for end Jan with ongoing monitoring embedded in Group Governance processes	Q4	G

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	Deadline	Status
DC	BAF3	Q&S	Quality Plan	There is a risk that the Trust is unable to reduce **amenable mortality** to the timescale set out in our plans because we do not identify interventions of sufficient heft to alter outcomes.	• No quantifiable plan to respond to amenable mortality and track progress. **<u>Actions</u>** 1. Through LfD programme identify all deaths amenable to prevention – and their causes 2. Continue to pursue improvements of the delivery of preventive care in diagnoses of known preventable mortality – specifically – Sepsis, VTE, AMI, Stroke, #NOF, High risk abdominal surgery 3. Re-launch mortality improvement plans 4. Track relevant care inputs through GPOs	1. 7/12 Medical Examiners appointed with plan to start in February. Repeat advert going out last week in January for additional medical examiner recruitment. Structured Judgment Reviewers to be appointed after working patterns for medical examiners fully established. 2. Currently reviewing Quality Plan and drafting KPIs to be monitored through Executive Quality Committee. For new MD to pick this up over next 2 months 3. Re launch scheduled for after quality plan reviewed 4. Scheduled following relaunch on Quality Plan.	**Q4** **Q4** **Q4** **Q4**	**G** **A** **A** **A**

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	Deadline	Status
DC	**BAF4**	**Q&S**	**Quality Plan**	The first-time CQC inspection may deem that BMEC is not fit to continue to provide a safe, high quality care in its current form, particularly to children on an emergency basis, leading to the Trust **losing 20% of its outpatient income** thus putting at risk the financial viability of SWBH.	• Agreement lacking across whole system in West Midlands in how to provide paediatric eye care **<u>Actions</u>** 1. Engage with BCH and NHSE Specialised Commissioning to agree and provide regional leadership in agreeing a regional solution to the children's emergency eye surgery problem. 2. Deliver a regional paediatric eye medical on-call rota 3. Engage with Spec Comm in overseeing a solution.	BCH have confirmed that they cannot support the preferred model and as such we need to consider regulatory resolution.	**Q4**	**R**

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	Deadline	Status
TW	**BAF5**	**FIC**	**Finance Plan**	There is a risk that our necessary level of **cost reduction** plans are not achieved in full or on time, compromising our ability to invest in essential revenue developments and inter-dependent capital projects.	• Lack of assurance on the sufficiency of our plan to achieve cost reduction **<u>Actions</u>** 1. Opportunity assessment against external benchmarks including specifically New Model Hospital underpinning multi-year & specific CIP plans 2. Ensure necessary and sufficient capacity & capability to deliver scale of improvement required	1. Plausible opportunity to deliver scale of necessary cost & margin improvement identified. Subject to on-going validation and milestone planning to determine realistic scale & pace of delivery. Options for non-recurrent and other measures to close any residual gap to be determined.0. 2. Coherent programme structure in place and with key personnel assigned to each work-stream. Re-alignment of PMO on-going. Executive prioritization of near term management agenda done & second tier resources being re-aligned accordingly. Residual capacity & capability assessment including use of subject matter experts to be determined.	**Q4** **Q4**	**R** **A**

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	Deadline	Status
					3. Align trust CIP to commissioner QIPP programmes to confirm coherence and credible route to collective cost reduction	3. Coherent programme includes specific QIPP work-stream. Common definition and understanding of QIPP vs CIP agreed with SWBCCG.	**Q4**	A
					4. Secure market opportunities to drive financial margin gain.	4. Detailed market share analysis done & repatriation opportunity identified. Specific work-stream in place with SWBCCG to influence & secure GP alignment with that endeavor.	**Q4**	A
					5. Secure system support for impact of Midland Met delay & remediation costs such that not borne by trust [or local health economy]	5. Working with THC and key stakeholders to determine and secure best solution to Midland Met delivery. Includes assessment of cost implications and dialogue as to source of any required funding support.	**Ongoing**	R

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	Deadline	Status
TW	**BAF6**	**FIC**	**Finance Plan**	There is a risk that our necessary level of **cash remediation** plans are not achieved in full or on time, compromising our ability to invest in essential revenue developments and inter-dependent capital projects. [*Note that a key assumption underpinning the cash remediation plan is delivery of year on year P&L results to plan and on a re-current, cash backed basis. The risk to that assumption is dealt with discretely at BAF4]*	• Lack of assurance on the sufficiency of our plan to achieve sufficient cash remediation **<u>Actions</u>** 1. Refresh LTFM to confirm scale of cash remediation required and consistent with level 2 SOF financial sustainability rating 2. Opportunity assessment & confirmation including external benchmarks for working capital management 3. Ensure necessary and sufficient capacity & capability to deliver scale of improvement required	1. On-going as part of 2018-20 annual plan process. High-level 5 year capital / cash / loans model indicates base case scenario with plausible route to cash remediation and capex funded from internally generated funds. Modest near term revenue loans required reflecting 'take-off' profile of CIP. Downside case indicates requirement for capital and revenue loan support. 2. Remediation reliant on STF recovery which depends on P&L delivery [see BAF 5], gains from commercialisation of fixed assets [specific CIP work-stream] and recovery of extant receivables. Creditor days stretched & currently at sustainable level. 3. Deputy DoF in place & which has released time for ADoF [compliance] to focus necessary tim on cash remediation.	**Q4** **Q4** **Complete**	**A** **A** **G**

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	Deadline	Status
					4. Secure borrowing necessary to bridge any financial gap	4. Requirement for loans managed to now fall into new financial year. On-going dialogue with NHSI suggests access to required revenue loans should be achieveable. Capital loans would be subject to a more involved ITFF process.	**Ongoing**	A
TW	**BAF7**	**FIC**	**Finance Plan**	The risk that changes from a **PBR system** to non-PBR system produces an income stream less sensitised to volume and complexity and our demand exceeds planned supply driving unsustainable cost and consequent financial imbalance in the organisation.	• Under-developed understanding of service line capacity, cost behavior & profitability • Absence of a preferred Trust or agreed system approach to non-PBR **<u>Actions</u>** 1. Develop BIU capability to include fit for purpose service line insight for improvement	1. Work in progress. Model Hospital data and KLOEs reviewed together with NHSI regional lead director and initial triangulation with local intelligence undertaken. Framework for service-line assessment of financial, operational and service standards in development. Performance & costing team now aligned to information team	**Ongoing**	A

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	Deadline	Status
					2. Develop & secure alternative funding & contracting mechanism to drive the right long term system behaviours	2. System review concluded and emergent ACS model to underpin drive for aligned action and real change. Encouraging dialogue with SWBCCG continues. Remains to be translated into action and tested in anger. CCG timetable for development of ACS contracting / commercial model unrealistic. Foreseeable that conclusion of 2018.19 contract will run to March 2018.	**Q4**	**R**
RG	**BAF8**	**People & OD Committee**	**People Plan**	There is a risk that **labour supply** does not match our demand for high quality staff, because of low training numbers or overseas options for students, and therefore we are unable to sustain key services at satisfactory staffing levels resulting in poorer outcomes, delayed delivery or service closures.	• Non-existence of a future workforce supply model that reflects new roles and ways of working • No influence over international recruitment policy • Lack of workforce plan across the region including retirement and education profile **<u>Actions</u>** 1. Refreshed workforce plan on regional basis	STP workstream is generating two regional workforce reports. A) the number of gaps in delivery for the next 5 years B) one off workforce planning report including retirement, age profile across the STP inclusive of primary care	**Q1**	**A**

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	Deadline	Status
RG	**BAF9**	**People & OD Committee**	**Education Learning and Develop-ment**	There is a risk that we do not invest precisely enough to improve sufficiently the **skill base of our staff** and as a result our altering staffing levels may not be appropriate for the care we are trying to provide.	• Skills audits of staff in other professions • Inclusion of newly emerging roles through levy in training needs analysis **<u>Actions</u>** 1. Involvement of groups in TNA 2. Integration of levy planning across region	1. Clinical groups have been engaged in TNA through the group reviews. Director of OD has written to all consultant colleagues outlining the new process for training spend. Consideration is being given to allocating training money to corporate priorities (e.g. ED and critical care) before the allocation of training monies for 2018/19. 2. SWBH is taking part in STP wide planning group to ensure that the design and implementation of new roles is fully embedded within the Trust. This is inclusive of nursing associates and nursing degree apprentice roles.	**Q1** **Q1**	**A** **R**
RB	**BAF10**	**MPA**	**Estates Plan**	There is a risk that we are unable to deliver the full change programme by July 2019 resulting in stranded services and stranded costs for disused but not yet decommissioned estate. This would compromise our ability to deliver **seven day multi professional services** because locational alignment is not achieved concurrently.	• Market pressure on the use of temporary staff (Plan A) becomes unsustainable and a Plan B is required			

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	Deadline	Status
					Actions 1. Estates development group chaired by COO to be established to oversee integrated delivery programme (estates & clinical service delivery[Q3]	1. Estates development group chaired by COO established.	**Q3**	**G**
					2. Form integrated programme office and effective governance by Q4 2018	2. Activities planned for Q4 to create integrated programme	**Q4**	**A**
					3. To design and deliver a detailed clear workforce delivery programme towards 2019 by end Q4 2017	3. Workforce plan in development	**Q4**	**A**
					4. Confirm MMH opening as some of the 7 day service plan is dependent on a single acute site end Q3 2017	4. Date not yet confirmed but working towards accepting handover of building in	**Q3**	**R**

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	Deadline	Status
TL	**BAF11**	**MPA**	**Estates Plan**	There is a risk that confusion over the governance of key decisions in West Birmingham compromises the redesign of services on a 'Midland Met' footprint resulting in **operational dysfunction** of the opening of the New Hospital.	• A programme to put in place controls is a foreseeable outcome from the GE review **<u>Actions</u>** 1. Draft problem specification document and seek to agree it with the CCG and BCC [October 2017] 2. Quantify for the Board the boundary impact of cross area and out of area patients [October 2017]	We have developed an outline ACS document which responds to the range of issues in the GE report, including aspects of the WB question. Reviewed with NHSI and NHSE on 9/11/17. Separate meetings with NHSI are being held to discuss relation development with UHB, including developing a shared system understanding of the intrinsic role of City in the Midland Met system. Cross boundary quantification is being done by the CCG and chased weekly at chair/CEO level. It has still not been completed despite this and will now be subject to a formal letter between chairs reflecting its role in our BAF. The drafting of a Western Birmingham document will be completed over the next two months as part of developing a locality plan. Director of Partnerships will work with the nominated CCG lead director from Birmingham, alongside the SWB leadership.	**Q4** **Q4**	**A** **A**

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	Deadline	Status
DC	BAF12	Q&S	R&D Plan	There is a risk that we are unable to achieve our qualitative and quantitative goals for research because we **do not broaden the specialties that are research active**, principally because we are unable to recruit personnel with the time and inclination for research.	• No explicit recruitment strategy for clinicians with a research interest **Actions** 1. Identify at least two new research active specialties for each year of the R&D plan – CCS and T&O year 1 2. Manage the growth of R&D activity through group PMO R&D Plans 3. Have an active medical recruitment strategy that favors new consultants with a research interest and track record.	1. Critical Care – REST study opened in June 2017 and COMPRESS-RCT study opened in September 2017. Orthopaedics - DRAFFT2: Distal Radius Acute Fracture Fixation Trial open mid October 2017 2. R&D plan is managed through Group PMO and monthly progress report on complete plan is shown on Exec PMO wall. 3. As part of the AAC recruitment process a university representative is invited onto the interview panel for recruitment. Research and teaching subjects are both covered in the questions as part of this process. Proposals for increasing time at QIHD meetings to promote research activity amongst wider team being explored.	- - -	G G G

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	Deadline	Status
TL	BAF13	Public Health, Community Development & Equality Committee	Public Health Plan	There is a risk that **we do not deliver improved mental health** and wellbeing across our workforce because our interventions do not work or are poorly targeted, or because the drivers of ill health grow through organisational and societal change and churn.	• Levels of sickness owing to MH are not reducing, strengthened actions required. • Current research registrar looking for enhanced best practice. **Actions** 1. Complete best practice review led by the Occupational Health Department 2. Develop annual mental well-being employee assessment proposal for pilot consideration	A plan has been agreed by the Board, which includes an assessment model. The OD team need a detailed impact and implementation plan which is an action from the Board's agreement to our sickness approach.	Q4	A
TL	BAF14		2020 Vision	There is a risk that the integrated care model preferred by SWBH is not consistent with wider regional NHS plans resulting in new organisational forms being developed in **competition** with the Trust.	• A programme to put in place controls is a foreseeable outcome from the GE review **Actions** 1. Present a paper to the November Trust Board outlining organizational form options for each district	Strong progress has been made with the BC STP ACS, which will be subject to a development workshop on February 9th and should be completed before the end of March. A similar timescale is the ambition for the SWB ACS and an initial event to co design a solution took place on January 20th. The CCG remains focused on an alliance model. The Trust continues to develop bilateral partnering agreements in support of a wider integration strategy.	Q4	A

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	Deadline	Status
RB	**BAF15**		**2020 Vision**	There is a risk that difficulties in recruiting and retaining local GPs leads to unwarranted variation in patterns of care resulting in **excess secondary care demand**.	• Absence of a preferred Trust or agreed system approach to non-PBR controls **<u>Actions</u>** 1. Establish new leadership posts to increase external facing leadership capacity to work on primary care relations and workforce plan - including Primary Care leadership in PCCT (2018)and the Director of Innovation and Partnership [Q2 2017]	1. Failed to recruit. New recruitment efforts in Q4 on track.	**Revised to Q4**	**R**
					2. Work with Primary Care leads in CCG to establish a joint workforce plan to support retainment and recruitment of GPs [Q4 2017]	2. Need to establish working group in Q4.	**Revised to Q1**	**R**
					3. Establish new model of care and contracting on an integrated and risk shared basis with primary care providers [Q1 2018]	3. ACS and contracting development in train and progressing well.	**Q1**	**A**

Exec Lead	Risk Ref:	Committee Oversight	Source	Strategic Risk Statement	Gaps in control or assurance and planned actions	Progress report against each action	Deadline	Status
					4. Ensure effective referral management processes in place [Q4 2017]	4. Electronic referral implementation >90% for planned care. Commitment with CCG leadership to work up an urgent care single point of access for Q1. Site visits successfully completed.	**Q4**	**A**
TL	**BAF16**		**2020 Vision**	Collapse in local care home provision arising from commercial pressures and immigration policy increases SWBH admissions and reduces patterns of discharge creating **pressure on acute hospital beds.**	• Analysis of current care provision against learning from care home Vanguards **<u>Actions</u>** 1. Develop care home network proposal for a future Trust Board meeting. 2. Brief the Trust Board in October on Better Care Fund submission [October 2017]	We have not resourced development of this proposal. Realistically it will take until the end of March to develop such, albeit a geography specific proposal for Tipton has been requested by the CCG from the Trust, which is being developed by Fiona Shorney and Dottie Tipton.	**Q4**	**R**

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

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:	1 February 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 two areas where, having implemented the planned mitigating actions, the potential of an adverse impact on the Trust remains significant. These relate to the Lack of results acknowledgment and the workforce plan 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 and
c) to agree the changes requested for **Risk 2849** and **Risk 215** with regards to removing risks from the TRR in order for them to be managed locally within Directorates/Groups and to note the updates.

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: 1 February 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 January 2018 meeting the Head of Risk Management has supported risk owners in further reviewing their risks and updated each risk assessment to provide an accurate position against the progress of mitigating actions.

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

2.3 There are two areas below merit a Board discussion on further actions planned and/or required to reduce the probability or severity of the risks materialising. **Risk 2642** (results acknowledgement) will remain the same until the implementation of Unity. Once implemented the risk will be mitigated. The process for the acknowledgement of abnormal results will be communicated to all staff accordingly. **Risk 114** (Workforce Plan), It is to be noted that this risk has been increased due to the reduced paybill. Groups/Directorates have been requested to develop and implement additional CIP plans to address identified CIP shortfall.

Risk No. 2642	Risk No. 114
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.	Insufficient policy levers to ensure effective delivery of Trust workforce plan establishment due to a reduction of 1400 WTEs, leading to excess pay costs.

2.4 The four areas shown below were highlighted at the January Trust Board and then subsequently discussed at January RMC as it were felt that having implemented the planned mitigating actions; the potential of an adverse impact on the Trust remains significant. Following discussions and review by the Executive leads, these have been now been updated on further actions planned and/ or required to reduce the probability or severity of the risks materialising.

2.4.1. **Risk 221** (EPR Implementation) - The risk rating had originally increased as the original March deadline to implement the EPR would not be met. The target date has been re-set to May (as identified by the Digital Committee), with a potential 'go-live' date of 20th June for implementation. This is dependent upon CEO approval and confirmation of digital champion training. The slippage of 2 months in the project has reduced the risk of further slippage therefore the current risk has been reduced to a risk score of 'Amber' 12 (L3xS4). All actions are on track to be completed on target.

2.4.2. **Risk 1643** (unfunded beds) – Remains as a high risk on the TRR as a risk score of 'Red' 16 (L4xS4). The funded bed model was approved in Quarter 3 2017/18 and recruitment is on track with substantive staffing improving. The Safety plan and Early warning trigger tools are in place on all wards and are tracked through Consistency of Care and Executive Performance Committee. Associated risks are managed at group level and tracked through Risk Management Committee. Consultant of the week rotas and Admit/Pull Model will be fully implemented in February. All projects have revised delivery plans for completion in Quarter 4 2017/18. Governance continues through Patient Flow PMO. Senior/Executive ward rounds are to be reviewed and there are plans to replace long LOS meetings. Revised LOS goals are to be explored to mitigate increased demand trend.

2.4.3. **Risk 2849** (Unfunded beds – Impact on financial delivery of CIP) **Appendix B** – This risk has significantly reduced from a risk score of 'Red' 20 (L4xS5) to 'Yellow' 6 (L2xS3). This is due to the winter monies allocated for Quarter 4 2017/18 to mitigate the financial risk, therefore the risk has been mitigated to this point and is at a level where it can be managed by the Directorate/Group and be considered for removal from the TRR. Further actions to sustain the risk score are necessary and in place to avoid the increase in the risk in Quarter 1 208/19 Reassessment for this risk is recommended for March 2018 and should the risk at any point fall back to 'Red 'or 'Amber' the Directorates/Group is advised to escalate it back to CLE following discussions at Risk Management Committee for consideration for it to be re-included onto the TRR.

2.4.4. **Risk 215** (Delayed Transfer of Care) **Appendix C** – Again, this risk has significantly reduced from a risk score of a 'Red' 20 (L4xS5) to 'Yellow' 8 (L2xS4). Birmingham city council bed base has been confirmed and expanded for 2017-18. Package of care service has been responsive. Sandwell Social Care continues to purchase beds at Rowley Regis to mitigate bed capacity issues and there are 7 Social Workers on site and DTOC patients in acute beds is less generally less than 10. Therefore the risk has been mitigated to this point and is at a level where it can be managed by the Directorate/Group and be considered for removal from the TRR. Reassessment for this risk is recommended for March 2018 and should the risk at any point fall back to 'Red 'or 'Amber' the Directorates/Group is advised to escalate it back to CLE following discussions at Risk Management Committee for consideration for it to be re-included onto the TRR.

2.5 There are no new risks are being escalated for the Board to discuss

3. Recommendations

Trust Board is recommended to:

a) consider, challenge and confirm the correct strategy has been adopted to keep potential significant risks under prudent control; and
b) advise on any further risk treatment required and
c) to agree the changes requested for **Risk 2849** and **Risk 215** with regards to removing risks from the TRR in order for them to be managed locally within Directorates/Groups and to note the updates.

Refeth Mirza
Head of Risk Management

25 January 2018

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***	20/01/2018	3x4=12	**Cross charging tariff affecting financial position.** **1**-Options for management of maternity pathways payment between primary and secondary provider for AN/PN care in progress by the Finance Director - with cross provider SLA planned. Risk proposed for removal from TRR when 2016-17 SLA is signed. **(28/02/2018))** **2**-Options appraisal from finance in progress which will be discussed between the Clinical Group Director of Operations and Director of Finance. **(28/02/2018)**	2x4=8	28/02/2018	Live (With Actions)
221 22/09/2015	Medical Director Office	Informatics(C)	There is a risk of failure of a trust wide implementation of a new EPR. Failure of the EPR to go-live in the timescale specified will impact on cost and lost benefits resulting in an inability to meet strategic objectives.	4x4=16	1-Recruitment of suitably skilled specialist resources for EPR Programme and Infrastructure Stabilisation 2-Funding allocated to LTFM 3-Delivery risk shared with supplier through contract 4-Project prioritised by Board and management. 5-Project governance including development, approval and tracking to plan. 6-Focus on resources to deliver the implementation including business change, training and champions.	Kulvinder Kalsi ***Mark Reynolds***	18/01/2018	3x4=12	**Insufficient skilled resources within the Trust to deliver the EPR system.** **1**-Develop and publish implementation checklists and timescales for EPR. Report progress at Digital PMO and Committee **(31/01/2018)** **2**-Agree a plan for Unity to go live meeting the needs of clinicians, Informatics and operational staff.. **(28/02/2018)** **3**-Embed Informatics implementation and change activities in Group PMOs and production planning **(31/01/2018)** **4**-Agree and implement super user and business change approaches and review and re-establish project governance **(30/01/2018)**	1x2=2	31/05/2018	Live (With Actions)
1643 11/02/2016	Corporate Operation	—	Unfunded beds with inconsistent nursing and medical rotas are reliant on temporary staff to support rotas and carry an unfilled rate against establishment. This could result in underperformance of the safety plan, poor documentation and inconsistency of care standards.	4x4=16	1-Use of bank staff including block bookings 2-Close working with partners in relation to DTOCs 3-Close monitoring and response as required. 4-Partial control - Bed programme did initially ease the situation but different ways of working not fully implemented as planned. **Additional controls** - Funded bed model approved in Q3 and recruitment on track with substantive staffing improving. Medicine forecast 35 band 5 vacancies at end of Q4 2017. Safety plan and Early warning trigger tools in place on all wards and tracked through Consistency of Care and Executive Performance Committee. Associated risks are managed at group level and tracked through Risk Management Committee.	Rachel Barlow ***Rachel Barlow***	15/03/2018	4x4=16	**Unfunded beds - insufficient staff capacity.** 1. Patient flow programme to be delivered to reduce LOS and close beds. This includes: consultant of the week model for admitting specialties / new push/ ull AMU led MDT/ADAPT pathway / no delay for TTA project/criteria led discharge / OPAU to directly admit from ED - **31/03/2018** Contingency bed plan is agreed in October for winter - L5 to be opened in November.**(31/12/2017) - COMPLETED**	1x4=4	31/03/2018	Live (With Actions)
228 22/09/2015	Medical Director Office	Informatics(C)	There is a risk that a not fit for purpose IT infrastructure as current systems are not flexible to support clinical activity redesign. This will result in a failure to achieve strategic objectives and significantly diminishes the ability to realise benefits from related capital investments.	3x4=12	1-Approved Business Case in place for Infrastructure Stabilisation programme (approved by Trust Board June 2015) 2-Specialist technical resources engaged (both direct and via supplier model) to deliver key activities 3-Informatics has undergone organisational review and restructure to support delivery of key transformational activities 4-Informatics governance structures and delivery mechanisms have been initiated to support of transformational activities	Dean Harris ***Mark Reynolds***	14/02/2018	3x3=9	**IT infrastructure not fit for purpose.** **1**-Establish infrastructure plan and track progress. **(31/12/2017) - Awaiting update from Dean Harris** **2**-Migrate SAN storage and close P4500 and 3PAR **(31/03/2018)** **3**-Migrate VMs from VMware to Hyper-V - **(31/03/2018)** **4**-Standardise network config to resolve performance issues **(31/03/2018)**	1x1=1	31/03/2018	Live (With Actions)
325 12/05/2015	Medical Director Office	Informatics(C)	There is a risk of a breach of patient or staff confidentiality due to cyber attack which could result in loss of data and/or serious disruption to the operational running of the Trust.	4x4=16	1-Prioritised and protected investment for security infrastructure via Infrastructure Stabilisation approved Business Case 2-Information security assessment completed and actions underway.	Mark Reynolds ***Mark Reynolds***	14/02/2018	2x4=8	**Sytems in place to prevent cyber attack.** **1**- Upgrade servers from version 2003. **(31/03/2018)** **2**-Implement security controls (VLAN, IPSEC) to stop access to and from restricted devices. Over time this should harden the Trust infrastructure against attack, recognising that securing the physical network is a challenge on the estate. **(31/03/2018)** **3**-Achieve Cyber Security Essentials **(31/03/2018)** **4**-The Trust must achieve cyber-security essentials as part of the minimum commitment to security. This will likely form part of our CQC inspections. **(31/03/2018)** **5**-Complete rollout of Windows 7. **(31/03/2018)** Restricted Devices Security Controls **(31/12/2017) - COMPLETED**	2x4=8	31/03/2018	Live (With Actions)
2642 20/06/2017	Medical Director Office	Medical Director's Office	There is a risk that results not being seen and acknowledged due to I.T. systems having no mechanism for acknowledgment will lead to patients having treatment delayed or omitted.	3x5=15	1-There is results acknowledgment available in CDA only for certain types of investigation. 2-Results acknowledgement is routinely monitored and shows a range of compliance from very poor, in emergency areas, to good in outpatient areas. 3-Policy: Validation Of Imaging Results That Require Skilled Interpretation Policy SWBH/Pt Care/025 4-Clinical staff are require to keep HCR up to date - Actions related to results are updated in HCR 5-SOP - Results from Pathology by Telephone (attached)	***David Carruthers***	15/02/2018	2x5=10	**Multiple IT systems some of which have no mechanism for acknowledgment or audit trail.** **1**-Implementation of EPR in order to allow single point of access for results and audit **(30/03/2018)** **2**-All staff to comply with the updated Management of Clinical Diagnostic Tests policy **(28/02/2018)** **3**-To review and update Management of Clinical Diagnostic Tests **(28/02/2018)**	1x5=5	31/03/2018	Live (With Actions)

TRUST RISK REGISTER - 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
1738 15/04/2016	Surgery	BMEC Outpatients - Eye Centre	There is a risk that children under 3 years of age, who attend the ED at BMEC, do not receive either timely or appropriate treatment, due to limited availability OOH of specialist paediatric ophthalmologists and/or the availability of a paediatric anaesthetist. This could potentially result in severe harm to the patient.	3x4=12	1-Contingency arrangement is for a general ophthalmologist to deal with OOH emergency cases. 2-Agreement with BCH to access paediatric specialists advice. 3-There is a cohort of anaesthetists who are capable of anaesthetising children under 3 who can provide back-up anaesthetic services when required. 4-Where required patients can be transferred to alternative paediatric ophthalmology services beyond the local area - potentially Great Ormond Street Hospital 5-The expectation of the department is that a general ophthalmologist should be able to treat to the level of a general ophthalmologist and will be able to deal competently with the majority of cases that present at BMEC ED.	Bushra Mushtaq ***David Carruthers***	15/12/2017	2x4=8	**Limited access to OOH service.** **1**-Engage with ophthalmology clinical lead at BCH and agree a plan for delivering an on call service. **(30/11/2017)** 2-Liaise with commissioners over the funding model for the Paediatric OOH service. **(31/03/2018)** 3-Paediatric ophthalmologists from around the region to participate in OOH service (for discussion and agreement at a paediatric ophthalmology summit meeting).**(31/03/2018) - Awaiting update** 4-Clarify with Surgery Group leads what the paediatric anaesthetic resourcing capacity is. **(22/12/2017) - Awaiting update**	1x4=4	31/03/2018	Live (With Actions)
215 16/09/2016	Corporate Operations	Waiting List Management (S)	There is high Delayed Transfers of Care (DTOC) patients remaining in acute beds, due to a lack of EAB beds in nursing and residential care placements and social services. This results in an increased demand on acute beds.	4x5=20	New joint team with Sandwell is in implementation phase. **Additional Controls - Birmingham city council: bed base confirmed and expanded for 2017-18. Package of care service responsive. Sandwell Social Care continue to purchase beds at Rowley Regis to mitigate bed capacity issues. 7 dat social workers on site and DTOC patients in acute beds <10 generally.**	Rachel Barlow ***Rachel Barlow***	13/03/2018	2x4=8	**Lack of EAB beds in nursing and residential care placements and social services.** **1**- The System Resilience plan awaits clarification from Birmingham City Council. The system resilience partners are considering risk and mitigation as part of A&E delivery group. **(31/12/2017) - COMPLETED** **2**- To review and update the ADAPT pathway, with a management data set and KPI standards. The new process to be implemented in September to provide more focused assessments and care planning. **(31/12/2017) - COMPLETED**	2x4=8	**COMPLETED**	Live (With Actions)
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***	13/03/2018	2x3=6	**1-** implement at pace the improvement programme to reduce LOS and improve EDD compliance - **(31/03/2018)** To reduce number of patients staying over 7 days **(31/12/2017) - COMPLETED** Ensure business intelligence available to mange at ward, group and corporate level in real time **(09/12/2017) - COMPLETED**	4x3=12	31/03/2018	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. **Additional controls** review of 6 months of 52 week breaches to review themes. consider clinician competency training.	Liam Kennedy ***Rachel Barlow***	13/03/2018	3x3=9	**Lack of assurance on 18 week process.** **1**-Data quality process to be audited - Monthly audits **(31/03/2018)** **2**- E-learning module for RTT with a competency sign off for all staff in delivery chain - to b e rolled out to all staff from October. **(31/03/2018)** **3**-Bespoke training platform for 18 weeks and pathway management for all staff groups developed in line with accredited managers programme. **(31/10/2017) - COMPLETED**	2x2=4	31/03/2018	Live (With Actions)
533 29/12/2015	Primary Care And Community Therapies	Oncology Medical	There is a risk of negative impact to cancer waiting times, caused the withdrawal of oncology consultants and transfer of patients to other providers, which may lead to longer waits for oncology treatment.	3x5=15	1- Use of locums to fill staffing gaps. 2- NHS Improvement-seconded UHB manager on site at SWBH to try and facilitate communication with UHB clinical team and improve perception of performance.	Stephen Hildrew ***David Carruthers***	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***	28/02/2002	4x5=20	**Lack of assurance on the sufficiency of our plans to achieve cost reduction and cash remediation** **1**- Deliver operational performance consistent with delivery of financial plan to mitigate further cash erosion **- (31/03/2018)** -Use relevant benchmarks to underpin multi-year & specific CIP plans -Align trust CIP to commissioner QIPP to secure collective system cost reduction -Secure market opportunities to drive financial margin gain **- (31/03/2018)** **2**- Ensure necessary & sufficient capacity & capability to deliver scale of improvement required **3**- Develop and secure alternative funding and contracting mechanisms with commissioners to secure income recovery and to drive the right long term system behaviours **- (31/03/2018)** **4**- Refresh LTFM to confirm scale of cash remediation required consistent with level 2 SOF financial sustainability rating - **((31/03/2018)** **5**- Secure borrowing necessary to bridge any financial gap **- (31/03/2018)**	2x5=10	31/03/2018	Live (With Actions)
534 29/12/2015	Primary Care & Community Therapies	Oncology Medical	There is a risk of Trust non-compliance with some peer review standards and impact on effectiveness of tumour site MDTs due to withdrawal of UHB consultant oncologists, which may lead to lack of oncologist attendance at MDTs	3x4=12	Oncology recruitment ongoing. Withdrawal of UHB oncologists confirmed, however assurance given around attendance at MDT meetings. Gaps remain due to simultaneous MDT meetings.	Jennifer Donovan ***David Carruthers***	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)

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
666 20/07/2017	Women and Child Health	Lyndon 1	Children-Young people with mental health conditions are being admitted to the paediatric ward due to lack of Tier 4 bed facilities. Therefore therapeutic care is compromised and there can be an impact on other children and parents.	4x4=16	1- Mental health agency nursing staff utilised to provide care 1:1 2- All admissions are monitored for internal and external monitoring purposes. 3-Awareness training for Trust staff to support management of these patients. 4-Children are managed in a paediatric environment.	Heather Bennett ***Rachel Barlow***	16/03/2018	4x4=16	**There is no specialist medical or nursing MH team to care for their needs with limited access to in/OOH CAMHS support.** **1**- The LA and CCG are looking to develop a Tier 3+ service. An update has been requested through the CCG and a response is awaited. Tier 4 beds are being reviewed nationally. **(31/03/2018)**	3x4=12	31/03/2018	Monitor (Tolerate)
566 17/10/2017	Medicine And Emergency Care	Accident & Emergency (S)	There is a risk that further reduction or failure to recruit senior medical staff in ED will lead to an inability to provide a viable rota at consultant level. This will impact on delays in assessment, treatment and will compromise patient safety.	4x5=20	1- Recruitment campaign in place through local networks, national adverts, head-hunters and international recruitment expertise. 2- Leadership development and mentorship programme in place to support staff development. 3-Robust forward look on rotas are being monitored through leadership team reliance on locums and shifts are filled with locums.	Michelle Harris ***Rachel Barlow***	13/03/2018	3x4=12	**Vacancies in senior medical staff in ED.** **1**- Recruitment ongoing with marketing of new hospital. **(31/03/2018)** **2**- CESR middle grade training programme to be implemented as a "grow your own" workforce strategy. **(31/03/2018)** **3**- Development of recruitment strategy **(31/03/2018)**	4x3=12	31/03/2018	Live (With Actions)
114 04/04/2016	Workforce And Organisational D	Human Resources	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 ***Raffaela Goodby***	04/03/2018	3x5=15	**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) - AWAITUNG UPDATE**	3x3=9	31/07/2018	Live (With Actions)
410 04/10/2016	Surgery	Outpatients - EYE (S)	Risk of Breach of Privacy and Dignity Standard, Information Governance Risk and Infection Control Risk at SGH Opthalmology Outpatient Department as a consequence of poor building design which can result in financial penalties and poor patient outcomes.	5x4=20	Staff trained in Information Governance and mindful of conversations being overheard by nearby patients / staff / visitors	Laura Young ***Rachel Barlow***	30/01/2018	3x4=12	**Poor building design of SGH Ophthamology OPD** **1**-Review of moving the community dental rooms. Plans being drawn up - should be available for consultation mid Sept 2017 - potential for renovation around mid 2018. **(31/07/2018)** **2**-Review plans in line with STC retained estate **(31/07/2018)**	2x2=4	29/09/2018	Live (With Actions)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Risk Assessment

Risk Number: 2849		**Status:**	*Live (With Actions)*
Site:	City Hospital	**Department:**	Medical/Surgical Team (C)
Clin. Grp / Corp Dir:	Corporate Operations	**Owner:**	Rachel Barlow
Directorate:	CEO	**Assessor:**	Rachel Barlow
Specialty:	Winter Pressure Ward	**RR Level:**	Clinical Group/Corporate Direc
Risk monitored by:	Trust Board		

Initial Risk	Current Risk	Target Risk
Severity (4) x Likehood (5) = 20 Red	Severity (4) x Likehood (5) = 20 Red	Sorry! No Target set

Risk Type: Finance **Risk Sub-Type:** Costs Not Planned

Risk Statement	Scope	Hazard
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. To reduce the number of patients staying over 7 days and meet LOS goals To ensure business intelligence is available to manage at ward, group and corporate level in real time	Deviation from the Trust financial plan and subsequent impact on future investment ability	Reputational risk as a result of not delivering bed closure and financial plan

Existing Controls:

1	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	Policy/Procedure/System
2		Policy/Procedure/System

Actions:

1	reduce number of patients staying over 7 days	31/12/2017	Open	Michelle Harris
2	ensure business intelligence available to mange at ward, group and corporate level in real time	09/12/2017	Open	Matthew Maguire
3	implement at pace the improvement programme to reduce LOS and improve EDD compliance	31/12/2017	Open	Rachel Barlow

Review Dates:

Last Review Date: / / **Next Review Date:** / /

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Risk Assessment

Risk Number: 215		**Status:**	*Live (With Actions)*
Site:	Sandwell General Hospital	**Department:**	Waiting List Management (S)
Clin. Grp / Corp Dir:	Corporate Operations	**Owner:**	Phil Holland
Directorate:	Waiting List Management	**Assessor:**	Rachel Barlow
Specialty:	Waiting List Management	**RR Level:**	Clinical Group/Corporate Direc
Risk monitored by:	Trust Board		

Initial Risk	Current Risk	Target Risk
Severity (5) x Likehood (4) = 20 Red	Severity (4) x Likehood (4) = 16 Red	Sorry! No Target set

Risk Type: Operational Performance **Risk Sub-Type:** Performance

Risk Statement	Scope	Hazard
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.	Sustained high DTOC patients remaining in acute bed capacity due to lack of nursing and residential care placements and social services capacity to provide timely support at home. The decrease in acute available bed capacity is a risk to the Emergency Care Target and potentially patients' outcomes due to the unnecessary lengthened stay in an acute hospital environment.	Patients Financial implications

Existing Controls:

1	New joint team with Sandwell is in implementation phase.	Policy/Procedure/System

Actions:

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	Open	Phil Holland
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	Open	Phil Holland

Review Dates:

Last Review Date: 23/08/2017 **Next Review Date:** 21/11/2017

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Perinatal Mortality Review update
SPONSOR (EXECUTIVE DIRECTOR):	Elaine Newell – Chief Nurse
AUTHOR:	Elaine Newell
DATE OF MEETING:	1st February 2018

EXECUTIVE SUMMARY:

This report provides an update on actions relating to the recent Perinatal Mortality review. The Board are assured that the majority of actions are closed with those outstanding on track for delivery within agreed timeframes.

Further objective assurance was sought by the executive on those cases not reviewed by the external team, to include cases occurring between the dates 1st January 2017 – 30th March 2017. This review has now been completed and a report received by Q & S on the 26th January. That report forms an addendum to this paper.

REPORT RECOMMENDATION:

The Board are requested to note the contents of this 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		Environmental		Communications & Media	x
Business and market share		Legal & Policy	x	Patient Experience	x
Clinical	**x**	Equality and Diversity	x	Workforce	x

Comments:

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

PREVIOUS CONSIDERATION:

Q & S committee January 2018

Perinatal Mortality Review update

1st February 2018

Following a rise in perinatal mortality rates in 2016-17, resulting in Sandwell and West Birmingham Hospitals becoming a national outlier in the MBRRACE-UK audit, the Trust Board commissioned and received an external review of the perinatal mortality cases. The report provided by the external reviewers demonstrated that due to time constraints, only a very small number of the cases that were made available had been reviewed by the external team during this process, therefore further objective assurance was sought by the executive. This included a review of all perinatal mortality cases that were not reviewed as an SI between the dates 1st January 2017 – 30th March 2017.

The report outlining the findings of this review is attached in Appendix 1

An action plan was established in order to address the issues and learning points raised by both review teams (See Appendix 2). The majority of actions have now been completed with good progress being made to complete the remainder of actions within the agreed timescales.

The national perinatal mortality review tool is expected to be released imminently; the team are in the process of completing the access forms to expedite this however meanwhile are using the NPSA standardised tool pending this launch. This has afforded greater consistency with a standardised approach to how cases are reviewed and CESDI grading apportioned and was initiated in July 2017, with cases from April 2017 going through this process at the Perinatal Mortality Review Board. This process is further evolving as a representative from SANDs (representing service users) is anticipated to join the panel shortly. In addition, objective peer oversight will be provided at these meetings by utilising and sharing resources from within the Local Maternity System.

Additional initiatives to better understand and facilitate proactive improvements include audit of unexpected term admission to neonatal unit (dissemination of findings by presentation 31.01.18) and the ongoing work as part of wave 1 of the National Maternity and Neonatal Safety Collaborative. This has involved a week long focus on safety across the maternity and neonatal service with input from national teams, engaging the clinical teams and sharing improvement initiatives. A focal area is on proactive identification and escalation of reduced fetal movements and revisions to the guideline in response to national outcomes, guidance and local factors. Assessment of the unit's safety culture is also commencing to gain enhanced insight to direct targeted improvements in this area.

Perinatal Mortality rates have reduced in recent months however the Group will continue to closely monitor these via the monthly Obstetric dashboard. The process for monitoring delivery of the action plan and subsequent actions resulting from any future cases, is via the Perinatal Mortality Review Board. The Board reports to the Directorate Governance Group and upwards to the Group Governance Board. Executive oversight and monitoring is provided by the Quality and Safety Committee.

A Maternity Safety Summit is planned for the 7th February, to be chaired by the CEO

Appendix 1:

Internal Quality Assurance Review of perinatal mortality cases from

1/1/17 – 30/4/17

Introduction

Following a rise in perinatal mortality rates in 2016-17, resulting in Sandwell and West Birmingham Hospitals becoming a national outlier in the MBRRACE-UK audit, the Trust Board commissioned an external review of the governance of perinatal mortality. The outcome of the invited external review has resulted in a change in perinatal mortality review process, improving the rigour of review and consistency of grading (CESDI – Confidential Enquiry into Stillbirths and Deaths in Infancy – see appendix 1 for definitions) of perinatal deaths. The new review process has now been in place since 1st July 2017 and applied to all cases that occurred since April 2017. Whilst the external review looked at the Trust governance processes it did not look into specific cases arising during the period of the Trust's outlier status. The recommendation of the external review was to re-assess perinatal deaths during this period applying the new rigorous and consistent standards. The purpose of this report is to review all cases of perinatal mortality between the dates 1st January 2017 – 30th March 2017 and determine if:

a) The CESDI grading was correct and

b) If not correct assign the new CESDI grading and

c) Explain the reasons for re-grading the case.

Methodology

The review group consisted of:

- Susan Smith, Midwife – lead for SCOR (Standardised Clinical Outcome Review) & Risk
- Miss Gabrielle Downey, Consultant Obstetrics & Gynaecology – Group Director Women & Children's
- Dr Roger Stedman, Consultant Anaesthesia & Critical Care – Former Medical Director

Data sources included for all cases:

The case notes - Paper records, including hand held notes and CTG readings

Clinical Data Archive and scanned records

Badger Net electronic record

The previous perinatal review reports and the CESDI grading.

The summary cases with their previous and reallocated grading plus reasons for the change are available on request.

Case Identification:

All perinatal cases stored in the Trust database on the S-drive and assessed as 22+0 (weeks gestation) as per MBBRACE monitoring, in the date range 1/1/17 – 30/4/17 were included. There were 25 cases identified.

