Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Anne Gibson Boardroom, City Hospital **Date** 26 March 2008 at 1430h

Members			**In Attendance**		
Mrs S Davis	(SD)	[Chair]	Mr G Seager	(GS)	
Mr R Trotman	(RT)		Miss K Dhami	(KD)	
Miss I Bartram	(IB)		Mr C Holden	(CH)	
Dr S Sahota	(SS)		Mrs J Kinghorn	(JK)	
Mrs G Hunjan	(GH)		Miss J Whalley	(JW)	
Prof D Alderson	(DA)		Mr S Grainger-Payne	(SGP)	[Secretariat]
Miss P Akhtar	(PA)				
Mr J Adler	(JA)				
Mr D O'Donoghue	(DO)				
Mr R Kirby	(RK)				
Mr R White	(RW)				
Miss R Overfield	(RO)				

Item	Title	Reference No.	Lead
1	**Apologies for absence**	**Verbal**	**SGP**
2	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting*	**Verbal**	**All**
3	**Chair's opening comments**	**Verbal**	**Chair**
4	**Minutes of the previous meeting** *To approve the minutes of the meeting held 26 February 2009 as true and accurate records of discussions*	**SWBTB (2/09) 049**	**Chair**
5	**Update on actions arising from previous meetings**	**SWBTB (2/09) 049 (a)**	**Chair**
6	**Questions from members of the public**	**Verbal**	**Public**
	MATTERS FOR DISCUSSION		
7	**Healthcare Commission Investigation into Mid-Staffordshire NHS Foundation Trust**	**SWBTB (3/09) 059** **SWBTB (3/09) 059 (a)** **SWBTB (3/09) 059 (b)**	**JA**
	MATTERS FOR APPROVAL		
8	**Single tender agreements**		
▶	Payment for echocardiography service sessions	SWBTB (3/09) 063	RK
▶	Carestream Health - maintenance contract (Imaging)	SWBTB (3/09) 062	RK
9	**Annual Plan 2009/10**	**SWBTB (3/09) 073** **SWBTB (3/09) 073 (a)**	**RK**

10	**2009/10 budget and medium term financial plan**	**SWBTB (3/09) 072** **SWBTB (3/09) 072 (a)** **SWBTB (3/09) 072 (b)**	**RW**
11	**Communications Strategy**	**SWBTB (3/09) 074** **SWBTB (3/09) 074 (a)**	**JK**
12	**Amendment to the Trust's Standing Orders/Standing Financial Instructions and Scheme of Delegation**	**SWBTB (3/09) 061** **SWBTB (3/09) 061 (a)**	**RW**
	MATTERS FOR INFORMATION/NOTING		
13	**Strategy and Development**		
13.1	'Towards 2010' programme: progress update	Verbal	RK
13.2	New acute hospital project: progress update	Verbal	GS
14	**Performance Management**		
14.1	Monthly performance monitoring report	SWBTB (3/09) 064 SWBTB (3/09) 064 (a)	RW
14.2	Monthly finance report	SWBTB (3/09) 051 SWBTB (3/09) 051 (a)	RW
14.3	Foundation Trust service performance report	SWBTB (3/09) 054 SWBTB (3/09) 054 (a)	RW
15	**Governance and Operational Management**		
15.1	Quarterly Integrated risk and complaints update	SWBTB (3/09) 066 SWBTB (3/09) 066 (a)	KD
15.2	Draft Healthcare Commission Core Standards declaration	SWBTB (3/09) 065 SWBTB (3/09) 065 (a) SWBTB (3/09) 065 (b) SWBTB (3/09) 065 (c) SWBTB (3/09) 065 (d)	KD
15.3	Quarterly Assurance Framework update	SWBTB (3/09) 056 SWBTB (3/09) 056 (a)	SGP
15.4	Infection control quarterly report	SWBTB (3/09) 057 SWBTB (3/09) 057 (a)	BAO
15.5	Infection control assurance framework	SWBTB (3/09) 052 SWBTB (3/09) 052 (a)	RO
15.6	Cleanliness report	SWBTB (3/09) 058 SWBTB (3/09) 058 (a)	RO
15.7	Single Equality Scheme update	SWBTB (3/09) 053 SWBTB (3/09) 053 (a)	RO
15.8	Mixed sex accommodation update	SWBTB (3/09) 060 SWBTB (3/09) 060 (a) SWBTB (3/09) 060 (b)	RO
15.9	Ward reviews update	SWBTB (3/09) 071 SWBTB (3/09) 071 (a) SWBTB (3/09) 071 (b) SWBTB (3/09) 071 (c)	RO
16	**Update from the Board Committees**		
16.1	Finance and Performance Management		
▶	Minutes from meeting held 19 February 2009	SWBFC (2/09) 020	RT

16.2	Audit Committee		
▶	Minutes from the meeting held 5 February 2009	SWBAC (2/09) 014	GH
17	**Any other business**	**Verbal**	**All**
18	**Details of next meeting** *The next public Trust Board will be held on 30 April 2009 at 1430h in the Churchvale/Hollyoak Rooms, Sandwell Hospital*	**Verbal**	**Chair**
19	**Exclusion of the press and public** *To resolve that representatives of the Press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).*	**Verbal**	**Chair**

MINUTES

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Trust Board (Public Session) – Version 0.2

Venue Churchvale/Hollyoak Rooms, Sandwell Hospital **Date** 26 February 2009 at 1430 hrs

Present:	Mrs Sue Davis	Professor Derek Alderson	Mr Richard Kirby
	Mr Roger Trotman	Miss Parveen Akhtar	Miss Rachel Overfield
	Miss Isobel Bartram	Mr John Adler	
	Mrs Gianjeet Hunjan	Mr Robert White	
	Dr Sarindar Sahota	Mr Donal O'Donoghue	
In Attendance:	Mr Graham Seager	Miss Kam Dhami	
	Mr Colin Holden	Mrs Jessamy Kinghorn	

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
There were no apologies for absence.	
2 Declaration of interests	**Verbal**
No interests were declared in connection with any agenda item.	
3 Chair's opening comments	**Verbal**
The Chair welcomed all to the meeting.	
4 Minutes of the previous meeting	**SWBTB (1/09) 033**
The minutes of the meeting held on 26 January 09 were approved.	
AGREEMENT: The minutes of the previous meeting on 26 January 09 were approved as a true and accurate reflection of discussions held	
5 Update on actions from previous meetings	**SWBTB (1/09) 033 (a)**
The updated action list was reviewed. There were no outstanding actions.	
6 Questions from members of the public	**Verbal**
There were no questions from members of the public. A representative from the Express and Star newspaper was present.	