Exclusion Criteria:

1. Termination of Pregnancy for fetal abnormalities or known lethal abnormality (1).
2. Any case that already had a previous full Serious Untoward Incident review (4).
3. Any delivery under the age of viability i.e. miscarriage (23+6) completed weeks of pregnancy) (1).
4. Any case with a lethal abnormality incompatible with life (3).

This left 16 cases in the analysis group.

Review Method:

The review team used a standardised toolkit method in line with the SCOR toolkit as published by the Perinatal Institute (see appendix 2). This is a methodology which has been in development and for which Sandwell and West Birmingham Hospitals has been a pilot site. An adaptation of the SCOR method is due to be adopted nationally as a standardised approach to review and scoring of perinatal deaths, once published in early 2018.

Findings

Of the 16 cases, 10 were regraded, 5 remained the same and 1 had a CESDI grade assigned as none had been assigned previously. Of the 10 regraded, 8 were downgraded and 2 were upgraded. Of the latter one was upgraded from 2 to 3 and one from 0 to 2.

Case (n=16)	
Grading changed	10
Grading unchanged	5
Grade Assigned	1
Downgraded	8
Upgraded	2

The main reasons for downgrading was the removal of patient-related factors e.g. late booker as just entered country, or the review team could not see any deviation from guidelines/policies. The two upgraded cases were:

- Case 1 - Contacted Maternity Triage on 2 occasions with diminished fetal movements and advised to come in but did not attend – no evidence of action taken to chase non-attendance. Intra Uterine Death diagnosed 3 days later (case from 0 to 2).
- Case 2 - Syntocinon augmentation commenced in presence of non-reassuring CTG – decision error, should have allowed 2 hours after artificial rupture of membranes. CTG not adequately monitoring fetal heart rate during attempted insertion of epidural – no action taken to address this. Regional block attempted for caesarean section causing delay in delivery (case from 2 to 3).

Immediate actions taken in response to upgrading

Following identification of two cases for which the CESDI grading has been increased the following actions have been taken:

Case 1 – a new standardised operating procedure for the triage area has been introduced for handling patients that DNA following a recommendation to attend.

Case 2 – this case has been referred to Trust Governance and Risk to be investigated as a SUI (serious untoward incident).

Conclusions

The CESDI grading was different once the standardised tool kit methodology was applied and mainly resulted in a downgrade when patient-related factors were removed. Case 1 upgrade was as a result of a robust application of the existing policy for DNAs. A DNA policy specific to Maternity Triage has been written and introduced in December 2017. Case 2 was upgraded and this review team did not think the initial reviewers fully appreciated the impact of the time delay in making a decision to deliver and the degree of fetal compromise on the neonatal death.

Recommendations

During the review, it was highlighted that actions were already in progress to continually improve the quality and safe care provision. To further develop this we would recommend:

- Evidence of individual and organisational learning as a result of case reviews identifying issues i.e. robust monitoring and closure of action plans
- Sign off at the Group Governance Board of the actions
- All SUI reports to have triumvirate sign off
- Audit of the impact of the new DNA policy for maternity triage

- A repeat Quality Assurance Exercise of cases assessed since 1/5/17 using the standardised tool kit to ensure the new process is more robust

CESDI Grading definitions

Table 1: CESDI Grading classification system

Grade 0	No Suboptimal care
Grade 1	Suboptimal care, but different management would have made no difference to the outcome
Grade 2	Suboptimal care - different care MIGHT have made a difference (possibly avoidable death)
Grade 3	Suboptimal care WOULD REASONABLY BE EXPECTED to have made a difference (probably avoidable death)

(CESDI Grading classification system)

APPENDIX2: Action Plan (individual case reviews & external review)

ACTION PLAN: Peer review Perinatal Mortality November 2017. UPDATED 17.01.18

Theme	Recommendation	Local Response	Actions	Responsibility	Timescale
1. Electronic and ultrasound fetal monitoring	Efm training standards to be agreed for all staff (mandatory with agreed compliance rates for midwives and medical staff)	EfM standards and compliance in place with monitoring for midwifery staff however was not available to the review team at time of visit.	Accuracy of findings raised with Review team; evidence available	Director of Midwifery	COMPLETE 03.11.17
			Standards and compliance for medical staff implemented.	Clinical Director	COMPLETE 06.10.17 Ongoing monitoring in progress
			Monthly evidence of CTG compliance to be reviewed at risk and governance meeting with associated actions to ensure compliance to agreed standard	Risk & Governance Lead Midwife	COMPLETE 06.10.17 Ongoing monitoring in Progress
	Clarify routes of communication and decision making when abnormal Doppler indicates need for intensive fetal surveillance	Individual care planning is in place with escalation to Consultant in practice. Revised guideline was implemented in practice to ensure consistency in care planning; not reviewed by review team at time of visit.	Accuracy of findings raised with Review team; evidence available	Director of Midwifery	COMPLETE 03.11.17
2. Incident investigation and reporting	Consider review of all SI events within 72hrs within Trust at senior level	This is the Trust pathway and decision had previously been taken for maternity incidents to be included alongside Trustwide process (shared with reviewers at time of visit).	Accuracy of findings raised with Review team; evidence available	Director of Midwifery	COMPLETE 03.11.17
			Trustwide implementation of revised process	Deputy Director of Governance	1.3.18 Awaiting final approval of process. Directorate instigating 72 hours review.
	RCA leads to be identified and trained in art of leading RCAs and report writing	RCA leads identified and training planned November 2017.	Complete scheduled Training	Director of Midwifery, Group Director & Risk & Governance leads	COMPLETE 02.11.17
	RCA to involve members of the team who were involved in incident and cover whole care pathway	Routine practice is for table top reviews to be convened and involve team members however perinatal mortality and risk Group has become the forum for this.	Review of process for RCA engagement; Trustwide implementation of revised model for review	Deputy Director of Governance & Group Director of Midwifery	COMPLETE 02.11.17
	Midwives involved in incidents should have support from a professional midwifery advocate and doctors from an educational supervisor	This is in place (formally support afforded by Supervisors of Midwives); PMA training progressing.	PMA training commenced September 2017 – April 2018 (6 places).	Director of Midwifery	30.04.18 In Progress

	RCA reports should be shared with staff	Summary reports are shared with whole teams through risk newsletter, QIHD, lessons learnt (effective handover). 1:1 debrief facilitated with staff involved.	Accuracy of findings raised with Review team; evidence available	Director of Midwifery	COMPLETE 03.11.17
	Reports should include areas of good practice, any deficiencies in staffing or organisational issues	New report template shared with reviewers which outlines requirement for good practice and organisational issues to be outlined.	Revised report used as standard for all reports	Risk & Governance Lead Midwife & Consultant :	COMPLETE from 01.06.17
	There must be an effective version control of RCA reports	Revised template introduced; version control requirement agreed.	Revised report used for all reports with version control as standard with corporate team oversight.	Risk & Governance Lead Midwife & Consultant :	COMPLETE from 01.06.17
	RCA reports should be reviewed and signed off within the organisation	SI reports are reviewed and signed off by executive lead, facilitated by corporate team; evidence demonstrated to review team during visit.	Issue to be raised with Review team	Director of Midwifery	COMPLETE 03.11.17
			Implement Group sign off process at Director level	Director of Midwifery, Group Director & Risk & Governance leads	COMPLETE 02.01.18
	Actions identified in reports must be tracked to ensure implementation	Process for tracked actions demonstrated to reviewers at time of review.	Issue to be raised with Review team	Director of Midwifery	COMPLETE 03.11.17
	The unit should undertake a review of all cases to identify the themes which must be addressed	Review team were informed of a new perinatal mortality board that was implemented in July 2017 and has reviewed all cases from May 2017 using the SCOR template to ensure objectivity and thematic review.	Perinatal mortality Review Board implementation in line with SCOR process/ template	Lead Consultant for Perinatal Mortality	COMPLETE 01.07.17
			All 2017 cases not reviewed in line with SCOR process to be re-reviewed with external to Group clinical expert to validate CESDI grades	Group Director	COMPLETE January 2018
	The unit should report its perinatal mortality to the Board in relation to both stillbirths and neonatal deaths as separate rates	Rates are reflected separately on the obstetric dashboard however combined on integrated performance report which is available to all CLE members.	Request to IPR to reflect stillbirths and neonatal deaths as separate rates.	Director of Midwifery	COMPLETE 23.10.17
3. Duty of candour	Duty of candour to be documented to a consistent standard as in SI4	SI4 used new template; reviewers advised this has afforded standardised approach for consistency and has been implemented across the Trust but was not evident in earlier reviews.	Issue to be raised with Review team	Director of Midwifery	COMPLETE 03.11.17

4. Guidelines	Must be authored in a consistent template and reflect external standards	Guideline revision meeting convened with involvement of clinical effectiveness; planned method for guideline review in place including review against NICE guidelines	All guidelines are in the process of being converted into new Trust template.	Lead for Guidelines and policies As guidelines reviewed and revised.	In progress (up to date Jan 2018)
	The guidelines for Day Assessment Unit and management of SRoM after 34 weeks must be updated	The reviewers were informed that both guidelines were under review pending sign off at time of visit; guidelines in place at time of care provision re. incident were shared with reviewers	Reviewers were informed of progress of guideline review during visit; raised with review team. Evidence available of revised guidelines in practice	Director of Midwifery	COMPLETE 03.11.17
	Fetal growth guidelines must be consistent with diagrams	Review of guideline in progress at time of review and since, completed.	Revised guideline implemented into practice.	Director of Midwifery	COMPLETE
5. Clinical records	The unit should review the entire process of recording clinical pathway in clinical record and use by staff to be assured that there are no aspects that may present a risk to patients or to the organisation	Neither of the reviewers were familiar with the BadgerNet system. SoPs or staff training programme were not requested or shared during the visit. A review of the SoPs is already in progress, as shared with the reviewers. N.B: Badgernet is widely recognised as a EPR for maternity and is an accepted maternity care record nationally	Regular review and introduction of Standard operational policy in line with upgrades and changes to BadgerNet and compliance monitoring.	Project lead midwife for maternity EPR:	1.4.18 IN PROGRESS
	CTGs must be stored securely in patient records.	1 set of records had been returned from case note scanning team and were returned without any documents having been secured. Incident raised and reported however CTG and all records had been scanned onto CDA and were available for viewing.	Escalation of incident to lead for Digital programme implementation	Director of Midwifery	COMPLETE 08.09.17

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Integrated Quality & Performance Report P09 December 2017**
SPONSOR (EXECUTIVE DIRECTOR):	**Tony Waite, Director of Finance & Performance**
AUTHOR:	**Dave Baker – Director of Partnerships and Innovation**
DATE OF MEETING:	**1 February 2018**

EXECUTIVE SUMMARY:

IPR – Key indicators summary – P09 December 2017 :

- ✓ **62 day cancer** compliant at 86% at November vs. target of 85%; all other cancer targets continue to deliver. Impact of prospective changes to oncology services on measured performance being assessed & could risk future compliance.
- ✓ **RTT pre submission** was 91.65% but extended validation meant that 92% (92.4%) was achieved and thus compliance achieved with national standard of 92%.
- ✓ **MSA Breaches** – no breaches for December following a change in policy agreed with the CCG, where adult acute assessment units and the surgical assessments units are exempt.
- ✓ **Mortality rate** indicator RAMI is 109. MDO review of emergent divergence between weekday and weekend rates 103 and 128 respectively was reportable to December (suggest shift to February to allow for new Medical Director transition).
- ✓ **VTE** assessments were 94.9% for December just missing the 95% target after 15 months of compliance. 394 assessments were missed. Full year compliant to national standard at 96.5 % as of December.
- ✓ **MRSA** – no cases year to date
- ✓ **CDiff** – compliant with target; in month 1x case in December; x18 cases year to date.

- × **ED 4 hour** performance for December 78.65% (82.68%) vs STF required standard of 90% with 3814 breaches of the standard.
- × **Acute Diagnostic waiting times** within 6 weeks to be confirmed for December. November was 98.89% compliant versus 99% standard with 103 breaches mainly due to equipment failure.
- × **Neutropenic sepsis** remains below 100% standard. In December 7/33 (21%) patients did not receive treatment within the required 1hr timeframe.
- × **52 week incomplete breaches** x3 in December on the incomplete pathway.
- × **Elective Operations Cancellations** consistently under-delivering. 46 (47) declared on sitrep for December. 28% (23%) were avoidable. Cancelled for non clinical reasons as a proportion of elective admissions was 1.4%.
- × **Hip fractures** not yet reported for December best practice tariff performance for November is at 70% [82%]. Hence remains below 85% standard on a persistent basis.
- × **Sickness rates** not yet reported for December. November reported at 4.68% (4.49%); cumulative sickness rate at 4.48%. Short-term sickness increased in October to 962 cases [889, 706; 664] showed a growing trend, long term sickness also increasing to reduced slightly in month 246 cases [251, 216; 232] month on month.

Requiring attention – action for improvement :

Progress since previous report – Cancer looks like it has successfully achieved its Q3 position. WHO Safer checklist improved from 97% to 99.6% in December so getting close to 100% target.

Neutropenic Sepsis

- As per persistent reds to be resolved by March 2018.

IPR Population

- Indicators are not signed off on a timely basis causing reporting gaps and delays, improvement has been requested at this was passed through the OMC for endorsement

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

Recovery Action Plans (RAPs)

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

The Trust now has the following RAPs ongoing for action:

1. Community Gynae referral to 1st OP within 4 weeks: failing target after successful delivery in previous months – the service is reacting to this.

   RAP dated April 2017. We understand that General Gynae clinics have been added to the list to assist productivity but cannot yet evidence that the Community Gynae patients are now hitting the 4 week target agreed with the CCG.

2. Safeguarding training: all levels of the training are now delivering to the 85% standard. This is a very good outcome for the training team. Should this now be closed?

3. Dementia and Falls Assessments (Community); Data quality issues resolved by Information Team. Performance still under expected trajectories.

4. Cancelled on day operations: sustainable progress not yet embedded.

   RAP dated March 2017 - Theatre Improvement Project overseeing. Improvement plan to be delivered in Q1.

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.

   RAP dated July 2017. 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

- Total available in full year = £8.8m
- Q3 reporting due shortly
- Q2 results reported to commissioners with a lost funding anticipated at £215k year to date (Q1 and Q2 year to date).
- Trust has declared success against all schemes except sepsis and eRS roll out.
- Awaiting feedback and confirmation from commissioners on Q2.
- 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, Clinical Leadership Executive, Quality and Safety Committee

Sandwell and West Birmingham Hospitals NHS Trust

Integrated Quality & Performance Report

Month Reported: December 2017

Reported as at: 15/01/2018

OPERATIONAL MANAGEMENT COMMITTEE

Contents

December 2017

Infection Control

Cdiff - compliant
- x1 C. Diff cases reported during the month of December;
- x18 cases year to date against trajectory maximum of 23;
- most recent two months exceed trajectory - escalted 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
December month:
- Non-elective patients screening 93.4%
- Elective patients screening 86.5%
- 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 6.3 compared to target of 9.42.

Harm Free Care

Safety thermometer - not compliant
- 93.4% reported for December;
- 94.5% year to date;

NHS Safety Thermometer target 95% consistent marginal failure

- x71 [x66] falls reported in December with x0 [x3] fall resulting in serious injury,
- x674 falls reported year to date
- In month, 38 falls within community, 33 falls in acute setting.
- 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.

- x10 [x9] avoidable, hospital acquired pressure sores reported in December of which 1x grade 4 (first time this year) x1 grade 3, x8 grade 2
- x5 separate cases reported within the DN caseload.
- CNO keep in view

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

- No never event was reported in December; x3 year to date
- WHO Safer Surgery (Audit - brief and debrief - % lists where complete) as at December at 99.6% (97.9%0 vs the 100% target. Improving, but persistent lists not de-briefed in Cardiology. Clinician/list specific follow up by Group Director of Ops to secure 100% compliance

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

x19 (x31) DOLS have been raised in December of which 19 were 7-day urgents;
cases reduced to last five months

- Venous Thromboembolism (VTE) Assessments in at 94.9% [97.5%] compliant with 95% standard across all Groups for December , missing the target after 15 months of compliance.
- 394 assessments were missed in December; being addressed through Safety Plan roll out to secure 100% compliance.

Obstetrics

C-section rate - not compliant
- The overall Caesarean Section rate for December is 26.6% (26.2%) and 25.7% year to date just above the 25% target, driven by non-elective cases
- Elective and non-elective rates are 5.3% (very low compared to historical trend) and 21.3% 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 December is 4.02 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 6.0 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 December is 4.02
- Neonatal Death Rate (Corrected) (per 1000 babies) is 0.0 in December

- Post Partum Haemorrhage (>2000ml) x2 cases against a threshold of 1 case in December, 18x cases year to date and below trust 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 December;
x1 death last 18mnths recorded in August.

- Breastfeeding initiation performance reports quarterly; September quarterly count is at 75.49% compliant with the 74% target. Q3 to be confirmed.

Mortality & Readmissions

Mortality - compliant
- The Trust overall RAMI for most recent 12-mth cumulative period is 109 (available data is as at September) 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 128 respectively. MDO review reportable to December Q&S
- SHMI measure which includes deaths 30-days after hospital discharge is at 103 for the month of July(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 September is 144.** This indicator measures in-month expected versus actual deaths so subject to larger month on month variations.
- Crude in-month mortality rate for November is 1.2% [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 x119 [x133] deaths in our hospitals in the month of November; slightly lower than last year same period which was at 129.

Mortality Reviews within 42 Days - not compliant
- Mortality review rate in October at 32% 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 November static 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 93.9% [93.3%] of patients are spending >90% of their time on a stroke ward - compliant with the 90% operational threshold

Admission - not compliant
- December admittance to an acute stroke unit within 4 hours is at 69.6% [77.6%] below the national standard of 80%.

Scans - compliant
- Pts receiving CT Scan within 1 hour of presentation is at 78% in December, but being consistently compliant with 50% standard;
- Pts receiving CT Scan within 24 hrs of presentation delivery in month at 100% [98.0%] meeting the 95% standard in month

Thrombolysis - compliant
IPR showing at 60%, but latest available validation has confirmed compliance at 100% in the month of December.

Angioplasty - compliant
For December 95.8% compliance on both Primary Angioplasty Door to balloon time (<90 minutes) and 100% Call to balloon time (<150 minutes) & delivering consistently against 80% targets

RACP - compliant
RACP performance for December 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 December is at 100% against the target of 70%.
- TIA (Low Risk) Treatment <7 days from receipt of referral delivery at December is 100% against a target of 75%.

Cancer Care

Cancer standards - compliant across all standards
- November delivery across all headline cancer targets including 62 Days at 86.0%; nationally the trust performs well on this target and with December delivery the Q3 performance has been achieved.
- Highlighting November 2WW delivering 97.8% against the 93% standard significantly improving on historical performance levels
- 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
- x12.0 [x11.0] patients waited longer than the 62 days at the end of October.
- 2 [x4] patients waited more than 104 days at the end of November
- The longest waiting time for treatment for a patient as at the end of November was at 173 days

Neutropenic sepsis - not compliant
- (7/33 patients) - 21% of neutropenic sepsis December cases failed to receive treatment within prescribed period (less than 1hr). ED driven residual cases, confined to OOH service and lack of patients identifying. Actions are in place to address remaining issues.

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. Fines are being proposed for the failure to achieve this target.

Patient Experience - MSA & Complaints

MSA - compliant
- There were zero reportable breaches reported in December .
- A change in reportable breaches was agreed with CCG and the reporting is on that basis. The trust continuous to monitor all 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 December is 71 [99] with 1.7 [2.0] formal complaints per 1000 bed days, showing an increase to previous rates, but lower to last year same period (2.6).
- 92% [90%] have been acknowledged within target timeframes (3 days).
- 12% [19%] month of responses have been reported beyond agreed target time; escalated to DG for remedy.

Patient Experience - Cancelled Operations

Cancelled Ops - not compliant
- 46 sitrep declared late (on day) cancelations were reported in December.
- Of the 46 patients who were cancelled on the day, 13 (28%) were avoidable;
- Elective operations cancelled at the last minute for non-clinical reasons, as a proportion of elective admissions, was 1.4% in December (since Jun16 consistently failing the tolerance of 0.8%). Improvement plans are in place to deliver target by Q1

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

Theatre In-Session Utilisation - not compliant
- Theatre in-session utilisation is consistently below the target of 85%; 70.3% in month, 72.7% year to date
- The in-session 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%. A second indicator will be added to measure 'overall session utilisation' (outside in-session timings, to sense-check productivity albeit outside a regular session)
- 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 December was 78.65% [82.68%] against the 90% STF & 95% national target
- 3,814 breaches were incurred in December

ED quarterly performance trend for 17/18: Q1 at 83.3% ; Q2 at 87.1%; Q3 at 82.30%

WMAS Handovers - partially compliant
- WMAS fineable 30 - 60 minutes delayed handovers at 208 [207] in December. An very small increase month on month.
- x11 [x6] cases were > 60 minutes delayed handovers in December - the Trust performs very well in this category with only 41 breaches year to date > 60 mins

- Handovers >60mins (against all conveyances) 0.23% in December increasing to last months and against target of 0.02% . This performance is against total WMAS conveyances of 4,725 in December which was an increase to November.
- On a year to date basis , handovers >60mins are at 0.10% against the 0.02% target.

Fractured NOF - no input for December performance
- 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 522 bed days in December; of which 226 beds were fineable to BCC. Sitrep defined DTOCs reported performance at 2.7% against the 3.5% target.
Sustained elevated levels of DTOCs; system plan to remedy remains to be assured.

Referral To Treatment

RTT - pre-submission at 91.65%, but further validation ongoing
- RTT incomplete pathway for December is at 91.65% [92.4%] ;
- The backlog (>18wks) as at end of December stands at 2,521 patients

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

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

Acute diagnostic waits - to be confirmed for December at this stage
'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 141,000 as at December 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 141,000 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 December is at 85.3% against the 95% target.
- Medical Appraisal at 82.1%.

Sickness - not reported as yet for December
- 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 13.3% [13.2%] in December increasing to previous months, higher to previous trend

Mandatory Training - not compliant
- Mandatory Training at the end of December is at 87.3% overall against target of 95%;
- Health & Safety related training is below the 95% target at 94.5% in December.
- Safeguarding training recovery plans (Level 2 Child & Adults) are hitting improvement trajectories and are delivering full standards.

CQUINs & Local Quality Requirements 2017/18

CQUINs :Q3 reporting due by mid-January.
- 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 shortfall of £215k against 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
- A year end forecast will be worked up as Q3 results are reported

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 performance 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 and DNAs; BMI fully compliant now for 3 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 attributed to 'general patients' diluting the booking horizon as outside of 4 weeks
- A&E including morning discharges and other A&E indicators are subject to an overall plan (RAP) and 'patient journey' project.

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 - December (In-Month)

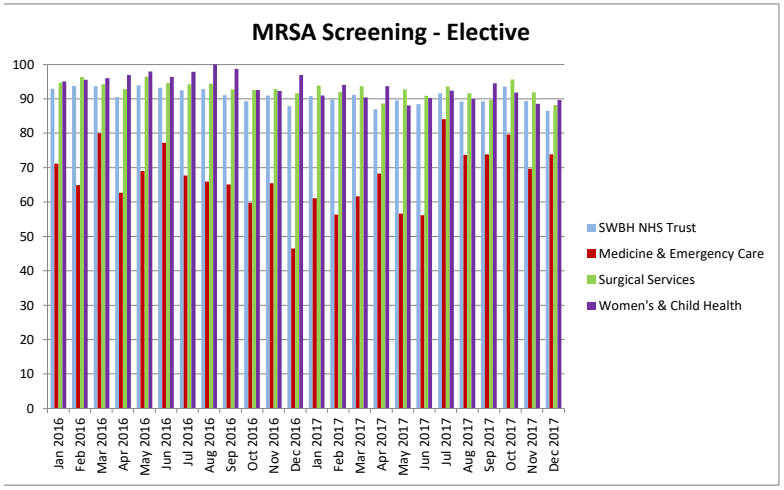
Summary Scorecard

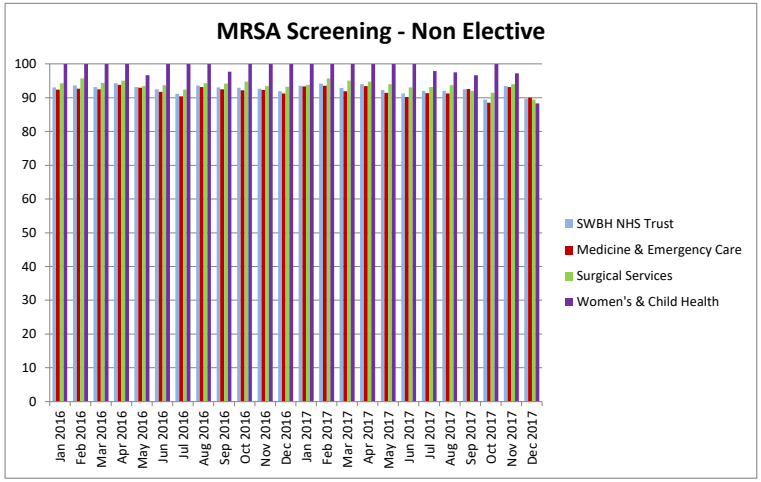
Section	Red Rated	Green Rated	None	Total
Infection Control	0	6	0	**6**
Harm Free Care	10	3	9	**22**
Obstetrics	3	6	6	**15**
Mortality and Readmissions	1	1	11	**13**
Stroke and Cardiology	1	10	0	**11**
Cancer	2	8	5	**15**
FFT. MSA, Complaints	15	1	5	**21**
Cancellations	5	3	0	**8**
Emergency Care & Patient Flow	10	6	4	**20**
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	55	104	**229**

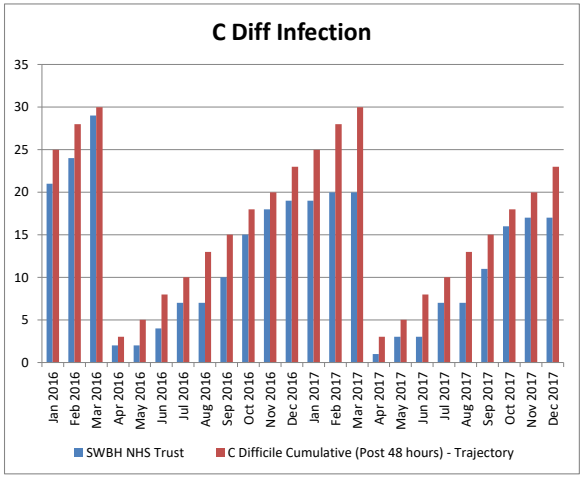
- Persistently red-rated performance (>12months) indicators are subject to improvement trajectories and monitoring.
- IBN002 is still an outstanding performance notice against which funding has been withheld now at risk of permanent removal. COO/FD have been asked for support to close this out (c£500k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

Patient Safety - Infection Control

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From Jul 2016) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
4			C. Difficile	<= No	30	2.5																			Dec 2017	1	0	0			0		1	18	
4			MRSA Bacteraemia	<= No	0	0																			Dec 2017	0	0	0			0		0	0	
4			MSSA Bacteraemia (rate per 100,000 bed days)	<= Rate2	9.42	9.42																			Dec 2017								9.9	6.3	
4			E Coli Bacteraemia (rate per 100,000 bed days)	<= Rate2	94.9	94.9																			Dec 2017								5.0	8.6	
3			MRSA Screening - Elective	=> %	80	80																			Dec 2017	73.8	88.2	89.7			0		86.5	89.5	
3			MRSA Screening - Non Elective	=> %	80	80																			Dec 2017	90	89.5	88.4			75		89.8	91.8	

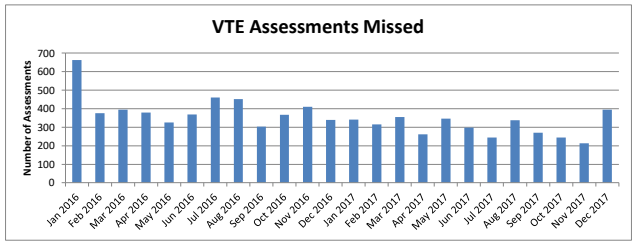


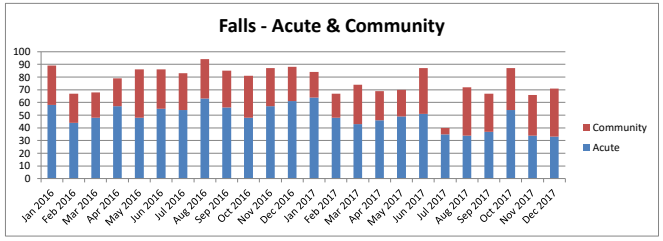


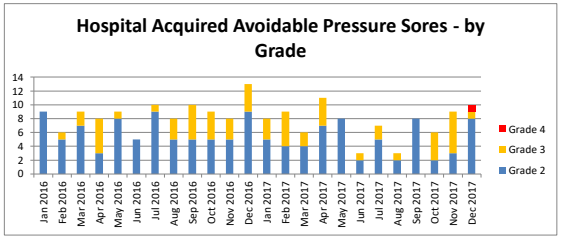


Patient Safety - Harm Free Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jul 2016) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	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																			Dec 2017								93.4	94.5	
8		•d	Patient Safety Thermometer - Catheters & UTIs	%			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	6.00	Dec 2017								0.51	0.25	
	NEW		Number of DOLS raised	No			-	-	-	-	25	22	15	14	23	15	14	6	27	22	20	48	31	19	Dec 2017	9	9	0	-	-	1		19	202	
	NEW		Number of DOLS which are 7 day urgent	No			-	-	-	-	25	22	14	14	23	15	14	6	27	22	20	48	31	19	Dec 2017	9	9	0	-	-	1		19	202	
	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	0	Dec 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	7	Dec 2017	3	0	0	-	-	4		7	75	
	NEW		Number patients discharged prior to LA assessment targets	No			-	-	-	-	6	6	2	11	6	3	11	7	7	9	9	11	7	2	Dec 2017	2	0	0	-	-	0		2	66	
	NEW		Number of DOLs applications the LA disagreed with	No			-	-	-	-	1	0	1	1	0	1	0	2	1	2	1	0	2	1	Dec 2017	1	0	0	-	-	0		1	10	
	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	0	Dec 2017	0	0	0	-	-	0		0	18	
8			Falls	<= No	804	67	83	94	85	81	87	88	84	67	74	69	70	87	85	72	67	87	66	71	Dec 2017	23	10	0	0	0	38		71	674	
9			Falls with a serious injury	<= No	0	0	1	3	3	1	2	3	3	1	2	1	1	1	1	3	2	3	1	0	Dec 2017	0	0	0		0	0		0	13	
8			Grade 2,3 or 4 Pressure Ulcers (Hospital Aquired Avoidable)	<= No	0	0	10	8	5	9	8	13	8	9	6	11	8	3	7	3	8	6	9	10	Dec 2017	9	1	0			0		10	65	
	NEW		Avoidable Grade 2,3 or 4 Pressure Ulcers (DN Caseload Acquired)	<= No	0	0	4	3	2	0	2	5	6	8	6	5	8	4	7	4	4	6	4	5	Dec 2017						5		5	47	
3		•d•	Venous Thromboembolism (VTE) Assessments	=> %	95	95																			Dec 2017	91.1	97.8	96.4					94.9	96.5	
3			WHO Safer Surgery - Audit - 3 sections (% pts where all sections complete)	=> %	100	100																			Dec 2017	100.0	99.9	99.7		100.0			99.9	99.8	
3			WHO Safer Surgery - brief (% lists where complete)	=> %	100	100																			Dec 2017	100	99	100		100			99.8	99.4	
3			WHO Safer Surgery - Audit - brief and debrief (% lists where complete)	=> %	100	100																			Dec 2017	100	99	100		100			99.6	98.6	
9		•d•	Never Events	<= No	0	0	1	0	0	0	1	0	0	1	0	0	1	1	0	1	0	0	0	0	Dec 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	1	0	0	0	Dec 2017	0	0	0	-	0	0		0	1	
9		•d•	Serious Incidents	<= No	0	0	5	6	4	6	5	10	5	6	5	4	4	3	1	8	5	4	6	4	Dec 2017	4	0	0	0	0	0	0	4	39	
9			Open Central Alert System (CAS) Alerts	<= No			11	12	12	14	10	8	6	5	4	8	9	27	3	3	8	10	6	5	Dec 2017								5	79	
9		•d	Open Central Alert System (CAS) Alerts beyond deadline date	No	0	0	0	1	1	2	1	2	0	1	0	0	0	1	1	1	0	0	1	1	Dec 2017								1	5	

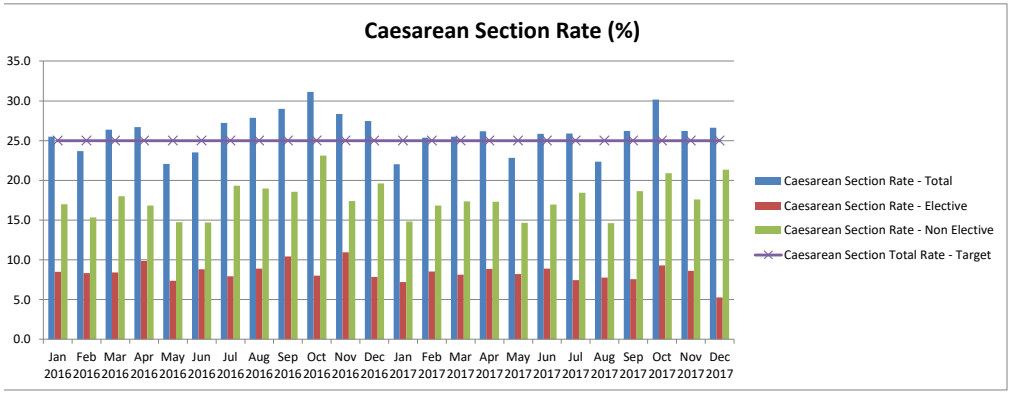


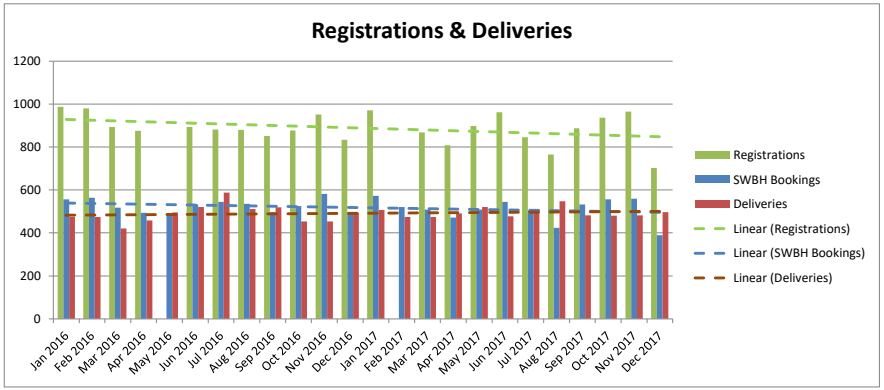




Patient Safety - Obstetrics

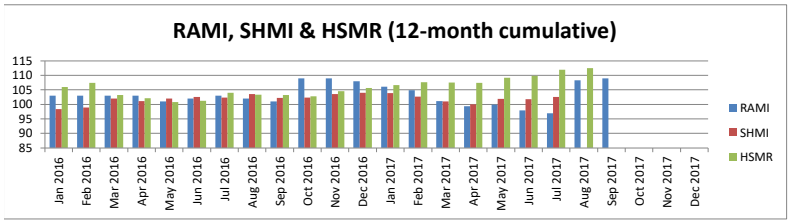
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory 2016-2017 Year	Trajectory 2016-2017 Month	Previous Months Trend (since Jul 2016) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Month	Year To Date	Trend
3			Caesarean Section Rate - Total	<= %	25.0	25.0																			Dec 2017	26.6	25.7	
3		•	Caesarean Section Rate - Elective	<= %			8	9	10	8	11	8	7	9	8	9	8	9	7	8	8	9	9	5.3	Dec 2017	5.3	8.0	
3		•	Caesarean Section Rate - Non Elective	<= %			19	19	19	23	17	20	15	17	17	17	15	17	18	15	19	21	17.6	21.3	Dec 2017	21.3	17.8	
2		•d	Maternal Deaths	<= No	0	0																			Dec 2017	0	1	
3			Post Partum Haemorrhage (>2000ml)	<= No	48	4																			Dec 2017	1	18	
3			Admissions to Neonatal Intensive Care (Level 3)	<= %	10.0	10.0																			Dec 2017	1.41	1.87	
12			Adjusted Perinatal Mortality Rate (per 1000 babies)	<= Rate1	8.0	8.0																			Dec 2017	4.02	6.00	
12			Stillbirth Rate (Corrected) (per 1000 babies)	Rate1			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2.11	2.10	4.02	Dec 2017	4.02	2.76	
12			Neonatal Death Rate (Corrected) (per 1000 babies)	Rate1			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	4.22	2.10	0.00	Dec 2017	0.00	2.07	
12			Early Booking Assessment (<12 + 6 weeks) - SWBH Specific	=> %	90.0	90.0													.						Dec 2017	78.9	77.6	
12			Early Booking Assessment (<12 + 6 weeks) - National Definition	=> %	90.0	90.0																			Dec 2017	111.9	134.5	
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) (%) -	<= %			1.4	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) (%)	<= %			1.4	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) (%)	<= %			1.4	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	

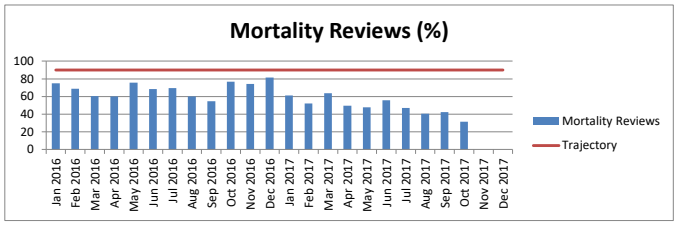


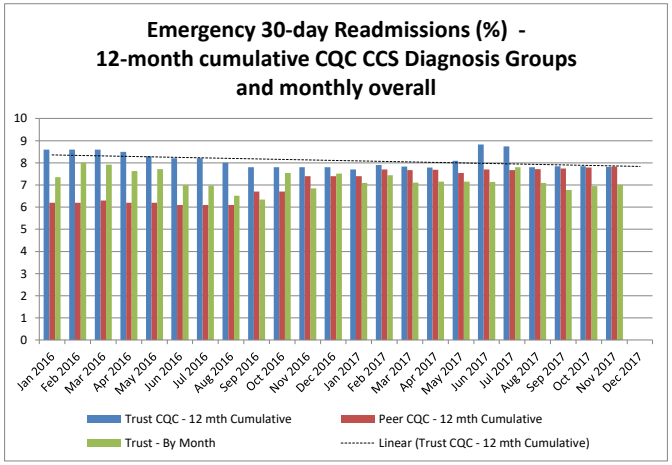


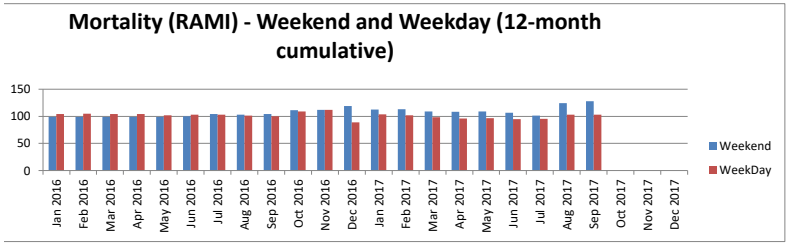
Clinical Effectiveness - Mortality & Readmissions

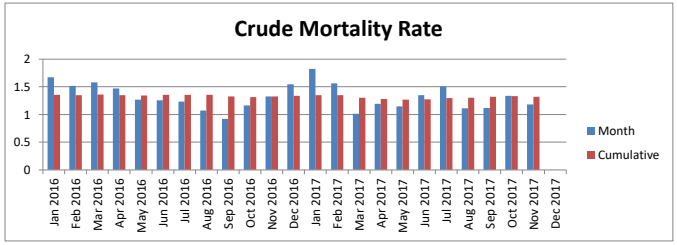
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jul 2016) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
5		C	Risk Adjusted Mortality Index (RAMI) - Overall (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	103	102	101	109	109	108	106	105	101	99	100	98	97	108	109	-	-	-	Sep 2017									611	
5		C	Risk Adjusted Mortality Index (RAMI) - Weekday Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	103	101	100	109	112	89	104	102	98	96	97	95	95	103	103	-	-	-	Sep 2017									589	
5		C	Risk Adjusted Mortality Index (RAMI) - Weekend Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	104	103	104	111	112	119	112	113	109	109	109	106	101	124	128	-	-	-	Sep 2017									677	
6		C	Summary Hospital-level Mortality Index (SHMI) (12-month cumulative)	SHMI	Below Upper CI	Below Upper CI	102	104	102	102	104	104	104	103	101	100	102	102	103	-	-	-	-	-	Jul 2017									406	
5		C	Hospital Standardised Mortality Rate (HSMR) - Overall (12-month cumulative)	HSMR			104	103	103	103	105	106	107	108	108	107	109	110	112	113	-	-	-	-	Aug 2017									550.9	
5		C	Deaths in Low Risk Diagnosis Groups (RAMI) - month	RAMI	Below Upper CI	Below Upper CI	103	43	56	94	139	84	105	72	88	62	61	78	78	71	144	-	-	-	Sep 2017								144		
3			Mortality Reviews within 42 working days	=> %	90	90																-	-	Oct 2017	28	57	100			0		32	45	
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (by month)	%			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	1.2	-	Nov 2017								1.18		
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (12-month cumulative)	%			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	1.3	-	Nov 2017									1.30	
	NEW		Deaths in the Trust	No			119	102	87	108	129	143	172	139	100	105	113	129	142	109	109	133	119	-	Nov 2017								119	959	
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			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	7.0	-	Nov 2017								7.01		
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			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	7.2	-	Nov 2017									7.18	
5		C	Emergency Readmissions (within 30 days) - CQC CCS Diagnosis Groups (12-month cumulative)	%			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	7.8	-	Nov 2017	-	-	-			-			7.82	





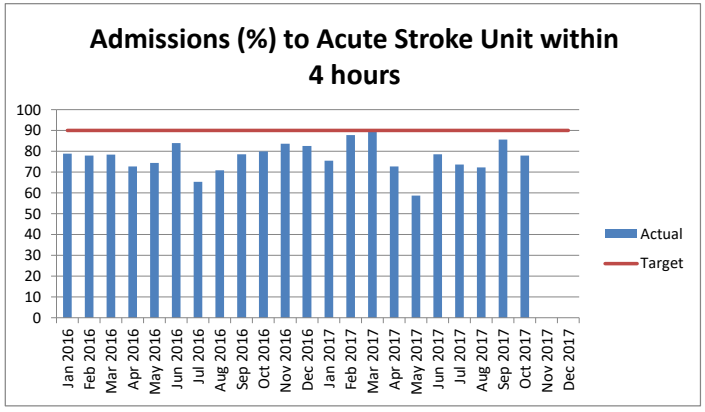


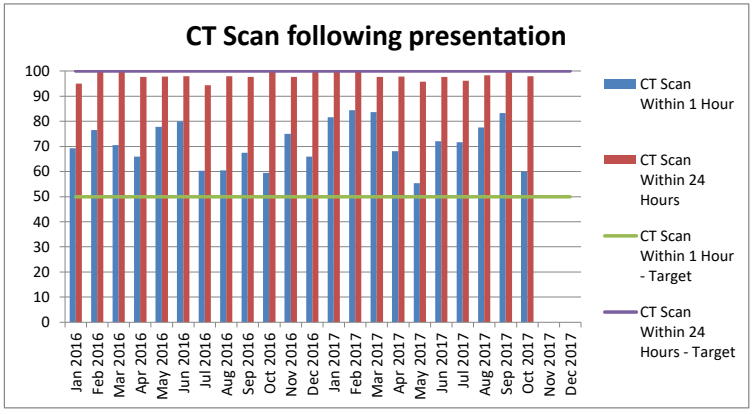


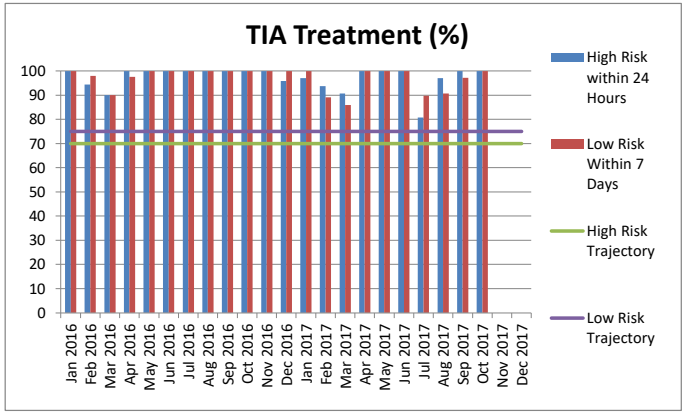


Clinical Effectiveness - Stroke Care & Cardiology

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (Since Jul 2016) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Month	Year To Date	Trend
3			5WD: Pts spending >90% stay on Acute Stroke Unit	=> %	90.0	90.0																			Dec 2017	93.9	93.4	
3			5WD: Pts admitted to Acute Stroke Unit within 4 hrs	=> %	80.0	80.0																			Dec 2017	69.6	73.4	
3			5WD: Pts receiving CT Scan within 1 hr of presentation	=> %	50.0	50.0																-			Dec 2017	78.0	72.3	
3			5WD: Pts receiving CT Scan within 24 hrs of presentation	=> %	95.0	95.0																			Dec 2017	100.0	97.3	
3			5WD: Stroke Admission to Thrombolysis Time (% within 60 mins)	=>	85.0	85.0																			Dec 2017	60.0	64.2	
3			5WD: TIA (High Risk) Treatment <24 Hours from receipt of referral	=>	70.0	70.0																			Dec 2017	100.0	97.1	
3			5WD: TIA (Low Risk) Treatment <7 days from receipt of referral	=>	75.0	75.0																			Dec 2017	100.0	96.2	
3			Stroke Admissions - Swallowing assessments (<24h)	=> %	98.0	98.0																-			Dec 2017	100.0	100.7	
9			Primary Angioplasty (Door To Balloon Time 90 mins)	=> %	80.0	80.0																			Dec 2017	95.8	94.6	
9			Primary Angioplasty (Call To Balloon Time 150 mins)	=> %	80.0	80.0																			Dec 2017	100.0	96.4	
9			Rapid Access Chest Pain - seen within 14 days	=> %	98.0	98.0																			Dec 2017	100.0	100.0	



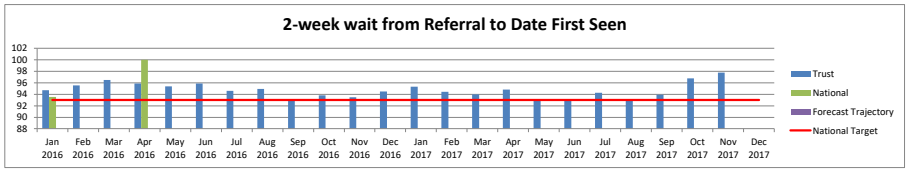


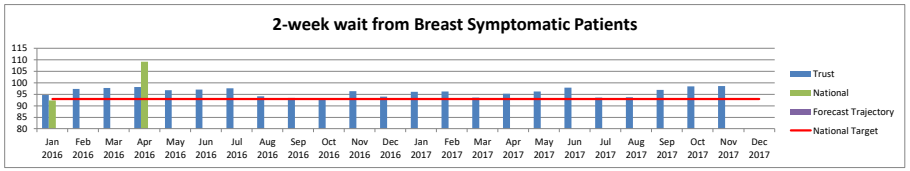


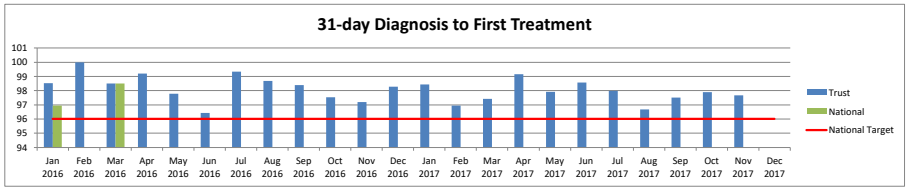
The stroke indicators in the IPR are based on 'patient arrivals' not 'patient discharged' as this monitors pathway performance rather than actual outcomes which may / may not change on discharge.
National SSNAP is based on 'patient discharge' which is more appropriate for outcomes based reporting.
Both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

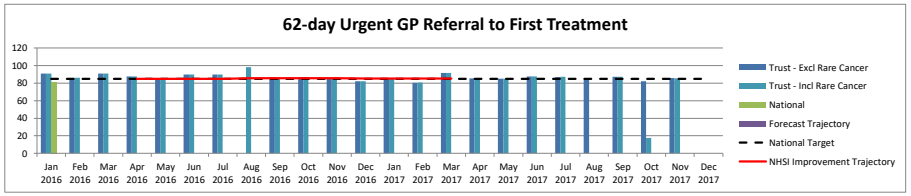
Clinical Effectiveness - Cancer Care

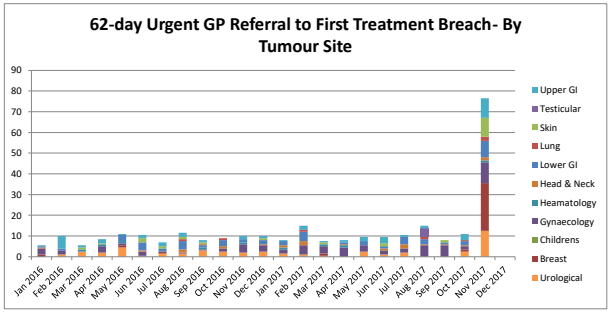
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jul 2016) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
1			2 weeks	=> %	93.0	93.0																			Nov 2017	97.2	98.2	98.0			0.0		97.8	94.6	
1			2 weeks (Breast Symptomatic)	=> %	93.0	93.0																			Nov 2017		-						98.6	96.3	
1			31 Day (diagnosis to treatment)	=> %	96.0	96.0																			Nov 2017	100.0	96.6	97.0			0.0		97.7	97.9	
1			31 Day (second/subsequent treatment - surgery)	=> %	94.0	94.0																			Nov 2017								94.7	97.1	
1			31 Day (second/subsequent treatment - drug)	=> %	98.0	98.0																			Nov 2017								100.0	100.0	
1			31 Day (second/subsequent treat - radiotherapy)	=> %	94.0	94.0																			Nov 2017								-	0.0	
1			62 Day (urgent GP referral to treatment) Excluding Rare Cancer	=> %	85.0	85.0																			Nov 2017	89.6	92.8	60.6			0.0		86.0	85.9	
1	NEW		62 Day (urgent GP referral to treatment) Including Rare Cancer	=> %	85.0	85.0																			Nov 2017	89.6	91.8	60.6			0.0		85.5	78.0	
1			62 Day (referral to treat from screening)	=> %	90.0	90.0																			Nov 2017	0.0	91.7	100.0			0.0		92.3	97.0	
1			62 Day (referral to treat from hosp specialist)	=> %	90.0	90.0																			Nov 2017	85.3	85.7	100.0			0.0		86.3	91.2	
1			Cancer - Patients Waiting over 62 days	No			7	12	8	10	11	10	8	15	8	8	10	10	11	11	9	11	12.0	-	Nov 2017	2.5	3.5	6.0			0.0		12.0	80.5	
1			Cancer - Patients Waiting over 104 days	No			3	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	2.0	-	Nov 2017	2.0	0.0	0.0			0.0		2.0	21.5	
1			Cancer - Longest Waiter in days	No			113	131	140	133	77	107	120	150	162	140	139	106	102	184	141	125	173	-	Nov 2017	173	0	0			0		173		
1			Neutropenia Sepsis Door to Needle Time Greater Than 1 Hour	=> No	0.0	0.0	13	5	15	12	12	19	17	8	6	11	6	4	10	3	7	8	7	7	Dec 2017	7	0	0			0		7	63	
	NEW		IPT Referrals - Within 38 Days Of GP Referral for 62 day cancer pathway	%			50	43	67	50	0	0	33	0	50	0	0	0	25	25	67	0	20	-	Nov 2017	-	-	-			-		20	17	

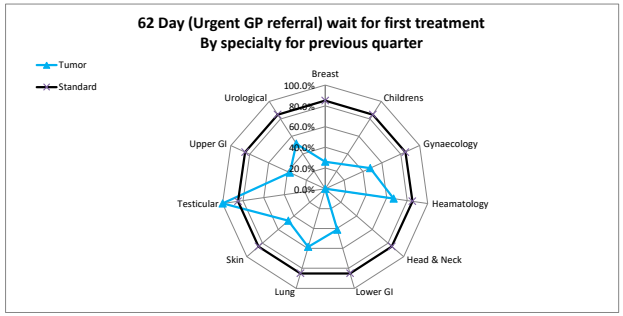


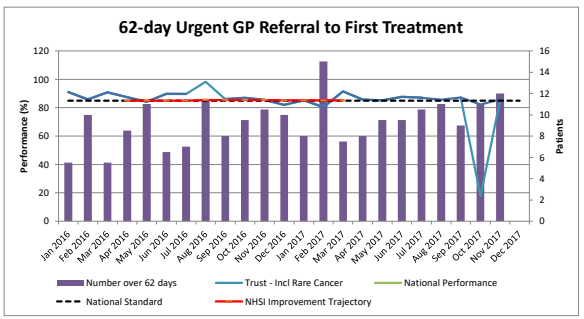






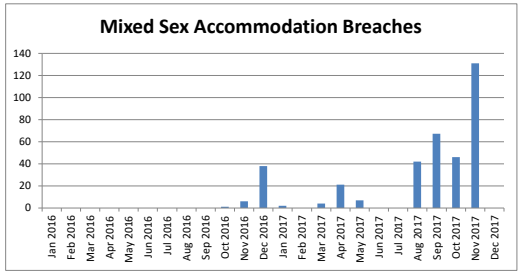


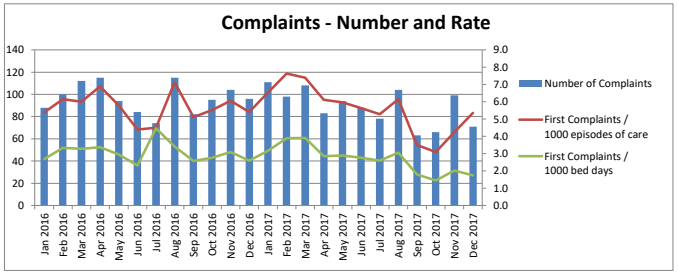


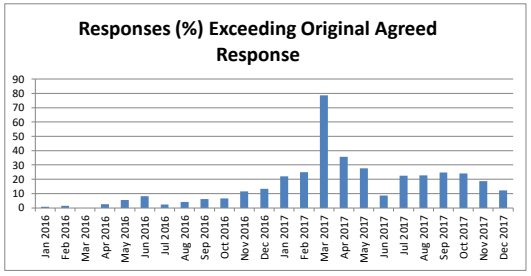


Patient Experience - FFT, Mixed Sex Accommodation & Complaints

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jul 2016) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	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	13	20	22	17	10	15	9.7	7.9	9.3	11	11	12.15	13	10	19	10	-	Nov 2017								10	12	
8		•a•	FFT Score - Adult and Children Inpatients (including day cases and community)	=> No	95.0	95.0	86	83	86	88	94	97	97	95	96	95	92	92	82.84	83	83	82	85	-	Nov 2017								85		
8		•b•	FFT Response Rate: Type 1 and 2 Emergency Department	=> %	50.0	50.0	7.8	7.5	7.1	5.6	4.8	5.9	5.4	4.3	4.2	5.5	3.8	2.4	3.827	2.8	3.4	3.3	3	-	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	86	83	78	73	75	73	77	76	73	75	71	73	72.23	75	73	73	58	-	Nov 2017	58							58		
8			FFT Response Rate: Type 3 WiU Emergency Department	=> %	50.0	50.0	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	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	86	89	88	88	89	90	88	88	90	90	89	88	90.51	89	89	91	92	-	Nov 2017								92		
8	NEW		FFT Score - Maternity Antenatal	=> No	95.0	95.0	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	74	81	93	90	91	29	83	91	86	73	73.08	81	84	89	81	-	Nov 2017								81		
8	NEW		FFT Score - Maternity Community	=> No	95.0	95.0	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	100	87	71	88	90	88	23	92	82	83	69	76.47	58	48	83	74	-	Nov 2017								74		
8			FFT Response Rate - Maternity Birth	=> %	50.0	50.0	0	1.4	15	5.9	17	13	8.2	5.4	21	8.9	11	7	7.083	5.2	5.2	13	7	-	Nov 2017								7	8	
13		•a	Mixed Sex Accommodation Breaches	<= No	0.0	0.0	0	0	0	1	6	38	2	0	4	21	7	0	0	42	67	46	##	0	Dec 2017	0	0	0		0	0		0	314	
9		•	No. of Complaints Received (formal and link)	No			74	115	82	95	104	96	111	98	108	83	94	88	78	104	63	66	99	71	Dec 2017	29	22	4	3	1	4	8	71	746	
9			No. of Active Complaints in the System (formal and link)	No			127	143	144	152	148	157	176	177	194	205	184	185	184	167	154	136	##	161	Dec 2017	67	47	19	3	1	9	15	161		
9		•a	No. of First Formal Complaints received / 1000 bed days	Rate1			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	1.7	Dec 2017	1.6	3.5	0.7			1.26		1.74	2.34	
9			No. of First Formal Complaints received / 1000 episodes of care	Rate1			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	5.4	Dec 2017	4.9	5.1	12			54.05		5.36	5.03	
9			No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)	=> %	100	100	96	100	100	99	100	100	99	98	94	100	100	100	100	100	98	100	90	92	Dec 2017	89	93	100	67	100	100	100	92	98	
9			No. of responses which have exceeded their original agreed response date (% of total active complaints)	<= %	0	0	2.4	4.2	6.3	6.6	11	13	22	25	79	36	28	8.6	22.56	23	25	24	19	12	Dec 2017	9.1	13	10	0	100	20	100	12	22	
9			No. of responses sent out	No			103	80	110	87	79	79	76	95	84	67	106	87	83	67	85	73	65	38	Dec 2017	17	8	2	1	5	2	3	38	671	
14		•e•	Access to healthcare for people with Learning Disability (full compliance)	Yes / No	Yes	Yes																			Dec 2017	N	N	N	N	N	N	N	No		

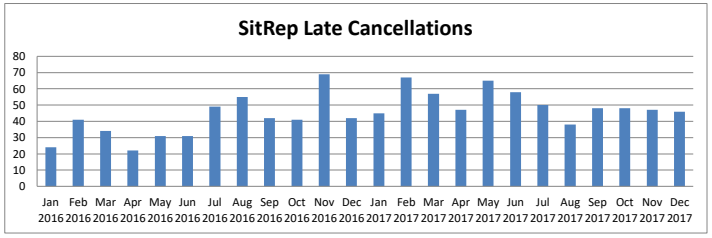


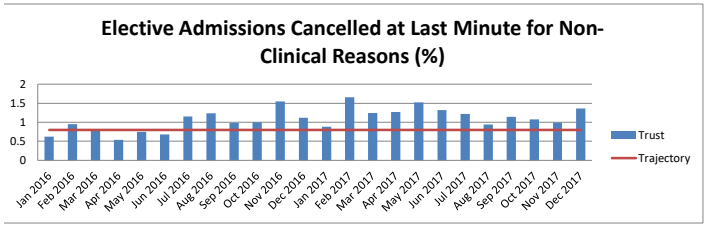


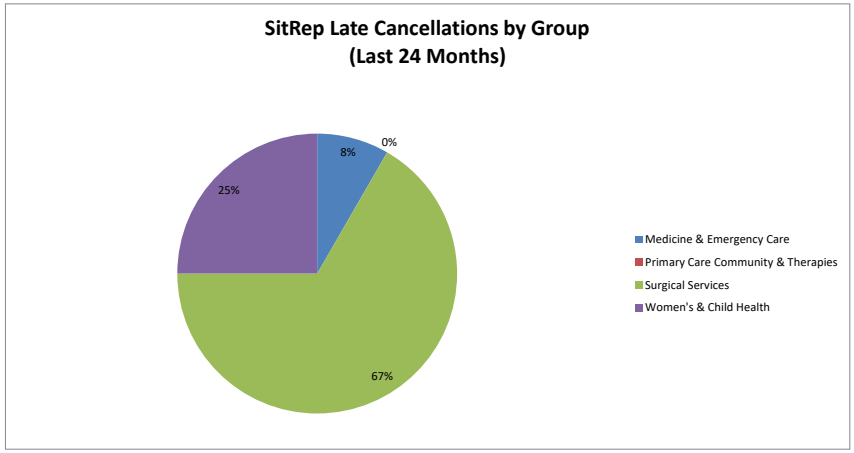


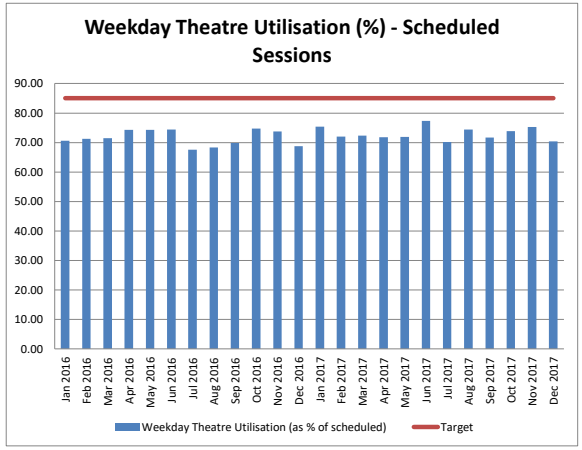
Patient Experience - Cancelled Operations

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jul 2016) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	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	49	55	42	41	69	43	45	67	57	47	65	58	50	38	48	48	47	46	Dec 2017	4	24	14			4		46	456	
2			No. of Sitrep Declared Late Cancellations - Avoidable	No			9	9	15	17	28	19	13	19	17	24	27	20	21	12	31	11	14	13	Dec 2017	3	4	4			2		13	182	
2			No. of Sitrep Declared Late Cancellations - Unavoidable	No			40	43	27	22	41	18	29	48	37	23	37	37	29	26	17	31	33	33	Dec 2017	1	20	10			2		33	266	
2			Elective Cancellations at last minute for non-clinical reasons (as a percentage of elective admissions)	<= %	0.8	0.8																			Dec 2017	0.97	1.31	6.31			0.52		1.4	1.2	
2			Number of 28 day breaches	<= No	0	0	0	0	0	1	0	3	6	0	0	1	0	0	0	2	0	0	0	0	Dec 2017	0	0	0			0		0	5	
2			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	Dec 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	Dec 2017	0.0	0.0	0.0			0.0		0	0	
3			No. of Sitrep Declared Late Cancellations (Pts. >1 occasion)	<= No	0	0	2	0	0	1	3	4	0	3	0	3	1	3	1	1	0	1	1	1	Dec 2017	0	0	1			0		1	12	
			Multiple Hospital Cancellations experienced by same patient (all cancellations)	<= No	0	0	56	51	60	49	50	63	61	62	67	51	45	72	55	53	71	70	62	59	Dec 2017	5	40	14			-		59	538	
3			All Hospital Cancellations, with 7 or less days notice	<= No	0	0	241	223	258	234	273	272	269	284	257	219	230	250	245	213	243	294	244	272	Dec 2017	22	212	38			-		272	2210	
3			Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0																			Dec 2017	0.0	71.1	75.0			54.6		70.3	72.7	



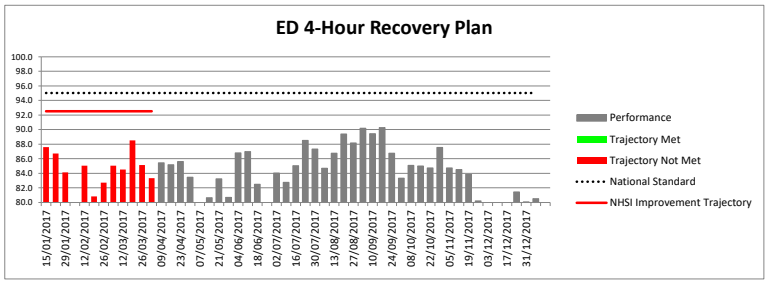


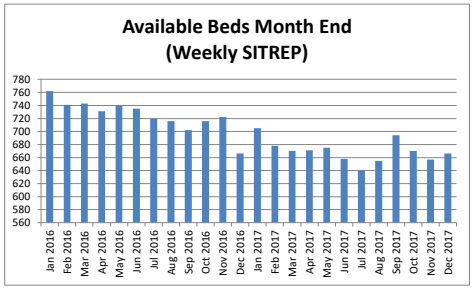


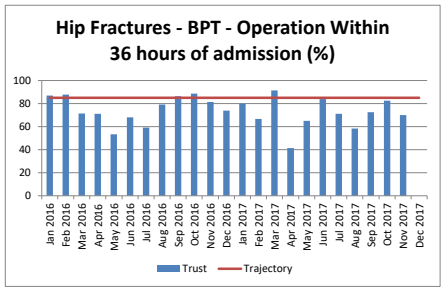


Access To Emergency Care & Patient Flow

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Unit S	Unit C	Unit B	Month	Year To Date	Trend
2			Emergency Care 4-hour waits	=> %	95.00	95.00																			Dec 2017	73.9	81.0	99.6	78.65	84.22	
2			Emergency Care 4-hour breach (numbers)	No			2168	1884	2051	2676	3237	3324	2821	3046	2875	2814	3549	3014	2686	2177	2150	2800	3168	3814	Dec 2017	2147	1663	4	3814	26172	
2			Emergency Care Trolley Waits >12 hours	<= No	0.00	0.00																			Dec 2017	0	1		1	1	
3			Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15.00	15.00																			Dec 2017	14	15	180	14	14	
3			Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60	60																			Dec 2017	67	64	87	67	63	
3			Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0																		-	Dec 2017	7.55	7.01	5.04	7.15	7.89	
3			Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0																			Dec 2017	5.13	7.13	1.29	5.89	5.52	
11			WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	<= No	0	0	122	112	135	112	162	193	162	129	107	110	159	242	111	127	90	143	207	208	Dec 2017	125	83		208	1397	
11			WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	<= No	0	0	8	6	9	16	21	19	11	13	5	0	12	6	1	0	1	4	6	11	Dec 2017	1	10		11	41	
11			WMAS - Handover Delays > 60 mins (% all emergency conveyances)	<= %	0.02	0.02																			Dec 2017	0.04	0.45		0.23	0.10	
11			WMAS - Emergency Conveyances (total)	No			4363	4204	4138	4233	4261	4622	4410	4034	4206	4137	4376	4254	4429	4278	4174	4557	4424	4725	Dec 2017	2488	2237		4725	39354	
2			Delayed Transfers of Care (Acute) (%)	<= %	3.5	3.5																			Dec 2017	1.7	4.3		2.7	2	
2			Delayed Transfers of Care (Acute) (Av./Week) attributable to NHS	<= No	<10 per site	<10 per site																			Dec 2017	7	9		16		
2			Delayed Transfers of Care (Acute) - Total Bed Days (All Local Authorities)	<= No	3.5% of available	3.5% of available	617	530	483	509	503	674	629	512	583	546	501	483	635	539	512	598	538	522	Dec 2017				522	4874	
			Delayed Transfers of Care (Acute) - Total Bed Days (All Local Authorities) as % of Available Beds	%	3.5	3.5	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	2.90	#DIV/0!	Dec 2017				2.81	3.23	
2			Delayed Transfers of Care (Acute) - Finable Bed Days (Birmingham LA only)	<= No	0	0	245	287	215	266	272	449	435	309	375	324	258	312	370	256	288	272	149	226	Dec 2017				226	2455	
2			Patient Bed Moves (10pm - 6am) (No.) -ALL	No			578	533	525	546	679	666	682	633	586	584	651	536	580	574	633	674	657	719	Dec 2017				719	5608	
2			Patient Bed Moves (10pm - 6am) (No.) - exc. Assessment Units	No			268	246	248	219	273	251	249	228	221	229	234	205	245	216	233	231	268	291	Dec 2017				291	2152	
	New		Patient Bed Moves (10pm - 6am) (No.) - exc. Assessment Units and Transfers for Clinical Reasons	No	0	0	84	78	94	69	101	86	75	86	85	88	87	82	82	62	88	90	110	136	Dec 2017				136	825	
			Hip Fractures - Best Practice Tarriff - Operation < 36 hours of admission (%)	=> %	85.0	85.0																		-	Nov 2017				70	67.3	

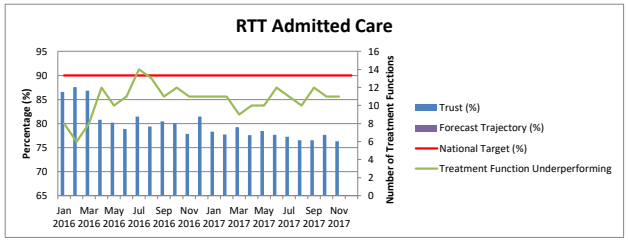


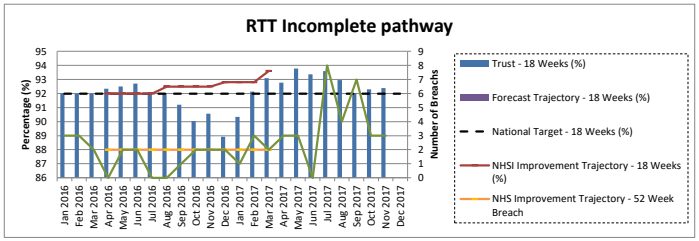


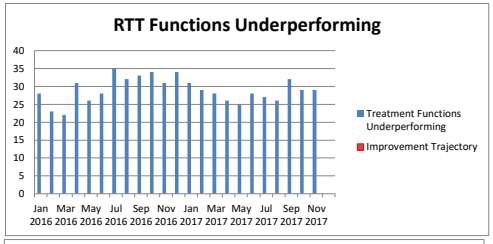


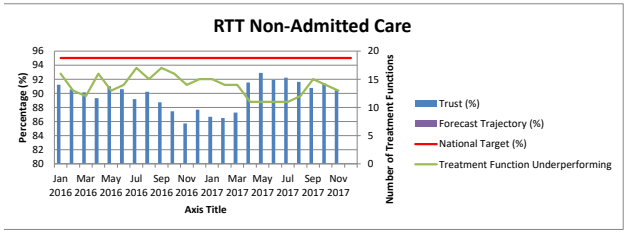
Referral To Treatment

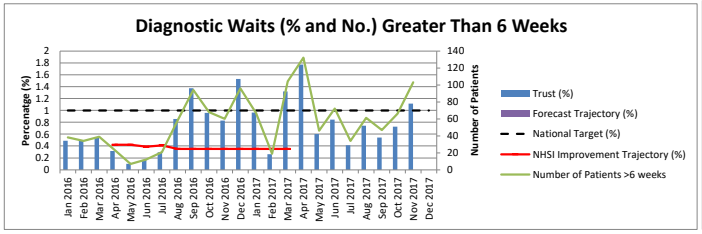
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jul 2016) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
2			RTT - Admittted Care (18-weeks)	=> %	90.0	90.0																		-	Nov 2017	87.0	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			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	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	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	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	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			502	470	500	711	817	498	902	387	577	942	931	650	833	652	1336	914	1064	-	Nov 2017	234	88	-		742	-		1064		

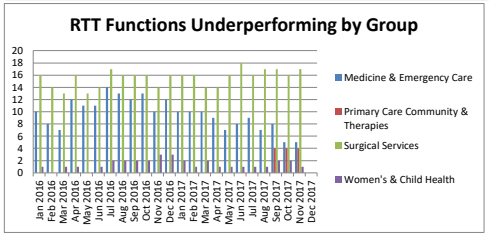


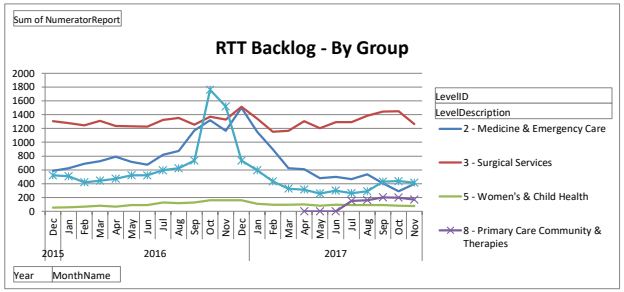


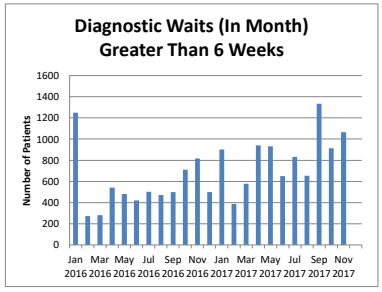


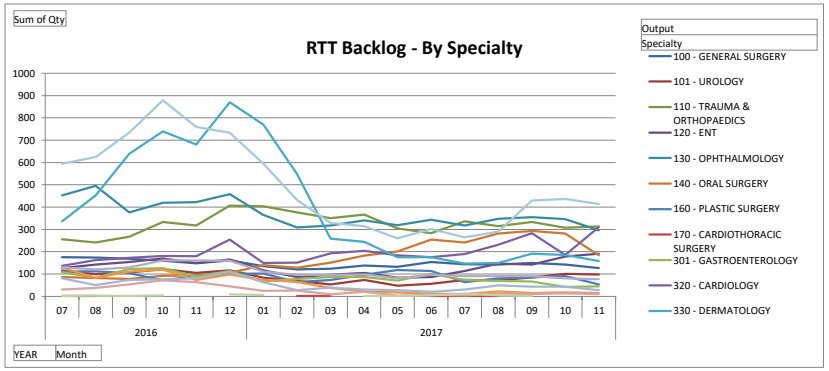






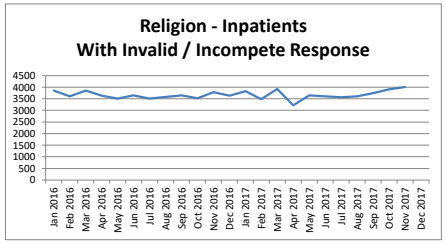


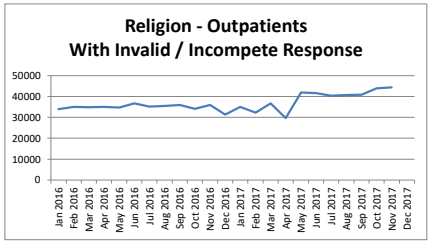


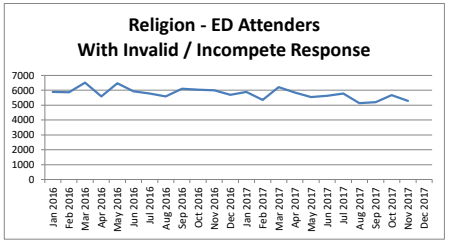


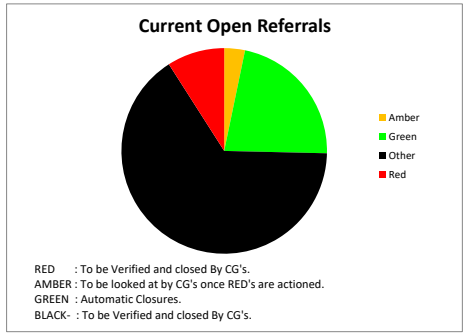
Data Completeness

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jul 2016) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
14			Data Completeness Community Services	=> %	50.0	50.0																			Dec 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	96.3	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	99.4	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	97.0	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	%			69.8	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	%			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	%			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	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	%			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	%			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			206,563	210,740	215,396	219,866	222,444	225,175	226,846	230,675	235,998	239,934	245,160	250,072	254,761	258,800	262,603	270,519	274,113	277,674	Dec 2017	64,194	140,979	35,501	7,473	707	28,820		277,674		
	NEW		Open Referrals without Future Activity/ Waiting List: Requiring Validation	No			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	141,009	Dec 2017	37,044	68,385	20,322	3,725	621	10,238		141009		

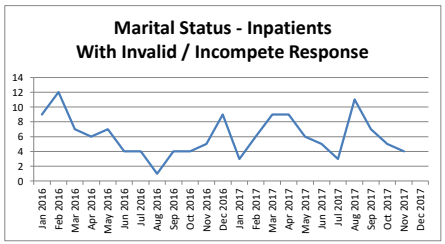


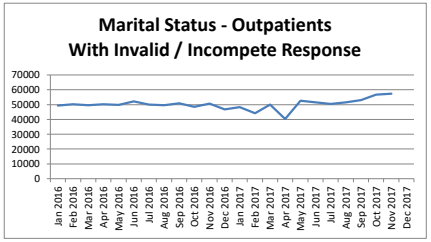


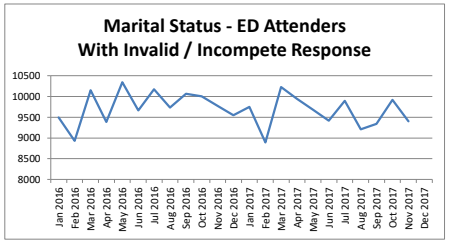




RED : To be Verified and closed By CG's.
AMBER : To be looked at by CG's once RED's are actioned.
GREEN : Automatic Closures.
BLACK- : To be Verified and closed By CG's.

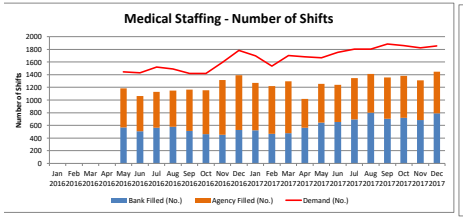


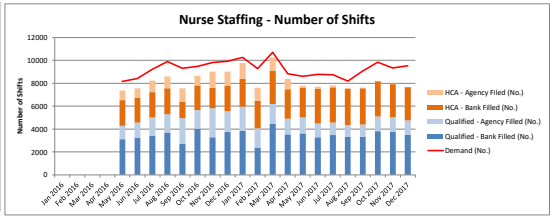




Temporary Workforce

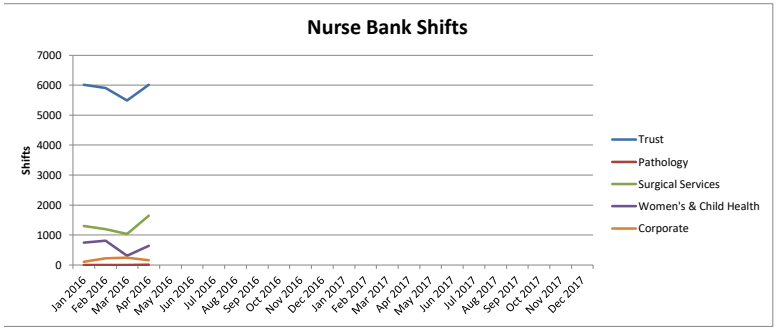
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory		Previous Months Trend (since Jul 2016)																Data Period	Group							Month	Year To Date	Trend
					Year	Month	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D		M	SS	W	P	I	PCCT	CO			
			Medical Staffing - Number of instances when junior rotas not fully filled	<= %	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-	-	-	-	-	
			Medical Staffing - Demand	No			1523	1491	1419	1419	1596	1786	1699	1534	1703	1682	1669	1753	1805	1804	1887	1858	1823	1854	Dec 2017	1273	437	113	0	31	0	0	1854	16135.0	
			Medical Staffing - Total Filled	%			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	78.05	Dec 2017	78	75.3	83.2	0	100	0	0	78	72.9	
			Medical Staffing - Bank Filled	%			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	54.66	Dec 2017	47.7	79	50	0	32.3	0	0	55	53.1	
			Medical Staffing - Agency Filled	%			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	45.34	Dec 2017	52.3	21	50	0	67.7	0	0	45	46.9	
			Medical Staffing - Filled Shifts - Snr Consultant	No			107	137	177	243	237	187	152	217	270	120	214	219	258	320	312	329	324	334	Dec 2017	230	64	9	0	31	0	0	334	2430.0	
			Medical Staffing - Filled Shifts - Jnr Doctor	No			1021	1010	998	951	1108	1196	1144	1001	1026	896	394	1019	1087	1092	1074	1052	987	1113	Dec 2017	763	265	85	0	0	0	0	1113	8714.0	
			Nursing - Demand	No			9220	9887	9312	9476	9802	9935	####	9268	####	8825	8616	8784	8760	8197	9080	9849	9335	9535	Dec 2017	5103	1970	976	10	90	1227	159	9535	80981	
			Nursing - Total Filled	%			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	80.6	Dec 2017	78.4	87.8	69.9	100	68.9	85.33	99.4	81	87.4	
			Nursing - Qualified - Bank Filled	%			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	47.21	45.5	Dec 2017	38.8	45.6	60.4	100	51.6	63.04	28.5	46	44.8	
			Nursing - Qualified - Agency Filled	%			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	16.39	16.3	Dec 2017	21.7	14.3	3.81	0	6.45	10.03	2.53	16	15.5	
			Nursing - HCA - Bank Filled	%			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	36.03	38.0	Dec 2017	39.4	39.8	35.8	0	41.9	26.84	69	38	37.4	
			Nursing - HCA - Agency Filled	%			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	0.378	0.2	Dec 2017	0.18	0.35	0	0	0	0.1	0	0	2.3	
			AHPs - Radiography - Demand (Shifts)	No			79	55	269	332	321	290	526	332	525	332	372	315	334	335	231	235	198	176	Dec 2017	0	0	0	0	176	0	0	176	2528	
			AHPs - Radiography - Filled (Shifts)	No			73	55	249	324	299	256	496	302	502	329	359	315	290	323	230	232	190	170	Dec 2017	0	0	0	0	170	0	0	170	2438	
			AHPs - Physiotherapy - Demand (Shifts)	No			192	55	63	38	190	186	276	478	356	180	242	257	104	99	100	108	88	75	Dec 2017	0	0	0	0	0	75	0	75	1253	
			AHPs - Physiotherapy - Filled (Shifts)	No			192	55	63	38	190	186	274	478	346	180	242	257	104	99	98	107	87	74	Dec 2017	0	0	0	0	0	74	0	74	1248	
			AHPs - Other - Demand (Shifts)	No			289	66	96	139	96	567	413	530	1009	459	527	471	511	536	482	532	460	451	Dec 2017	102	52	0	0	67	93	137	451	4429	
			AHPs - Other - Filled (Shifts)	No			288	55	95	95	200	567	412	527	885	457	527	471	508	534	476	520	445	440	Dec 2017	99	50	0	0	67	90	134	440	4378	
			Admin - Demand (Shifts)	No			1902	2147	2765	2839	2479	2442	2381	4128	5135	4198	4228	4423	4054	4429	4091	4015	3928	3535	Dec 2017	674	601	42	278	43	330	1567	3535	36901	
			Admin - Filled (Shifts)	No			1855	2061	2450	2589	2452	2405	2348	4026	5079	4162	4184	4423	4031	4412	4025	3951	3838	3412	Dec 2017	664	599	35	244	43	320	1507	3412	36438	
			Facilities - Demand (Shifts)	No			1442	1451	2160	2185	1997	2172	2066	1971	2485	1795	2031	2101	1996	2182	2025	2059	2122	2008	Dec 2017	13	68	4	0	11	1	1911	2008	18319	
			Facilities - Filled (Shifts)	No			1405	1397	1942	2135	1969	2107	1992	1926	2425	1737	1999	2101	1966	2165	2006	2019	2098	1951	Dec 2017	10	66	1	0	11	1	1862	1951	18042	
			Interpreters - Demand (Shifts)	No			5110	5034	5321	5026	5508	4803	5159	4983	5634	4511	5139	5291	5101	4905	5116	5343	5699	4595	Dec 2017	-	-	-	-	-	-	-	4595	45700.0	
			Interpreters - Total Filled	%			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	99.7	Dec 2017	-	-	-	-	-	-	-	100	99.7	
			Interpreters - Bank Filled	%			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	77.8	Dec 2017	-	-	-	-	-	-	-	78	77.8	
			Interpreters - Agency Filled	%			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	22.2	Dec 2017	-	-	-	-	-	-	-	22	22.2	
			Interpreters - Unfilled	%			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	0.3	Dec 2017	-	-	-	-	-	-	-	0	0.3	