7 Single tender agreements	
Sandwell MBC child development staff salaries	**SWBTB (2/09) 045**
Mr Kirby presented a single tender action for approval in respect of retrospective payment for salaries of a co-ordinator, administration support and a nominal amount for running costs associated with the provision of the child development services run by Sandwell MBC. The Trust has had an SLA in place with Sandwell MBC for the provision of this service for a number of years and is usually invoiced over several months of the year. In this instance, payment has been requested to cover the entire year, therefore raising the cost to a level requiring Trust Board approval. The payment to Sandwell MBC is £54,600. The Trust Board approved the single tender arrangement.	
AGREEMENT: The Trust Board approved the single action arrangement in respect of payment for child development staff salaries and running costs	
Payment of project management fees	**SWBTB (2/09) 044**
Mr Kirby presented a single tender action for approval in respect of project management fees to support the establishment of the South Birmingham ophthalmology contract. The value of the fees is £63,508. It was highlighted that this support is necessary given the tight timescales between award of the contract and making the service operational. Dr Sahota suggested that future requests for the payment of agency fees need to disclose the name of the agency to be engaged. Mr Trotman asked whether the project management fees were subject to VAT. He was advised that this is the case and the VAT is included in the cost requested for payment. The Trust Board approved the single tender arrangement.	
AGREEMENT: The Trust Board approved the single action arrangement in respect of payment for project management fees	
Purchase of Optical Coherence Tomography equipment	**SWBTB (2/09) 043**
Mr Kirby presented a single tender action for approval in respect of the purchase of Optical Coherence Tomography equipment. The value of the equipment is £58,000 plus VAT. The equipment was noted to be required to replace obsolete equipment. It was reported to be compatible with existing equipment in the department and had been trialled successfully with clinicians. The Trust Board approved the single tender arrangement.	
AGREEMENT: The Trust Board approved the single action arrangement in respect of the purchase of Optical Coherence Tomography equipment	

Purchase of Electro Diagnostic Testing equipment	**SWBTB (2/09) 042**
Mr Kirby presented a single tender action for approval in respect of the purchase of Electro Diagnostic Testing equipment. The value of the equipment is £86,071.50 plus VAT. The equipment was noted to be required to replace obsolete equipment. It was reported to be compatible with existing equipment in the department and had been trialled successfully with clinicians. The Trust Board approved the single tender arrangement.	
AGREEMENT: The Trust Board approved the single action arrangement in respect of the purchase of Electro Diagnostic Testing equipment	
Payment for general orthopaedic services	**SWBTB (2/09) 046**
Mr Kirby presented a single tender action for approval in respect of the payment for general orthopaedic services provided by local private hospitals. The value of the payment required is £65,000. Mr Kirby explained that the use of private sector facilities had been required for nine patients who needed to be treated within the 18-week waiting time target, yet due to operational pressures were not able to be seen by Trust's own consultants. Mr Kirby gave assurances that the additional costs incurred by using the private sector facilities would be managed within existing budgets. Mr O'Donoghue asked whether there were any further patients of which Mr Kirby was aware, who would need to be treated using private sector facilities. He was advised that although there was a possibility in the future, the amount of patients being treated in this way has declined steadily over recent years. It was suggested that Mr Kirby present an overview of patients treated using private sector facilities during the past three years, at a future meeting of the Finance and Performance Management Committee. The Trust Board approved the single tender arrangement.	
ACTION: Richard Kirby to present a three year view of any of the Trust's patients requiring to be treated in private sector facilities **AGREEMENT: The Trust Board approved the single action arrangement in respect of payment for general orthopaedic services**	
8 Amendment to the Trust's bank account signatory list	**SWBTB (2/09) 039**
Mr White reported that following a recent review of the Trust's bank account signatory list, it had been noted that it contained names of individuals who either no longer work for the Trust or whose roles are not conducive to them being a signatory. It was proposed that Mrs Pauline Werhun, Mr Paul Wilkinson and Dr Hugh Bradby be removed from the bank signatory list. It was suggested that the names of the current Chief Nurse and Medical Director be	

added to the list.	
ACTION: **Robert White to arrange for Rachel Overfield and Donal O'Donoghue to be added to the signatory list for the Trust's bank account** **AGREEMENT:** **It was agreed that Pauline Werhun, Paul Wilkinson and Hugh Bradby be removed from the signatory list for the Trust's bank account**	
9 Stage 2 of Department of Health Energy and Sustainability Fund	**SWBTB (2/09) 037**
Mr Seager presented a proposal to proceed with a bid for £429,500, from the Department of Health Energy and Sustainability Fund, via the issue of the new Public Dividend Capital. The plans support the proposed Cost Improvement Programme scheme around energy. Should the PDC not be made available, then the Trust may choose not to proceed with the implementation of the energy saving schemes and instead undertake what measures are possible, given the internal resources available.	
AGREEMENT: **The Trust Board agreed that the bid for funds from the Department of Health Energy and Sustainability Fund should be submitted**	
10 Strategy and Development	
10.1 'Towards 2010' programme: progress report	**SWBTB (2/09) 047** **SWBTB (2/09) 047 (a)** **SWBTB (2/09) 047 (b)**
Mr Kirby presented the standard monthly progress report on progress with the Towards 2010 programme. The 'traffic light' report was noted to show an improved position on delivery of the various 2010 projects, with only two projects now not expected to meet end of year targets. Most of the Strategic Model of Care Steering Groups (SMOCS) commenced work in February. They will concern themselves with issues such as service redesign. The Board noted the schedule for the completion of Primary Care developments and other capital schemes. Mr Trotman asked whether any of the planned treatment centres required refurbishment, changes to the land or acquisition by a Compulsory Purchase Order. He was advised that the need for a Compulsory Purchase Order is not envisaged, given that there are alternative potential sites and options available. Any refurbishment requirements should not present a problem.	
10.2 New acute hospital project: progress report	**Verbal**
Mr Seager reported that discussions were continuing with the Department of Health regarding the Outline Business Case for the new hospital. Part of the approvals process also involved a meeting with the Treasury in early February to discuss the OBC. Work has started to prepare for the procurement phase of the project.	

11 Performance Management	
11.1 Monthly performance monitoring report	**SWBTB (2/09) 048** **SWBTB (2/09) 048 (a)**
Mr White reported that there had been three breaches of the two-week cancer waiting times during December. The status against other cancer waiting time targets was reported to be green. Mr Kirby advised that the new cancer targets mean that appointments arranged more two weeks after referral, as a consequence of patients not being able to attend within the two week target, will now be counted as breaches. As such, it is expected that the Trust will report a higher level of breaches in future, although there is anticipation that the overall target threshold will be lowered to some degree to take into account this change. The number of delayed transfers of care were reported to have increased from previous months. Of the delays reported, two thirds were attributable to Sandwell Social Services. The Board was advised that a recent correction to the way in which performance against the stroke target is calculated has meant an improved proportion of stroke patients who spend the majority of their stay has been demonstrated. The figure is now 46.1%. The performance against the Accident and Emergency waiting target during January was reported as 98.4%, improving the year to date position to 97.75%. The number of *C difficile* cases was reported to have increased during January, with increases having been seen on both sites. MRSA bacteraemia cases remain within trajectory for the year. The Chair reported that Dr Oppenheim, the Trust Director of Infection Prevention and Control, and members of her team, had been invited to a ceremony where in recognition of the Trust's adoption and development of Infection Control technologies, the Trust was to be presented with an award and would receive funding to be spent on Infection Control technology. Performance against the contracted activity plan was in excess of the plan for the month, with the year to date position showing little change from the previous month. A number of indicators lifted from the Maternity Dashboard are now included within the performance report. It was noted in particular that the caesarean section rate appears to have fallen significantly, although a degree of caution was suggested on the basis that information arising from the new Evolution information management system needs to be fully verified. Mr O'Donoghue confirmed however that manual checking of the information has suggested that there is no reason to doubt the performance reported. The Chair suggested that the figures should be scrutinised in detail at the next meeting of the Maternity Taskforce. Improvements were noted in relation to performance against the ambulance turnaround targets and the proportion of bank shifts filled. Sickness has increased slightly to 4.89%. Mr Kirby reported that the performance against the Accident and Emergency target was steadily increasing, although the hospitals continue to remain under significant pressure.	

Professor Alderson enquired why phlebitis was reported within the set of infection control targets. Miss Overfield advised that this referred specifically to venous site infections (VAP) and as such, was correctly reported within this set of indicators. Professor Alderson remarked that the position regarding theatre utilisation did not seem to have changed significantly from previous months, in that there remains a high level of sessions starting late. Mr Kirby reported that in line with previous discussions, there is much thinking underway as to how performance may be improved. The action plan to address the situation would however, take a number of months before an improvement is seen. Mr O'Donoghue confirmed that the issue was complex and could not be fixed quickly. It was suggested that the issue be considered in two phases: the general approach to be adopted and the schedule of actions planned. It was agreed that the general approach be shared at the next meeting of Finance and Performance Management Committee.	
ACTION: **Richard Kirby to share the general approach for addressing theatre utilisation issues at the next meeting of the Finance and Performance Management Committee**	
11.2 Monthly finance report	**SWBTB (2/09) 035** **SWBTB (2/09) 035 (a)**
Mr White reported that the Trust was still on course to deliver the planned £2.5m surplus by the end of March 09. The current position was outlined to be slightly above the plan, with a year to date surplus reported to be £2,531k. A number of technical budget adjustments have been made, which have improved the position of Medicines A & B and Surgery A divisions. Capital spend has increased in month, although the Capital Resource Limit is still expected to be underachieved. Stable cash balances are expected throughout the next twelve months. The current cash position was reported to be £0.2m above the revised plan as at 31 January 2009.	
11.3 Foundation Trust service performance report	**SWBTB (2/09) 038** **SWBTB (2/09) 038 (a)**
Mr White presented the Foundation Trust service performance report. The report presented the Trust's governance risk rating as green. It was agreed that the report should be harmonised with the usual monthly performance report, where possible.	
12 Governance and Operational Management	**SWBTB (2/09) 036** **SWBTB (2/09) 036 (a)**
Mr Adler reported that the Healthcare Commission had issued a report, 'State of Healthcare in 2008'. The key themes of the report had been distilled and mapped to existing Trust workstreams. This mapping suggested that the Trust was active in all the areas identified by the Commission.	

13 Update from the Committees	
13.1 Finance and Performance Management	**SWBFC (1/09) 010**
The Board noted the minutes of the Finance and Performance Management Committee meeting held on 22 January 2009.	
13.2 Governance and Risk Management Committee	**SWBGR (1/09) 009**
The Board noted the minutes of the Governance and Risk Management Committee meeting held on 22 January 2009. It was agreed that Dr Sahota would attend the meeting, should an update on Patient Safety be included on the agenda.	
14 Any other business	**Verbal**
There was none.	
15 Details of the next meeting	**Verbal**
The next meeting is scheduled for Thursday 26 March 2009 at 14.30pm in the Anne Gibson Boardroom, City Hospital.	
15 Exclusion of the press and public	**Verbal**
The Board resolved that representatives of the Press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1 (2) Public Bodies (Admission to Meeting Act 1960).	

Signed ……

Print……

Date ……

Next Meeting: 26 March 2009, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

26 February 2009 - Sandwell Hospital

Members: Mrs S Davis (SD), Mr R Trotman (RT), Ms I Bartram (IB), Mrs G Hunjan (GH), Prof D Alderson (DA), Ms P Akhtar (PA), Dr S Sahota (SS), Mr J Adler (JA), Mr D O'Donoghue (DO), Mr R White (RW), Miss R Overfield (RO), Mr R Kirby (RK)

In Attendance: Miss K Dhami (KD), Mr G Seager (GS), Mr C Holden (CH), Mrs J Kinghorn (JK), Ms J Whalley (JW)

Apologies: None

Secretariat: Mr S Grainger-Payne (SPGP)