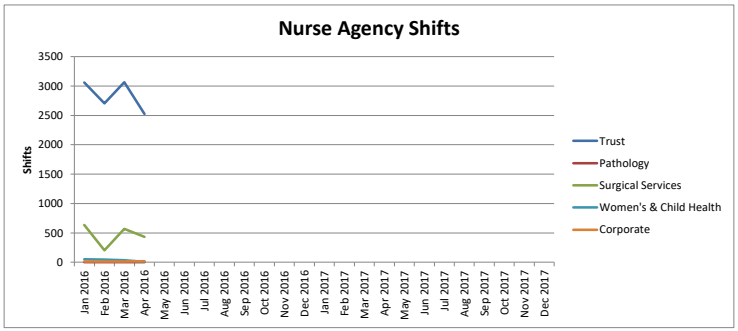


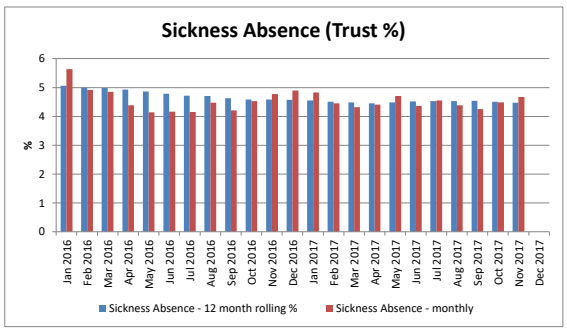


Workforce

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Jul 2016) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
7		b	WTE - Actual versus Plan (FTE)	No			818	871	866	790	783	845	786	730	768	772	796	816	847	816	816	756	741	762	Dec 2017	218.3	157.6	104.8	44.06	28.2	86.72	122.5	762		
3		b	PDRs - 12 month rolling	=> %	95.0	95.0																			Dec 2017	68.1	77.4	72.5	75.5	71.6	87.3	81.5		85.3	
7		b	Medical Appraisal	=> %	95.0	95.0																			Dec 2017	83.0	76.9	76.4	90.0	86.7	104.6	50.0	81.1	82.1	
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	4.5	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	4.7	4.5	
3	NEW		Sickness Absence - Long Term (Monthly)	No			249	247	253	245	247	246	253	205	213	214	241	218	225	232	216	251	246	-	Nov 2017	49	47	30	5	6	36	2	246	1843	
3	NEW		Sickness Absence - Short Term (Monthly)	No			752	745	727	837	922	911	956	808	785	414	445	444	612	664	706	889	962	-	Nov 2017	233	170	135	48	39	128	5	962	5136	
3			Return to Work Interviews following Sickness Absence	=> %	100.0	100.0																			Dec 2017	67.4	90.0	82.4	86.5	79.6	82.6	81.1	80.2	79.2	
3			Mandatory Training	=> %	95.0	95.0																			Dec 2017	83.0	88.0	88.6	91.2	88.7	91.4	92.6		87.3	
3			Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-	-	-		-	
3			Mandatory Training - Health & Safety (% staff)	=> %	95.0	95.0																			Dec 2017	90.0	0.0	92.5	96.0	92.9	0.0	97.2		94.5	
7		b	Employee Turnover (rolling 12 months)	<= %	10.0	10.0																			Dec 2017								13.3	12.5	
	NEW		Nursing Turnover	%			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			8	4	4	3	0	3	4	3	9	14	1	3	4	4	2	7	4	5	Dec 2017	2	0	1	0	1	0	1	5		
7			Vacancy Time to Fill	Weeks			24	24	21	25	21	21	21	22	21	20	21	23	25	20	21	21	21	23	Dec 2017								23		
7			Professional Registration Lapses	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Dec 2017	0	0	0	0	0	0	0	0	0	
7			Qualified Nursing Variance (FIMS) (FTE)	No			339	343	341	313	293	305	268	246	257	256	276	281	289	287	269	252	244	265	Dec 2017								265		
15			Your Voice - Response Rate	No			-->	-->	-->	-->	-->	-->	16.0	-->	-->	-->	-->	-->	18.8	-->	-->	-->	-->	-->	Jul 2017	11.8	15.3	15.9	23.7	23.8	29	21.2	18.8		
15			Your Voice - Overall Score	No			-->	-->	-->	-->	-->	-->	3.70	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	-->	Jan 2017	3.68	3.79	3.66	3.82	3.58	3.83	3.64	3.7		







Local Quality Indicators - 2017/2018

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From Jul 2016) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Group M	SS	W	P	I	PCCT	CO	Month	Year To Date	Trend
			Safeguarding Adults Advanced Training	=> %	85	85	-	-	80	80	81	81	80	79	81	81	81	79	83	86	85	85	86	88	Dec 2017								88.312	83.97	
			Safeguarding Children Level 2 Training	=> %	85	85	72	73	71	71	73	75	76	77	77	78	79	78	78	83	86	86	87	88	Dec 2017								88.2	82.6	
			Safeguarding Children Level 3 Training	=> %	85	85	75	74	73	73	75	78	78	81	84	85	88	89	88	87	85	85	90	90	Dec 2017								90.0	87.3	
			WHO Safer Surgery - Audit - brief and debrief (% lists where complete) - SQPR	=> %	100	100	100	99	100	98	97	95	97	99	99	98	98	98	99	99	99	99	98	99.6	Dec 2017	99.6	99.5	100			0		99.6	98.6	
			Morning Discharges (00:00 to 12:00) - SQPR	=> %	35	35	17	13	16	16	17	17	20	17	16	16	15	17	17	15	16	15	15	18	Dec 2017	17.1	12.6	29.3			31		17.7	15.9	
			ED Diagnosis Coding (Mental Health CQUIN) - SQPR	=> %	85	85	87	87	87	85	86	86	86	86	87	86	86	85	84	84	84	84	85	85	Dec 2017								84.5	84.8	
			CO Level >4ppm Referred For Smoking Cessation - SQPR	=> %	90	90	80	83	76	83	92	80	78	93	87	80	86	76	82	82	85	79	80	100	Dec 2017								100.0	83.5	
			BMI recorded by 12+6 weeks of pregnancy - SQPR	=> %	90	90	79	78	87	86	82	81	84	81	77	78	80	79	88	92	94	93	96	97	Dec 2017								96.6	88.4	
			CO Monitoring by 12+6 weeks of pregnancy - SQPR	=> %	90	90	82	82	75	76	76	75	73	78	79	76	75	75	74	71	74	80	76	79	Dec 2017								78.6	75.3	
			Community Gynae - Referral to first outpatient appointment Within 4 weeks of referral	=> %	90	90	17	19	29	25	8	11	33	66	83	93	95	92	67	38	13	20	65	-	Nov 2017								65.5	65.0	
			Community Nursing - Falls Assessment For Appropriate Patients on home visiting caseload	=> %	100	100	61	55	65	42	77	69	60	62	58	69	-	57	58	57	54	55	52	60	Dec 2017								59.7	57.4	
			Community Nursing - Pressure Ulcer Risk Assessment For New community patients at intial assessment	=> %	95	95	65	63	71	47	80	71	63	65	63	77	-	63	65	66	62	63	63	70	Dec 2017								70.2	65.9	

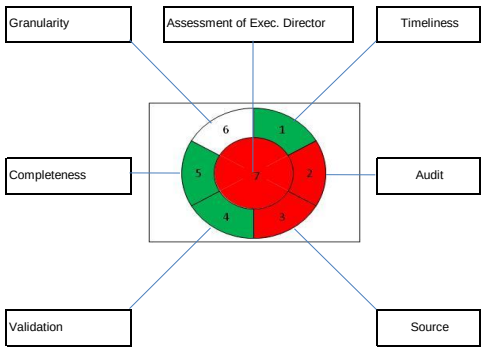
Legend

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

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Section	Indicator	Measure	Trajectory		Previous Months Trend																Data Period	Directorate			Month	Year To Date	Trend
			Year	Month	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D		EC	AC	SC			
Patient Safety - Inf Control	C. Difficile	<= No	30	3																			Dec 2017	1	0	0	1	14	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0																			Dec 2017	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective (%)	=> %	80	80																			Dec 2017	79	85	20	73.8		
Patient Safety - Inf Control	MRSA Screening - Non Elective (%)	=> %	80	80																			Dec 2017	90	85	93	90.0		
Patient Safety - Harm Free Care	Number of DOLS raised	No			-	-	-	-	19	20	14	14	16	9	7	5	12	13	9	19	15	9	Dec 2017	1	8	0	9	98	
Patient Safety - Harm Free Care	Number of DOLS which are 7 day urgent	No			-	-	-	-	19	20	12	14	16	9	7	5	12	13	9	19	15	9	Dec 2017	1	8	0	9	98	
Patient Safety - Harm Free Care	Number of delays with LA in assessing for standard DOLS application	No			-	-	-	-	4	0	0	0	0	0	0	0	1	0	0	0	0	0	Dec 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	3	Dec 2017	0	3	0	3	44	
Patient Safety - Harm Free Care	Number patients discharged prior to LA assessment targets	No			-	-	-	-	5	6	2	11	5	1	6	3	1	3	5	6	3	2	Dec 2017	0	2	0	2	30	
Patient Safety - Harm Free Care	Number of DOLs applications the LA disagreed with	No			-	-	-	-	1	0	1	1	0	0	0	2	1	2	0	0	1	1	Dec 2017	0	1	0	1	7	
Patient Safety - Harm Free Care	Number patients cognitively improved regained capacity did not require LA assessment	No			-	-	-	-	5	2	1	0	0	1	1	1	5	0	0	0	0	0	Dec 2017	0	0	0	0	-	
Patient Safety - Harm Free Care	Falls	<= No	0	0	39	47	44	34	41	47	50	38	34	36	39	34	34	28	31	48	22	23	Dec 2017	10	13	0	23	295	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	1	2	2	0	2	3	3	1	2	1	1	0	0	1	1	3	0	0	Dec 2017	0	0	0	0	7	
Patient Safety - Harm Free Care	Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	5	5	4	5	7	9	5	5	4	5	4	2	4	2	5	3	5	9	Dec 2017	0	9	0	9	39	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			Dec 2017	89.8	88.6	95.9	91.1		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	100.0	100.0																			Dec 2017	100.0	100.0	0.0	100.0		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	100.0	100.0																			Dec 2017	100	100	0	100.0		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	100.0	100.0																			Dec 2017	100	100	0	99.6		
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			Dec 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	Dec 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			Dec 2017	2	2	0	4	18	
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100	98																	-	-	Oct 2017	26	28	31	28		

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Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			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	11.1	-	Nov 2017				**11.2**		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			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	9.8	-	Nov 2017					**9.5**	

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Section	Indicator		Trajectory Year	Trajectory Month	Previous Months Trend J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	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															-				Dec 2017		100.0		100.0	100.7	
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																			Dec 2017		95.8		95.8	94.6	
Clinical Effect - Stroke & Card	Primary Angioplasty (Call To Balloon Time 150 mins) (%)	=> %	80.0	80.0																			Dec 2017		100.0		100.0	96.4	
Clinical Effect - Stroke & Card	Rapid Access Chest Pain - seen within 14 days (%)	=> %	98.0	98.0																			Dec 2017		100.0		100.0	100.0	
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0																			Nov 2017			97.2	97.2		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0																			Nov 2017			100.0	100.0		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																			Nov 2017			89.6	89.6		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			3	4	3.5	1	2.5	2	1.5	3	2.5	2	2	4.5	1	2.5	2	3.5	2.5	-	Nov 2017	-	-	2.50	2.50	20	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			2	1.5	2	0	0	1	1	1	1	1	0	1	0	0	0	2	2	-	Nov 2017	-	-	2.00	2.00	6	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			113	107	140	75	71	107	111	135	105	140	91	106	97	99	81	125	173	-	Nov 2017	-	-	173	173		
Clinical Effect - Cancer	Neutropenia Sepsis Door to Needle Time Greater than 1hr	=> No	0.0	0.0	13	5	15	12	12	19	17	8	6	0	6	4	10	3	7	8	7	7	Dec 2017	-	-	7	7	52	
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0.0	0.0	0	0	0	0	6	30	2	0	4	21	7	0	0	3	61	46	129	0	Dec 2017	0	0	0	0	267	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			25	40	23	27	40	35	40	45	42	34	42	40	27	49	24	26	47	29	Dec 2017	19	8	2	29	318	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			46	47	55	56	63	62	66	61	75	79	79	91	83	82	74	59	75	67	Dec 2017	44	20	3	67		

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Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate			Month	Year To Date	
			Year	Month	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D		EC	AC	SC			
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Dec 2017	-	5.76	-	0.97		
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	2	0	0	0	0	Dec 2017	0.0	0.0	0.0	0	3	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	0	6	1	0	6	2	4	6	2	3	11	3	5	2	8	2	3	4	Dec 2017	0.0	4.0	0.0	4	41	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	28	32	28	57	44	29	51	37	41	28	35	63	31	62	41	#####	#####	#####	Dec 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	Dec 2017	0.00	0.00	0.00	0.00	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour waits (%)	=> %	95.0	95.0																			Dec 2017	73.9	81.0	Site S/C	77.6	83.2	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			1333	1227	1280	1579	1750	1866	1776	1769	1721	1662	1742	1580	1483	1280	1257	1636	1714	2188	Dec 2017	1919	4	265	2188	14542	
Emergency Care & Pt. Flow	Emergency Care Trolley Waits >12 hours	<= No	0	0																			Dec 2017	0.0	1.0	Site S/C	1	1	
Emergency Care & Pt. Flow (Group Sheet Only)	Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15.0	15.0											-								Dec 2017	14.0	15.0	Site S/C	14	14	
Emergency Care & Pt. Flow (Group Sheet Only)	Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60.0	60.0																			Dec 2017	67.0	64.0	Site S/C	66	60	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0																-			Dec 2017	7.6	7.0	Site S/C	7.3	8.2	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0																			Dec 2017	5.1	7.1	Site S/C	6.2	5.8	
Emergency Care & Pt. Flow	WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	<= No	0	0	122	112	135	112	162	193	162	129	107	110	159	242	111	127	90	143	207	208	Dec 2017	125	83		208	1397	
Emergency Care & Pt. Flow	WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	<= No	0	0	8	6	9	16	21	19	11	13	5	0	12	6	1	0	1	4	6	11	Dec 2017	1	10		11	41	
Emergency Care & Pt. Flow	WMAS - Turnaround Delays > 60 mins (% all emergency conveyances)	<= %	0.02	0.02																			Dec 2017	0.04	0.45		0.23	0.10	
Emergency Care & Pt. Flow	WMAS - Emergency Conveyances (total)	No			4363	4204	4138	4233	4261	4622	4410	4034	4206	4137	4376	4254	4429	4278	4174	4557	4424	4725	Dec 2017	2488	2237		4725	39354	
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	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	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	14	13	12	13	10	12	10	10	10	9	7	8	9	7	8	5	5	-	Nov 2017	0	4	1	5		

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

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Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	
			Year	Month	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D		EC	AC	SC			
Data Completeness	Open Referrals	No			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	64,194	Dec 2017	14,194	25,968	24,032	64194		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Req	No			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	37,044	Dec 2017	11,873	14,846	10,325	37044		
Workforce	WTE - Actual versus Plan	No			220	229	231	229	231	244	202	194	208	205	199	227	236	223	223	204	200	218	Dec 2017	118.5	96.85	0	218		
Workforce	PDRs - 12 month rolling (%)	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2017	67.88	68.2	0		78.2	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2017	70.73	92.45	0		77.8	
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			49	47	43	45	40	39	39	33	40	53	59	48	45	54	49	51	49	-	Nov 2017	23	26	0	49	408	
Workforce	Sickness Absence - Short Term - In month	No			180	179	162	194	206	243	223	207	182	66	68	80	131	145	157	173	233	-	Nov 2017	91	141	0	233	1053	
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	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2017	84	82.39	0		81.8	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-		-	
Workforce	New Investigations in Month	No			1	1	0	0	0	0	0	1	2	3	0	0	1	1	0	0	1	2	Dec 2017	0	2	0	2		
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		

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Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate					Month	Year To Date	Trend
			Year	Month	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D		GS	SS	TH	An	O			
Patient Safety - Inf Control	C. Difficile	<= No	7	1																			Dec 2017	0	0	0	0	0	0	4	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0																			Dec 2017	0	0	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80	80																			Dec 2017	89.83	93.94	0	0	62.86	88.2		
Patient Safety - Inf Control	MRSA Screening - Non Elective	=> %	80	80																			Dec 2017	88.68	91.67	0	75	91.67	89.5		
Patient Safety - Harm Free Care	Number of DOLS raised	No			-	-	-	-	4	0	0	0	2	1	3	0	12	7	6	15	12	9	Dec 2017	4	0	0	5	0	9	65	
Patient Safety - Harm Free Care	Number of DOLS which are 7 day urgent	No			-	-	-	-	4	0	0	0	2	1	3	0	12	7	6	15	12	9	Dec 2017	4	0	0	5	0	9	65	
Patient Safety - Harm Free Care	Number of delays with LA in assessing for standard DOLS application	No			-	-	-	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Dec 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	0	Dec 2017	0	0	0	0	0	0	13	
Patient Safety - Harm Free Care	Number patients discharged prior to LA assessment targets	No			-	-	-	-	0	0	0	0	1	0	3	0	6	5	2	2	1	0	Dec 2017	0	0	0	0	0	0	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	0	Dec 2017	0	0	0	0	0	0	2	
Patient Safety - Harm Free Care	Falls	<= No	0	0	12	12	9	10	12	13	8	6	6	10	7	11	11	4	5	5	10	10	Dec 2017	5	3	1	0	1	10	73	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	Dec 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	2	2	0	4	0	1	1	2	1	1	3	0	2	0	0	2	2	1	Dec 2017	0	1	0	0	0	1	11	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			Dec 2017	98.06	96.41	0	99.1	97.48	97.8		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	100.0	100.0																			Dec 2017	99.85	99.68	0	100	100	99.9		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	100.0	100.0																			Dec 2017	0	0	100	0	99.21	99.5		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	100.0	100.0																			Dec 2017	0	0	100	0	99.21	99.5		
Patient Safety - Harm Free Care	Never Events	<= No	0	0	1	0	0	0	1	0	0	0	0	0	1	1	0	0	0	0	0	0	Dec 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	Dec 2017	0	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			Dec 2017	0	0	0	0	0	0	7	
Clinical Effect - Mort & Read	Mortality Reviews within 42 working days	=> %	100	98.0																	.	.	Oct 2017	50	63	0	0	0	57.1		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			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	5.4	-	Nov 2017						5.5		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			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	6.21	-	Nov 2017							6.0	

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Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate					Month	Year To Date	
			Year	Month	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D		GS	SS	TH	An	O			
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0																		-	Nov 2017	98.2	-	0.0	-	-	98.18		
Clinical Effect - Cancer	2 weeks (Breast Symptomatic)	=> %	93.0	93.0																		-	Nov 2017	98.6	-	-	-	-	98.63		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Nov 2017	96.6	-	0.0	-	-	96.63		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		-	Nov 2017	92.8	-	0.0	-	-	92.78		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			4	7	4	7	4	5	5	8	2	2	5	3	8	3	2	6	4	-	Nov 2017	-	-	-	-	-	3.5	31	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			1	2	2	2	2	2	0	2	1	1	1	0	2	2	0	2	0	-	Nov 2017	0	-	0	-	-	0	8	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			201	292	245	351	191	158	103	193	105	119	114	98	134	108	84	110	0	-	Nov 2017	0	-	0	-	-	0		
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	Dec 2017	0	-	0	-	-	0	0	
Pt. Experience - FFT,MSA,Comp	Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	1	0	8	0	0	0	0	0	0	0	39	6	0	2	0	Dec 2017	0	0	0	0	0	0	47	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			24	38	30	37	29	26	32	25	36	24	29	20	28	29	18	16	28	22	Dec 2017	5	2	4	0	11	22	214	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			41	45	47	51	39	45	62	63	66	78	61	51	57	50	38	40	36	47	Dec 2017	17	11	2	2	15	47		
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Dec 2017	2.46	0.54	0	-	0.48	1.31		
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	0	1	0	3	4	0	0	0	0	0	0	0	0	0	0	0	Dec 2017	0	0	0	0	0	0	0	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	45	43	32	29	57	31	35	49	45	32	49	38	41	28	37	35	35	24	Dec 2017	20	1	0	0	3	24	319	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	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	71.1	Dec 2017	70.9	67.0	0.0	88.6	70.9	71.11		
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	Dec 2017	0	0	0	0	0	0	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (%)	%	95.0	95.0	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	99.6	Dec 2017	-	-	-	-	99.55	-	-	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	<= No	0	0	119	121	63	92	76	109	70	68	112	137	109	93	106	69	73	84	80	89	Dec 2017	46	38	0	1	4	89	840	
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	Dec 2017	-	-	-	-	0	-	-	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0	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	-	5.0	Dec 2017	-	-	-	-	5.04	-	-	
Emergency Care & Pt. Flow	Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0	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	1.3	Dec 2017	-	-	-	-	1.29	-	-	
Emergency Care & Pt. Flow	Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15	15	14	41	15	26	14	14	0	0	0	0	0	-	0	0	0	0	0	0	Dec 2017	-	-	-	-	180	0	0	
Emergency Care & Pt. Flow	Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60	60	121	110	103	107	100	99	-	-	-	-	-	-	-	-	-	-	-	-	Dec 2017	-	-	-	-	87	-	-	
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

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Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate					Month	Year To Date	
			Year	Month	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D		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	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	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	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			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	140,979	Dec 2017	48,521	16,009	0	5,358	71,091	140979		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Requ	No			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	68,385	Dec 2017	26,251	8,177	0	3,595	30,362	68385		
Workforce	WTE - Actual versus Plan	No			158	155	152	146	140	151	185	157	166	168	172	176	196	181	180	172	169	158	Dec 2017	50.06	24.17	38.3	17.16	28.89	157.59		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			Dec 2017	72.0	81.8	87.5	66.3	76.9		85.1	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0																			Dec 2017	74.36	83.33	0	67.35	84.31		78.6	
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			56	46	53	52	50	53	52	33	32	30	41	38	51	50	47	49	47	-	Nov 2017	12.0	10.0	12.0	11.0	0.0	47.0	353.0	
Workforce	Sickness Absence - Short Term - In Month	No			162	168	169	181	173	181	166	149	138	61	50	55	96	96	119	159	170	-	Nov 2017	46.0	37.0	41.0	40.0	0.0	170.0	806.0	
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																			Dec 2017	89.5	85.5	93.2	89.2	81.3		86.6	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-		-	
Workforce	New Investigations in Month	No			2	0	1	3	0	0	2	1	2	2	0	0	2	2	2	4	1	0	Dec 2017	0	0	0	0	0	0		
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						-	-	

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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**	

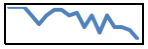
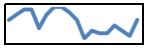
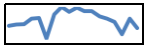
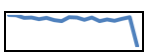
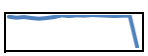
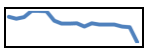
Women & Child Health Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend
			Year	Month	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D		G	M	P			
Patient Safety - Inf Control	C. Difficile	<= No	0	0																			Dec 2017	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Bacteraemia	<= No	0	0																			Dec 2017	0	0	0	0	0	
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80.00	80.00																			Dec 2017	90.4			89.7		
Patient Safety - Inf Control	MRSA Screening - Non Elective	=> %	80.00	80.00																			Dec 2017	0	88.4		88.4		
Patient Safety - Harm Free Care	Number of DOLS raised	No			-	-	-	-	0	0	0	0	0	1	0	0	0	0	0	0	0	0	Dec 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	0	Dec 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	0	Dec 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	0	Dec 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	0	Dec 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	0	Dec 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	0	Jan-00	0	0	0	0	0	
Patient Safety - Harm Free Care	Falls	<= No	0	0	1	1	2	3	1	1	2	1	1	0	3	1	0	0	0	1	1	0	Dec 2017	0	0	0	0	6	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Dec 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	1	0	0	0	0	Dec 2017	0	0	0	0	1	
Patient Safety - Harm Free Care	Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			Dec 2017	99.1	95.4		96.4		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections	=> %	100.0	100.0																			Dec 2017	99.4	100		99.7		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	100.0	100.0																			Dec 2017	100	100		100.0		
Patient Safety - Harm Free Care	WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	100.0	100.0																			Dec 2017	100	100		100.0		
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			Dec 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0																			Dec 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0																			Dec 2017	0	0	0	0	4	

Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Directorate G	Directorate M	Directorate P	Month	Year To Date	
Patient Safety - Obstetrics	Caesarean Section Rate - Total	<= %	25.0	25.0																			Dec 2017		26.6		26.6	25.7	
Patient Safety - Obstetrics	Caesarean Section Rate - Elective	%			8	9	10	8	11	8	7	9	8	9	8	9	7	8	8	9	9	5	Dec 2017		5.28		5.3	8.0	
Patient Safety - Obstetrics	Caesarean Section Rate - Non Elective	%			19	19	19	23	17	20	15	17	17	17	15	17	18	15	19	21	18	21	Dec 2017		21.3		21.3	17.8	
Patient Safety - Obstetrics	Maternal Deaths	<= No	0	0																			Dec 2017		0		0	1	
Patient Safety - Obstetrics	Post Partum Haemorrhage (>2000ml)	<= No	48	4																			Dec 2017		1		1	18	
Patient Safety - Obstetrics	Admissions to Neonatal Intensive Care	<= %	10.0	10.0																			Dec 2017		1.41		1.4	1.9	
Patient Safety - Obstetrics	Adjusted Perinatal Mortality Rate (per 1000 babies)	<= Rate1	8.0	8.0																			Dec 2017		4.02		4.0		
Patient Safety - Obstetrics	Stillbirth (Corrected) Mortality Rate (per 1000 babies)	Rate1			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1	2	Dec 2017		4.02		4.0		
Patient Safety - Obstetrics	Neonatal Death (Corrected) Mortality Rate (per 1000 babies)	Rate1			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	1	0	Dec 2017		0		0.0		
Patient Safety - Obstetrics	Early Booking Assessment (<12 + 6 weeks) (>=%) - SWBH Specific	=> %	90.0	90.0													-						Dec 2017		78.9		78.9		
Patient Safety - Obstetrics	Early Booking Assessment (<12 + 6 weeks) (%) - National Definition	=> %	90.0	90.0																			Dec 2017		112		111.9		
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		-	-	Oct 2017	100	0	0	100.0		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			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	5.5	-	Nov 2017				5.5		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			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	4.6	-	Nov 2017					4.7	
Clinical Effect - Cancer	2 weeks	=> %	93.0	93.0					#DIV/0!													-	Nov 2017	98		0	98.0		
Clinical Effect - Cancer	31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Nov 2017	97			97.0		
Clinical Effect - Cancer	62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		-	Nov 2017	60.6			60.6		
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			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	6	-	Nov 2017	6	-	0	6	30	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			0	0	0	0	0	0	0.5	1.5	3.5	3	1	0	0	3	1	0	0	-	Nov 2017	0	-	0	0	8	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			62	70	97	76	98	98	120	150	162	126	139	95	102	184	141	90	0	-	Nov 2017	0	-	0	0		
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	Dec 2017	0	-	0	0	0	

Women & Child Health Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	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	Dec 2017	0			0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			15	15	15	12	9	12	14	14	12	13	8	12	6	12	8	8	7	4	Dec 2017	3	1	0	4	78	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			19	21	23	23	16	21	24	24	22	19	12	15	14	14	17	15	13	19	Dec 2017	0	0	0	19		
Pt. Experience - Cancellations	Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Dec 2017	8.24		-	6.3		
Pt. Experience - Cancellations	28 day breaches	<= No	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	Dec 2017	0			0	0	
Pt. Experience - Cancellations	Sitrep Declared Late Cancellations	<= No	0	0	4	6	9	12	6	10	6	12	10	12	5	17	4	8	3	10	8	14	Dec 2017	14			14	81	
Pt. Experience - Cancellations	Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	76	76	76	79	79	71	80	83	81	83	82	82	80	79	77	73	79	75	Dec 2017	75	-		75.0		
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	Dec 2017	0	-	0	0	0	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			10	7	43	18	38	38	20	23	15	9	10	7	11	4	13	15	32	27	Dec 2017	9	0	18	27	128	
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	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	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	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	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Directorate G	M	P	Month	Year To Date	
Data Completeness	Open Referrals	No			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	35,501	Dec 2017	8,959	17,709	8,833	35501		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Requiring Validation	No			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	20,322	Dec 2017	5,430	11,905	2,987	20322		
Workforce	WTE - Actual versus Plan	No			97.1	118	116	107	109	126	119	111	116	119	124	116	117	108	96.9	92	94.5	105	Dec 2017	15.4	56.3	32.9	104.8		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			Dec 2017	79.3	60.4	84.5		85.5	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0																			Dec 2017	75	90	70.6		85.6	
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			39	43	44	43	43	30	30	23	29	27	36	28	31	30	29	34	30	-	Nov 2017	4	18	8	30.0	245.0	
Workforce	Sickness Absence - Short Term - in month	No			111	96	106	113	125	114	142	83	105	50	41	40	88	89	91	128	135	-	Nov 2017	7	92	35	135.0	662.0	
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																			Dec 2017	83.4	88.7	89.8		87.8	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-		-	
Workforce	New Investigations in Month	No			1	1	0	0	0	0	0	0	1	3	1	0	0	0	0	1	1	1	Dec 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	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D		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			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	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	88.9	-	Nov 2017		-		88.86	86.28	
WCH Group Only	HV (C3) - % of births that receive a face to face new birth visit by a HV >days	%			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	6.48	-	Nov 2017		-		6.48	10.71	
WCH Group Only	HV (C4) - % of children who received a 12 months review by 12 months	=> %	95.0	95.0	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	95.1	-	Nov 2017		-		95.1	92.82	
WCH Group Only	HV (C5) - % of children who received a 12 months review by the time they were 15 months	%			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	96.7	-	Nov 2017		-		96.69	80.47	
WCH Group Only	HV (C6i) - % of children who received a 2 - 2.5 year review	=> %	95.0	95.0	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	93.8	-	Nov 2017		-		93.75	87.34	
WCH Group Only	HV (C6ii) - % of children who receive a 2 - 2.5 year review using ASQ 3	%			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	81	-	Nov 2017		-		80.99	83.2	
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	-	-	-	Sep 2017		-		1	1	
WCH Group Only	HV (C8) - % of children who receive a 6 - 8 week review	=> %	95.0	95.0	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	98.9	-	Nov 2017		-		98.9	99.27	
WCH Group Only	HV - % of infants for whom breast feeding status is recorded at 6 - 8 week check	=> %	100	100	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	97	-	Nov 2017		-		96.99	98.92	
WCH Group Only	HV - % of infants being breastfed at 6 - 8 weeks	%			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	23.3	-	Nov 2017		-		23.29	37.59	
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	-	-	-	-	-	-	-	-	-	-	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	365	413	313	132	306	377	-	357	365	390	361	401	403	329	386	388	-	Nov 2017		-		388	3023	
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	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			393	376	409	347	330	310	342	-	322	205	197	212	210	326	263	223	246	-	Nov 2017		-		246	1882	
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	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			393	375	346	347	339	323	343	-	-	26	20	19	28	317	24	21	27	-	Nov 2017		-		27	482	
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	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	38	45	41	34	31	63	-	-	125	171	151	134	193	125	135	141	-	Nov 2017	-	141	1175	
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	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Directorate HA	HI	B	M	I	Month	Year To Date	Trend
Patient Safety - Harm Free Care	Never Events	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2017	0	0	0	0	0	0	0	
Clinical Effect - Cancer	Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Nov 2017	-	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Nov 2017	-	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Nov 2017	-	-	-	-	-	-		
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			1	2	1	2	3	2	4	1	2	1	1	1	0	1	0	3	1	3	Dec 2017	1	2	0	0	0	3	11	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			2	2	2	3	3	1	3	4	4	3	2	2	3	3	3	4	2	3	Dec 2017	1	2	0	0	0	3		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Dec 2017	-	-	-	-	-	-	-	
Data Completeness	Open Referrals	No			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	7,473	Dec 2017	2,254	0	2,565	0	2,654	7,473		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Requiring Validation	No			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	3,725	Dec 2017	1,287	0	1,244	0	1,194	3,725		
Workforce	WTE - Actual versus Plan	No			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	44.1	Dec 2017	9.9	7.6	15	6.2	-0.1	44		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2017	68	61	82	83	84		88.98	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2017	80	100	50	100	100		75.34	
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	15	13	12	14	6	5	6	8	6	6	6	8	5	3	9	5	-	Nov 2017	0.0	0.0	4.0	0.0	0.0	5	48	
Workforce	Sickness Absence - Short Term - In Month	No			35	36	30	43	49	41	36	35	45	30	30	39	40	51	49	50	48	-	Nov 2017	10.0	6.0	21.0	5.0	3.0	48	337	
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	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2017	95	88	91	91	96		91.3	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-		-	
Workforce	New Investigations in Month	No			0	0	2	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	Dec 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		

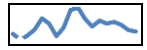
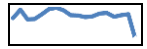
Imaging Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend
			Year	Month	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D		DR	IR	NM	BS			
Patient Safety - Harm Free Care	Never Events	<= No	0	0																			Dec 2017	0	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0																			Dec 2017	0	0	0	0	0	0	
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	<= No	0	0	1.0	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	1.0	-	Nov 2017					3.2		
Clinical Effect - Mort & Read	Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	=> %	0	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	20.0	-	Nov 2017						5.14	
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			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Nov 2017	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Patients Waiting Over 104 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Nov 2017	-	-	-	-	-	-	
Clinical Effect - Cancer	Cancer - Oldest wait for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Nov 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	Dec 2017	0	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			1	2	1	1	4	5	4	1	1	4	2	2	3	1	3	2	1	1	Dec 2017	0	1	0	0	1	19	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			2	2	0	1	4	9	3	2	2	1	3	4	5	2	4	3	3	1	Dec 2017	0	1	0	0	1		
Pt. Experience - Cancellations	Urgent Cancelled Operations	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Dec 2017	-	-	-	-	-	-	
Emergency Care & Pt. Flow	Emergency Care 4-hour breach (numbers)	No			86	66	54	55	60	55	66	54	100	102	128	94	106	100	97	122	111	140	Dec 2017	140	0	0	0	140	1000	
RTT	Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0																		-	Nov 2017	0.73				0.73		
Data Completeness	Open Referrals	No			342	361	376	399	428	438	461	481	498	512	532	545	560	577	608	623	666	707	Dec 2017	707	0	0	0	707		
Data Completeness	Open Referrals without Future Activity/ Waiting List: Requiring Validation	No			299	315	331	346	373	386	403	421	438	454	474	492	506	531	553	570	596	621	Dec 2017	621	0	0	0	621		
Workforce	WTE - Actual versus Plan	No			45	47	45	41	40	38	32	31	32	35	39	36	35	30	25	20	24	28	Dec 2017	13	3.1	3.6	3	28.2		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			Dec 2017	67.8	70	84.6	70.2		84.0	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0																			Dec 2017	85.7	0	100	0		86.9	
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	7	6	7	13	10	15	13	9	6	10	7	7	4	6	8	6	-	Nov 2017	2.0	0.0	1.0	1.0	6.00	54.00	
Workforce	Sickness Absence - Short Term - in month	No			31	23	26	29	41	40	53	36	32	29	22	24	22	22	34	31	39	-	Nov 2017	23.0	0.0	1.0	10.0	39.00	223.00	
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																			Dec 2017	84.2	91.8	93.3	95.9		87.0	
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	1	0	1	Dec 2017					1		
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			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-								

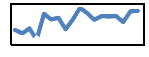
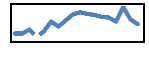
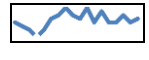
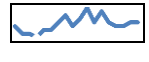
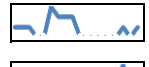
Primary Care, Community & Therapies Group

Section	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Data Period	Directorate AT	IB	IC	Month	Year To Date	Trend
Patient Safety - Inf Control	MRSA Screening - Elective	=> %	80.0	80.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2017	0	0	0	0		
Patient Safety - Harm Free Care	Number of DOLS raised	No			-	-	-	-	2	2	1	0	5	4	4	1	3	2	5	14	4	1	Dec 2017	0	1	0	1	38	
Patient Safety - Harm Free Care	Number of DOLS which are 7 day urgent	No			-	-	-	-	2	2	2	0	5	4	4	1	3	2	5	14	4	1	Dec 2017	0	1	0	1	38	
Patient Safety - Harm Free Care	Number of delays with LA in assessing for standard DOLS application	No			-	-	-	-	2	0	0	0	0	0	0	0	2	0	0	0	0	0	Dec 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	4	Dec 2017	0	4	0	4	18	
Patient Safety - Harm Free Care	Number patients discharged prior to LA assessment targets	No			-	-	-	-	1	0	0	0	0	2	2	4	0	1	2	3	3	0	Dec 2017	0	0	0	0	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	0	Dec 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	0	Dec 2017	0	0	0	0	2	
Patient Safety - Harm Free Care	Falls	<= No	0	0	29	31	29	33	30	27	20	19	31	23	21	36	36	38	30	33	32	38	Dec 2017	1	36	1	38	287	
Patient Safety - Harm Free Care	Falls with a serious injury	<= No	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	2	1	0	1	0	Dec 2017	0	0	0	0	5	
Patient Safety - Harm Free Care	Grade 3 or 4 Pressure Ulcers (avoidable)	<= No	0	0	3	1	1	0	1	3	2	2	1	5	1	1	1	0	3	1	2	0	Dec 2017	0	0	0	0	14	
Patient Safety - Harm Free Care	Never Events	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2017	0	0	0	0	0	
Patient Safety - Harm Free Care	Medication Errors	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2017	0	0	0	0	1	
Patient Safety - Harm Free Care	Serious Incidents	<= No	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Dec 2017	0	0	0	0	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	Dec 2017	0	0	0	0	0	
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			4	5	4	3	8	4	6	1	1	4	3	8	4	10	2	7	6	4	Dec 2017	4	0	0	4	48	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			8	9	7	5	5	6	6	6	6	9	10	12	9	11	8	8	8	9	Dec 2017	6	2	1	9		

Primary Care, Community & Therapies Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate			Month	Year To Date	
			Year	Month	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D		AT	IB	IC			
Workforce	WTE - Actual versus Plan	No			154	152	135	104	109	122	115	112	118	128	130	131	132	136	130	112	97.9	86.7	Dec 2017	33.4	26.8	26.6	86.72		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			Dec 2017	80.9	90	88.8		90.6	
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			24	27	29	22	23	29	32	24	24	24	19	19	15	24	21	26	36	-	Nov 2017	6	-	-	36	184	
Workforce	Sickness Absence - Short Term - in month	No			80	83	53	74	104	101	102	93	82	57	60	57	78	84	76	121	128	-	Nov 2017	34	55	39	128	661	
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																			Dec 2017	0	91.4	0		90.2	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-		-	
Workforce	New Investigations in Month	No			0	1	0	0	0	1	0	0	0	0	0	1	0	0	0	1	0	0	Dec 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	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D		AT	IB	IC			
Community & Therapies Group Only	DVT numbers	=> No	730	61	-	-	-	-	-	-	-	-	-	41	54	59	70	54	56	55	55	29	Dec 2017				29	473	
Community & Therapies Group Only	Adults Therapy DNA rate OP services	<= %	9	9	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	1.29	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	14.9	Dec 2017				14.9	12.9	
Community & Therapies Group Only	STEIS	<= No	0	0	0	0	2	1	1	0	0	0	0	0	0	-	1	2	3	0	-	0	Dec 2017				0	6	
Community & Therapies Group Only	Green Stream Community Rehab response time for treatment (days)	<= No	11.0	11.0	-	-	-	-	-	-	-	-	-	15.5	16.7	18.3	18.5	19.4	15.5	14.7	12.4	15.3	Dec 2017				15.27	146.08	
Community & Therapies Group Only	DNA/No Access Visits	%			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	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	59.2	Dec 2017				59.18	56.74	
Community & Therapies Group Only	Falls Assessments - DN Intial Assessments only	%			61	55	65	42	77	69	60	62	58	69	63	57	58	57	54	50	60	60	Dec 2017				59.74		
Community & Therapies Group Only	Pressure Ulcer Assessment - DN Intial Assessments only	%			65	63	71	47	80	71	63	65	63	77	68	63	65	66	62	59	72	70	Dec 2017				70.22		
Community & Therapies Group Only	MUST Assessments - DN Intial Assessments only	%			36	32	37	26	52	46	48	36	46	58	52	46	49	49	49	43	54	55	Dec 2017				54.68		
Community & Therapies Group Only	Dementia Assessments - DN Intial Assessments only	%			30	37	45	14	53	53	52	62	44	55	-	-	60	38	63	41	50	47	Dec 2017				47.21		
Community & Therapies Group Only	48 hour inputting rate - DN Service Only	%			90	92	86	94	93	93	69	93	94	92	-	93	92	93	93	94	96	-	Nov 2017				95.51		
Community & Therapies Group Only	Making Every Contact (MECC) - DN Intial Assessments only	%			222	222	270	177	251	369	308	382	460	488	467	453	428	420	369	556	398	337	Dec 2017				63.11	58.2	
Community & Therapies Group Only	Avoidable Grade 2,3 or 4 Pressure Ulcers (DN Caseload acquired)	No			4	3	2	0	2	5	6	8	6	5	8	4	7	4	4	6	4	5	Dec 2017				5	47	
Community & Therapies Group Only	Avoidable Grade 2 Pressure Ulcers (DN caseload acquired)	No			3	1	1	0	2	2	4	6	3	5	8	4	7	4	3	3	4	4	Dec 2017				4	42	
Community & Therapies Group Only	Avoidable Grade 3 Pressure Ulcers (DN caseload acquired)	No			1	1	1	0	0	3	2	2	2	0	0	0	0	0	0	1	0	1	Dec 2017				1	2	
Community & Therapies Group Only	Avoidable Grade 4 Pressure Ulcers (DN caseload acquired)	No			0	1	0	0	0	0	0	0	1	0	0	0	0	0	1	2	0	0	Dec 2017				0	3	

Corporate Group

Section	Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate							Month	Year To Date	Trend
			Year	Month	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D		SG	F	W	M	E	N	O			
Pt. Experience - FFT,MSA,Comp	No. of Complaints Received (formal and link)	No			4	13	8	13	11	12	11	11	14	3	9	5	10	2	8	4	9	8	Dec 2017	1	0	1	0	0	4	2	8	58	
Pt. Experience - FFT,MSA,Comp	No. of Active Complaints in the System (formal and link)	No			9	17	10	13	18	13	12	17	19	16	17	10	13	5	10	7	11	15	Dec 2017	1	0	1	0	1	6	6	15		
Workforce	WTE - Actual versus Plan	No			106	130	146	123	118	133	98.6	94.5	105	99.5	103	102	102	107	123	114	111	122	Dec 2017	9.08	-1.04	1.61	22.5	-2.13	47	45.5	122.46		
Workforce	PDRs - 12 month rolling	=> %	95.0	95.0																			Dec 2017	68	77	72	84	73	86	79		87.5	
Workforce	Medical Appraisal and Revalidation	=> %	95.0	95.0																			Dec 2017			95					50.0	59	
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			59	62	65	64	64	79	0	1	0	2	1	2	2	2	2	1	2	-	Nov 2017	2.00	0.00	0.00	0.00	0.00	0.00	0.00	2.00	14.00	
Workforce	Sickness Absence - Short Term - in month	No			153	160	181	203	224	191	7	8	8	3	2	3	1	4	10	4	5	-	Nov 2017	3.00	0.00	0.00	0.00	0.00	2.00	0.00	5.00	32.00	
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																			Dec 2017	0	91	96	90	97	91	95	92.6	90	
Workforce	Mandatory Training - Staff Becoming Out Of Date	%			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-	-	-	-	-	
Workforce	New Investigations in Month	No			4	1	1	0	0	2	1	1	4	6	0	2	1	1	0	0	1	1	Dec 2017	0	0	0	0	0	1	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:	Persistent Reds
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance
AUTHOR:	Dave Baker, Director of Transformation and Partnerships
DATE OF MEETING:	Thursday 1 February

EXECUTIVE SUMMARY:

The Trust has a number of indicators that have been red for some time and need addressing. The plan to address these has five component parts:

1. Named responsible lead;
2. Articulate the root cause of each of the issues;
3. Build trajectories for improvement supported by action plans;
4. Articulate where and why any particular indicators cannot be resolved before the end of March 2018;
5. Rather than trying to fix them all at once categorise them between: **resolve** fully before 31 March 2018; **improve** before 31 March 2018; **tolerate** until 31 March 2018; TBC (meaning to be worked through); and **remove** (where the indicator is not a persistent red or does not align to the IPR)

On this basis three persistent reds will be resolved by 31 March 2018 being:

- Harm Free Care - Neutropenia sepsis door to needle time greater than one hour;
- Access to Emergency Care and Flow - emergency care patient impact – unplanned reattendance rate %;
- Referral to Treatment – Treatment Functions Underperforming (Admitted, Non Admitted, Incomplete).