Last Updated: 20 March 2009

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status	Review Date
SWBTBACT. 048	Annual complaints report	SWBTB (7/08) 055 SWBTB (7/08) 055 (a)	03-Jul-08	Consider a more appropriate way of providing a comparison of the Trust's performance regarding the number of complaints received with other organisations	KD	04-Sep-08	Currently the only comparative date in this areas is published by the Information Centre for Health and Social Care and is reported in the Trust's annual report on complaints handling. Options will continue to be explored to identify alternative ways of accessing this information and will be reported back to the Board should the information become available	Completed Since Last Meeting	
SWBTBACT. 074	Amendment to the Trust's bank account signatory list	SWBTB (2/09) 039	26-Feb-09	Arrange for Rachel Overfield and Donal O'Donoghue to be added to the signatory list for the Trust's bank account	RW	26-Mar-09	Added as requested	Completed Since Last Meeting	
SWBTBACT. 073	Payment for general orthopaedic services	SWBTB (3/09) 046	26-Feb-09	Present a three year view of any of the Trust's patients requiring to be treated in private sector facilities at a future meeting of the Finance and Performance Management Committee	RK	23-Apr-09	Scheduled for the April meeting of the Finance and Performance Mgt Committee	Review next meeting	
SWBTBACT. 075	Monthly Performance Monitoring Report	SWBTB (2/09) 048 SWBTB (2/09) 048 (a)	26-Feb-09	Share the general approach for addressing theatre utilisation issues at the next meeting of the Finance and Performance Management Committee	RK	23-Apr-09	As March meeting concerned review of financial plan, this item has been scheduled for the April meeting of the Finance and Performance Mgt Committee	Review next meeting	

Next Meeting: 26 March 2009, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham NHS Trust - Trust Board

26 February 2009 - Sandwell Hospital

Members: Mrs S Davis (SD), Mr R Trotman (RT), Ms I Bartram (IB), Mrs G Hunjan (GH), Prof D Alderson (DA), Ms P Akhtar (PA), Dr S Sahota (SS), Mr J Adler (JA), Mr D O'Donoghue (DO), Mr R White (RW), Miss R Overfield (RO), Mr R Kirby (RK)

In attendance: Miss K Dhami (KD), Mr G Seager (GS), Mr C Holden (CH), Mrs J Kinghorn (JK), Ms J Whalley (JW)

Apologies: None

Minutes: Mr S Grainger-Payne (SPGP)

Last Updated: 20 March 2009

Reference No	Item	Paper Ref	Date	Agreement
SWBTBAG.074	Minutes of the previous meeting	SWBTB (1/09) 033	26-Feb-09	The minutes of the previous meeting were approved as a true and accurate record of discussions held
SWBTBAG.075	Sandwell MBC child development staff salaries	SWBTB (2/09) 045	26-Feb-09	The Trust Board approved the single action agreement in respect of payment for Child development staff salaries and running costs
SWBTBAG.076	Payment of project management fees	SWBTB (2/09) 044	26-Feb-09	The Trust Board approved the single action agreement in respect of payment for project management fees
SWBTBAG.077	Purchase of Optical Coherence Tomography equipment	SWBTB (2/09) 043	26-Feb-09	The Trust Board approved the single action agreement in respect of the purchase of Optical Coherence Tomography equipment
SWBTBAG.078	Purchase of Electro Diagnostic Testing equipment	SWBTB (2/09) 042	26-Feb-09	The Trust Board approved the single action agreement in respect of the purchase of Electro Diagnostic Testing equipment
SWBTBAG.079	Payment for general orthopaedic services	SWBTB (2/09) 046	26-Feb-09	The Trust Board approved the single action agreement in respect of the payment for general orthopaedic services
SWBTBAG.080	Amendment to the Trust's bank account signatory list	SWBTB (2/09) 039	26-Feb-09	It was agreed that Pauline Werhun, Paul Wilkinson and Hugh Bradby be removed from the signatory list for the Trust's bank account
SWBTBAG.081	Department of Health Energy and Sustainability Fund	SWBTB (2/09) 037	26-Feb-09	The Trust Board agreed that the bid for funds from the Department of Health energy and sustainability fund should be submitted

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Healthcare Commission Investigation into Mid-Staffordshire NHS Foundation Trust
SPONSORING DIRECTOR:	John Adler, Chief Executive
AUTHOR:	John Adler, Chief Executive
DATE OF MEETING:	26 March 2009

KEY POINTS:

The Healthcare Commission published the findings of its investigation into Mid-Staffordshire NHS Foundation Trust on Wednesday 18 March.

The summary of the report is attached, together with a follow-up letter from the NHS Chief Executive. The full report is available at www.healthcarecommission.org.uk.

There are 3 key areas which will require further follow-up work by the Trust in the light of the report. These are:

Mortality rates – This will be the subject of a detailed report to the April Board which will set out the Trust's current position and recommendations for improving the Trust's oversight of mortality and morbidity, both in the light of existing initiatives and in response to the reports recommendations. In the meantime, Board members will wish to note that the Trust's overall standardised mortality rate for the period April 2008 – January 2009 (as reported by Dr Foster) was 99.2. This comparatively low overall figure does mask site and specialty variations and these will be analysed in more detail in the April report.

Standards of nursing care at ward level – The Trust now has in place a systematic approach to assessing standards of care through the Ward Review process led by the Chief Nurse. This is the subject of a separate report on this agenda.

Accident and Emergency and Emergency Assessment services – The Board will note that PCTs have been instructed to review their providers' services. We will obviously wish to co-operate with this review and to assure ourselves that the systemic failures identified in the report are not present in local services. An initial stocktake will be undertaken as quickly as possible.

PURPOSE OF THE REPORT:

○ **Approval** ○ **Noting** ◉ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is recommended to:

- Note the contents of the HCC report
- Agree to receive a more detailed report on the Trust's response at its April meeting
- Agree to receive a specific report on mortality at its April meeting

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

Improvement in quality of nursing care Patient safety action plan

IMPACT ASSESSMENT:

FINANCIAL	☐	
ALE	☐	
CLINICAL	☑	
WORKFORCE	☑	
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

From the Office of David Nicholson CBE
Chief Executive of the NHS in England

Richmond House
79 Whitehall
London
SW1A 2NS
Tel: 020 7210 5142
Fax: 020 7210 5409
david.nicholson@dh.gsi.gov.uk

To: All NHS Chairs
All NHS Chief Executives
All Medical Directors
All Nurse Directors

CC: All NHS Foundation Trusts
Monitor

Gateway ref: 11543

18 March 2009

Dear Colleague,

I am writing to bring your attention to a report published yesterday by the Healthcare Commission, detailing the findings of their investigation into Mid-Staffordshire NHS Foundation Trust. The report is a damning account of the services provided to patients in receipt of emergency care, underpinned by a systematic failing of processes and governance at every level.

For all staff in the NHS, it is a sobering reminder of the consequences for our patients if we fall short of meeting their right to a basic standard of care. As leaders it is incumbent on each of us to reflect on this report and the lessons within it to ensure these failures cannot be repeated by any organisation providing NHS care. A copy of the report is appended to this letter.

Where senior management and boards fail to act to assure the ongoing quality and safety of the care they provide, they must and will be held accountable. I urge each of you to ensure that the recommendations laid out in this report are fully understood by your boards and that any local actions necessary are implemented with immediate effect. I know the Chairman of Monitor, Bill Moyes, is also writing in similar terms to NHS Foundation Trusts.

For PCT Boards in particular, I expect, in addition, that you look very closely – in the light of the specific shortcomings identified – at the Accident and Emergency services you commission for your patients, to assure yourselves that day in, day out, they meet the standards that patients and the public rightly expect from the NHS.

We know that the vast majority of patients receive a high standard of care from dedicated and professional NHS staff. However, events like this are a slight on all of us and we must together act quickly and decisively in response.

Yours sincerely

David Nicholson CBE
NHS Chief Executive

Investigation

Investigation into Mid Staffordshire NHS Foundation Trust

March 2009

Healthcare Commission

Inspecting Informing Improving

Summary

The Healthcare Commission carried out this investigation into apparently high mortality rates in patients admitted as emergencies to Mid Staffordshire NHS Foundation Trust since April 2005, and the care provided to these patients. It also considered the trust's arrangements for monitoring mortality rates and its systems for ensuring that patients were cared for safely.

Our particular focus was on emergency admissions. We looked at the pathway of care for patients admitted as emergencies: the accident and emergency (A&E) department, the emergency assessment unit, and the surgical and medical elements of emergency admissions.

The investigation was carried out between March 2008 and October 2008. Staff from the Healthcare Commission worked with a team of external expert advisers. The membership is listed in appendix B. We interviewed over 300 people, including almost 100 patients admitted as emergencies or their relatives, past and present staff at the trust, and staff at other organisations. We reviewed the case notes of more than 30 patients who were admitted as emergencies and subsequently died. We examined over 1,000 documents including policies, reports, audits and records of meetings.

Synopsis of events leading to our decision to investigate

During the summer and autumn of 2007, the Healthcare Commission became aware, through its programme of analysis of mortality in England, of a number of apparently high mortality rates for specific conditions or operations at the trust.

In our work on mortality, we recognise that some 'alerts' (that is, indications that patients may be exposed to greater than expected risk) can be due to errors in the data or to insufficient adjustment for other factors, so a team of analysts assesses each case to establish whether there are sufficient concerns to follow up with a trust. If we do follow up an alert, we will initially ask a trust to provide further information. In many cases, this is enough to satisfy us that no further action is needed. We can escalate a case if concerns about the safety of patients have not been adequately addressed, or we think these have not been properly recognised by the trust.

In this investigation, further analysis showed that the trust consistently had a high mortality rate for patients admitted as emergencies, which it could not explain.

The rate had been comparatively high for several years, but the trust had not investigated this. In April 2007, Dr Foster's Hospital Guide showed that the trust had a hospital standardised mortality ratio (HSMR) of 127 for 2005/06, in other words more deaths than expected. The trust established a group to look into mortality, but put much of its effort into attempting to establish whether the high rate was a consequence of poor recording of clinical information.

The response of the trust to our requests for information contained insufficient detail to support its claim that the alerts were due to problems with its recording of data, and not problems with the quality of care for patients. This response, and the concerns from local people about the quality of care, led the Commission to decide that a full investigation was required.

Our key findings are summarised below and set out in full in the body of the report.

The views of patients and relatives at the trust

When we announced the investigation, we had an unprecedented response. In all, 103 patients and relatives contacted us. Of these, 99 were critical of, or had had a poor experience at, the trust. The main areas of concern they raised were A&E, the emergency assessment unit and medical wards 10, 11 and 12. Concerns were also expressed about some surgical wards. A major concern expressed by patients and relatives related to poor standards of nursing care.

Although we recognise that this was not a statistically representative sample of patients and relatives, their concerns reinforced what we found through observations, reviews of case notes, complaints and interviews – disorganisation, delays in assessment and pain relief, poor recording of important bodily functions, symptoms and requests for help ignored, and poor communication with patients and families.

In the Healthcare Commission's 2007 survey of inpatients (the latest national survey available), the trust was in the worst 20% for 39 out of 62 questions. This was a poor result. The trust was in the worst 20% for overall standards of care and whether patients felt that they were treated with respect and dignity in the hospital.

Mortality rates at the trust

Through our programme to analyse mortality rates in England, we received an unprecedented 11 alerts about high mortality at the trust, four of these after the investigation was launched. Six came from the Dr Foster Research Unit at Imperial College, London, as part of its analysis of data, and five from the Commission's own internal surveillance of data from all trusts. Details of the alerts are set out in appendix E.

The alerts at the trust were wide-ranging and suggested a general problem with regard to mortality. We considered data across the trust, which showed that mortality was high as regards emergency admissions, but not for elective admissions.

Our analysis focused on patients aged 18 and over who were admitted as emergencies. The results were 'standardised' (that is, made comparable with each other by taking account of various factors) for a number of factors, including age, sex and the type of condition that they had when admitted to the hospital. Since April 2003, the trust's standardised mortality ratio (SMR) had been consistently higher than expected. If outcomes were the same as would be expected when compared with similar trusts, the SMR would be 100. For the three years from 2005/06 to 2007/08, the trust's SMR for patients admitted as emergencies aged 18 and over varied between 127 and 145.

Looking at the three financial years covered by the investigation, we conducted a statistical analysis of the SMRs to examine to what extent they could have been due to random variation. We concluded that, for the three years we examined, there was a less that 5% probability that the high mortality rates at the trust for patients admitted as emergencies aged 18 or over were due to chance.

Standardised mortality was found to be high across a range of conditions including those involving the heart, blood vessels, nervous system, lungs, blood and infectious diseases. Our full investigation, including visits to the trust, examination of documents and wide-ranging interviews, has led us to conclude that there were systemic problems across the trust's system of emergency care.

The trust's arrangements for the collection, reporting and use of clinical information

The trust had a long history of poor information about its services. The accuracy of coding of information (that is, the system for cataloguing types of surgical and other interventions) had been poor, but had improved since 2007. The log of activity in theatres had been badly maintained and it was not possible to match information between systems, such as the theatre log and the national Hospital Episode Statistics data. Individual patients' data could not be tracked or linked in these different systems.

Although Dr Foster's analysis showed that the trust had the fourth highest hospital standardised mortality ratio (HSMR) in England for the three-year period 2003-2006, the trust only began to monitor clinical outcomes after the publication of the high rate by Dr Foster in 2007. The trust established a group to consider mortality, but considered that poor coding was the likely explanation for the high rate.