It is proposed that a further five are removed, four of these being where the root cause is stated that it is not flagging as a persistent red in the IPR and is being regularly achieved . The remaining one stating that the target has defaulted to 0% turnover as no actual target has been set.

A further fourteen areas will be improved in advance of 31 March 2018 and have plans but that we expect them to take longer to resolve. Two areas will be tolerated in the short term. The final seven areas require a little more work in advance of a decision as to whether they will be resolved before 31/3/18; removed; tolerated or improved.

REPORT RECOMMENDATION:

1. That the Board accept the approach and monitor against resolution and improvement.
2. That the Board consider any others that they feel should be prioritised for resolution or significant improvement before 31 March 2018.

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	X

Comments:

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

Link to IPR

PREVIOUS CONSIDERATION:

Regular review

Persistent Red Recovery Plan

	Indicator	Responsible Lead	Plan In Place Yes / No	Root Cause of Issue	Treatment	Q4 Only Jan18	Q4 Only Feb18	Q4 Only Mar18	Q4 Actions Plans Jan18	Q4 Actions Plans Feb18	Q4 Actions Plans Mar18	Explanation of why resolution cannot be achieved before 31 March 2018
Obstetric	Caesarean Section Rate - Total	Amanda Geary	Yes	**Clinical decision making in line with clinical presentation, clinical need, clinical guidelines (local and national) and patient choice.**	Tolerate				Endeavour to maintain Trust target of 25% through rigour regarding adherence to guidelines and supportive measures for women when booking elective caesarean sections. Where CS rate exceeds 25% assurance sought that appropriate care provided to meet clinical indication/ need. Main priority is patient safety, incorporating patient choice within boundaries of safety and application of national guidance. Assurance measure and monitoring in place: all emergency caesarean sections are reviewed by MDT within 24 hours of case taking place; critical review to determine if appropraite action and where this is not the case, learning identified and shared amongst team with 1:1 facilitated if required. Good practice also highlihgted with strong focus reamining outcomes (i.e. reduction in perinatal mortality and morbidity).Review in place to determine whether increase in locums impacts rate			Achievement of target is determined by clinical decision and intervention to yield safe outcome for mother and baby (see action plan section).
	Early Booking Assessment (<12 + 6 weeks) - SWBH Specific	Amanda Geary	Yes	**External patient factors, primary care referral processes and other organisation's capped bookings impacts on timeliness of patient referral and receipt by Trust for processing and booking within 12+6 to meet 90% hence targets adjust to 80% in line with outcome of local review.**	Tolerate	80%	82%	85%	Many breaches result in 'out of area' women presenting late, but also some late bookings (internal issue). Actions include: 1) DoM writing to GPs about late presentation (outside trust control) and 2) discussion with teams on late bookings (within trust control).	Further improvements delivered following actions in January. Sample, continous indicator validation will be on-going during Jan-Mar to ensure the reasons for the breaches are eliminated especially for trust controlled breaches.	If indicator performance is validated to be persistently outside of trust control, the trust will aim to address specifics with the CCG with a view to either reduce the target or support improvement in areas outside of trust control.	Target threshold of 90% exceeds improvement within control of SWBH owing to external factors as reflected in RAP. Adjusted target of 80% more realistic however reporting reflects bookings that were done in the past (i.e. women who have delivered in month, not those who were booked in month), therefore improvements implemented in Q4 will be anticipated to be reflected from Q 2, when these women deliver.
Harm Free Care	Patient Safety Thermometer - Overall Harm Free Care	Debbie Talbot	Yes	**failure to implement preventative strategies via person centred risk asessment and care planning**	Improve	94%	95%	95%	stop the pressure to focus on wards with high numbers of pressure ulcers - commencing with D16, email from medical director re VTE compliance , reinforce safety plan and accountability's	extend stop the pressure and use of safety cross	study day for tissue viability(inclues continence training_) - wards targeted for attendance	
	Falls	Debbie Talbot	Yes	**as above (no falls lead**	Improve	10%	8%	8%	target based on OBD 8% target for community beds, detailed review of incidents to determine trends , new dementia team to reduce falls from intentional wandering 20 hi lo beds ordered (10 disseminated to date)	replace non mechanical beds at Leesowes, staff training	falls lead to start ward based activity (awaiting confirmation of funding)	
	WHO Safer Surgery - Audit - brief and debrief (% lists where complete)	David Carruthers	Yes	1. Different processes have been needed to gather compliance data for non ORMIS areas and for the Brief & Debrief elements in the ORMIS areas. 2. Data quality issues have been identified through clinical effectiveness department. 3. Missed brief/debriefs	TBC			99%	DT to meet with C&T GDON re improvement plan A further sample of data for November is currently being analysed.	The majority of cases where a Debrief was not recorded as being undertaken were for consultants in Cardiology (16/31). A specific audit examining the consent taking within cardiology has been included in the Trusts Clinical Audit Plan for 2017/19. The audit is planned to be completed in Q4 of this financial year.		The fundamental challenge in collecting the data in one system is that the 3 sections requires to be collected at a patient level and the Team Brief and Team debrief collected at organisational (list) level. To take this forward it is recommended that a small working group is convened, with representation from the Theatre management team, Communications, Medical Directors Office, Hospital Information Services and Clinical Effectiveness
	Mortality Reviews within 42 working days	David Carruthers	Yes	1. Intermittent problems with mortality review system with conultants not received reviews to complete. 2. Sometimes the review is automatically routed to the wrong consultant eg surgery routed to medicine consultant. If this is not highlighted it won;y get reviewed. 3. Some consultants are not completing their allocated mortality reviews. This could be due to clinical competing demands on time or non-engagement in the process. 4. There is no dedicated support for the administration of mortality reviews therefore reliant on ad hoc checks of compliance progress. 5. When consultants leave or CDs change if the system isn't updated then consultants who have left will be assigned rev iews and they will not be completed. 6. Sometimes the scanned notes are not available for the review to be completed.	Improve			50%	1. Manual requests for reviews will be sent out once so we are sure all reviewers are receiving their allocated reviews.			The mortality process is currently being reviewed as part of the Learning From Deaths framework. It is expected that the processes currently in place will change and therefore the manual processes in place will be for the interim period. The new policy for Learning from Deaths will indicate the deaths that are required to be reviewed. The KPI should be reviewed to reflect this change.
	Neutropenia Sepsis Door to Needle Time Greater Than 1 Hour	Michelle Harris	Yes	**non compliance with designed process**	Resolve	100%	100%	100%	1) Patients carry ID card to present to ED (live Dec17); 2) From 1st Jan the consultant will be alerted of all neutropenic sepsis cases	Clarification of criteria being sort via Yasmina in regard to patients prestning in ED with an unrelated presentation that do not identify themselves as having Chemo or have no associated issues. Also seeking advice in regard to antibiotic stewardship		
Cancelled Operations	Elective Cancellations at last minute for non-clinical reasons (as a percentage of elective admissions)	Tina Robinson	Yes	**non complaince with policy and delay in improvement opportunties related to scheduling and theatre efficiency**	TBC			0.8%	1) Priority improvement areas Oral, ENT, Ophthalmology for scheduling and efficiency in theatres			
	No. of Sitrep Declared Late Cancellations - Total		Yes	**non complaince with policy and delay in improvement opportunties related to scheduling and theatre efficiency**	TBC	27%	23%	20%	Same as above	Same as above	Same as above	
	Weekday Theatre Utilisation (as % of scheduled)	Liam Kennedy	Yes	**In principle under utilised theatres will be removed for cost savings. There has been a delay in design and implementation of improvement programme to remove theatres in year at scale. In Q4 the programme will be modelled through to end of 2019 with a clear implementation plan.**	TBC	70%	72%	75%	1)Model theatre demand and capacity against contract	2) Compelte modeelign and outlien programme design	3) start implementation of utilisation programme	Modelling needs to accommodate 2018-19 contract uplift in activity and have time and resource to deliver this change at scale,
Access To Emergency Care & Patient Flow	Emergency Care 4-hour waits	Rachel Barlow	Yes	**Delay in implementation of ED and Patient Flow improvement plans; increased demand over winter**	Improve to consistently beyond 85%?	85%	87%	90%	1) Implement Patient Flow programme particularly admit pull and COW model	1) Implement Patient Flow programme gaining benefit from admit pull and COW model and implementing on call rota	1) Full implementation of improvement programmes	1) Increased demand and delay in delivery of improvement plans
	Emergency Care 4-hour breach (numbers)	Rachel Barlow	Yes		TBC	82	71	55	Correlated to the above indicator	Correlated to the above indicator	Correlated to the above indicator	
	Emergency Care Timeliness - Time to Initial Assessment (95th centile)	Michelle Harris	Yes	**THIS IS NOT A PERSISTENT RED - KPI achieved for last 11 months**	Remove							
	Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	Michelle Harris	Yes	**underperformance analysed in 6 month audit which has informed improvement focus as follows: gynae pathway, GP direct bookings, catheter pathway to SAU, frequent attenders MDT**	Resolve	5.5%	5.3%	5.0%	Audit completed in December and themes for improvement agreed. Performance on track in March18	implement improvement approach	complete implementation of improvement approach	
	Delayed Transfers of Care (Acute) - Total Bed Days (All Local Authorities)	Caroline Rennalls	No	This doesn't seem to align to the IPR where DTOCs are not an issue	Remove				Meeting to discuss threshold vs performance & count			
	Delayed Transfers of Care (Acute) (Av./Week) attributable to NHS	Caroline Rennalls	No	This doesn't seem to align to the IPR where DTOCs are not an issue	Remove							
	Non clincial bed moves all (10pm -6am)	Rachel Barlow	Yes	**This indiciator has deficition has been redefined. The bench mark data will be assessed. An initial goal of 25% reduction will be set and reviewed at end Q4.**	TBC	benchmark			This indicator has deficition has been redefined. The bench mark data will be assessed. An initial goal of 25% reduction will be set and reviewed at end Q4. 2) Implement the admit pull model and COW to improve flow	1) realise benefits of admit pull and COW improvments 2)redesign flow into community beds ie book in advance	3) Continue improvement work and evlaaute progress to inform further trajectory	Review benchmark and forward trajectory
	Non clinical bed moves excluding the assessment unit (10pm -6am)	Rachel Barlow	Yes	**As above**	TBC	benchmark			as above	as above	as above	as above
	Patient Bed Moves (10pm - 6am) (No.) - exc. ALL moves for clinical reasons	Rachel Barlow	Yes		Improve	109	90	80			In Q4 reduce non-clinical bed moves by 25% (currently at 109) ; Q1 all non-clinical moves will be eliminated	
	Hip Fractures - Best Practice Tarriff - Operation < 36 hours of admission (%)	Tina Robinson	Yes	**Challneges in acuity and pathways management . Recent challenge with snow and large demand.**	Improve	75%	80%	85%	1) Review of Trauma planning meeting for improvement in January; 2) review of effectiveness of snow and bad weather response in imaging and theatre team planning	implement improvement plan	implement improvement plan	
	PDRs - 12 month rolling	Raffaela Goodby	Yes	PDR completion flucuates over the year to reach 95% by the end of March. During 2018/19 all PDR's will be completed during Apr-June	Improve		80%	95%	Accredited manager training rolled out inclusive of Aspiring to Excellence Training for managers.		Close down PDR's ready for new PDR year and objective setting in April to June	
	Medical Appraisal	David Carruthers	Yes	Late medical appraisals.	Improve			85%	1. Revised escalation process implemented. Information from PReP is now used to update IPR frontsheet for medical appraisal compliance. 2. All appraisees receive a reminder in the month before their appraisal is due.	1. Summary of doctors in escalation process to be distributed to GDs and GDOPs monthly. 2. Copies of escalation letters will be sent to appropriate HR Business Partners, Clinical Director and Specialty Lead.		The escalation process has only recently been implemented and therefore those doctors who have just moved into the process could still be non-compliant at the end of the March We have discussed the option of bringing forward Q4 medical appraisal into Q3 to ensure that any appraisals in Q4 are those that are late and in escalation. This should help to ensure that all doctors have one medical appraisal in every appraisal cycle and therefore improve overall compliance.
	Sickness Absence (Rolling 12 Months)	Raffaela Goodby	Yes	Sickness has remained consistent during September - Jan but overall 12 months rolling sickness has improved.	Improve				Launch of manager training on sickness absence & Well being. Group review scrutiny on sickness, incl long term sickness cases. Review of hot spot areas in medicine by DON & HRBP	Further manager training on sickness and well being. WCH specific workshops for managing absence. Focus on RTW interviews.	Escalations to group directors through group reviews for LT sickness cases. Review of sickess policy. Training & Development	Sickness absence has remained above trajectory and target for the past 12 months, as detailed in November and December board papers. A set of escalated interventions are being implemented, including manager
	Sickness Absence (Monthly)	Raffaela Goodby	Yes	In month sickness has remained high with short term sickness increasing in Q3 and Q4. Long term sickness has reduced over the past 12 months.	Improve	.4.6%	.4.5%	4%	Launch of manager training on sickness absence & Well being. Group review scrutiny on sickness, incl long term sickness cases. Review of hot spot areas in medicine by DON & HRBP	Further manager training on sickness and well being. WCH specific workshops for managing absence. Focus on RTW interviews.	Escalations to group directors through group reviews for LT sickness cases. Review of sickess policy. Training & Development	Sickness absence has remained above trajectory and target for the past 12 months, as detailed in November and December board papers. A set of escalated interventions are being implemented, including manager

Persistent Red Recovery Plan

	Indicator	Responsible Lead	Plan In Place	Root Cause of Issue	Treatment	Q4 Only			Q4 Actions Plans			
			Yes / No			Jan18	Feb18	Mar18	Jan18	Feb18	Mar18	Explanation of why resolution cannot be achieved before 31 March 2018
Workforce	Sickness Absence - Long Term (Monthly)	Raffaela Goodby	Yes	In month sickness has remained high with short term sickness increasing in Q3 and Q4. Long term sickness has reduced over the past 12 months.	Improve				as above	as above	as above	
	Sickness Absence - Short Term (Monthly)	Raffaela Goodby	Yes	In month sickness has remained high with short term sickness increasing in Q3 and Q4. Long term sickness has reduced over the past 12 months.	Improve			4%	as above	as above	as above	
	Return to Work Interviews following Sickness Absence	Raffaela Goodby	Yes	Return to work interviews had a rapid improvement at the end of 2016 then have remained stubbornly at 80% since then. Q4 will see a key focus on RTW interviews thorugh the Accredited Manager Roll out and through the Director of OD focus	Improve			90%	In order to implement an improvement trajectory of 10% in Q4 : 1) the director of People and OD is writing to every line manager in January, who reports a RTW compliance rate of below 85%.	Accredited manager training contains focus on health and well being, including the importance of return to work interviews.	Follow up and communications around importance of return to work interviews, through accreidted manager communications and corproate communications	
	Mandatory Training	Raffaela Goodby	Yes	Past 12 months transition year for mandatory training, including a lack of focus around safeguarding training and a performance notice from the CCG. This is in turnaround since August last year.	Improve				Safeguarding improved across the board and performance notice has now been removed from the Trust. Launch of new corporate induction	BLS Delivery as part of CQC Improvement plan will impact figures, Safeguarding improvements will be embdedded. Corporate Induction Changes embdedded.	BLS Delivery as part of CQC Improvement plan will impact figures, Safeguarding improvements will be embdedded. Corporate Induction Changes embdedded.	Mandatory training will increase by the end of Q4, in particular the Safeguarding and BLS topics which are key for CQC and CCG improvement delivery.
	Mandatory Training - Health & Safety (% staff)	Raffaela Goodby	Yes	**This is not a persistent red. It has regularly achieved this year**	Remove							
	Employee Turnover (rolling 12 months)	Raffaela Goodby	Yes	**This is not a persistent red. The Trust board has never set an objective on employee turnover, consider for 2018**	Remove							

Persistent Red Recovery Plan

	Indicator	Responsible Lead	Plan In Place	Root Cause of Issue	Treatment	Q4 Only			Q4 Actions Plans			
			Yes / No			Jan18	Feb18	Mar18	Jan18	Feb18	Mar18	Explanation of why resolution cannot be achieved before 31 March 2018
	Nursing Turnover	Raffaela Goodby	Yes	% target has not ybeen formally set and so has defaulted to 0%. Need to agree target. Sugested 10.7% at Trust Board in March 2017	Improve			.10.7%				
Referral to Treatment (RTT)	RTT - Admittted Care (18-weeks)	Liam Kennedy	Yes	Trajectory to deliver in Q4 impacted by winter pressure and cancellation of elective activity	Tolerate	85%	87%	88%	deliver activity plan	deliver activity plan	deliver activity plan	impact of winter pressures and elective cancelations
	RTT - Non Admittted Care (18-weeks)	Liam Kennedy	Yes	Trajectory to deliver in Q4 impacted by winter pressure and cancellation of elective activity	Tolerate	93%	92%	94%	deliver activity plan	deliver activity plan	deliver activity plan	impact of winter pressures and elective cancelations
	Patients Waiting >52 weeks	Liam Kennedy	No	Year to date analysis completed to inform improvement activities. Training 56% completed successfully.Improvment trajectory TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	Historical inaccurate clock stops
	Treatment Functions Underperforming (Admitted, Non-Admitted, Incomplete)	Liam Kennedy	Yes	Trajectory to deliver in Q4 impacted by winter pressure and cancellation of elective activity	Resolve	4%	3%	3%	deliver activity plan	deliver activity plan	deliver activity plan	impact of winter pressures and elective cancelations
Open Referrals	Open Referrals without Future Activity/ Waiting List: Requiring Validation	Liam Kennedy	Yes		TBC					Make PAS system changes		

Persistent Red Recovery Plan

	Indicator	Responsible Lead	Plan In Place Yes / No	Root Cause of Issue	Treatment	Q4 Only Jan18	Q4 Only Feb18	Q4 Only Mar18	Q4 Actions Plans Jan18	Q4 Actions Plans Feb18	Q4 Actions Plans Mar18	Explanation of why resolution cannot be achieved before 31 March 2018
Friends and Family	FFT Response Rate - Adult and Children Inpatients (including day cases and community)	**Elaine Newell**	**Yes**	**initial targets may have been unrealistic: Q3 22% west midlands , Q4 26% national due to low scoring baseline , absence of senior nursing in clinical groups, lack of corporate nursing lead (due to absence for Q3) , inconsistent technical and telecomms support /sign in**	Improve	10%	15%	22%	disseminate and collect cards for defined areas, escalate need for IVM to Chief Nurse , ensure wards have functioning IPAds, meet with volunteers on wards to gain support to undertake	dementia lead nurse to review wider patient experience including FFT and ensure views of vulnerable adults accessed, named techincal support and telecomms to action IVM		impact of Winter Pressures,
	FFT Score - Adult and Children Inpatients (including day cases and community)		**Yes**		Improve							
	FFT Response Rate: Type 1 and 2 Emergency Department		**Yes**		Improve							
	FFT Score - Adult and Children Emergency Department (type 1 and type 2)		**Yes**		Improve							
	FFT Response Rate: Type 3 WiU Emergency Department		**Yes**		Improve							
	FFT Score - Outpatients		**Yes**		Improve							
	FFT Score - Maternity Birth		**Yes**		Improve							
	FFT Response Rate - Maternity Birth		**Yes**		Improve							
LD	Access to healthcare for people with Learning Disability (full compliance)	**Elaine Newell**	**Yes**		Remove					corporate nursing temporary support to walk wards to undertake survys		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	52 week RTT breach analysis for 2017
SPONSOR (EXECUTIVE DIRECTOR):	Rachel Barlow – Chief Operating Officer
AUTHOR:	Liam Kennedy – Deputy Chief Operating Officer Planned Care
DATE OF MEETING:	1st February 2018

EXECUTIVE SUMMARY:

This paper provides a briefing on the Trust current in year 52 week breach performance, providing :

- A definition
- Analysis and root cause
- Improvement approach and outline trajectory to zero tolerance

There have been 40 patient pathways that have resulted in first definitive treatment at or after 52 weeks from referral on a planned care pathway. We treat c.260,000 patients on a planned care pathway annually. There has been no identifiable harm to the 40 patients who regrettably waited over 52 weeks for treatment. The patient experience obviously falls short of what we aim to provide in terms of waiting times and access to treatment.

The 52 week breach rate is identified in the Trust draft Enforcement Undertakings document as an operational issue in need of improvement.

REPORT RECOMMENDATION:

The Trust Board ae asked to:

- Discuss the root cause and improvement approach
- To consider the trajectory to zero tolerance of 52 week breaches

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	**x**	Legal & Policy		Patient Experience	x
Clinical	**x**	Equality and Diversity		Workforce	
Comments:					

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

RTT performance, Quality of care

PREVIOUS CONSIDERATION:

IPR

52 week breach analysis

Definition

The definition of a 52 week breach is that a patient referred on a planned care pathway receives their first definitive treatment at or after 52 weeks of referral. So far in 2017 we have regrettably had 40, 52+week breaches up to and including December 2017. In the same period we have treated 193,000 patients on a planned care Referral to Treatment (RTT) pathway.

Analysis

25 out of the 40 (63%) were due to 'Referral to Treatment (RTT) clock stop' being applied in error' on the PAS system during a patient pathway. A further 13 were also down to poor internal pathway management but coded under different reasons, bringing the total to 95% of 52 week breaches being due to errors in pathway administration. As the RTT clock had stopped, none of these patients were visible on the RTT patient tracking list and consequently their pathways were not managed in a timely way. The patient's actual care was however progressed.

There were only 2, 52+ week breaches that were known about before being classified as 52 week breaches. These were in April 2017, both in Dermatology and both as a result of a lack of operational understanding of the RTT pathway at the time. This has now been rectified, a complete review of dermatology waiting list management completed and improved governance and in depth training established.

The main root cause for the Trust 52 week breach rate is historical administration errors of clock stops being applied live patient pathways.

Appendix 1

Table1: showing the classification of all 52+ week incomplete breaches in 2017.

Root cause analysis

Every 52+ week patient breach has a Root Cause Analysis completed (appendix 2). This includes the steps in the pathway, what learning has been taken from the breach and whether or not any clinical harm has come from the delay in definitive treatment. These are discussed at Group reviews, Trust wide Patient Tracking List Meeting and at the Operational (performance) Management Committee and any learning disseminated.

There has been no reported clinical harm to any of the 40 patients but clearly the time taken to treatment is a poor experience. There is one current root cause analysis in train for a pending investigation for potential harm; this will be completed in early February.

In order to ensure transparency and collaboration with our commissioners and NHSI both were invited and took part in a detailed review of all our 52 week breaches and invited to suggest other methods not currently being explored to improve the position. Through this process it was identified that 45% of incorrect clock stops were applied at the diagnostic stage and 37.5% at the Outpatient clinic stage. Of the diagnostic errors 40% of this was related to a pathway administration issue in dermatology which was known and rectified in June 2017. The outcomes have informed the improvement approach.

Improvement approach

Training and competency of staff is essential. There are hundreds of staff Trust wide involved in the RTT delivery chain and administration. A detailed and mandated programme of training and assessment has been designed initially for administration staff to be completed by the end of Feb 2018 and then for clinical staff to complete by end May 2018.

The training of these staff groups will mitigate 80% of the breaches with a small number of localised referral or pathway issues already resolved.

Ongoing audit is essential to maintain the data quality and a monthly audit will be completed to ensure improvement and continued learning.

Due to the legacy issue of incorrect RTT clock stops being applied it is difficult to apply a precise trajectory until assurance on staff competence and data quality is achieved. With the training and competency trajectory completed by end May, the Trust would expect to see a near zero tolerance to 52 week breaches in Q4 2018/19

Feb 2018 – Complete training for all non-clinical staff with sign off of test pass results
May 2018 – complete training for clinical staff
October – 2018 complete review of all waiting lists to ensure accuracy
Feb – 2019 – benefits of the training programme start to take effect and number of 52 week breaches to a tolerance of 1 per month.
October 2019 – zero tolerance on 52 week breaches

To achieve a zero tolerance earlier would require validation of the last 14 months clock stops this would require a large validation resource.

Conclusion

The Trust Board ae asked to:

- Discuss the root cause and improvement approach
- To consider the trajectory to zero tolerance of 52 week breaches

Appendix 1 52 week breach analysis

Table 1 52 week analysis by speciality and reason

w Labels	ALLOWING PATIENT CHOICE	APPT FROM ANOTHER PATHWAY ON THIS PATHWAY	CANCELLED OP DELAY REBOOKING	CAPACITY To FIRST OPA	NON RESPONDER	NURSE LED APPT ON CONS PATHWAY	RTT APPLIED IN ERROR	No RCA	Referral Process Failure	Grand Total
Dermatology				2	3	1	4			10
Ophthalmology						2	3			5
Plastics							3	1		4
Other(paedplas)			1				3			4
T&O	1						1		1	3
Urology						2	1			3
ENT							3			3
General Surgery							2			2
Oral Surgery							2			2
Gynae On							1			1
Gynaecology							1			1
Cardiology		1								1
Gastro							1			1
Grand Total	**1**	**1**	**1**	**2**	**3**	**5**	**25**	**1**	**1**	**40**

Table 2 showing where and how the breach in the pathways occurred:

	Diagnostic				OPA		Capacity	Admin Error		Grand Total	% Error at Diagnostic Stage	% Error by Clinical Team	% Error by Admin Team
Row Labels	**Admin**	**Clinical**	**Generic Machine**	**Reporting**	**Admin**	**Clinical**	**Capacity**	**Admin**	**Admin Error**				
Dermatology		4		1	2		2		1	10	50.00%	40.00%	30.00%
Ophthalmology		1		2	1	1				5	60.00%	40.00%	20.00%
Plastics					3		1			4	0%	0.00%	75.00%
Other(paedplas)					1	2		1		4	0.00%	50.00%	50.00%
T&O					1	1			1	3	0.00%	33.33%	66.67%
Urology			1	2						3	100.00%	0.00%	0.00%
ENT	1	1			1					3	66.67%	33.33%	66.67%
General Surgery	2									2	100.00%	0.00%	100.00%
Oral Surgery	1	1								2	100.00%	50.00%	50.00%
Gynae On						1				1	0.00%	100.00%	0.00%
Gynaecology	1									1	100.00%	0.00%	100.00%
Cardiology								1		1	0%	0.00%	100.00%
Gastro					1					1	0.00%	0.00%	100.00%
Grand Total	**5**	**7**	**1**	**5**	**10**	**5**	**3**	**2**	**2**	**40**	45.00%	30.00%	47.50%

Appendix 2

RCA template

52 WEEK BREACH: TIMELINE OF EVENTS Patient: Mr X Ref: RXKXXX CCG:05L-NHS SANDWELL AND WEST BIRMINGHAM CCG		
DATE	**ACTION TAKEN**	**RTT PATHWAY**
	Referral received from GP	 Clock starts (0 weeks)
5.1.17		 Clock ticking (9 weeks)
25.1.17	Incorrect Clock Stop applied	

52 WEEK BREACH: TIMELINE OF EVENTS Patient: Mr X Ref: RXKXXX CCG:05L-NHS SANDWELL AND WEST BIRMINGHAM CCG		
DATE	**ACTION TAKEN**	**RTT PATHWAY**
		Clock ticking (12 weeks)
7.11.17		 Clock ticking (53 weeks)
17.11.17		 Clock ticking (54 weeks)
28.11.17		 Clock ticking (56 weeks)

52 WEEK BREACH: TIMELINE OF EVENTS Patient: Mr X Ref: RXKXXX CCG:05L-NHS SANDWELL AND WEST BIRMINGHAM CCG		
DATE	**ACTION TAKEN**	**RTT PATHWAY**
13.12.17		 Clock ticking (58 weeks)
4.1.18		 Clock ticking (61 weeks)
52 WEEK BREACH: LESSONS LEARNT		

52 WEEK BREACH: TIMELINE OF EVENTS Patient: Mr X Ref: RXKXXX CCG:05L-NHS SANDWELL AND WEST BIRMINGHAM CCG		
DATE	**ACTION TAKEN**	**RTT PATHWAY**

Issue	Action Plan

52 WEEK BREACH: Clinical Impact of Delay to Treatment	
Main Delay Reason	**Severity of Impact (RAG)**

52 WEEK BREACH: Final Treatment Update TCI/Outcome	
TCI Date/Outcome	**Comment**

52 WEEK BREACH: Identification by 40 Plus Pathway	
TCI Date/Outcome	**Comment**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Financial performance – P09 December 2017**
SPONSOR (EXECUTIVE DIRECTOR):	**Tony Waite – Finance Director**
AUTHOR:	**Dinah McLannahan – Deputy Director of Finance** **Tim Reardon – Associate Director of Finance (Compliance)**
DATE OF MEETING:	**1st February 2018**

EXECUTIVE SUMMARY:

Headlines

The key messages in this paper are that:

- The forecast is for delivery of pre-STF control total consistent with that necessary to recover Q4 STF funds of £2.8m. This reflects a judgement that non-recurrent opportunities sufficiently exceed residual risks.
- The focus of organisational effort is on run rate improvement at scale & pace consistent with securing sustainable finances across 2018-20. There is not yet a complete plan to do that but significant progress is being made. This is considered further in the private board.
- The cash position & outlook remains consistent with any borrowing requirement being deferred to the new financial year. A focus on recovery of receivables to further strengthen that position.

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, mainly the profit on sale of land at the City site. A recovery plan is being developed by the Trust executive that is designed to address the underlying position of the Trust as well as the incremental challenge for the new financial year. Alongside this, the finance team have developed a list of risks and upsides to the financial position in the current financial year.

Based on the development of the recovery plan and the above list, the £8m deficit forecast (pre-STF) was updated to a (pre-STF) deficit of £3.953m, and NHSI were notified that this was the Trust's intent, but that it would revert formally for the period 9 return.

The forecast included key assumptions as follows and the report contains further detail on each;

- £264.5m SWB CCG Income, secured;
- £17.4m CIP delivery - £1.343m off track ytd at P09 - £3m underperformance allowed for in current projection;
- Production plan delivery of £110m – £0.955m off track in P09 – and projection looks challenging. Mitigated by emergency activity to some extent, and the year-end deal with SWBCCG;
- £4m additional CIP+ stretch delivery – identified, mostly non-recurrently. Additional non-recurrent opportunity identified through the process of listing risks and upside opportunity.

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, which reports through to the Exec CIP Board, held weekly.

In addition to the above work and confirmation of risks and opportunities at P09, the Trust has been notified during December of c£2m of winter money, £1.1m of which must go to the bottom line and improve the financial position of the Trust. The remaining £0.95m can support winter pressures, including the non-delivery of CIP relating to bed closures. In addition to this, in December the Trust received £7m from NHSE in relation to taper relief for double running costs relating to Midland Met. The Trust had assumed £5.8m for 2017/18. These two items alone totalled £2.3m of improvement to a £4m deficit, meaning that the Trust would need to find an additional £1.7m to reach the control total. This is worth £2.6m of cash backed STF. On this basis the recommendation is that the Trust aims to achieve the control total for 2017/18, and has submitted to NHSI on this basis for P09 reporting.

Also during December, the Trust was notified regarding new treatment of 0.5% of CQUIN funding (full year value £1.8m) for 2017.18, which had been the subject of a national discussion between NHSI and NHSE. The Trust was notified that as it had not met its control total for 2016.17, it must not assume any year to date or forecast income in relation to 0.5% of CQUIN in its books. The Trust has reflected this as asked. This notification does mean that the control total is harder to achieve by the same number but in our assessment is manageable within the list of risks and opportunities. It is possible that the Trust will receive the funding back in Month 12, subject to as yet unidentified criteria. This would have the impact of improving the position by £1.8m from a deficit of 0.55m, to a surplus of £1.25m. The Trust is entitled to full finance related STF on achievement of the £0.55m deficit, without relying on CQUIN.

The aim of the Trust has been consistently to achieve the best possible forecast outturn for 2017/18, and to address as much as possible the run rate going into 2018/19.

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, and is currently expected in Q1 of 2018.19.

Key actions:

- Manage identified key risks and opportunities in months 10-12 to secure control total delivery.
- Keep in view the potential impact of Midland Met delay & remediation plan and work with regulators and stakeholders to secure financial support necessary to obviate that impact on the trust and local health system.
- Progress & where possible accelerate actions to secure improvement in run rate income & costs. Specifically, CIP delivery, and identification and delivery through implementation of FIP2 next steps plan, and 10 key actions, "CIP+", to address the underlying deficit of the Trust and the incremental challenge in 2018/19.

Key numbers:

- Headline year to date surplus £4.494m being £10.918m ahead of plan due to profit of land sale.

- Underlying YTD deficit -£22.957m being £7.468m adverse to plan.
- STF of £5.006m assumed earned for year to date.
- Pay bill £26.3m (remains stubborn); Agency spend £1.246m (vs. £0.725m in P8 – but technical improvement went against the agency line in P8, so effectively flat).
- Capital spend at £17m is £11.9m behind plan to date.
- Cash at 31st December is £15m being above plan by £13.5m.

REPORT RECOMMENDATION:

The Board is recommended to

- NOTE the report and specifically the remedial actions proposed to improve the forecast outturn to the "best possible" for 2017/18, confirmed at Month 9 as being the control total, 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

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

Financial	**X**	Environmental		Communications & Media	
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:

Finance Report

Period 09 2017/18
December 2017

Trust Board
1st February 2018

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Summary & Recommendations

Period 09 2017/18

Statutory Financial Duties	Plan Value	Outlook	Note
I&E control total surplus	£9.9m	√	1
Live within Capital Resource Limit	£46.6m	√	2
Live within External Finance Limit	£92.3m	√	3

1. **Forecast surplus £7.024m formally reported (Performance STF)**
2. **CRL remains to be confirmed by NHSI. Plan £46.6m, expected outturn £28m.**
3. **EFL based on £9.9m surplus and opening cash of £14.4m. Changes to capital programme and asset disposal proceeds provide mitigation. Can be managed within working capital.**

Outlook

- NHSI P09 return forecast surplus £7.0m, under-shoot relates to performance element of STF.
- Risk to delivery of pre-STF control total now mitigated and this is reflected in forecast.
- Step reduction in operational exit run rate costs required to avoid compounding scale of 2018.19 financial challenge and address underlying 2017.18 position

P09 key issues & remedial actions

- P09 YTD headline performance reported as £10.9m 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. Re-phased plan requires stretch in remaining months.
- Pre-STF £8m deficit forecast dependant on production plan (£110m) and CIP delivery (£17.4m), plus £4m expedient CIP+ measures - identified route to pre-STF deficit of £4m.
- Additional winter funding (notified late December 2017) provides £1.1m improvement to pre-STF £4m deficit forecast.
- 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 £28m. CRL remains to be confirmed by NHSI. To be done with P09 reporting.
- Resulting impact on cash has been communicated to NHSI. No revenue loan is required until Q1 2018/19.

Recommendation

- Challenge and confirm:
  - reported P09 position and the current assumptions relating to the £7.0 post STF surplus forecast
  - arrangements to recover the position from a pre-STF forecast £8m deficit.

Finance Report

Performance to date – I&E and cash

Period 09 2017/18

Financial Performance to Date

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

- P09 year to date reported ahead of plan excluding STF
- Headline I&E surplus of £4.5m, exceeds NHSI plan by £10.9m as a result of £16.3m land sale profit, offsetting STF A&E failure and operational performance.
- Underlying I&E deficit £22.9m being £7.5m adverse to plan
- Capital spend of £17.1m being £11.9m behind plan;
- Cash at 31st December £15.0m being £13.5m more than plan.
- Use of resources rating at 3 year to date.

I&E

P09 year to date reported as ahead of plan due to profit on sale of land. STF not due because of A&E waiting time performance failure reported at £1,808k year to date.

The reported delivery is dependent on the benefits from £23.0m of contingencies and flexibility. This includes the land sale which was intended to provide the mitigation against the £13m ask included in P12.

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 £29.3m have been delivered to date. This includes the £16.3m N/R profit on disposal of surplus assets. Not counting this disposal £13.0m CIP delivery has been achieved to date. This includes non-recurrent technical items and is 75% of the full year operational CIP required. CIP delivery is being heavily scrutinised as part of the financial recovery work. In concluding on the forecast outturn for 2017/18, circa £3m of CIP under-delivery has been allowed for.

Capital

Capital expenditure to date stands at £17.1m against an original full year plan of £46.7m. Key variance to date is in respect of timing of EPR and MMH. The full year programme has now been revised to £28m and the application for CRL to NHSI will reflect this number. The impact of this, cost pressures on future years and the appointment of a liquidator for Carillion PLC is being assessed.

Cash

The cash position is £13.5m above plan at 31st December. This is due to deferred capex spend and asset disposal proceeds.

Based on a revised capital forecast for 2017/18 the 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, as does the revised capital programme. Any risk to compliance is expected to be managed through working capital balances.

Better Payments Practice Code

Performance in December deteriorated when measured by value while volume was maintained, 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 09 2017/18

Period 9	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	34,421	(915)	318,298	310,597	(7,701)	424,405	415,406	(8,999)
Other Income	4,406	5,425	1,019	37,052	43,545	6,493	59,706	57,358	(2,348)
Income total	**39,742**	**39,846**	**104**	**355,350**	**354,142**	**(1,208)**	**484,111**	**472,764**	**(11,347)**
Pay	(25,048)	(26,330)	(1,282)	(230,036)	(235,437)	(5,401)	(300,666)	(310,973)	(10,307)
Non-Pay	(12,398)	(12,328)	71	(113,049)	(111,843)	1,206	(155,280)	(146,395)	8,885
Expenditure total	**(37,446)**	**(38,658)**	**(1,212)**	**(343,085)**	**(347,281)**	**(4,196)**	**(455,946)**	**(457,368)**	**(1,422)**
EBITDA	**2,296**	**1,188**	**(1,107)**	**12,265**	**6,862**	**(5,403)**	**28,165**	**15,396**	**(12,769)**
Non-Operating Expenditure	(2,099)	(2,078)	21	(18,847)	(2,414)	16,433	(9,271)	(8,588)	683
Technical Adjustments	18	(39)	(57)	158	46	(112)	(8,961)	216	9,177
DH Surplus/(Deficit)	**215**	**(929)**	**(1,144)**	**(6,424)**	**4,494**	**10,918**	**9,933**	**7,024**	**(2,909)**
Add back STF	*(1,048)*	*(734)*	*314*	*(6,814)*	*(5,006)*	*1,808*	*(10,483)*	*(7,574)*	*2,909*
Winter Monies		*(238)*	*(238)*		*(238)*	*(238)*			*0*
Adjusted position	***(834)***	***(1,901)***	***(1,067)***	***(13,238)***	***(750)***	***12,489***	***(550)***	***(550)***	***0***
Technical Support (inc. Taper Relief)	*(250)*	*(552)*	*(302)*	*(2,250)*	*(22,207)*	*(19,957)*	*(3,000)*	*(22,127)*	*(19,127)*
Underlying position	***(1,084)***	***(2,453)***	***(1,369)***	***(15,488)***	***(22,957)***	***(7,468)***	***(3,550)***	***(22,677)***	***(19,127)***

The Trust reported a headline surplus for P09 YTD of £4.4m being £10.9m 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 £11.2m of contingency and support of which £3.9m was not in the original plan.

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 P09 YTD is therefore recorded as £23.0m. In order to maintain the integrity of the forecast to year end underlying position of the trust, and to achieve the control total, the implication is that no more technical support will be fed into the position. This is unlikely to be the case, and therefore presents a risk of a deterioration in the underlying position of the Trust, driven mainly by CIP slippage (estimated to be circa £3m).

Finance Report

I&E Performance – Revised Plan delivery

Period 09 2017/18

	Actuals									Revised Forecast			
	£'000s Apr-17	£'000s May-17	£'000s Jun-17	£'000s Jul-17	£'000s Aug-17	£'000s Sep-17	£'000s Oct-17	£'000s Nov-17	£'000s Dec-17	£'000s Jan-18	£'000s Feb-18	£'000s Mar-18	£'000s Total Outturn
1 - 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**
2 - 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**
3 - 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)**
4 - 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)**
5 - Non Operational Costs	(2,064)	(2,098)	(2,037)	(2,079)	14,235	(2,038)	(2,049)	(2,049)	(2,049)	(2,049)	(2,049)	(2,049)	**(8,372)**
Grand Total	**(2,048)**	**(2,650)**	**(1,799)**	**(1,414)**	**13,254**	**(2,131)**	**(1,809)**	**(238)**	**(1,661)**	**(688)**	**(1,708)**	**(1,058)**	**(3,951)**
Actual							(2,197)	136	(1,663)				
Variance - Month							(388)	374	(2)				
Variance - Cumulative							(388)	(14)	(16)				

Notes

- The above table reflects delivery against the revised plan pre-STF out-turn deficit of £3.953m, the most likely outturn previously notified to the committee and Board, and informally to NHSI.
- 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.
- December's I&E performance was supported by £0.790m 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.
- Over the past two months the finance team have been developing a live log of risks to the financial position alongside opportunities to improve it, not currently in the forecast. The conclusion of this work is that the Trust will be able to reach its control total deficit of £0.550m.
- This will require, therefore, improvement of £3.4m. £1.1m of this will come from winter money, notified in December. The balance will come from non-recurrent measures.