We found that, when challenged, neither the trust nor individual consultants could produce an accurate record of their clinical activity or outcomes for patients. This meant that we could not analyse the volume of surgical work and its outcomes.

Management of patients requiring emergency care

A&E and the emergency assessment unit

The detailed evidence for these findings is outlined in the section in this report on the A&E department and the emergency assessment unit (EAU). It came from a wide range of sources including interviews with staff, relatives and patients, observations, reviews of case notes, complaints, trust documents and external reports.

When we visited the A&E department in May 2008, the initial evidence raised serious concerns. We held an urgent meeting with the chief executive and followed this immediately with a formal letter requiring urgent action.

The trust did not have clear protocols and pathways for the management of patients admitted as emergencies. The A&E department was understaffed and poorly equipped. There were too few nurses to carry out an immediate assessment of patients. This was left to the receptionists, who had no clinical training. The patients in the waiting room could not be seen from the reception area. The department lacked essential equipment, such as sufficient defibrillators for every resuscitation trolley.

The nurses in A&E had not had enough training and development, and leadership had been weak. Patients often waited for medication, pain relief and wound dressings. There were delays in scanning patients out of normal hours. The most senior surgical doctor in the hospital after 9pm was often junior and inexperienced.

There were too few consultants to provide on-call cover all day, every day. There were too few middle grade doctors. The junior doctors were not adequately supervised, and were often put under pressure to make decisions quickly in order to avoid breaches of the target for all patients to be seen and moved from A&E in four hours. For the same reason, patients were sometimes rushed from A&E to the EAU without proper assessment and diagnosis, or they were moved to the 'assess and treat' area, even though staff were not formally allocated to the area and patients were not properly monitored there.

The EAU was large, with a poor layout, making it difficult for nurses to see patients. It was busy and frequently chaotic. It was understaffed, and communication was often poor between nurses and patients, and nurses and doctors.

During 2007/08, the nurses had little in-service training. Not all the nursing staff had the correct skills to observe and care for the variety of patients admitted as surgical and medical emergencies. On the bays with cardiac monitors, the nurses had not been trained to read the monitors. On occasions, the equipment was turned off.

Observations of patients were not carried out as they should have been and poor records were kept of patients' intake and output of fluids and food. Patients sometimes received incorrect medication or did not get their correct medication in a timely manner, if at all. There was poor compliance with generally accepted standards of practice in the control of infection.

Patients admitted as medical emergencies

The detailed evidence for these findings is outlined in the section on medical admissions. It included interviews with staff, relatives and patients, observations, complaints, trust documents, national surveys and external reports.

For patients admitted to the medical wards, there was sometimes poor communication with, and handover from, the EAU. Care was reported to be good for patients with heart attacks on the acute coronary unit, although there were problems with the cardiac monitors. However, because of lack of beds on the coronary unit, some patients with heart attacks remained in the EAU and were nursed in a non-specialist area.

The reconfiguration of the medical beds on floor two and associated changes in nursing staff had led to the creation of clinical areas that were poorly managed and understaffed.

The care of patients was unacceptable. For example, patients and relatives told us that when patients rang the call bell because they were in pain or needed to go to the toilet, it was often not answered, or not answered in time. Families claimed that tablets or nutritional supplements were not given on time, if at all, and doses of medication were missed. Some relatives claimed that patients were left, sometimes for hours, in wet or soiled sheets, putting them at increased risk of infection and pressure sores. Wards, bathrooms and commodes were not always clean.

Nurses often failed to conduct observations and identify that the condition of a patient was deteriorating, or they did not do anything about the results.

There was only one bay, with four beds, for patients with acute stroke. This was insufficient for the number of patients. There was no facility on the respiratory ward for non-invasive ventilation. There had been a number of problems with arrangements for resuscitation, including some serious incidents involving the contents of resuscitation trolleys. The bleep system for the management of cardiac arrests did not work effectively on several occasions. Mobile phones had to be used as a contingency.

Patients admitted as surgical emergencies

The detailed evidence for these findings is outlined in the section on patients admitted in an emergency with surgical problems or traumatic injuries. It included interviews with staff, relatives and patients, observations, reviews of case notes and inquest summaries, trust documents and external reports.

Many doctors and nurses working in surgery considered that staff on the EAU and on medical wards did not have the right training and skills to look after surgical patients.

The general surgeons did not work well together and there were few agreed protocols in surgery. This meant that patients needing emergency operations out of normal hours might receive different care and a different operation to that received from 9am to 5pm, Monday to Friday.

There were not enough doctors on duty out of hours, and the most senior surgical doctor after 9pm at night could be quite inexperienced.

In line with local understanding, the ambulance service took most, but not all, patients with severe or multiple trauma to other hospitals with specialised trauma services. For this reason, there was no trauma team at the trust. However, some staff were concerned that nurses on the EAU did not have the right training to look after those patients with traumatic injuries (such as broken limbs) who were admitted to the trust. In addition, the unit did not have equipment for traction or specialist hoists. We noted that, at times, there were too few staff to open a sufficient number of critical care beds.

For patients requiring emergency surgery, there was only one list for theatre at weekends. There was no system to assign priority to cases. Often emergency caesarean sections or surgical operations (such as removing an appendix) would take priority. This meant that patients with a broken hip might have to wait from Friday to Monday or Tuesday to have their operation. This inappropriate management meant that, for several days, these patients would not be allowed to eat or drink for many hours. On some occasions, patients who were designated as 'nil by mouth' were also inadvertently not given their essential medication.

From our review of case notes, from inquests and from findings from the alerts that the Healthcare Commission received on mortality, we noted a number of cases where patients had developed clots in the deep veins of their legs or pelvis and died from these clots breaking off and blocking the blood flow to their lungs. The trust did not have effective arrangements to prevent this or comply with accepted national guidance.

The care of post-operative patients was poor, such that signs of deterioration were missed or ignored until a late stage. When things went wrong, the trust was poor at recognising errors, reporting serious incidents and learning lessons.

Review of case notes

The Healthcare Commission reviewed the case notes of 30 patients who had died. Our case reviews were undertaken on a small scale, but nevertheless threw significant light on the arrangements for clinical quality and governance prevailing in the trust. We found that, in many of the cases, at least one element of the clinical management or monitoring of their condition was unsatisfactory. Areas of concern included infrequent reviews of patients by doctors, the lack of systematic monitoring of whether the patients were recovering or deteriorating, and the failure to respond adequately to signs of deterioration. There was inadequate monitoring to identify common complications of surgery.

What were the reasons for the failings at the trust?

It is the view of the Healthcare Commission that there were deficiencies at virtually every stage of the pathway of emergency care. This can be illustrated by following the patient's pathway.

When patients arrived in A&E, they were usually assessed by reception staff with no clinical training, before waiting in an area out of sight of the staff in reception. There was no regular check by nursing staff of the patients in the waiting room. Some essential equipment, such as cardiac monitors, was missing or not working. Assessment and treatment were often delayed.

There were too few doctors and nurses, alongside poor training and supervision, and junior doctors were put under pressure to make decisions quickly without advice and support from more senior doctors. Doctors were moved from treating seriously ill patients to deal with those with more minor ailments, in order to avoid breaching the four-hour waiting time target. Patients were moved to the clinical decision unit to 'stop the clock' but were then not properly monitored, since this area was not staffed. Patients had to wait for medication, pain relief, wound dressings and antibiotics. There was only a relatively junior doctor available after 9pm to give advice on surgical patients. There was no specialist trauma team. In summary, the care and assessment of patients fell well below acceptable standards.

Sometimes patients were rushed to the emergency assessment unit (EAU) without proper assessment or discussion, and without appropriate specialist care. The EAU was a large ward with a poor layout. It was busy, noisy and sometimes chaotic with too few nurses. Many of the nurses did not understand the cardiac monitors and did not always carry out observations adequately to identify whether a patient's condition was deteriorating. There were many instances of patients not receiving the medication they needed.

There were too few beds for patients who had had a stroke, not all patients with heart attacks went to the acute coronary unit, there was no non-invasive ventilation on the respiratory ward, and critical care beds were not always available. The medical wards on floor two were seriously understaffed and there were grave concerns about the standards of nursing care.

There were too few theatre sessions at weekends and consequent delay in getting to theatre, especially for trauma patients, and some patients did not get essential

medication. Post-operative complications were not always recognised.

Surgical practice was idiosyncratic, relationships were poor and there was little multidisciplinary team work. There were concerns about the level of cover by medical staff at night and at weekends.

Across the trust, there were shortcomings in resuscitation and arrangements to avoid potentially fatal blood clots were inconsistent. There was a shortage of critical care beds and concern about access to medical advice from critical care specialists.

It is our view that all these factors would have contributed to a poor outcome for patients.

The trust's approach to its mortality rate

One of the aims of the investigation was to clarify how the trust investigated its apparently high mortality rates.

The trust assured us that its mortality outcomes group undertook reviews of samples of case notes of patients who had died in hospital during particular periods. This was to ascertain whether the deaths were expected (unavoidable) and whether there were any questions arising about the quality of care provided to the patients.

Our scrutiny of their information, however, found that the reviews had not been sufficiently objective or robust. Moreover, the case notes revealed some sub-standard practice, which should have been identified and learned from.

Arrangements for governance and risk

The chief executive inherited a structure of governance that did not function effectively. Since 2005, there had been considerable change in the structure and responsibilities relating to governance and the management of risk.

The trust's system for identifying serious untoward incidents was poor, with failures to report some incidents and opportunities to learn lessons missed. Other incidents that were reported by staff consistently highlighted problems relating to the levels of staff, poor care for patients, and poor handovers when patients were moved from one ward to another. Many of these issues required consideration and resolution at a strategic level, but were rarely considered by the board or by its governance and risk sub-committees. There was no systematic mechanism to follow up any actions required or to share lessons.

The medical and surgical divisions failed to resolve problems such as 'nil by mouth', cardiac monitors, the cardiac bleep system, portable suction, and preventing blood clots and pulmonary embolism. Often these problems were listed on the corresponding risk register, but little effective action had been taken.

There were many complaints from patients and relatives about the quality of nursing care. These primarily related to patients not being fed, call bells not being answered, patients left in soiled bedding, medication not being administered, charts not being completed, poor hygiene and general disregard for privacy and dignity. Worryingly, the trust's board appeared to be largely unaware of these. In the reports seen by the board, these complaints were grouped into, and effectively lost in, categories such as "communication" or "quality of care".

The trust reported it had made efforts to engage clinical staff, but many senior doctors whom we spoke to considered that the trust was driven by financial considerations and did not listen to their views. They gave credit for the trust having a clear direction, but said that inflexible ways of imposing change had left many feeling marginalised.

Although most non-clinical staff thought that care at the trust was good, the majority of doctors we interviewed would not have been happy for a relative to be treated at the trust. In a 2006 survey, only 27% of staff said they would be happy to be cared for at the trust, compared with 42% nationally.

The trust generally performed poorly on clinical audit. There was no one taking the lead for clinical audit for a year and the trust-

wide group did not meet at all during this period. When audits were carried out, there was no robust mechanism to ensure that changes were implemented. When re-audits were required, they were often not undertaken, even if they had been recommended by a Royal College. The trust did not participate in many of the national audits run by the specialist societies.

The trust did not have an open culture where concerns were welcomed. Overall, the system that was intended to bring clinical risk to the attention of the board did not function effectively, and the board appeared to be insulated from the reality of poor care for emergency patients.

The trust's board and outcomes for patients

The board stated that the care of patients had always been a priority. However, no information on clinical outcomes went to the board until the publication by Dr Foster of the hospital standardised mortality ratio (HSMR) in April 2007. Even then, it went only to the private part of the meeting.

No annual report on the control of infection went to the board until July 2007, and that only went to the private part of the meeting.

The routine reports on performance that went to the board were at so high a level that they did not identify the failings in care of patients. The information on complaints and incidents was often incomplete, or so summarised that it left non-executives at a disadvantage in being able to perform their role to scrutinise and challenge on issues relating to the care of patients.

Informing the public

The trust's board preferred to discuss matters in private, even those that were not confidential or commercially sensitive. It did not discuss the Dr Foster HSMR or the alerts from the Healthcare Commission in public.

An outbreak of *Clostridium difficile (C. difficile)* occurred in the spring of 2006, and rates continued to be high during that year, but the trust did not report or acknowledge in public that it had an outbreak.

The actions of the trust's board

The year 2006/07 was a challenging one for the NHS, as trusts were required to achieve financial stability. That year, the trust set itself a challenging agenda to meet national targets for cost improvement, stabilise its finances, and become an NHS foundation trust. The trust set a target of saving £10 million, including a planned surplus of £1 million. This equated to about 8% of turnover. To achieve this, over 150 posts were lost. Although the stated intention was to minimise the loss of clinical staff, the number of nurses was significantly reduced. This was in a trust that already had comparatively low levels of staff (see pages 90-93 for details) and at a time when nurses felt they were poorly supported as a profession.