Finance Report

I&E Performance – Forecast and remediation plans - Pay

Period 09 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)**	**(26,330)**					
Variance - actuals to forecast							**(149)**	**(29)**	**(687)**					
April 2018 target run rate														**(24,076)**
Gap to close														**(2,079)**

Notes

- There were no technical or non-recurrent mitigations processed against pay in Month 9, meaning that the underlying forecast held true. The overall in month position was managed with income and non-pay adjustments to hit the overall improved forecast to £4m.
- Month 8's pay bill was improved by £871k with non-recurrent mitigations.
- Mitigations planned are mainly non-recurrent, work is ongoing to determine any recurrent impact.
- The level of risk within the technical mitigations is assessed as low, albeit they are non-recurrent.
- Managing the avoidance of future costs currently in the forecast will require closer management.
- Work continues to realise the above plans and also identify new opportunities to further improve 2017/18, or manage risks identified in the previous slide should they materialise to any extent.
- Work also continues to address the April 2018 challenge.

Finance Report

Pay bill & Workforce

Period 09 2017/18

Pay and Workforce	Current Period	Previous Period	Change between periods	%	Plan YTD	Actual YTD	Variance YTD
Pay - total spend	£26,330k	£25,515k	£815k	3%	£230,036k	£235,437k	£5,401k
Pay - substantive	£22,324k	£22,337k	-£13k	0%	£199,724k	£198,564k	-£1,160k
Pay - agency spend	£1,246k	£725k	£521k	72%	£10,482k	£11,994k	£1,512k
Pay - bank (inc. locum) spend	£2,760k	£2,454k	£307k	13%	£19,830k	£24,880k	£5,050k
WTE - total	6,823	6,903	-80	-1%	6,740	6,823	83
WTE - substantive	6,075	6,099	-24	0%	5,974	6,075	101
WTE - agency	142	156	-14	-9%	182	142	-39
WTE - bank (inc. locum)	605	647	-42	-7%	585	605	20
Memo: locum spend	£798k	£687k	£112k	16%	£380k	£6,665k	£6,285k
Memo: locum WTE	66	62	4	7%	4	66	62

NHSI locum spend target	£6,307k

Paybill & Workforce

- Total workforce at the end of December of 6,823 WTE [being 83 higher than plan] and including 142 WTE of agency staff.
- Total pay costs (including agency workers) were £26.3m in December. Plan pay spend for December is £25.1m, this is the plan level throughout quarter 3. In January plan pay spend reduces to £24.6m. Technical support was released through the pay line in P08 and the impact of this can be seen in the comparison with P08 above. This is a lower figure than is in the revised plan which was carried out at Month 5 and reconfirmed at Month 6, reflected on the previous slide. Month 8 pay at £25.515m was improved by circa £871k of technical written back accruals – meaning that underlying, pay remains flat.
- 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 December. 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 P09 the Trust had spent £11,994k on agency. Work is underway to ascertain at which point the Trust will reach a run rate consistent with the agency cap, given the focus on reducing variable pay.
- Despite this performance at £16m the full year forecast represents an £8m reduction compared to 2016/17. Nursing and HCA agency spend is down and HCA vacancies are approaching zero. These results reflect the combined sustained efforts of the Deputy Director of HR and the Trust bank office .

Finance Report

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

Period 09 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 £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)**	**(12,328)**					
Variance to forecast							**(401)**	**(202)**	**407**					**(11,300)**
Gap to close - current M13 view versus required														**(1,477)**

Notes

- 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.
- In Month 9, the non-pay position was better than required, but benefitted from £534k of non-recurrent improvement.
- Underlying position is again impacted mainly by over-performance on pass through drug costs which will be offset by income over-performance against budget.

Finance Report

I&E Performance – Forecast and remediation plans – Income

Period 09 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	34,421				
Variance to forecast							(250)	331	(212)				

Notes

- The SLA income assumed in the forecast is matched back monthly to the SLA monitoring (SLAM) system to ensure movements are tracked. The current month 9 view (final month 9 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). CEOs have completed discussions to agree this sum.
- Production plan income was hit in December by adverse weather conditions, flu and disruption caused by increased emergency activity, the latter compensating overall income levels.

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 Actual	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**	**7,649,721**				
VARIANCE TO PLAN						**59,365**	**60,886**	**61,174**	**(955,306)**				

Notes

- The adverse conditions noted above are demonstrated in the current view of the production plan performance in December.
- The final production plan position will include “cashing up” – which means capturing all clinic and day case activity, which was last recorded on 2nd January. This may improve the production plan number.

Finance Report

Income Analysis

Period 09 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	170,519	166,305	-4,214		£24,194	£18,184	£18,952	£768
Emergencies	45,400	33,955	34,440	485		£85,899	£64,298	£68,617	£4,319
Emergency Short Stay	10,217	7,888	5,489	-2,399		£7,536	£5,821	£4,124	-£1,697
Excess bed days	10,495	7,461	11,483	4,022		£2,906	£2,073	£2,999	£927
Urgent Care						**£120,535**	**£90,375**	**£94,693**	**£4,318**
OP New	169,764	127,292	141,148	13,856		£25,597	£19,194	£20,576	£1,382
OP Procedures	61,597	46,188	54,507	8,318		£10,487	£7,863	£8,915	£1,052
OP Review	387,088	290,235	254,005	-36,229		£27,394	£20,540	£18,551	-£1,989
OP Telephone	12,965	9,716	11,200	1,483		£298	£223	£237	£14
DC	39,887	29,907	26,639	-3,267		£32,844	£24,626	£21,313	-£3,313
EL	6,408	4,805	4,830	25		£16,430	£12,319	£11,644	-£675
Planned Care - production plan						**£113,049**	**£84,766**	**£81,236**	**-£3,529**
Planned care outside production plan	28,884	24,241	28,645	4,403		£4,683	3,825	£4,059	£233
Maternity	20,284	15,094	14,904	-189		£19,193	£14,284	£14,328	£45
Renal dialysis	565	423	499	76		£68	£51	£60	£9
Community	619,003	462,974	483,438	20,465		£36,658	£27,437	£27,692	£254
Cot days	12,932	9,834	11,557	1,723		£6,782	£5,157	£5,345	£188
Other contract lines	3,630,049	2,724,967	3,131,418	406,451		£95,766	£72,707	£74,879	£2,172
Unbundled activity	72,583	56,581	55,714	-866		£8,512	£6,876	£6,775	-£101
Other						**£171,662**	**£130,338**	**£133,138**	**£2,800**
Sub-Total: Main SLA income (excl fines)						**£405,246**	**£305,479**	**£309,066**	**£3,588**
Year to date refresh of prior months' data						£0	-£17	£0	£17
Income adjustment - pass through drugs						£746	£500	-£1,084	-£1,583
Fines and penalties						-£600	£517	-£2,400	-£2,917
Cancer Drugs Fund						£2,636	£1,977	£683	-£1,294
Pass Through Drugs Accrual						£0	£0	-£165	-£165
NHSE Oncology top up						£425	£0	£0	£0
UHB Oncology						£1,701	£0	£0	£0
National Poisons						£734	£551	£546	-£5
SLA income -interpreting						£255	£191	£192	£1
SLA income -Neurophys / Maternity etc						£1,735	£1,302	£1,182	-£120
Mental Health Trust SLA						£29	£22	£22	£1
Individual funding requests						£0	£0	£23	£23
Private patients						£236	£177	£124	-£53
Overseas patients						£768	£576	£1,234	£657
Overseas patients Non EEA						£0	£0	£526	£526
Prescription Charges Income						£39	£29	£33	£4
Injury cost recovery						£1,249	£936	£513	-£423
NHSI Plan phasing adjustment						£5	-£708	£0	£708
Other adjustments						£1	£36	£100	£64
GRAND TOTAL patient related income						**£415,207**	**£311,567**	**£310,597**	**-£970**

Notes

- This table shows the Trust's year to date patient related income including SLA income performance by point of delivery as measured against the contract price & activity schedule.
- Planned care within the production plan is behind by £3.6m for the year to date as measured against the [CCG] contract plan profile. This contract plan is different from the internal production plan. This is subject to regular review and re-phased based on YTD performance.
- Current expectations are that year to date underperformance will be recovered in the full year. However, the impact of cancellations in relation to Winter pressures are under review.
- This is clearly more of a risk given the national dictate to drastically reduce elective activity to manage non-elective pressures. This is only now a risk for SWBH in relation to non-SWBCCG activity. An allowance for this has been made in assessing the ability to reach control total.

Finance Report

CIP achievement

Period 09 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	3,101	1,577	4,678	-2,184
Surgical Services	3,343	1,463	915	2,378	-965
Women and Child Health	909	454	470	924	15
Primary Care, Community and Therapies	2,485	1,844	775	2,619	134
Pathology	1,321	988	341	1,329	8
Imaging	1,807	953	649	1,602	-205
Sub-total Clinical groups	**16,727**	**8,803**	**4,727**	**13,530**	**-3,197**
Strategy and Governance	170	127	43	170	0
Finance	289	217	72	289	0
Medical Director	403	302	101	403	0
Operations	711	404	273	677	-34
Organisational Development	162	35	102	137	-25
Estates and NHP	562	392	130	522	-40
Corporate Nursing and Facilities	682	345	195	540	-142
Sub-total Corporate	**2,979**	**1,822**	**916**	**2,738**	**-241**
Central	13,294	18,687	2,460	21,147	7,853
Total CIPs	**33,000**	**29,312**	**8,103**	**37,415**	**4,415**
Annual Target 17/18	**33,000**			**33,000**	**0**
(Deficit) / Excess of Schemes Above Plan	**0**			**4,415**	**4,415**

Notes

- The above table demonstrates the step up in CIP delivery required in Q4 versus year to date.
- In the assumed control total compliance, the Trust has allowed for circa £3m in CIP under-delivery against likely achievement. This relates directly to a risk assessment of forecast outturn against defined schemes at Month 9
- During December there was £380k under-performance against CIP (ytd £1.343m). 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 09 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	16,019	11,154	(4,865)	*5,356*	20,624	16,340	4,284
Information	9,942	4,034	(5,908)	*5,625*	10,572	8,331	2,241
Medical equipment / Imaging	2,331	997	(1,334)	*559*	5,006	2,791	2,215
Contingency	0	0	0	*0*	0	0	0
Sub-Total	**28,292**	**16,184**	**(12,108)**	*11,540*	**36,202**	**27,462**	**8,740**
Technical schemes	567	753	186	*0*	10,386	986	9,400
Donated assets	63	124	61	*0*	84	78	6
Total Programme	**28,922**	**17,062**	**(11,860)**	*11,540*	**46,672**	**28,526**	**18,146**

Notes

- Spending is £11.9m 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 has been assessed and has been taken into account in year end control total compliance consideration.
- 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, which is likely to reduce slightly further to reflect the capitalisation of Unity related project salary costs. This means the likely ask of NHSI for CRL will be circa £28m.
- 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. This reduction in forecast predates the announcement of Carillion's terminal financial problems including the appointment of a liquidator. It is expected that this may cause some delay to the MMH programme and so the implications for the 2017/18 forecast will need to be considered.
- On the basis of this reduced in year capital programme the anticipated revenue loan requirement will not crystallise until Q1 2018/19. NHSI have been notified of this revised expectation.

Finance Report

SOFP

Period 09 2017/18

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

	Balance as at 31st March 2017 £000	Balance as at 31st December 2017 £000	NHSI Planned Balance as at 31st December 2017 £000	Variance to plan as at 31st December 2017 £000	NHSI Plan as at 31st March 2018 £000	Forecast 31st March 2018 £000
Non Current Assets						
Property, Plant and Equipment	207,434	209,743	228,385	(18,642)	242,166	220,917
Intangible Assets	166	718	239	479	239	239
Trade and Other Receivables	43,017	60,315	80,255	(19,940)	92,045	69,710
Current Assets						
Inventories	5,268	5,559	4,179	1,380	4,177	4,177
Trade and Other Receivables	25,151	50,947	20,946	30,001	20,946	25,946
Cash and Cash Equivalents	23,902	14,995	1,508	13,487	309	4,500
Current Liabilities						
Trade and Other Payables	(68,516)	(77,243)	(57,407)	(19,836)	(38,646)	(63,249)
Provisions	(1,138)	(859)	(1,196)	337	(1,196)	(1,196)
Borrowings	(903)	(1,306)	(1,903)	597	(3,353)	(2,187)
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)	(38,907)	(44,158)	5,251	(50,077)	(31,767)
DH Capital Loan	0	0	0	0	0	0
	197,023	**220,661**	**227,893**	**(7,232)**	**263,598**	**224,078**
Financed By						
Taxpayers Equity						
Public Dividend Capital	205,362	224,340	242,368	(18,028)	252,540	232,055
Retained Earnings reserve	(24,972)	(20,522)	(31,298)	10,776	(5,822)	(24,857)
Revaluation Reserve	7,575	7,785	7,765	20	7,822	7,822
Other Reserves	9,058	9,058	9,058	0	9,058	9,058
	197,023	**220,661**	**227,893**	**(7,232)**	**263,598**	**224,078**

Notes

- The table is a summarised SOFP for the Trust including the actual and planned positions at the end of December 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.
- 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 09 2017/18

Sandwell & West Birmingham Hospitals NHS Trust

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 Actual £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	23,376	22,361	22,361	22,361
Associates	6,278	6,675	6,356	6,393	6,500	6,418	6,509	6,176	6,277	6,466	6,466	6,466
Other NHS	1,980	750	646	1,151	1,204	856	487	925	1,476	1,161	1,428	1,772
Specialised Services	3,583	3,374	3,838	6,668	4,327	3,373	3,536	3,787	3,364	3,858	4,520	5,420
STF Funding and Taper Relief	0	0	0	0	0	1,337	0	0	8,467	0	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	4,689	0	0	4,405
Public Dividend Capital	5,050	5,138	0	5,500	0	0	0	0	3,290	2,215	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	1,459	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	52,397	38,136	39,651	46,459
Payments												
Payroll	13,431	13,789	14,017	13,567	14,042	14,023	13,877	13,627	14,290	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	10,197	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	9,295	11,660	10,800	10,810
Non Pay - Capital	11,368	4,422	1,720	1,645	1,179	3,155	2,244	2,600	1,656	2,989	2,068	3,546
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	173	240	240	240
Total Payments	45,595	48,442	45,544	41,487	45,809	45,799	44,402	42,190	40,768	46,429	41,656	46,656
Cash Brought Forward	23,873	19,919	14,582	9,292	12,556	27,285	18,459	9,375	3,366	14,995	6,702	4,697
Net Receipts/(Payments)	(3,954)	(5,337)	(5,290)	3,264	14,729	(8,826)	(9,084)	(6,009)	11,629	(8,293)	(2,005)	(197)
Cash Carried Forward	19,919	14,582	9,292	12,556	27,285	18,459	9,375	3,366	14,995	6,702	4,697	4,500

Notes

- This cashflow confirms that the Trust will not need to borrow during this financial year.
- The main reasons for this are the receipt of £7m of taper relief in December – the Trust had not assumed this previously. In addition, a reduction in capital expenditure planned and MMH related payment has improved the position.
- This cash flow is based on actual cash flows for April to December. The future months forecast incorporates intelligence in relation to capital planning, income and contracting, exchequer services and estates.
- Consequently this cash flow statement reflects the latest collective view of cash flows and incorporates the land sale.
- STF is forecast for receipt at the end of the following quarter in which it is earned.

Finance Report

Use of Resources Rating

Period 09 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	3		PRR0160
Liquidity rating	+	4	3		4	4		PRR0170
I&E margin rating	+	4	1		1	1		PRR0180
I&E margin: distance from financial plan	+		1			2		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			2.40		PRR0202
If unrounded score ends in 0.5	+		0.00			0.00		PRR0204
Plan risk ratings before overrides	+		2			2		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

Notes

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

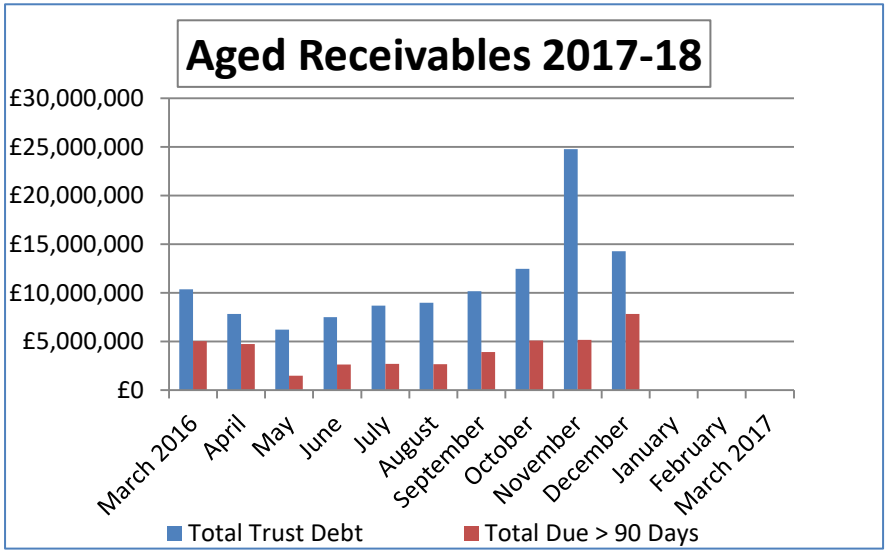
- Capital service cover is calculated using margin before profit on sale and so is unaffected and consequently remains red;
- Agency spend remains more than plan resulting in a score of 3.

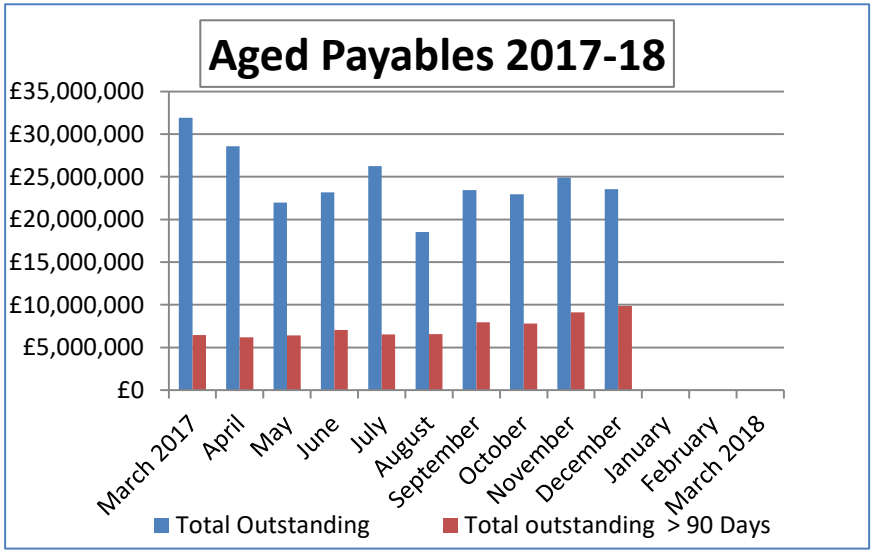
*This is P08 and is consistent with P07. P09 is not yet available.

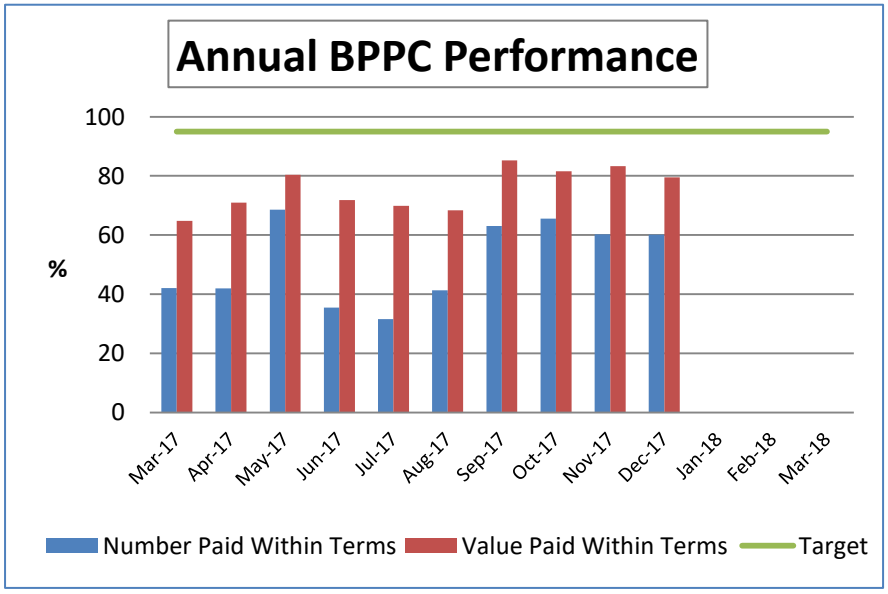
Finance Report

Aged Receivables, Aged Payables, BPPC and Cash Forecast

Period 09 2017/18







Note

- The December debt position reduced as Q3 L&D and PFI Taper Relief invoices were paid. Overall Non NHS debt increased as did the >90 day debt position, the latter of which is largely being driven by further aging of NHS Invoices that will be discussed through the Month 9 Agreement of Balances exercise.
- The overall Payables position has reduced in December 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 is possible. 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 09 2017/18

Contingency & flexibility utilised in delivering actual performance to date

	P09 Month	P09 YTD
Unplanned contingency & flexibility	**£k**	**£k**
GRNI accrual released from balance sheet		808
Relase of pay accrual for Medical staffing		480
Accrual for winter pressures income	238	238
Release EDF Invoice accrual	177	177
Release Sandwell MBC Invoice accrual	79	79
Release invoices under £1k accrual	278	278
Relase of pay accrual for Admin, Nursing and Scientific staff groups		391
EPR accrual released from balance sheet		743
Taper relief - timing - income excess over costs accrued	(233)	700
Other contingency & flexibilities utilised		0
Profit on sale		3,573
	540	7,468
Planned contingency & flexibility		
Taper relief - income used to fund planned capex	250	2,250
Other contingency & flexibilities utilised	0	0
	250	2,250
Contingency & flexibility required to delivered YTD plan	**790**	**9,718**
Residual profit on sale currently available for £13m risk mitigation in March		12,727
Total contingency & flexibility utilised	**790**	**22,445**

*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.

Notes

This details the non-operational support that has been utilised to achieve 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 £7m now received. Costs have been accrued in the Q3 position.
- 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 finance team are maintaining a log of risks to the financial position, alongside further technical and non-recurrent opportunities. This is being used to manage the financial position against forecast and has informed the decision to forecast control total compliance.

Finance Report

Appendix 2 - Group I&E Performance

Period 09 2017/18

Period 9	Current Period			Run rate change	Year to Date			Full Year
	Plan	Actual	Variance	since P8	Plan	Actual	Variance	Plan
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Medicine & Emergency Care	2,055	1,799	(255)	180	15,237	12,010	(3,226)	20,835
Surgical Services	808	36	(772)	(1,545)	13,228	7,129	(6,099)	18,484
Women's & Child Health	1,891	1,446	(445)	(478)	17,280	13,785	(3,495)	23,377
Primary Care, Community and Therapies	112	765	653	404	7,274	5,054	(2,220)	10,456
Pathology	321	395	74	(38)	3,137	3,319	182	4,338
Imaging	309	205	(104)	(30)	2,580	1,593	(987)	3,593
Clinical Groups	**5,494**	**4,646**	**(848)**	**(1,507)**	**58,736**	**42,890**	**(15,846)**	**81,083**
Strategy and Governance	(1,164)	(981)	183	269	(11,777)	(11,254)	523	(15,632)
Performance & Insight	(108)	(108)	(0)		(973)	(924)	49	(1,298)
Finance	(324)	(317)	7	43	(3,004)	(3,028)	(23)	(3,947)
Medical Director	(940)	(946)	(5)	88	(7,348)	(7,485)	(137)	(9,704)
Operations	(1,136)	(1,033)	102	254	(10,370)	(10,287)	83	(13,709)
Workforce & Organisation Development	(623)	(698)	(75)	(214)	(4,545)	(4,585)	(40)	(5,975)
Estates & New Hospital Project	(1,044)	(1,151)	(107)	(17)	(9,518)	(9,543)	(25)	(12,516)
Corporate Nursing & Facilities	(1,411)	(1,611)	(201)	(24)	(13,183)	(14,172)	(989)	(17,285)
Corporate Directorates	**(6,750)**	**(6,845)**	**(95)**	**398**	**(60,718)**	**(61,279)**	**(561)**	**(80,066)**
Central	252	(146)	(398)	(1,396)	(696)	12,826	13,522	692
Income	2,219	1,693	(526)	443	12,279	11,053	(1,225)	16,009
Reserves	(1,017)	(237)	780	(717)	(16,181)	(1,043)	15,139	(7,993)
Technical Adjustments	17	(39)	(56)	(58)	156	46	(110)	208
DH Surplus/(Deficit)	**215**	**(929)**	**(1,144)**	**(2,838)**	**(6,425)**	**4,494**	**10,919**	**9,933**

Notes

- While the bottom line Trust variance year to date is £10.9k favourable related to land sale, the underlying Group variance of £15.8m adverse is highlighted as being offset by central items and release of reserves.
- Forecast scenarios based on P06 YTD performance indicate that achievement of the control total will require significant use of non-recurrent measures, recognition of non-recurrent income, and further non-commitment of reserves.

Finance Report

Appendix 2 - Group I&E Variances

Period 09 2017/18

Period 9	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	5,257	1,645	0	(906)		(106)	6,908	(7,062)	(6,704)	(92)	(1,645)	(521)	0	(3,226)
Surgical Services	(4,424)	(66)	(83)	239		132	4,632	(3,368)	(1,769)	(516)	149	(1,024)	0	(6,099)
Women's & Child Health	(254)	85	0	(1,144)		(366)	3,559	(1,589)	(792)	(2,058)	(85)	(851)	0	(3,495)
Primary Care, Community and Therapie	749	673	(1,294)	361		(122)	3,476	(2,234)	(1,121)	(2,016)	621	(1,314)	0	(2,220)
Pathology	220	0	0	(82)		440	1,116	(236)	0	(1,038)	(0)	(238)	0	182
Imaging	(324)	0	0	64		(119)	674	(580)	(374)	110	0	(437)	0	(987)
Clinical Groups	**1,223**	**2,338**	**(1,377)**	**(1,468)**	**0**	**(140)**	**20,366**	**(15,070)**	**(10,760)**	**(5,610)**	**(960)**	**(4,386)**	**0**	**(15,846)**
Strategy and Governance	0	0	0	1,189		416	(5)	(123)	(108)	92	0	(938)	0	523
Performance & Insight	0	0	0	0		0	138	(7)	(86)	1	0	4	0	49
Finance	0	0	0	0		15	291	(131)	(161)	21	0	(58)	0	(23)
Medical Director	0	0	0	0		(451)	809	(302)	(2)	56	0	(246)	0	(137)
Operations	0	43	(263)	267		355	1,417	(511)	(447)	(21)	220	(983)	0	78
Workforce & Organisation Developmer	0	0	0	0		226	(195)	(155)	1	123	0	(42)	0	(40)
Estates & New Hospital Project	0	0	0	0		111	21	(29)	(45)	26	0	(109)	0	(25)
Corporate Nursing & Facilities	1	0	0	(8)		35	1,564	(1,460)	(90)	(606)	0	(425)	0	(989)
Corporate Directorates	**1**	**43**	**(263)**	**1,448**	**0**	**705**	**4,040**	**(2,719)**	**(937)**	**(309)**	**220**	**(2,796)**	**0**	**(566)**
Central	(17)	0	0	(665)	(1,808)	(703)	42	242	527	0	0	(553)	16,459	13,522
Income	(3,815)		0	1,583		959	71	0	0	0	0	0	(23)	(1,225)
Reserves	0	0	0	0		1	0	0	0	5,239	0	9,899	0	15,139
Technical Adjustments	0	0	0	0		0	0	0	0	0	0	0	(110)	(110)
DH Surplus/(Deficit)	**(2,608)**	**2,380**	**(1,640)**	**898**	**(1,808)**	**821**	**24,518**	**(17,547)**	**(11,170)**	**(680)**	**(740)**	**2,164**	**16,326**	**10,914**

Notes

- 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. The favourable variance seen in Central pay is the non-recurrent November adjustment. Other pay relates to unidentified CIPs in Groups and the benefit of the reserve held for incremental drift. The pass through variance including cancer drugs fund and FP10 prescribing is net nil with Group overspends on other non-pay and the release of non-pay reserves benefiting the position.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Winter Plan**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow Chief Operating Officer**
AUTHOR:	**Rachel Barlow Chief Operating Officer**
DATE OF MEETING:	**1st February 2018**

EXECUTIVE SUMMARY

The paper sets out the current urgent care demand and Length of Stay (LOS) against our winter planning assumptions. Admissions into the in-patient medical bed base are above plan by 16% and compared to the same time last year have increased by 20%. Our LOS is 0.42 days above plan, January to date. The Trust Board will be aware that both the implementation of the ED and Patient Flow improvement plans are yet to make full impact. Consultant of the week starts in earnest on 29th January; it is through this implementation and leadership consistency that the compliance with Expected Date of Discharge and progress on the Length of Stay reduction will be progressed.

In order to meet the 4 hour ED (Emergency Department) performance standard and work within the planned and funded bed base, the paper considers a number of planning scenarios for Quarter 4 (Q4). The first is our original plan and the second is a further Length of Stay reduction in acute medical and community medically fit beds to accommodate a scenario that admissions remain incrementally above plan. Appendices include:

Appendix 1 and 2 demonstrate current and future LOS changes in medicine and community medically fit bed bases
Appendix 3 The EDD league table

REPORT RECOMMENDATION:

The Trust Board are asked to consider and discuss:

- the plan vs current activity and LOS
- planning scenarios for Quarter 4 bed closures

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

1. Introduction

The paper sets out the current urgent care demand and Length of Stay (LOS) against our winter planning assumptions.

Admissions into the in-patient medical bed base are above plan by 16% and compared to the same time last year have increased by 20%.

Our LOS is 0.42 days above plan, January to date.

In order to meet the 4 hour ED (Emergency Department) performance standard and work within the planned and funded bed base, the paper considers a number of planning scenarios for Quarter 4 (Q4).

The Trust Board will be aware that both the implementation of the ED and Patient Flow improvement plans are yet to make full impact.

2. ED Performance

The Trust continues to underperform against the ED 4 hour performance standard. December out turned at 78.65% and January to date is 82.58%. The number of patients waiting over 8 hours from arrival has deteriorated over the winter, with 433 of the 17864 patients attending our ED's in December staying in ED for over 8 hours. 61% of these long waits were at Sandwell. 78% of all patients waiting over 8 hours were admitted to hospital. 69% of the over 8 hour breaches occurred out of hours. The bed occupancy has been over 97%. The Quality and Safety Committee have a focus on the safety aspects of winter in January.

There was a 12 hour Decision to Admit (DTA) breach in December. A table top review deemed this avoidable. No direct harm was caused to the patient although they were regrettably exposed to potential risk unnecessarily. Recommendations and related action plans will be implemented as a result of this learning.

3. Plan versus actual activity and LOS assumptions

ED and ambulatory care activity

December's Trust level ED activity was down by 3% compared to last year. Sandwell for the same month however had 7% more attendances than in 2016. Attendances in January appear to be following a similar trend. At the same time ambulatory patient pathways have increased on each site with 639 patients streamed for ED to AMAA in December, compared to 261 in 2016 (a 59% increase).

Ambulance and admission activity

The Black Country region has experienced an increase in WMAS conveyances to ED with ambulance arrivals 20-30% above prediction in December.

Admission activity to our AMU and onward to our medicine bed base is above our modelled bed plan noting the high acute bed occupancy that continues to run >97%.

Table 1 bed model assumptions vs actuals				
Daily numbers	**Bed model assumption**	**November**	**December**	**January 1st – 22nd**
Average daily ED attendances		612	576	596
WMAS arrivals per day		158	158	158
Admissions to AMU	65 / day	70/day	73.8/day	77 / day
Medicine admission to inpatient beds (direct or from AMU)	45 /day	42/day	50.45 / day	52.83 / day
Average LOS (including AMU)	7.51 days	8.25days	8.13 days	7.93 days

In context to the same period last year, in January 2017 we admitted an average of 42 patients per day into the bed base compared to 55 patients a day this year. By March last year the admission rate reduced by 5 patients per day to 37 patients requiring admission to the inpatient medical bed base.

4. Looking ahead to Quarter 4 - planning scenarios

Based on the need to reduce 82 medicine occupied beds in Q4 to close unfunded beds and reduce MOL (returning surgery bed base to for surgical activity) there are a number of planning scenarios to consider:

i) The admission rate reverts back to plan and we achieve a further LOS reduction of 0.3 days based on current LOS

ii) Assume admission rates reduce by 5 patients a day by March and reduce LOS by 1.2 days in the acute in patient bed base

iii) Reduction in LOS in Medically Fit for Discharge bed base to support patient outflow from medicine or mitigate under delivery of medicine bed closure plan

Planning scenarios

i) The admission rate reverts back to plan and we achieve a further LOS reduction of 0.3 days based on current LOS.

Month	January	February	March
Medicine admission to inpatient beds (direct or from AMU)	55 /day	50/day	45 / day
Average LOS (including AMU)	7.9 days	7.6 days	7.5 days
Bed requirements (unfunded and MOL)	82	41	0

The implementation of the patient flow programme is behind plan and the high impact interventions including consultant of the week and the admit/pull model are yet to make full impact on reducing LOS. The Consultant of the Week rota is fully effective from 29th January, hence the improvement trajectory. Condition based LOS goals mapped to the LOS target will be fully implemented to drive the LOS change.

ii) Assume admission rates reduce by 5 patients a day by March and reduce LOS by 1.2 days in the acute in patient bed base.

Month	January	February	March
Medicine admission to inpatient beds (direct or from AMU)	55 /day	52/day	50 / day
Average LOS (including AMU)	7.9 days	7.2 days	6.6 days
Bed requirements (unfunded and MOL)	82	46	0

This LOS reduction is ambitious. The modelling below and in appendix 1 sets out how we could achieve this:

How to get to a 6.6 day LOS in medicine

a) Focus on patients with a LOS of 3-7 days

- 49 % of in-patients have a 3-7 day LOS
- This group account for 38% of our bed days
- We will reduce LOS by 0.5 day for this group releasing equivalent to 3690 bed days a year

Improvement approach:

- Consultant of the week fully implemented
- Admit pull model effective
- Condition based LOS implemented in line with 6.6 day LOS

b) Focus on patients with a LOS of 8-21 days

- 27 % of in-patients have a 8-21 day LOS
- This group account for 55% of our bed days
- We will reduce LOS by 2 days for this group releasing equivalent to 8140 bed days a year

Improvement approach:

- Consultant of the week fully implemented
- Executive and senior clinical ward round long LOS review
- Earlier flow to medically fit wards / IMC

Impact of above LOS reduction

- Based on 50 admissions to the bed base a day
- With a 95% bed occupancy
- LOS 6.64
- Medicine would operate within its funded bed base

iii) Reduction in LOS in Medically Fit for Discharge bed base to support patient outflow from medicine or to mitigate under delivery of medicine bed closure plan

In the scenario where we need medically fit bed capacity to support the LOS reduction in the medical bed base or that we fail to achieve the medicine bed reduction and need to achieve alternative bed closures, the modelling below and in appendix 2 sets out how we could achieve this:

a) Focus on patients with a LOS of 8-20 days

- 30 % of in-patients have a 8-20 day LOS
- This group account for 36% of our bed days
- We will reduce LOS by 1 day for this group releasing equivalent to 702 bed days a year

Improvement approach:

- Multi provider long length of stay reviews and improvement work

b) Focus on patients with a LOS of 21-28 days

- 6% of in-patients have a 21-28 day LOS
- This group account for 13 % of our bed days
- We will reduce LOS by 4 days for this group releasing equivalent to 540 bed days a year

Improvement approach:

- Multi provider long length of stay reviews and improvement work

c) Focus on patients with a LOS of 29 days plus

- 8 % of in-patients have a 29 day plus day LOS
- This group account for 35 % of our bed days
- We will reduce LOS by 5 days for this group releasing equivalent to 980 bed days

Improvement approach:

- Multi provider long length of stay reviews and improvement work

The impact of above LOS reduction combined with achieving a 98% bed occupancy would result in 8 empty beds to be used to support in-patient medicine or contribute to the Trust bed closure programme.

Patient flow improvement

The capacity challenges certainly have a significant impact on ED performance and at times both EDs have activated the scenario cards to manage patients on corridors. The Patient Flow Improvement Plan remains incomplete with large elements of Consultant of the Week and therefore the Admit Pull Model still to be implemented. The full Consultant of the Week rota will be in place from 29th January with improvements from consistency of clinical leadership to be gained in LOS reduction and EDD compliance.

The key success measures remain LOS (which will be reset to 6.6 days) and Expected Date of Discharge (EDD) compliance. Appendix 3 shows the current league table and summary performance at admitting specialty level. The incoming consultants of the week will be briefed on the improvement focus areas and supported through coaching and a performance framework. All ward

teams have dashboards and visual management on the wards to prospectively manage LOS and EDD compliance.

ED Improvement plan

The ED specific improvement plan is largely centred around people, be it their development, retention or recruitment. 30% of ED shift situational leaders were assessed in December as being still uncompliant with practicing consistency in professional standards or behaviours. Each member of staff has a development plan which will be reviewed in February for completion. By March any staff member who cannot meet the expected standards will no longer to be rostered to lead shifts and they will be managed in line with Trust policy.

Recruitment to the senior clinical leadership team continues with optimism regarding consultants and senior nurses. The Registrar cohort has 10 vacancies out of an establishment of 24. Overseas recruitment is now in scope as part of a recruitment plan. The impact of the vacancies has resulted in 40 % of registrar shifts being vacant with at the time the rota is written and an overall 10% vacant shift rate once temporary staffing has been put in place. This gap has been addressed through a review of the rota by the Directorate leadership team which has resulted in a number of SHOs stepping up into the registrar vacancies, block booking of bank and agency staff, prioritisation out of hours shifts, and a greater flexibility of cross site working.

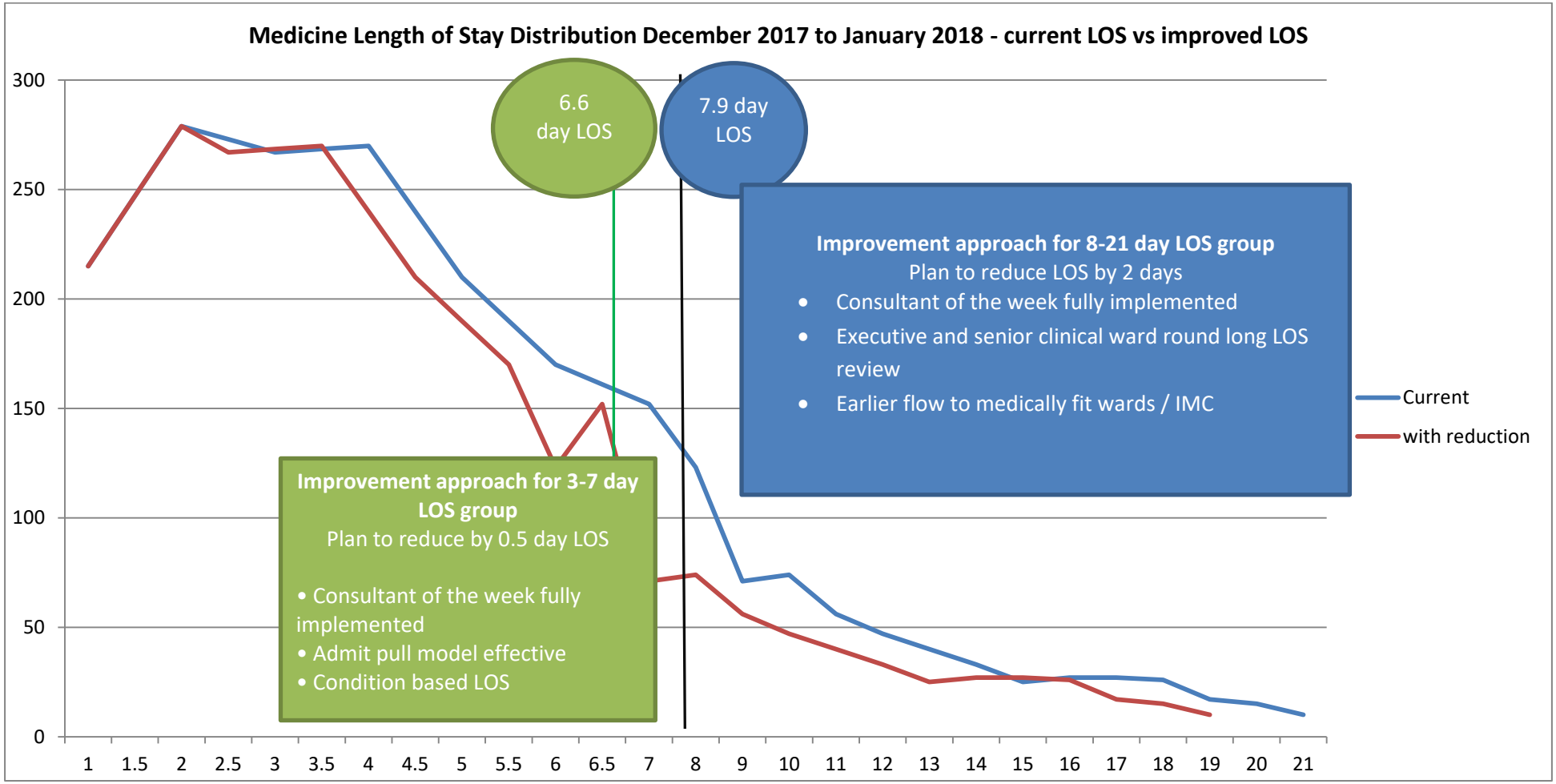
The new on-call 5 tier rotas goes live from 1.2.18 to support out of hours site management and flow. The impact of this will be reviewed later in the year.

Conclusion

The Trust Board are asked to consider and discuss:

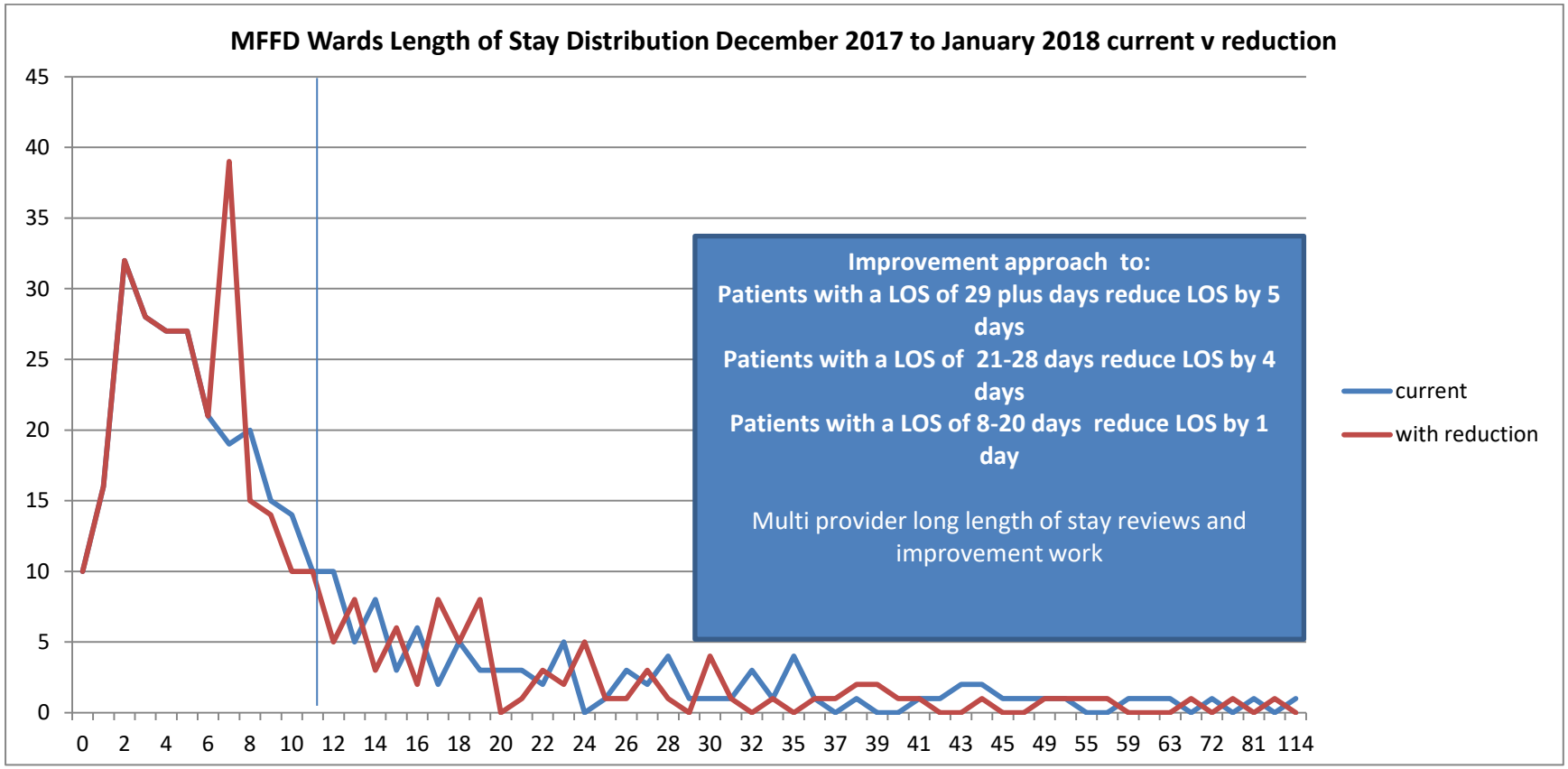
- the plan vs current activity and LOS
- planning scenarios for Quarter 4 bed closures

Appendix 1: Current LOS profile and future LOS profile to achieve LOS of 6.6 days in medicine



LOS

Appendix 2: Current LOS profile and future LOS profile to achieve a reduction of 8 beds in MFFD requires a move of 1 day average LOS from 11 days to 10 days



LOS

Appendix 3 EDD compliance summary

TREND OF EDD Accuracy By Specialty From 4th December to 15th January

	04-Dec	11-Dec	18-Dec	25-Dec	01-Jan	08-Jan	15-Jan		LOW	HIGH	AVG
Cardiology	70.00	45.45	26.92	20.00	35.71	42.86	20.00		20.00	70.00	#REF!
Gastroenterology	23.40	15.91	7.02	17.11	20.00	19.40	36.36		7.02	36.36	19.89
Geriatric Medicine	24.07	0.00	4.90	0.00	14.29	14.47	18.60		0.00	24.07	**10.91**
Respiratory Medicine	21.62	0.00	25.53	0.00	15.38	20.59	31.67		0.00	31.67	16.40

TREND OF EDD Changes By Specialty From 4th December to 15th January

	04-Dec	11-Dec	18-Dec	25-Dec	01-Jan	08-Jan	15-Jan		LOW	HIGH	AVG
Cardiology	1.60	3.09	1.92	2.60	1.50	1.57	2.00		1.50	3.09	2.04
Gastroenterology	2.49	3.33	2.07	3.30	2.03	1.54	1.96		1.54	3.33	2.39
Geriatric Medicine	3.39	4.50	3.45	2.00	3.25	3.03	2.94		2.00	4.50	**3.22**
Respiratory Medicine	1.76	0.00	0.32	10.00	0.71	1.75	1.15		0.00	10.00	2.24

LOS

last 2 weeks in November, first 4 in December

MEDICINE EDD League Table | last 6 weeks

RANK	Spec	CODE	Changes	Discharges	Movement
1	Respiratory Medicine	Z	0	7	▲
2	Dermatology	A	0	4	⇆
3	Diabetic Medicine	F	0	1	▲
4	Rheumatology	I	0	1	▲
5	Gastroenterology	Q	0.05	20	▲
6	Clinical Pharmacology	H	0.08	24	▼
7	Gastroenterology	J	0.08	12	▲
8	Respiratory Medicine	V	0.19	16	▲
9	Acute Internal Medicin	P	0.21	19	▼
10	Respiratory Medicine	D	1	15	▼
11	Gastroenterology	AD	1	2	▲
12	Clinical Haematology	Y	1.25	8	▲
13	Clinical Haematology	AE	1.25	4	▼
14	Cardiology	C	1.5	8	⇆
15	Respiratory Medicine	B	1.62	65	▼
16	Cardiology	S	1.93	15	▲
17	Cardiology	O	2	5	⇆
18	Gastroenterology	T	2.06	35	▼
19	Gastroenterology	AB	2.49	35	⇆
20	Cardiology	K	2.5	12	▼
21	Clinical Haematology	AF	2.59	17	▲
22	Gastroenterology	E	2.63	41	▼
23	Geriatric Medicine	AA	2.71	28	▼

More Than 3 changes on average

24	Geriatric Medicine	R	3	97	▼
25	Geriatric Medicine	X	3.25	55	⇆
26	Clinical Haematology	N	3.43	7	▼
27	Gastroenterology	M	3.68	19	▼
28	Geriatric Medicine	G	3.8	60	▼
29	Neurology	AC	4	4	▼
30	Cardiology	L	4	3	▼
31	Clinical Haematology	U	4.5	6	▼
32	Neurology	W	5	2	▼

RANK	Spec	CODE	Compliance %	discharges	Movement
1	Diabetic Medicine	F	100%	1	▲
2	Cardiology	K	100%	12	▲
3	Cardiology	L	100%	3	▲
4	Neurology	AC	100%	4	▲
5	Clinical Haematology	AE	100%	4	▲
6	Cardiology	O	80%	5	▲
7	Geriatric Medicine	AA	79%	28	▲
8	Clinical Haematology	AF	76%	17	▲
9	Geriatric Medicine	G	75%	60	⇆
10	Cardiology	S	73%	15	▲
11	Geriatric Medicine	R	72%	97	⇆
12	Respiratory Medicine	V	69%	16	▲
13	Gastroenterology	M	68%	19	▼
14	Clinical Haematology	U	67%	6	▲
15	Geriatric Medicine	X	64%	55	⇆
16	Gastroenterology	AB	63%	35	▲
17	Clinical Haematology	Y	63%	8	▲

LESS THAN 60%

18	Gastroenterology	E	59%	41	▼
19	Clinical Haematology	N	57%	7	▼
20	Gastroenterology	T	57%	35	▼
21	Respiratory Medicine	B	52%	65	▼
22	Cardiology	C	50%	8	▼
23	Clinical Pharmacology	H	50%	24	▼
24	Neurology	W	50%	2	▼
25	Gastroenterology	AD	50%	2	▲
26	Gastroenterology	Q	45%	20	▼
27	Respiratory Medicine	Z	43%	7	▼
28	Acute Internal Medicine	P	37%	19	▼
29	Respiratory Medicine	D	27%	15	▼
30	Gastroenterology	J	8%	12	▼
31	Dermatology	A	0%	4	▼
32	Rheumatology	I	0%	1	▼

Overall

Combination of EDD changes and Discharge before EDD performance

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

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Trust Evacuation and Shelter Proposal Emergency Preparedness - Evacuation Plans
SPONSOR (EXECUTIVE DIRECTOR):	Rachel Barlow, Chief Operating Officer
AUTHOR:	Caroline Rennalls, Head of Operations and Resilience, Rachel Barlow Chief Operating Officer
DATE OF MEETING:	1st February 2018

EXECUTIVE SUMMARY:

Total hospital evacuation maybe required to maintain safety for patients and staff. The size of such an undertaking would require the trust to declare critical incident or a major incident depending on the cause and activate a command and control structure to ensure the sequence of events required to successfully execute the necessary response was well coordinated.

The aim of this paper is to set out to the Trust Board how we, as an organisation, would manage a partial or whole site evacuation of one of the Trusts main sites, with a view to adapting the plan in the context of our 2020 vision in line with our future real estate and distribution of clinical services in the Midland Metropolitan Hospital, Birmingham and Sandwell Treatment Centres and a range of community locations.

REPORT RECOMMENDATION:

The Trust Board are asked to discuss the Trust Evacuation and Shelter Plan and to note the forward work programme to develop and maintain this aspect of emergency planning in line with our 2020 vision.

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

Comments:

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

Aligned to the trust Hospital evacuation policy, major incident and the business continuity plan
NHSE EPRR standards

PREVIOUS CONSIDERATION:

Other aspects of emergency planning have been presented to Trust Board – Private

SANDWELL AND WEST BIRMIMGHAM HOSPITALS NHS TRUST

Report to the Trust Board on 1st February 2018

Evacuation and shelter proposal

1. Introduction:

The aim of this paper is to set out to the Trust Board how we, as an organisation, would manage a partial or whole site evacuation of one of the Trust's main sites, with a view to adapting the plan in the context of our 2020 vision in line with our future real estate and distribution of clinical services in the Midland Metropolitan Hospital, Birmingham and Sandwell Treatment Centres and a range of community locations.

There are many types of emergencies that may affect an NHS Trust and its abilities to maintain its normal business safely. These various risks may result in healthcare facilities requiring partial or complete alternative shelter or evacuation for patients and staff at risk of harm from a threat. Events such as power or other utility failure, explosion or suspect packages, adverse weather including flooding, fire, the accidental release of hazardous material and terrorist events may require evacuation and shelter plans to be activated.

Under the Civil Contingency Act 2004 the Trust is a Category 1 Responder, other examples would include ambulance services and local authority organisations. As a Category 1 Responder we are required to have an evacuation and shelter plan. The Trust Hospital Evacuation and Shelter Plan meets the guidance issued from NHS England Emergency Preparedness Response and Recovery (EPRR) Dec 2014 and April 2016 and considers on site and off site solutions in the event of major service disruption. Whilst it should be read and put into practice with other related policies (such as the Major Incident Plan, Mass Casualty Plan, Fire Evacuation Plan and/or Business Continuity Plans) it provides details on key roles and responsibilities, options for partial or complete site evacuation and defines a process to be followed. The policy addresses, invocation, partial site evacuation and identifies organisations who we would liaise with to execute off-site evacuation.

2. Evacuation and responses

There are three primary levels when evacuation may be necessary or should be considered:

Table 1: Evacuation Levels

Level	Implication
Level 1	No immediate threat to life or safety, but there is an incident on an ascending floor in an ascending building (advanced warning provided)
Level 2	A situation with no immediate threat, but one where an incident is likely to spread, or be prolonged so as to affect patient care in that area, from adjoining areas (advanced warning provided)
Level 3	The situation where there is an immediate threat to life or safety (no warning provided)

The evacuation level may trigger business continuity responses through to a full major incident response based on a (M)ETHANE assessment (**M**ajor Incident Declared, **E**xact Location, **T**ype of Incident, **H**azards present or suspected, **A**ccess that we are safe to use, **N**umbers, type and severity of casualty affected, **E**mergency services present and those required to respond). Establishing the credibility of a threat to services, patients and staff within that assessment is essential early on. That threat will be assessed internally by the Tactical Command and team and the response agreed by the Strategic Command. Other emergency service strategic leads for example fire or police may also activate a major incident that requires a site to evacuate partially or completely.

Responses to evacuation levels may include:

- **Business continuity response**: Activation of business continuity plans including scaling back services to emergency service provision only whilst the moderate to longer term impact is assessed. Eg; Failure of equipment for instance air flow in theatre, pathology analysers
- **Internal Critical Incident**: Internal invocation or cross site relocation to enable emergency or full service provision to continue. Mutual aid may be required to support service delivery from an alternative partner or provider. Depending on the service affected this may trigger an internal critical incident (or external major incident) e.g; flood impact to part of a site or evacuation of services from part of the estate due to environmental damage
- **Major Incident**: The need to evacuate a critical service or services may lead to a major incident response in which support to evacuate and accommodation to evacuate to, both need support from external agencies.

As part of the West Midland Conurbation, should we as a Trust be required to carry out a total site evacuation NHS England EPRR team would coordinate a system wide response to provide mutual aid within the Health Sector and our neighbouring Local Authorities to support the delivery of health care to our local population.

In line with national guidance our policy includes consideration for areas that require particular security arrangements during the process and at the completion of an evacuation process.

In the event of evacuation patient management is managed in line with a triage system within the policy. It is the responsibility of all healthcare staff to do the most for the most during an incident involving the evacuation of patients. The triage system to be used to assist with evacuating patients is outlined in NHSE guidance (NHSE, 20140 and adopted within our current Evacuation and Shelter Policy.)

Given our current real estate and clinical service distribution, we have 2 acute sites and multiple community sites within which there are options to redistribute services. As we scale down our bed base there are empty ward facilities to open in the event of a partial evacuation scenario. Essential services have on site alternative evacuation location identified. In the event of full site evacuation the Trust would look to relocate services within the Trust itself and look for mutual aid in the event this plan did not meet critical and emergency service provision in the initial hours of an incident.

The longevity of an incident can also call for a development in incident response. For example if a discrete department is temporarily impacted and evacuated, the initial response may include deflection of emergency activity to the opposite site and cancellation of elective care for hours or several days. If the need to evacuate was prolonged consideration will be given to future emergency and planned care services which will require a developed moderate term solution for example modular mobile services or mutual aid.

Each individual incident and threat should be considered on its own merit. Responses could be over a matter of hours, days or weeks dependant on the scale of evacuation. Control and command structure in line with our Trust policies are essential infrastructures. The Strategic Command is responsible for longer term incident response planning.

3. Updating plans as we change how we work

Learning from other organisations, our current plans will be further strengthened by expansion of action cards for key roles and will undergo a table top test by end of June.

In preparation for UNITY, our forthcoming electronic patient record, the plans need to be updated to reflect how medical notes would transfer with patients in an evacuation process. All emergency preparedness for UNITY will be signed off through the Trust Emergency Planning Preparedness and Resilience Committee before UNITY goes live.

Our future 2020 real estate plans and clinical service design has 1 acute hospital site, 2 Treatment Centres and expanding community services. This will require a different response and preparedness. In preparation for that the Trust has set up a project to design the future state evacuation and shelter response with essential partners including local authorities. The time line for this work is that by the end of December 2018 the plan is designed and testing takes place later in the year.

4. Conclusion

The Trust Board is asked to discuss the Trust Evacuation and Shelter Plan and to note the forward work programme to develop and maintain this aspect of emergency planning in line with our 2020 vision.

Caroline Rennalls
Head of Operations and Resilience

Rachel Barlow
Chief Operating Officer

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Purple Point
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Karen Wood, Head of Complaints Allison Binns, Deputy Director of Governance
DATE OF MEETING:	1 February 2018

EXECUTIVE SUMMARY:

This report provides information about the inception of the 'Purple Point' and provides information on how patient experience will be enhanced by this new innovative approach, how we will communicate to both those who may use it and those staff who will need to respond.

The Purple Point, is not a replacement for locally resolving concerns, enquiries raised informally (PALS) or formal complaints, rather, it gives an alternative route, but with the advantage of a timely response and action for patients who are in our care and have immediate concerns.

The Purple Point will provide us with information on trends and themes for concerns of inpatients which we can share and learn from, thus improving the care and services we provide.

REPORT RECOMMENDATION:

The Board is asked to **NOTE** and **DISCUSS** the plan for implementing the Purple Point.

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 Care promises.

PREVIOUS CONSIDERATION:

CLE, Hot Topics, Heartbeat

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report to the Trust Board on 1st February 2018

Introduction of the Purple Point

1. Introduction

1.1 Patients, carers, relatives and visitors and have many ways to raise concerns at any point and for any reason. Some raise these concerns directly with the staff who are available on the ward or in a department, through our website or NHS Choices, or by writing to the Trust both informally or as formal complaints.

1.2 Healthwatch helped the Trust to identify, with the aid of patients who at the time were inpatients, that there were opportunities for us to be more approachable to their concerns.

1.3 In response to this gap and to enhance existing opportunities to raise concerns, the concept of introducing a service, delivered through a telephone, was devised.

2. The Purple Point

2.1 Purple Point is a facility available outside inpatient areas where patients, their family or carers are able to raise a concern, via a telephone, twelve hours of each day, seven days a week.

2.2 Calls will be answered by a dedicated team of staff working within the Governance Support Unit (GSU). This team deals daily with concerns from patients and their representatives and personally help to resolve 'low level' concerns

2.3 There are six telephone extensions available for those wanting to raise a concern, one for those who wish to use English and then five additional numbers, one for each of the top five languages: Bengali, Urdu, Polish, Romanian and Punjabi (based on interpreter usage over the last 3 years). Calls from these five languages will still come through to the GSU, then a pre-recorded message will advise the caller that we are connecting with language line to employ the services of an interpreter, allowing us to ensure we correctly understand the concern they want to raise.

2.4 Unlike PALS concerns, the GSU staff will not try to get a resolution and feed back to the patient or their representative, but will facilitate a resolution between the most appropriate person and the person raising the concern. The emphasis of 'Purple Point' calls is that the caller will receive some initial feedback, particularly if resolution cannot be immediate, but with a plan for resolving the concern raised and action being taken. It is particularly important that the resolution of the concern is discussed and agreed with

the person who is raising the concern and if that is not the patient, consent and confidentiality must still be maintained at all times.

2.5 The 'Purple Point' will also allow patients and their representatives to make a compliment about a staff member, team or service, or give thanks, something we do not currently advertise but recognising that it occurs. This service will go some way to measuring this as a balance to the number of concerns and complaints received. Those wishing to make a compliment will be directed to a dedicated answering machine where their compliment will be recorded with assurance that this will be passed to the team/person to which it applies.

2.6 Once the concern is understood and the basic details logged, the GSU advisor will follow a set of decision making trigger points to identify the type of enquiry and, where needed, the best person at that time to respond to the patient or their representative. These trigger points include:

a. an issue in need of local and immediate resolution (being the type of enquiry this service was designed for)
b. a caller asking to make a formal complaint
c. a call unrelated to patient care and will fall to the GSU or Complaints team to manage as an informal complaint.

2.7 Those concerns that require the immediate and local resolution will begin with the GSU advisors making contact, on the caller's behalf to the relevant decision maker in question. This person will be identified through use of guidance on the types of scenarios which have been raised previously, for those who are inpatients, either through the formal complaints procedure or via PALS.

2.8 GSU advisors will know who to contact during normal hours and out of hours. Each of these enquiry types will be categorised with an expected time to make contact to initiate resolution. For example, if a patient is waiting for pain relief and is in agony, then staff must visit the patient and resolve the issue within a 1-2 hour window, recognising that further pain relief may not be immediately available to administer and require additional prescription.

However, a family member who asks to speak to the Consultant may have to wait until later that day, the next day or even after the weekend for this to occur. Discussion with an on call / ward Consultant or alternative is to be offered to provide some information whilst an appointment with the patient's Consultant is organised. The patient or family member making the request must have this organised and arranged within the next 24 hours.

Some examples of concerns, the suggested responder and the priority are outline below, but this will also be partly defined by the callers needs too.

Topic/ theme of concern	First line	Escalation	Priority*
Do not agree with the doctor's advice / diagnosis	The doctor involved	1. Consultant of the week 2. Medical Director	4
There is DNACPR in place that the family do not agree with	Consultant responsible or consultant of the week	1. Medical Director	2
End of life issues	Junior Doctor / Clinical Nurse Practitioner	1. Consultant of the week 2. Medical Director	3
Neglect in care (hydration, nutrition continence management, hygiene care)	Junior Doctor / Clinical Nurse Practitioner	1. Consultant of the week 2. Medical Director	1
The bed area/ ward is unclean (infection control) including samples in toilets	Nurse In Charge (NIC)	1. Matron 2. Clinical Nurse Practitioner	1
Medication error	Matron (out of hours - Clinical Nurse Practitioner)	1. Group Director of Nursing / Group Director 2. Chief Nurse / Medical Director	1
Delays in discharge due to treatment / intervention/ medication delay	CEO	Not applicable	1
Unnecessary delays in treatment / intervention / medication	Matron (out of hours- Clinical Nurse Practitioner)	1. Group Director of Nursing 2. Chief Nurse	1

* Priority	
1	1-2 hrs
2	2-6 hrs
3	6-12 hrs
4	24 hrs
5	Next working day including waiting until after the weekend

2.9 When a call is placed outside opening hours (9am-9pm) the caller will be advised to call back during this time. In anticipation that this may mean the caller does this away from the 'Purple Point' the telephone number to call to raise a concern is advertised at the Purple Point. At **Appendix 1** there is an illustration of the backboard which will be the 'Purple Point' (A1 / flipchart paper size). These have been devised in such a way so that

as we need to change the information or the languages available this can be done easily and inexpensively.

2.10 Consideration has been given to access of the phone and so is being placed at a level to suit people of all heights and those who may be confined to a wheelchair. A Loop is also available for those who require it due to hearing impairment.

2.11 Shortly we will be launching some planned communications to patients, families and carers regarding the availability of the Purple Point through various media. These communications centre on the use of social media and local news feeds. Within the Trust we are promoting raising concerns locally, within the department/ward, and through the 'Purple Point' with the use of posters and bedside information.

3. Responding to a Purple Point concern

3.1 The concept of listening and responding immediately and locally to concerns is not new and most staff do an excellent job of addressing the issues. The Purple Point will not replace this but patients or their representatives may feel less inhibited about telling someone not directly involved in care, about their concerns. The Purple Point provides an alternative option to voice concerns.

3.2 Communications to staff on the Purple Point have been outlined in Hot Topics and Heartbeat during January 2018. Over the next few weeks, prior to the 'go live' week of 26 February 2018, targeted communications will be sent to frontline staff, junior doctors, Consultants, Ward Managers, Sisters, Matrons, managers and senior managers who will be expected to respond when contacted by the GSU advisor. These communications will include a staff leaflet (providing more information on the Purple Point), FAQ sheet, a short video, a screen saver and a more comprehensive list of the types of concerns we might receive with associated responders and timeframes, as given in the example above.

3.3 The importance of staff understanding that the concerns raised through these calls need immediate response and are not placed into the current processes for responding to PALS concerns and formal complaints, cannot be minimised. Hence the need and plan for communications throughout the organisation.

4. Monitoring

4.1 The phone system we are using to provide the 'Purple Point' allows us to gain information about call volumes, and times. All calls will be logged through an existing database, which will provide us with information about the nature of the issues and their resolution. Both sets of information can tell us what themes and trends are and by sharing this information, together with solutions, learning can take place Trust wide.

4.2 In evaluating the 'Purple Point' approach data from caller satisfaction, the Friends & Family Test and patient surveys will be collated to assess patient experience improvement.

5. Conclusion

5.1 The 'Purple Point' is an exciting innovative approach which will be achieved through a shared vision of accountability and immediacy. Its success, and how valuable it is to inpatients and their representatives, depends heavily on the commitment of staff to act with efficiency and empathy to all calls forwarded to them by the GSU advisors.

5.2 The 'Purple Point' enhances our ability to receive feedback, particularly in real time, and to improve the experience of patients and their representatives, through its availability and taking demonstrable, timely action.

5.3 The ability to collect compliments and thanks and pass these onto the relevant staff, teams and services will provide those carrying out caring functions with positive feedback, supplementing what is already provided at a local level.

5.4 Whilst the 'Purple Point' is being instigated to enhance patient experience, it may also reduce the number of informal and formal complaints received which take staff away from other duties to investigate and respond to.

5.5 Once the 'Purple Point' use has taken off, we will also be able to see if other patient experience measures, such as Friends & Family Test, patient surveys, have improved. Monitoring of the types of enquiries will allow the sharing of themes and trends and in particular learning and show the improvements made to services. Work is in progress to assess how best we can collect information on satisfaction of the 'Purple Point' approach for the person who originated the call.

5.6 Ultimately, the success of the initiative in itself is that the service gets reduced enquiries as the culture of proactively seeking to defuse difficult issues on the ward, and tackle concerns with confidence and empathy is further embedded.

6. Recommendation

6.1 The Board is asked to **NOTE** and **DISCUSS** the plan for implementing the Purple Point.

Karen Wood, Head of Complaints
Allison Binns, Deputy Director of Governance

24 January 2018

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PURPLE point

NHS

How well are we looking after you?

If you, or your loved one, have concerns about care or treatment, call us and we will help.

You can also call us if you want to compliment individual staff.

"We want to hear from you. I promise that your care won't be compromised by speaking up. With your help we can get our care right for everyone."

Dr David Carruthers, Medical Director

9am–9pm
Monday–Sunday

Alternatively, please dial 0121 507 4999 direct from your own phone

Please dial

8180	English
8181	ਪੰਜਾਬੀ
8182	Polskie
8183	اردو
8184	Română
8185	বাঙালি

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD PUBLIC MEETING MINUTES

Venue: The Education Centre, Sandwell General Hospital **Date:** 4th January 2018; 09:30h – 12:45h

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)
Prof K Thomas, Non-Executive Director	(WZ)	Prof D Carruthers, Medical Director	(CD)
Mrs M Perry, Non-Executive Director	(MP)		
Mr M Hoare, Non-Executive Director	(MH)		
Mr T Lewis, Chief Executive	(TL)	**Board Support**	
Mr T Waite, Finance Director	(TW)	Miss R Fuller, Executive Assistant	(RF)
Mrs R Goodby, Director of OD	(RG)		
Ms R Barlow, Chief Operating Officer	(RB)		
Miss K Dhami, Director of Governance	(KD)		

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

Apologies were received from Ms R Wilkin, Mrs C. Rickards and Ms C Dooley.

Mr. Samuda welcomed Prof David Carruthers as Medical Director to the meeting.

Declaration of Interests - No declarations of interest were received.

2. Patient Story	**Presentation**

Mrs Newell introduced Louise Thompson, Feeding Coordinator, in maternity services, and presented a video of a mother with a new born baby who required treatment, outside of the maternity unit, in Cardiology.

The patient required admittance into cardiology post pregnancy and the patient spoke of issues around administrating medication which had contra-indications for post pregnant mothers. She also spoke about issues in relation to expressing breastmilk, and suitable storage for breastmilk on the ward. The patient spoke of a positive patient experience with good inter-department harmony.

Mrs Newell reflected the film showed how difficult it was for staff to assist this mother outside of the normal maternity environment and how an awareness communication on breastfeeding was required to help support requests of this nature. The Trust Board supported an awareness campaign to staff on breastfeeding.

The non executives enquired to the circumstances where drugs with contra-indications are given to mothers especially when the patient expressed anxiety about taking this medication. It was explained the BNF is used as a guide, but upon risk assessment the benefits far outweigh the risks for breastfeeding mothers. The Trusts Drugs and Therapeutics Committee are also the advisory for authorisation of using drugs with contra-indications.

The Trust Board also discussed the environment of having a new born baby in an adult ward environment and ensuring there was wrap-around care for adult and child and that staff know who to contact in these unusual circumstances. This also included the safety of the child on an adult ward, but the risk to the baby was less than the impact of mother and baby separation and the mother stopping breastfeeding.

The Trust Board continued to discuss the environment of having mothers and babies on adult wards and why it was not feasible to have a reserved room on standby for expectant mothers. It was noticeable that a clearer communication chain was required to ensure mothers and their families are not unduly distressed in these circumstances. Mrs Newell assured the Trust Board the maternity team has since put a number of actions in place to ensure staff outside of maternity services are supported in relation to treatment for pregnant or nursing mothers.

The Trust Board also acknowledged there was an issue with storing breastmilk in fridges outside of the special fridges held in the neonatal unit and paediatric wards. It was agreed that appropriate arrangements should be put in place for the storage of breastmilk outside of these areas.

ACTION:

- The communication of a breast feeding awareness strategy for staff when treating patients that are breastfeeding mothers.
- Clarity to be provided to staff on who to contact regarding contra-indications of drugs when treating breast feeding mothers.
- Appropriate arrangements to be put in place outside of maternity services for mothers storing breastmilk.

3. Update on actions from previous patient stories	**Verbal**

Mrs Newell updated the Trust Board on a patient story which highlighted patients with visual and hearing impairments and how best to support them. There are a number of actions and learning lessons that are being addressed which included:

- Appointment Letters – the template will be changed to make the contact number more visible.
- Contact Centre – increased training of staff to empower them to asked patients questions around special requirements and how to refer to the Equality and Disability team if help is required.
- CCG – Dottie Tipton is working with CCG colleagues to identify patients who require additional assistance when attending for treatment.
- Eye Hospital Appointments – all letters will be printed in large print, on yellow paper, which makes them easy to read. The Trust Board discussed the cost of all letters being put on yellow paper as many patients would benefit from easier to read letters. Mrs Newell stated there is a cost implication but would look into this and inform Mr Lewis outside of the meeting. Ms Barlow also confirmed that there will be a decrease in the use sending external letters to patients as in future letters will be emailed which is part of the Trust's sustainability promise.
- Staff training – 140 staff will received training in deaf awareness and the British Sign Language in the next financial year.
- Assistance Dogs – The policy has been changed and will be approved at the end of January 2018 to enable assistance and therapy dogs access to patients while in hospital.

Interpreter Services – the contract has been changed and now includes a broader range of assistance including people who can sign.

ACTION

- Mrs Newell and Ms Barlow to review the cost of using yellow paper for all correspondence to patients.

4. Questions from the public	**Verbal**

No questions were received from the Public

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

Mr Samuda highlighted the following:

Bollywood Ball – The charity team organised a fund raising event which was fun and well attended. Mr. Samuda asked to be informed how much the evening raised.

Get It Right First Time (GIRFT). This is a national campaign looking at effective ordering services and looking at cost efficiencies. The Finance and Investment Committee have already discussed the GIRFT programme and have invited Non-Executive Directors to become involved and join some of the clinical sessions to show support. It was acknowledged more clinical engagement by leaders will be a feature of future Private Trust Board meetings and Mr Baker agreed to provide a briefing note about the visits to Trust Board members.

Mr Samuda acknowledged the CQC report and A&E.

ACTION:

- The Board to be informed how much money was raised during the Bollywood Ball.

6a. Major Projects Authority – 15th December 2017	**Tabled & SWBTB (01/18) 001**

Mr Hoare reported to the Trust Board work is progressing with DHL on logistic of stock management. An expert has been found and the programme is being planned and mobilised.

Mr Hoare informed the Trust Board that MPA spend time discussing the Trust's digital solution which dovetails with the report by the Chief Executive.

Hard facilitation management with Carillion. The company are looking to re-finance and are making progress, which includes the hard facilities management service, which will have an effect on the timing of TUPE arrangements for staff. Current staff will receive communication but the recent announcement of a future sale to one organisation will mean staff will need to wait to find out who will be the provider of the Hard FM contract. An update, if available, will be provided for the next meeting.

Wi-Fi. Mr Lewis informed the Trust Board no decision has been taken to provide free Wi-Fi. Mr Samuda commented on a national initiative. However, there were issues to be addressed on the commercialisation of the estate as some revenue will need to be raised. Mr. Lewis confirmed there would be an element of free Wi-Fi but at this point it was not clear how much. Mr Lewis agreed to pick this up with Mr Samuda outside of the meeting.

The minutes of the meeting held on the 20th October were noted.

ACTION:

- Verbal update required on TUPE transfer details of the Hard FM contract.

6b. Quality and Safety Committee – 22nd December 2017	**SWBTB (01/18) 002** **SWBTB (01/18) 003**

Ms Dutton highlighted the following to the Trust Board:

IPR Persistent Reds. It was discussed progress had not been made to an acceptable standard, in Q4 a different approach will apply and be report to the Trust Board.

Perinatal Mortality Progress Report. The internal review undertaken by Dr Roger Stedman will be presented to the January Quality and Safety Committee and will then be presented to the February Trust Board.

Safety Plan. The plan has been deemed a success and the focus will be to ensure sustainability is maintained. Mr Samuda asked for congratulations to the teams to be conveyed.

Minutes of the meeting 24th November 2017. Medical Appraisal. Mr Lewis commented an error with the minutes (24.11.17).

6c. Finance & Investment Committee – 22nd December 2017	SWBTB (01/18) 004 SWBTB (01/18) 005

Mr Hoare informed the Trust Board of the current financial position and the challenge to get to a balanced position. Mr Waite, Finance and the Executive team were thanked for their hard work in the last 6 weeks in forecasting a surplus of £1m. Capital spend is behind plan which will be revised and brought back to the February Committee.

Mr Lewis reported the CCG have agreed the income for this year, however it is on a non recurrent basis which causes a material risk due to the size of the challenge next year.

The minutes of the meeting held on the 24th November 2017 were noted.

7. Chief Executive's Report	SWBTB (01/18) 006

Mr Lewis updated the Trust Board on key …

Digital – the **Rhapsody system** has been replaced and has made some difference to the daily outage key workers were experiencing. The Trust is now nearing the end of the infrastructure journey and Mr Lewis will be presenting a report to the MPA Committee on the entire journey (beginning to end) as one of the biggest areas of staff negativity being experienced in the Trust was the IT system. **Winscribe** – this system is a clinical user system for electronic correspondence to GPs and patients. This will be relaunched again to a cohort of users and monitored until there is confidence the system works before complete roll out is agreed. **Unity** – the deployment of this system was deferred from November and no revised date as yet been secured, however work is heading to an unofficial deployment date of June.

The Trust Board discussed the need to have a bedding in period with Unity before moving into Midland Met. Mr Lewis informed the Trust should be working towards an implementation date of May/June as the risk of leaving an implementation date until the Autumn will impact on Winter planning and beds. Mr Lewis also informed the Trust Board that he has assembled a Clinical Cabinet group comprising of senior clinical leaders who are reviewing confidence in Unity, this will also include a test period which the system will need to show it is working before roll out. To lessen the impact on clinical staff Ms Barlow and Mr Reynolds are creating a user manual including areas of accountability/implementation for staff as Unity should release clinical time for administrators, porters etc. It was discussed maybe during ward visits the benefits of releasing time could be discussed with staff as it is only through live experiences that the project gain credibility. This manual could also be used to provide assurance to the Trust Board at a future date.

Mr Lewis discussed all employees of the Trust will need to have computer skills and support will continue until March 2019 when all current staff will have the required IT skills. The investment into the digital infrastructure will only succeed with all staff using technology as part of their role and there has been efforts post live to manage staff with little or no IT skills.

Flu Vaccination. The total is just under 80% (approximately 100 more vaccines to reach target) and the Trust is close to being the best in the West Midlands.

Purple Phone Point. This is a new and exciting initiative to enhance the patient experience and NHSE are supportive of our model. This model will be a big change for patients and clinical staff therefore over the next 6 weeks a full communication campaign will be enacted and the Trust Board will discuss further at its next meeting the launch of the Purple Phone Point Service. Cllr Zaffar concurred Purple Phone Point was an exciting development and he queried how complaints from communities, who do not usually complain, will be addressed. Miss Dhami confirmed Karen Wood, Head of Patient Advisory Liaison Service and Complaints has been visiting communities to discuss Purple Phone Point. The purple phone will have a language line built in so the caller can speak to someone in their own language. Mr Lewis stated the biggest areas to address is patient complaints while they are an inpatient, as patients have the perception it will have an impact on care. Mr Lewis continued to inform the Trust Board that there is no evidence to suggest patients care is affected if they complain but Prof Carruthers and Mrs Newell will be reinforcing the view that patients can complain while an inpatient with clinical staff. This service will be a 7 day a week service.

52 week Breaches. This will be discussed in more detail during the Private Trust Board and Ms Barlow will prepare a paper for the next meeting highlighting the issues.

Gynae-oncology. Notice was served on the gynae-oncology tertiary service in April 2017 and despite national arbitration the 40% income cut in service has not been addressed and no provider is available to transfer the service to. It has therefore been agreed to continue the service into Q4 to ensure patient care is maintained.

The Trust Board asked for an update on the EWTT regarding D16 and Lyndon 5. Mrs Newell confirmed improvement has been seen but it is too early to report. A new Ward Manager has been appointed and an update will be provided to the Quality and Safety Committee.

PROMs annex. This will be discussed outside of the meeting with Ms Dutton and Mrs Newell.

ACTION:

- Mr Lewis will present a report to the MPA Committee showing the journey of the IT infrastructure from beginning to end.
- Purple Point. The next Trust Board meeting to receive a update
- 52 week Breaches. This will be discussed in more detail during the Private Trust Board and Ms Barlow will prepare a paper for the next meeting highlighting the issues
- Mrs Newell to provide an update to the Quality and Safety Committee on EWTT on Ward D16 and Lyndon 5

8. CQC Improvement Plan Winter Plan	**SWBTB (01/18) 007**

Miss Dhami reported on the 'Going for Good' approach for the next 12 months, following the Care Quality Commission inspection that took place in March 2017 and the published report in October 2017. There has been a development of an improvement plan to address the 101 areas identified where the Trust must and should take action. The timeline for these improvements was 3 months to December 2017 or 6 months to March 2018. 36 of the 57 actions have been delivered for December - 10 actions are off track but have revised dates for delivery and will be monitored weekly. 11 remain off track with no confirmed date for delivery. Through the Group Director of Operations they are overseeing the implementation changes to practice and improvements are in place until a revised timeframe is confirmed. The actions for delivery by March 2018 are being monitored to ensure delivery is met.

To provide assurance that the actions have been completed and are sustained, there will be regular in-house inspections, clinical audits, observations and speaking to staff and patients. The 'Going for Good' approach is about maintaining sustainability following 70% of the Trust's services being rated good or outstanding. The intention is to achieve a Good rating by 2019.

Miss Dhami noted the concerns on BMEC and its ED department as part of the learning the team will be contacting local and speciality hospitals for advice. The Non-Executive Directors queried BMEC ED paediatric patients and stress on ED staff and the resources to complete the actions. Mr Lewis confirmed that a Regional solution is still being sought to address the BMEC ED paediatric and young child issues. Mr Lewis was confident following a meeting with the Chief Executive of Birmingham Children's Hospital a solution could be found, however by March if there was no deal in place Mr Lewis would ask for a Quality Summit with NHSE. Mr Lewis also stated many of the ED issues will be picked up by the Consistency of Care work.

Miss Dhami continued to inform the Trust Board that many of the actions were based on the fundamentals of patient care which is how we have agreed to work and issues exampled as improvements to resuscitation trolley's is an essential 'must do' piece of work. The behaviour of some staff would need to change to ensure consistency is maintained.

The Trust Board discussed a safe room to care for patients with mental ill health issues, and it was confirmed City have a room which meets requirements for mental health patients, however the room at Sandwell requires work for it to meet the standard.

Following a brief discussion the Trust Board noted the report and agreed some of the actions were currently outside of the Trust's control but the Quality and Safety Committee and the Executive Quality Committee will be monitoring progress.

9. Winter Plan: EDD performance and bed closure position	**SWBTB (01/18) 008**

Ms Barlow outlined the Trust performance against delivery of the improvement plans for Winter urgent care. December A&E's performance deteriorated to 78% which is the lowest it's been in a number of years which relates to 5 – 6 more daily admissions than planned. Most of the demand was at Sandwell which reinforces the high pressure the Black Country is facing.

Executive team support will be provided to Medicine and there is confidence of improved progress over the next few weeks following the launch of the Consultant of the Week model.

The Trust Board discussed elements of limited sources in social care and the issues around labour shortage in recruiting ED nurses and doctors. It was noted this Trust is faring better than most others due to its business understanding with the ambulance service and its staff as the Trust provides a quicker turnaround than other organisations. Unfortunately this did not halt the Level 4 being issued over Christmas and the New Year. Level 4 is called due to safety concerns and is usually when the resus bay is at full capacity. Ms. Barlow agreed to circulate the level 4 criteria to Trust Board members with an explanatory note of how overwhelmed the department can be even when resus is not completely full. Mr. Lewis stressed at no time was the A&E department operating unsafely and he offered to speak to any Board member outside of the meeting if anyone had concerns.

Ms Barlow continued to inform the Trust Board that she will be presenting a paper to the March Trust Board on closing the unfunded beds safety against the agreed original plan and the Trust Board discussed the current initiatives in place to reduce length of stay. Mr Lewis noted the 8 consultants changed EDD (estimated discharge date) more than 8 times according to the EDD league table. Ms Barlow informed the Trust board EDD should not be changed, however the individual consultants will be coached to change behaviour as by keeping to EDD the management of length of stay should see the required reduction.

ACTION:

- Ms Barlow to circulate the level 4 criteria to Board members
- Ms Barlow continued to inform the Trust board that she will be presenting a paper to the March Trust board on closing the unfunded beds safety against the agreed original plan and the Trust Board discussed the current initiatives in place to reduce length of stay.

10. Integrated Quality & Performance report	**SWBTB (01/18) 009**

Mr Waite addressed the following issues following the previous Trust Board's discussion under item 9 – Winter Plan and item 11 – Decreasing Sickness Absence

Theatre Utilisation – Ms Barlow informed the Trust Board the plan is to remove under-utilised time as part of the theatre reduction and savings. It was noted some internal support would be required to finalise the trajectory to achieve the required efficiency saving.
Elective Activity. There was an impact on the recent bad weather (snow) on elective surgery. The Trust cancelled 14 cases mostly in oral surgery as staff were unable attend their shifts, an additional 3 trauma lists were undertaken during this time.

10.1 IPR Persistent Reds – PO8 November 2017	**SWBTB (01/18) 010**

Mr Waite reported progress in the last month was not sufficient and prospective improvement is now required. The executive leads through Q4 are setting milestones together with expected trajectory for measured improvement. Monitoring is being undertaken by PMC, and the Quality and Safety Committee.

10.2 Finance Report – P08 November 2017	SWBTB (01/18) 011

Mr Waite reported on performance against the revised financial plan which is to achieve a headline surplus £1m being consistent with a pre STF deficit of £4m. As at month 08 the position is on track against the remedial plan. This includes the benefit of non-recurrent measures. The underlying position remains a significant deficit with necessary action required to improve the monthly run rate by reducing the monthly cost base.

Mr Waite drew the Board's attention to some key assumptions as:

- £264.5m income expectation from Sandwell CCG and which commitment to that has been secured
- Production plan delivery of £110m and which is at risk from winter pressures
- £17m CIP delivery with specific risk on bed reduction and
- On-going reliance on non-recurrent measures which had been scaled and secured

Mr Waite advised that Winter monies had now been confirmed and which would cover c£1m of slippage on bed closure CIPs and a further £1m which was expected to improve the headline financial performance for the year. This would be addressed in reporting P09 results and forecast. Mr Lewis stated that closing beds by end Q4 remained necessary and consistent with required run rate improvement.

Mr. Lewis noted the achieved reduction in agency spend from £2.4m to £1.4m. He queried if that reduction is sustainable and how further reductions would be made consistent with run rate improvement and trust compliance with its agency ceiling. Mr. Waite agreed to review the specific proposals on pay that impact on that £1.4m agency spend.

Capital was noted as being behind original plan reflecting an on-going re-phasing of schemes is taking place. A revised five-year capital plan would be considered by the Board in due course.

The Board noted that any cash loan to support operating costs will likely not now be required in this financial year.

The Trust Board focussed discussion on savings necessary to secure underlying financial balance. Within the Private Trust Board, a detailed discussion would take place on the scale and timing of those necessary pay and non-pay costs savings and any prospective reduction in permanent workforce which may be required.

ACTION:

- Mr. Waite agreed to review the specific proposals impacting on the current £1.4m agency spend.

11 Decreasing Sickness Absence & Improving Employee Mental Wellbeing	SWBTB (12/17) 012

Mrs Goodby reminded the Trust Board of the action from the November meeting to improve sickness absence and improve employee mental well-being. The Trust Board were informed of the OHH Department intention to submit a mental health service tender next week. This service would give staff access to receive treatment sooner through cancelled appointments from patients.

The Trust Board were informed about current initiatives at the trust in order to achieve best practice, these included: the gym, a weight management programme and smoking cessation. There is also a review of the sickness policy which will be replaced with a new Attendance Policy. The team are also looking at reintroducing the Attendance Recognition scheme which gives certificates and monetary vouchers to staff.

The Trust Board also discussed the "time to be well" element and Mrs Goodby stated this has not been modelled yet as Trust Board approval was required. Staff will be able to use contracted time to attend exercise and other well being classes but strict governance protocols would be in place to monitor this. Mr Samuda was positive above the proposals and stated this could help to break the cycle of absenteeism and financially become self-funding as the sickness rate would be reduced. Mrs Goodby also informed the Trust Board that through the accredited manager programme staff communication with line management should improve. Mr. Lewis stated the attendance policy should be trialled in facilities before rolling out across the organisation, as success in facilities would be a good basis for success across the organisation.

Mr. Lewis queried 2 points: - how much of these interventions would reduce the sickness rate from 4.86% to 3%, and the paper did not address significantly staffs mental health wellbeing. The Trust should take a pre-emptive intervention measures for certain staff groups i.e. maternity, A&E and theatres who have a high risk of stress. Mr Lewis suggested waiting for staff to inform the Trust they are ill should not be accepted but having pre-emptive measures in place to address any issues before a member of staff is unable to work should be reviewed. It was suggested obtaining information on how other industries addressed stress of staff working in high risk areas should be explored and discussed with the LNC.

ACTION:

- Mrs Goodby was authorised to model the "time to be well" initiative.
- Mrs Goodby was asked to obtain information on the percentage of sickness reduction would be achieved from the interventions contained in her report.
- Have a clear strategy on pre-emptive actions for staff employed in high risk areas to be developed.

12 Nursing Career Escalator	**SWBTB (12/17) 013**

Mrs Newell presented a paper showing the approach in retention of nurses by formulating a career escalator for bands 4 – 6 nurses. Year 1 – 2 is a preceptor year when objectives are set. At the end of Year 2 a full review of objectives set are scored against and if a score of 4A or similar is achieved a discussion will be held with the line manager. The nurse will then have an option to escalate development in either a management role, a clinical role or stay as they are. Nurses who chose to undertake the escalator route will receive a pay uplift whilst development is undertaken. Following discussion it was noted that the escalator programme should substantially reduce turnover of staff and eventually would pay for itself. It was discussed a lock in would need to built into the programme to ensure staff are not immediately leaving the Trust once the programme has ended. Ms Newell would review this and create an 18 month lock in following advice. This programme would be unique to SWBH and would be a positive benefit of working for this Trust. Mrs Goodby also informed the Trust board that all band 6 vacancies would be ring-fenced for nurses on the programme.

Mr Samuda queried if nurses were able to secure a bursary. Mrs Newell explained there was no nursing bursary available only a student loan. Mrs Newell agreed to update the Trust Board on loans and availability of post qualifications at the next meeting. The Trust Board also asked for a financial impact assessment to be completed for March prior to launch in April.

ACTION:

- Mrs Newell to update the board on available loans of offer to nurses studying.
- Mrs Newell to present a financial impact assessment to the March Trust Board before launch in April

13 Trust Risk Register	**SWBTB (12/17) 014**

Miss Dhami reported no new risks have been escalated from the Clinical Leadership Executive, however the following risk were noted:

Delayed Transfers of Care (DTOC). Ms Barlow will ask the Risk Management Board to review this risk as the position has improved compared to 12 months ago. Ms Barlow informed the Trust Board this risk is framed on Birmingham City Councils lack of EAB beds in nursing and residential care, which as significantly contributed to the DTOC position.

14. Building Sustainable Finances – Outline Finance Plan 2018/19	**SWBTB (01/18) 015**

Mr Waite informed the Trust Board of the scale of the financial plan for 2018/19 which is challenging but achievable if a number of measures are achieved. The plan is consistent to meet the control total and earn significant STF, which is important as securing STF will ensure the capital funding programme is kept on track without recourse of significant borrowing. Mr Waite confirmed the recommendations in the paper will be maintained over the next 12 months and were not to be viewed as a 'one-off' measure.

Highlighted to the Trust Board was the financial impact of oncology services transferring out of approximately £3.4m, however the Trust will be putting a proposal to Commissioners for compensation so as not to suffer any financial detriment as a result of the decision.

Mr Waite stated the financial position of the Trust will be discussed in more detail at the Private Trust board and requested the Public Trust Board to review how the plan is shaping up over the next few weeks.

15. Minutes of last meeting	**SWBTB (01/17) 016**

The following addendum to the minutes was made:

5c. Sandwell and West Birmingham Hospitals NHS Trust Charities – Annual Report and Accounts 2016/17. Amendment to 2nd paragraph on page 3. Paragraph should read:

'Mr Lewis queried the amount of pre commitments of funding in relation to grants. Mr Waite advised that it was normal practice for the accounts to recognise the full value of commitments at the time of making those commitments. Accordingly, the accounts reflected those commitments which had been made to date. He further advised that financial reporting to the Charity Committee was being enhanced consistent with routinely having a medium term view of income expectations, commitments and fund balances available.'

15. Update on actions from previous meetings (action log)	**SWBTB (12/17) 017**

The following updates were provided:

5th October 2016

5) **Junior Doctors Hours** – Mrs Goodby informed the Trust Board she has spoken to Dr. Christine Wright, Doctors Guardian who has reported no issues with junior doctors hours. Mrs Goodby requested this action be closed. Mr Lewis informed the Trust Board there was an issue in ENT which is being addressed but he will be asking the People and OD Committee to look at junior doctors hours as there could be significant under reporting by trainees and he had no assurance that there are no issues. Prof Carruthers noted the Royal Colleague would be visiting ENT to review doctor services.

16. Matters arising	**Verbal**

There were matters arising to discuss

17. Equality and Inclusion Report (January 2018)	**SWBTB (01/18) 018**

The Trust Board noted the contents of the report and following recommendation from the Public Health Committee approved the 2017 Equality and Inclusion Report to be uploaded on the Trust's web site.

18. On-boarding New Colleagues	**SWBTB (01/18) 019**

Mrs Goodby informed the Trust Board the new Induction model was to be launched on 1st April 2018 following a pilot test taking place in February. The contents of the report was noted but the Trust Board asked for early indicators to be reported to the March Trust Board.

ACTION:

- Mrs Goodby will update the March Trust Board on results from the pilot scheme taking place in February 2018

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 1st February 2018 starting at 09:30am in Anne Gibson Board Room, City Hospital.	

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Public Trust Board Action Log – 4th January 2018

	Action	Assigned to	Due Date	Status
From Meeting held on 4th January 2018				
1)	Patient Story: ➢ The communication of breast feeding awareness strategy for staff when treating patients who are breastfeeding mothers. ➢ Clarity to be provided to staff on who to contact regarding contra-indications of drugs when treating breastfeeding mothers. ➢ Appropriate arrangements to be put in place outside of neonatal unit and paediatrics for mothers storing breast milk.	Elaine Newell	March 2018	Open
2)	Previous Patient Story: A review of using yellow paper for all patients correspondence	Elaine Newell/ Rachel Barlow	February 2018	Open
3)	MPA – 15th December. A verbal update require on TUPE transfer details of the Hard FM Contact		February 2018	
4)	Chief Executive's Report: ➢ A report to be presented to the MPA showing the journey of the IT infrastructure from beginning to end. ➢ Purple Point. An update to be provided to the next meting ➢ 52 week Breaches. A paper to be presented to the next Board meeting highlighting the issues ➢ EWTT – an update to be presented to the Quality and Safety Committee regarding wards D16 and Lyndon 5	Toby Lewis Kam Dhami Rachel Barlow Elaine Newell	February 2018 February 2018 February 2018 February 2018	Open Closed Closed
5)	Winter Plan: ➢ Level 4 criteria to be circulated to Board members ➢ Update paper on closing unfunded beds to be presented to the Board	Rachel Barlow Rachel Barlow	February 2018 March 2018	Open

	Action	Assigned to	Due Date	Status
6)	Mr. Waite agreed to review the specific proposals impacting on the current £1.4m agency spend.	Tony Waite	February 2018	Open
7)	Decreasing Sickness Absence and Improving Employee Mental Wellbeing: ➢ Authorisation given to mode the "time to be well" initiative ➢ The board to be informed of the percentage of sickness reduction would be achieved from the interventions contained in the report ➢ Have a clear strategy on pre-emptive actions for staff employed in high risk areas.	Raffaela Goodby	February 20918	Open
8)	Nursing Career Escalator: ➢ Update the Board on available loans on offer to nurses studying ➢ Present to the Board a financial impact assessment prior to the April launch	Elaine Newell	March 2018	Open
From Meeting held on 7th December 2017				
6)	Safety plan close out – monitoring to continue to be presented to the Quality and Safety Committee	Elaine Newell	May 2018	Open
From Meeting held on 2nd November 2017				
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				
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	Closed
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)	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

TRUST BOARD

DOCUMENT TITLE:	Complaints Report: Quarter 3
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Karen Wood, Head of PALS & Complaints
DATE OF MEETING:	1st February 2018

EXECUTIVE SUMMARY:

This report sets out details of Complaints and PALS enquiries received between October and December 2017 (Quarter 3).

The report provides high level data on Formal and Informal Complaints (previously referred to as PALS and Complaints), the reasons those complaints were made and work underway to improve complaints management.

Year to date, 95% of complaints received since April 2017 have been managed within their target date. In this quarter, it is reported that the complaints activity has stayed the same as the previous quarter, at 206 compared to 203, and also shows that 82% of complaints have been managed within their target (total case load).

Themes and outcomes remain consistent with previous quarters and shows a continued focus on lessons learned, and quality responses that are caring, transparent, timely and responsive to the needs of complainants. In response to a request at the last Board/ Quality and Safety Committee, an appendix has been added showing this data in comparison to previous months/ quarters.

REPORT RECOMMENDATION:

The Board is recommended to DISCUSS and NOTE the contents of the report.

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

Accept	Approve the recommendation	Discuss
✓		✓

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

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

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

Safe, high quality care
Improve and heighten awareness of the need to report and learn from complaints.

PREVIOUS CONSIDERATION:

Quality and Safety Committee 26 January 2018

SWBTB (02/18) 022

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Complaints Report

2017/18: Quarter 3

Where EVERYONE Matters

At a glance

206

Formal complaints dealt with in Q3 2017/18

528

Informal complaints dealt with in Q3 2017/18

38.41

The average number of days taken to complete a formal complaint

82% (525)

Complaints were responded to on or prior to their target date in Q3 2017/18.

95% (503)

Complaints received in Q3 2017/18 that were responded to on or prior to their target date to

1.9

Number of complaints received per 1000 bed days

4.2

Number of complaints received per 1000 finished consultant episodes (FCEs)

63% (128)

Of the complaints received were about the clinical care provided

63% (105)

Of resolved complaints were either partially or wholly upheld in favour of the complainant

30

Complaint was reopened in Q3 2017/18 because of dissatisfaction with the original response

1 new / 0 closed

PHSO investigations for Q3 2017/18

In detail

The total number of compliments for this quarter was not available as the collection of this data has not been recorded consistently. This is reflective of the fact that this data is not collected in systemic way. Details of plans around improving the collection method are detailed in 'Key Areas for Focus'.

A total of 218 complaints were presented to the Trust in Q3 2017/18 compared with 12 cases withdrawn leaving a total of 206 to manage.

A total of 528 informal complaints were registered in Q3 2017/18 (previously referred to as PALS enquiries) and whilst there are fluctuations between the numbers of these informal complaints, the topics complained about remain relatively constant.

The average number of days taken to resolved complaints that have been received since 1 April 2017 is 30.76 with 27 cases received since 1 April 2017 has breached their target date, against 530 sent (95%)

The average number of days taken to conclude the all cases closed in Q3 2017/18 was 38.41, exceeding the 30 day KPI.

The number of complaints per 1000 bed days has reduced again to 1.9 in Q3 2017/18. Surgery still has the highest complaints rate, but the differential is again less prevalent this quarter.

The number of complaints per 1000 FCEs has also reduced to 4.7 compared to 5.4 in Q1 2017/18, 6.0 in Q4 2016/17, and 5.3 in Q3 2016/17. Surgery still has the highest complaints rate for FCE also, and the differential is also less prevalent this quarter.

The most complained about theme, continues to be clinical care, at 63% (128). This quarter, the second most complained about issue was the attitude of staff at 11% of complaints (and was also the case for the last three quarters). The third most complained about issue is once again our management of outpatient appointments at 10%.

63% of complaints (105) closed in Q3 2017/18 were either partially or wholly upheld in favour of the complainant.

30 complaints were reopened as a result of the complainant's dissatisfaction with their original response, in Q3 2017/18. 1 of these cases was because we had not answered all issues in the complaint; the average number reopened for this reason over the last 2 years is 2 per quarter.

There was only 1 new PHSO case open in Q3 2017/18, which is unusually low, with 0 cases being closed in Q3 2017/18, again, unusually low.

Learning from patient feedback

Concerns and complaints raised by patients and visitors must be viewed positively as an unsolicited form of feedback. These are opportunities to improve our services and the care we provide based on user experience.

It is the Trust's responsibility to ensure that this feedback is used to improve patient safety, the delivery of service, and patient experience.

Below are some examples of improvements made as a direct result of complaints received

A complaint was received about the fact that one of the Trust Patient Transport drivers did not actively support a patient who became very unwell in the Trust car park. The driver had the word Ambulance written on the back of their jacket. It has since been recognised that this was a misleading indicator that driver may have been able to offer clinical support, like that of a paramedic and **the signs on the jackets will be changed** to avoid the distress this caused both the patient's family, and the driver themselves.

A patient with dementia was not treated with the appropriate sensitivity because to new staff on shift, they did appear to have capacity. Additional needs for this patient were sometimes missed. When meeting with the family during the complaint resolution process they suggested **altering the colour of the bed linen** to signify a dementia patient sensitively to avoid a repeat experience for patients where their behaviour is not typical of someone with dementia.

A complaint was raised where a maternity patient had a poor birthing experience as a result of the missed opportunity to provide specialised support based on the emotional wellbeing of the patient. This case was used in a Quality Half Day training session to **heighten awareness of the differing needs of women during birth** so that medical and nursing staff can learn how to manage a similar presentation better in the future.

Positive
Complainant feedback

The following is an extract from an email from the Deputy Head of Complaints, in her management of a complaint about a deceased patient.

I have had a regular discussion with the bereaved complainant and her advocate, to update them both on the complaint investigation progress, including the delays and difficulties encountered, being open and honest with her at all times. Because this complaint had breached its original target date, there was a danger that it would be responded to on or around the first anniversary of the death of the patient (and over the festive period which she found difficult), so I worked with her to ensure the timing was managed sensitively. She specifically contacted me to thank me for the way I updated her, and provided reassurance around the case, at this very difficult time for her. She said she felt that I understood her concerns and that her needs were a priority for me and that I had supported her. She could in turn could then seek her own support and be prepared to receive my investigation report, mindful of the impact the contents might have on her emotional wellbeing.

In summary

- 27 of the cases received since 1 April 2017 has exceeded their due date, resulting in a 95% compliance rate for these cases. Whilst this means that only 5% of cases have exceeded their target date, the number of responses breaching this target has increased despite the contingency measures that had been implemented and is reported as largely to do with staffing issues. Recruitment continues and training and support for all new staff is now underway. Cases outstanding from 2016/17 are still to be completed, although these numbers are small and are being actively managed.

- The declining trend in the number of informal and formal complaints has steadied with no particular stand out Clinical Group, compared to the previous quarter.

- The time taken to turn cases around has again averaged over the accepted 30 day quality standard, both in terms of the overall case load, and those that have been received since 1 April 2017. This is the first time that these cases have exceeded the 30 day target, and this is attributed to the increased number of breaches for this quarter.

- Whilst the main theme of complaints has not changed this quarter the number of complaints and concerns about appointments has again reduced. Whilst this has traditionally been the second most complained about theme, it has now been ranked in third place for 12 months.

- PHSO cases have dropped with only 1 new case being investigated in Q3 2017/18. 0 case were closed this quarter, (resulting in a total of 13 cases in the current PHSO case load). There are a number ready to conclude so Q4 2017/18 should see a number close before the end of the financial year.

Key areas for focus from the financial year 2017/18 and into Q4 2017/18

As previously reported, there are a number of quality improvement initiatives that are being undertaken by the Complaints Team, many of which are still ongoing.

1. To ensure that no complaint breaches its target date in 2017/18.
2. The need to engage
3. Better understand and implement a strategy to address the continued issue of disproportionality in the complaints rate of different ethnic groups The need to engage with complainants who have used the process, and better understand their experience.
4. To report and monitor complaints that arise as a result of the use of agency staff.

1.

In Q3 2017/18 the complaints team revisited what was needed to work better with Investigation and Governance Leads in Clinical Groups to ensure that no complaint logged since 1 April 2017 breaches its target date. This was done in November's Quality and Improvement Half Day. Escalation and planning were identified as key to the timely completion of investigations and responses.

Given the number of new staff joining, and yet to join the team, Standard Operating Procedures and training plans are also currently being redeveloped to ensure a more responsive result in 2018/19, but also to stem the trend of increased breached cases to ensure that the final year result be as close to the 97% as possible.

2.

It is recognised that the current survey method used for complaint service feedback is not effective, and does not provide data that identifies service improvement opportunities.

A meeting was held with Healthwatch in October 2017 in order to understand how the Trust can work with them to improve overall patient experience and also complaints management. Further work is planned with the Patient Experience Manager in Q4 2017/18.

3.

Over many reports, it has been recognised that there is a need to acknowledge and better understand why certain ethnic groups make disproportionate numbers of complaints, compared to their patient numbers.

In Q3 2017/18 it is noted that the complaints numbers by ethnicity are much more reflective of the patient population. There is still a plan in place to work in partnership with the Black and Minority Ethnic (BME) staff group. However the data fluctuation highlights that this work is important to ensure the importance of cultural sensitivity being considered in all aspects of the delivery of care, not necessarily to effect a change in complaints rates.

4.

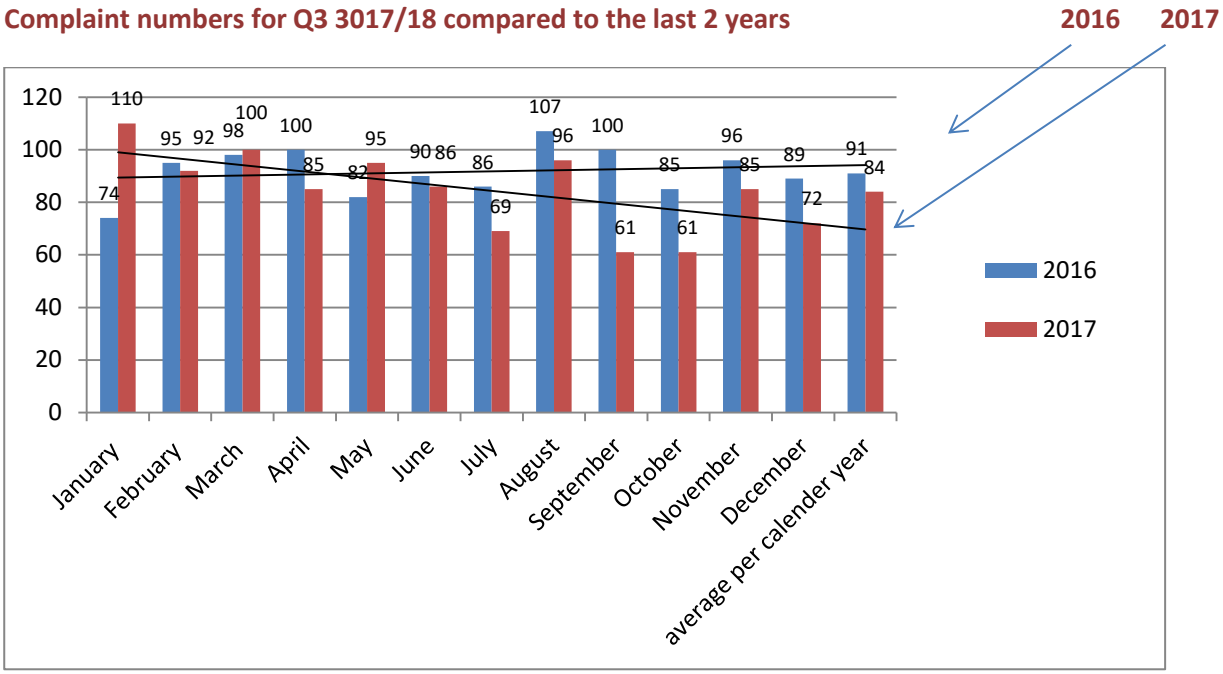
As previously reported, agency staff can be identified in the reporting of complaint details and this work has now been completed.

It would be worth noting that in Q3 there were no issues to report in terms of agency staff, and in future reports, will only feature in the report if agency staff have been complained about.

Appendix 1

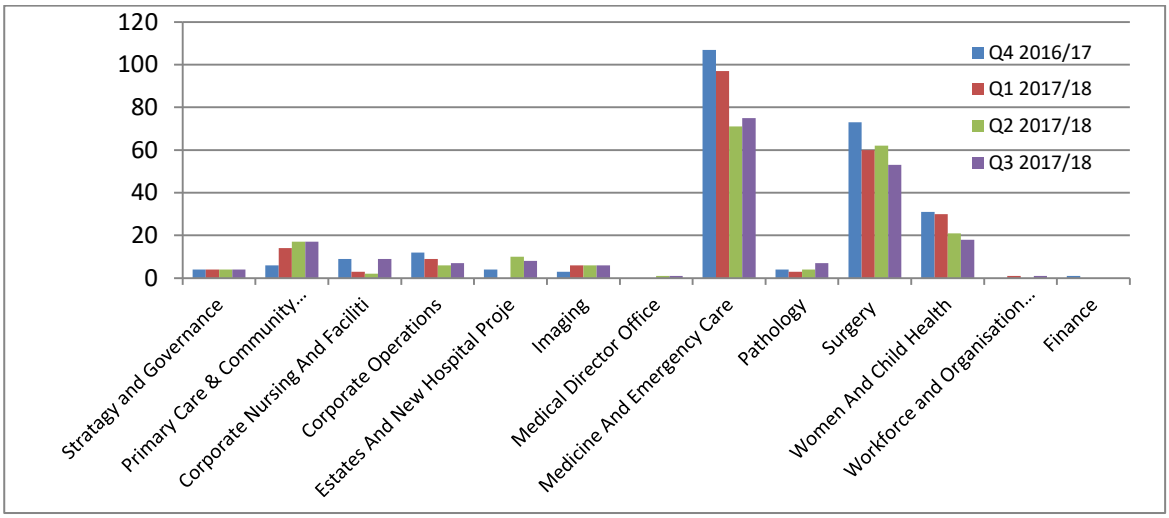
Table showing trends form the workbook across main themes

Complaint numbers for Q3 3017/18 compared to the last 2 years



Comparison numbers year on year show a decline in complaint numbers with the trend line for 2017 showing a decline toward the end of the year also.

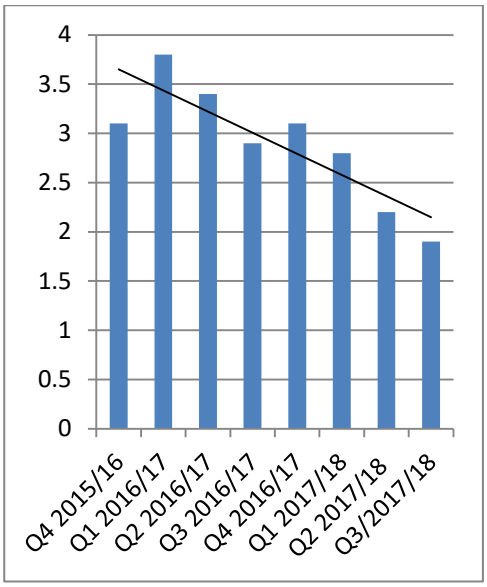
Complaints received by Clinical Group and Corporate Directorate for Q3 2017/18 compared to previous 3 quarters.



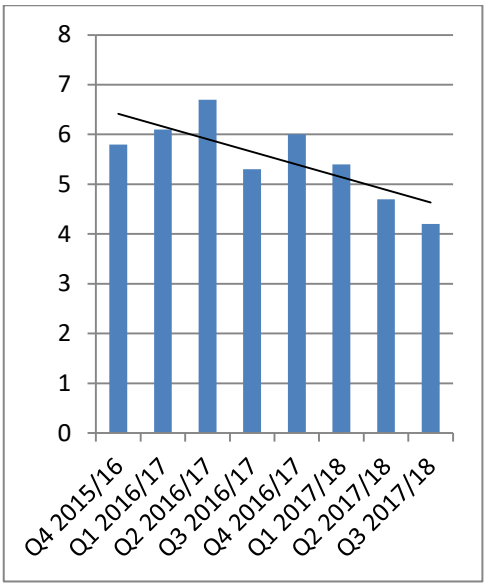
The decline in complaint numbers is evident in all clinical groups, but a small increase can be seen in Primary Care, Communities and Therapies (PCCT). This is largely due to a clinical restructure that sees complaints about scheduled care reported in PCCT

Complaints rates by FCE and bed days for Q3 2017/18 compared to the last 7 quarters

Bed days

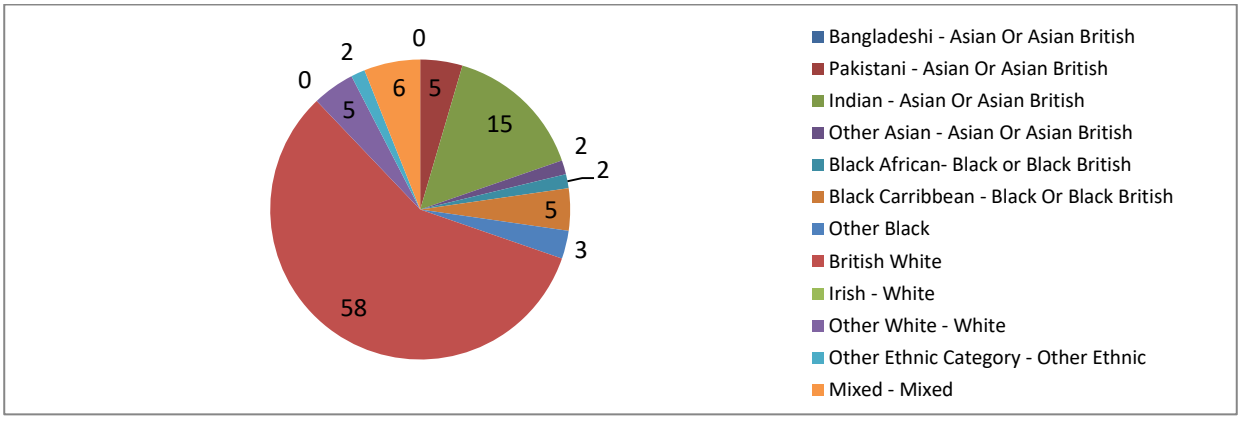


FCEs



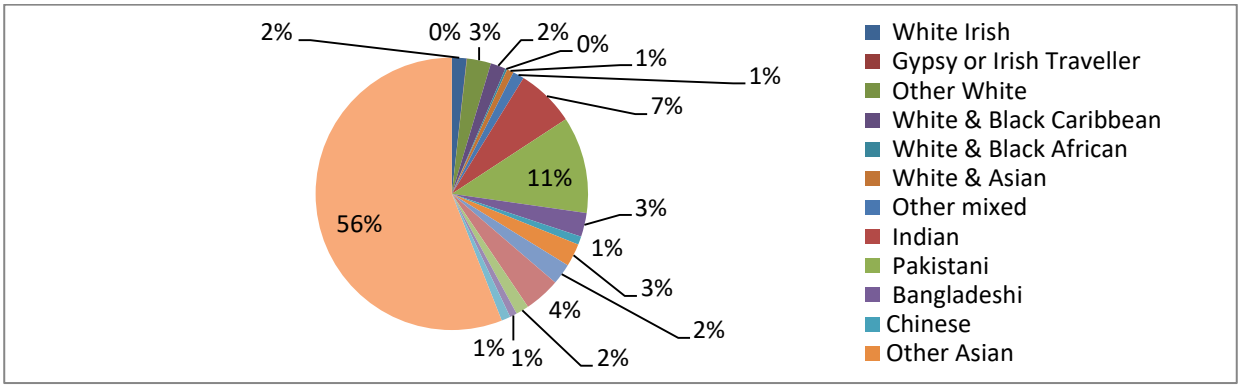
Whether the measure is by Bed days or FCE, there is a declining trend for both and this is notable in all Clinical Groups and Corporate directorates but more pronounced in Surgery.

A breakdown of all complainants by % of those where ethnicity was recorded for Q3 2017/18

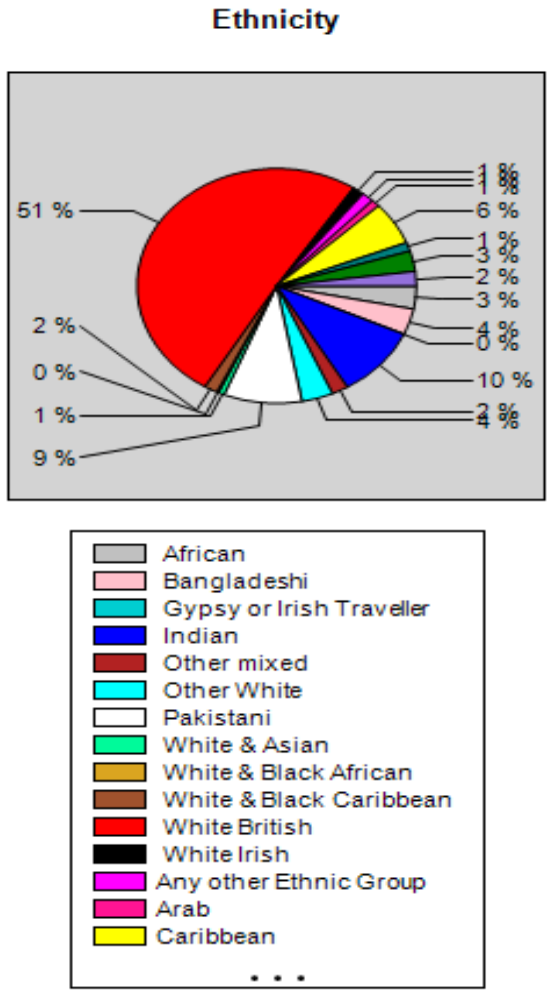


Shown here is a much more representative complaint split, than in previous quarters

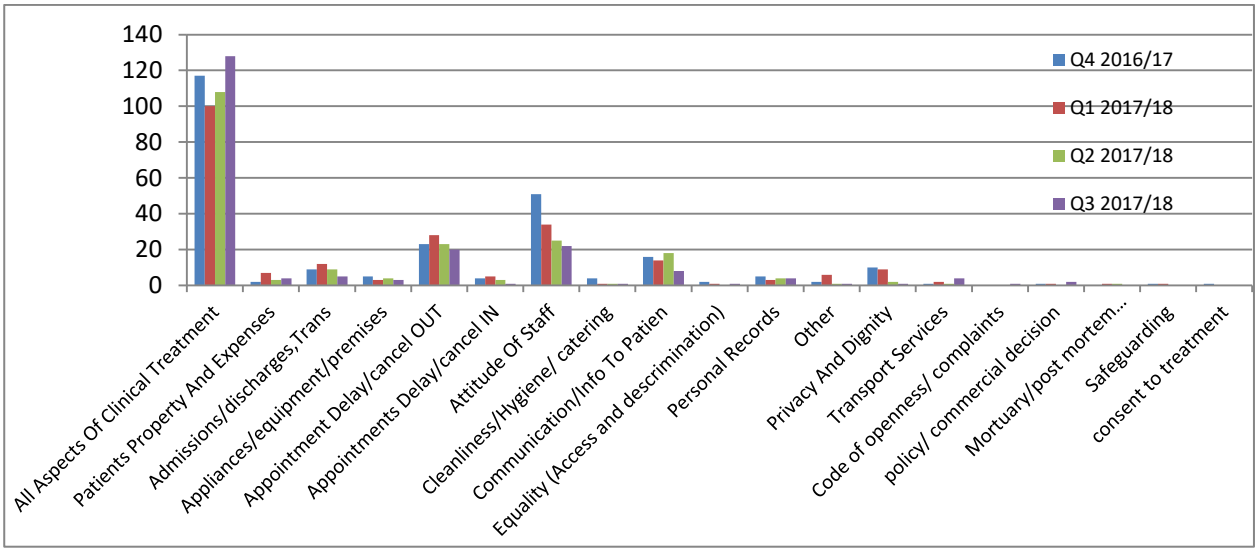
Ethnicity split by Sandwell and West Birmingham Population as taken from the 2011 census and quoted out to the Local Demography report prepared by the Trusts Equality and Diversity team in 2013.



Ethnicity split of patient population

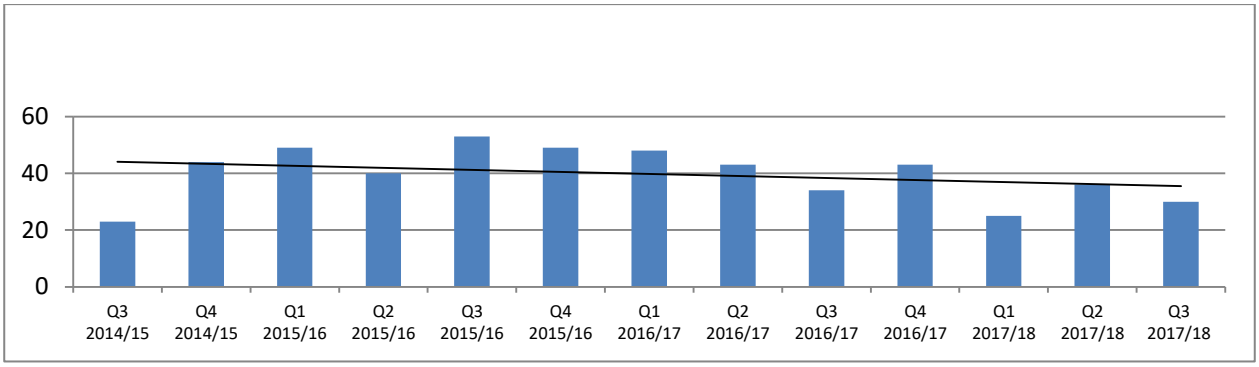


A breakdown of the top three complaint themes, for Q3 2017/18 compared to the last 3 quarters



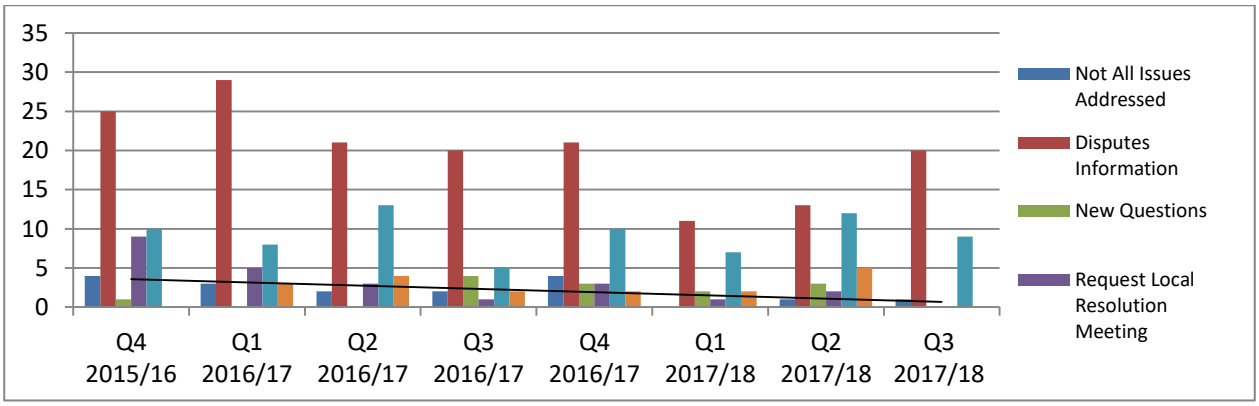
Clinical treatment remains the most complained about issue, with an increase noted over the last 12 months, with complaints about the management of appointments showing a steady decline, now ranking third, not second in the top three topics complained about.

Complaints that have been reopened in Q3 2017/18 compared to the last 7 quarters.



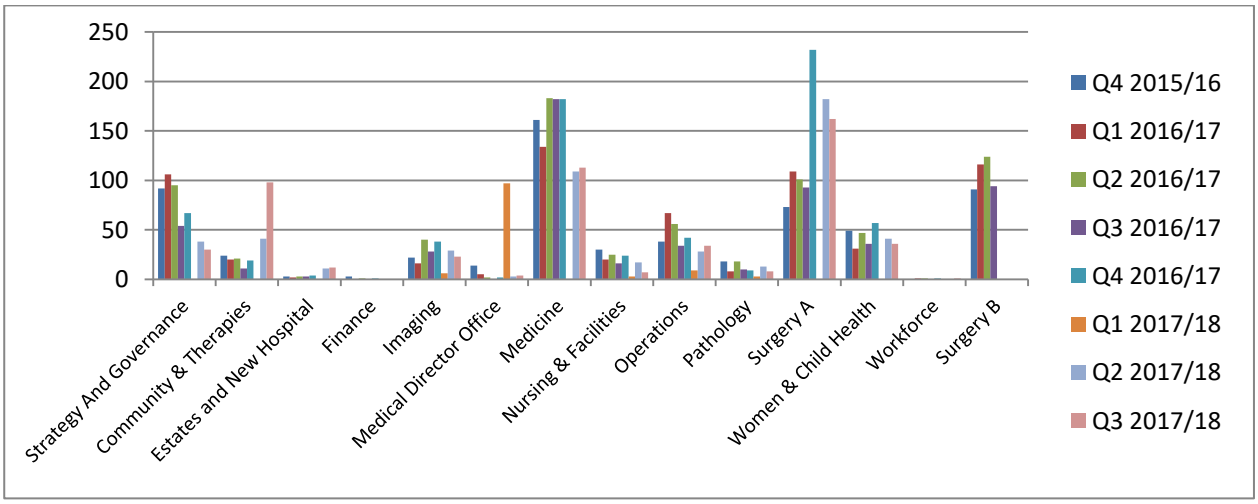
Showing an overall decline in the number of cases reopened due to the dissatisfaction of the original response

Complaints that have been reopened in Q3 2017/18 compared to the last 7 quarters.



Showing an overall decline in the number of cases reopened because not all issues were addressed in the original response

PALS enquiries broken down by group Q3 2015/16 compared to the last 7 quarters



Showing that by Clinical Group and Corporate Directorate the trend of declining enquiry numbers has steadied, an notably in medicine has declined more so than in ant other group, although those enquiries belonging to scheduled care (that used to report to Medicine and Emergency care) now belong to PCCT)