The combination of the reorganisation of wards, the reduction of beds (more than 100 fewer beds between 2005 and 2008, 18% of the total) and the loss of staff meant that the care of patients was further compromised. Areas with longstanding problems, such as A&E, were not given sufficient attention by managers.

The board claimed that its top priority was the safety of patients. However, even though clinical problems were well known, and the trust declared a financial surplus in 2006/07, it did not seek to redress the staffing problem it had exacerbated by reducing the number of nurses. The evidence suggests that the top priority for the trust was the achievement of foundation trust status. The failure of the trust to resolve the problems in A&E and to invest in staff is not consistent with the trust doing its reasonable best to provide a safe and effective service for patients.

The fact that the organisation concentrated mainly on clinical coding as the explanation for poor outcomes suggests that there was a reluctance to acknowledge, or even consider, that the care of patients was poor.

It was clear from the minutes of the trust's board that it became focused on promoting itself as an organisation, with considerable attention given to marketing and public relations. It lost sight of its responsibilities to deliver acceptable standards of care to all patients admitted to its facilities. It failed to pay sufficient regard to clinical leadership and to the experience and sensibilities of patients and their families.

Developments since the investigation was announced

It is, of course, impossible to determine what actions would have been taken by the trust if there had not been an investigation. The agreement at the end of March 2008 to fund the deficit in the numbers of nurses was taken after the board knew there was going to be an investigation.

Since January 2008, there has been a net gain of 46 qualified nurses and 51 healthcare support workers. The trust has increased the number of matrons from three to 12. However, in November 2008, the trust's board noted that further recruitment had been stopped because of actual and anticipated financial pressures, although the trust was 40 nurses below the previously agreed establishment. The trust, though, has told us that the board has not stopped recruitment and will, as part of the 2009/10 business plan, revisit the review of the establishment and take a view on recruiting to the outstanding posts.

When we expressed concerns to the trust, it welcomed them, responded positively and began to take action. The trust received formal notification of our concerns about the A&E department on 23 May 2008. It immediately set up a steering group for emergency care. Significant progress has been made, but there is still a need for further improvement. Two new consultants have been appointed, but the original consultant went on long-term sick leave. The middle grade rota is now fully staffed and there is a programme of training for junior and middle grade doctors. The number of nurses increased, but many of the new staff were inexperienced and there was still only one band seven nurse. A new model of care was introduced in the autumn of 2008. Triage is in place for 12 hours a day.

Ward-based training on the use of modified early warning scores (MEWS) was introduced in the autumn of 2008. A training package was also agreed to ensure that staff were competent to use cardiac monitors. A four-bedded surgical assessment unit was opened. Two additional beds were opened on the trauma ward. The trust is reviewing the provision of emergency theatre lists at weekends. Additional sessions have been arranged at short notice when necessary.

The mortality group has become the clinical outcomes group and is chaired by the chief executive. The trust reports that it is taking action in order to ensure that changes happen following complaints. Early signs are that mortality for emergency admissions is lower than previously, although the definitive figures for 2008 are not available yet.

The trust deserves credit for the improvement in the prevention and control of infection and it was recently found to comply with the hygiene code.

Overall conclusion about the trust

This was a small trust trying to support a range of specialties. It had become a foundation trust and improved its finances. However, it did not have a grip on operational and organisational issues, with no effective system for the admission and management of patients admitted as emergencies. Nor did it have a system to monitor outcomes for patients, so it failed to identify high mortality rates among patients admitted as emergencies. This was a serious failing.

When the high rate was drawn to the attention of the trust, it mainly looked to problems with data as an explanation, rather than considering problems in the care provided. The trust's board and senior leaders did not develop an open, learning culture, inform themselves sufficiently about the quality of

care, or appear willing to challenge themselves in the light of adverse information.

The clinical management of many patients admitted as emergencies fell short of an acceptable standard in at least one aspect of basic care. Some patients, who might have been expected to make a full recovery from their condition at the time of admission, did not have their condition adequately diagnosed or treated. As late as September 2008, we found unacceptable examples of assessment and management of patients. The trust was poor at identifying and investigating such incidents.

In the trust's drive to become a foundation trust, it appears to have lost sight of its real priorities. The trust was galvanised into radical action by the imperative to save money and did not properly consider the effect of reductions in staff on the quality of care. It took a decision to significantly reduce staff without adequately assessing the consequences. Its strategic focus was on financial and business matters at a time when the quality of care of its patients admitted as emergencies was well below acceptable standards.

The trust deserves credit for progress on infection control and for responding positively to the concerns of the Healthcare Commission.

The role of external organisations

Although South Staffordshire Primary Care Trust (PCT) commissioned services from the trust, it was initially distracted by the organisational change following the merger that created the PCT in 2006, and then focused on the number of patients treated and the cost. They had few measures of the quality of care or outcomes at the trust, and relied in part on external measures such as the Healthcare Commission's annual health check. Once the concerns of a campaign group were drawn to their attention, the PCT took action to address the individual concerns of patients and relatives, and to investigate and help to improve the quality of care at the trust.

West Midlands Strategic Health Authority (SHA) had also been created in 2006 through a merger and it too suffered from the accompanying loss of organisational memory. There was nothing to alert the SHA to concerns about the quality of care until the publication by the Dr Foster unit of the high hospital standardised mortality ratio in the spring of 2007. The SHA was reassured by the trust that it was investigating mortality appropriately.

We thought that information from the coroner would be useful for the investigation. We were disappointed that he declined to provide us with any information about the number or nature of inquests involving the trust.

The national picture and lessons for other organisations

A number of the findings of this investigation in respect of acute hospital care are potentially relevant to the whole NHS. These include the need for:

- Trusts to be able to get access to timely and reliable information on comparative mortality and other outcomes, and for trusts to conduct objective and robust reviews of mortality rates and individual cases, rather than assuming errors in data.
- Trusts to identify when the quality of care provided to patients admitted as emergencies falls below acceptable standards and to ensure that a focus on elective work and targets is not to the detriment of emergency admissions. Care must be provided to an acceptable standard 24 hours a day, seven days a week.
- Trusts to ensure that a preoccupation with finances and strategic objectives does not cause insufficient focus on the quality of patients' care.
- Trusts to ensure that systems for governance that appear to be persuasive on paper actually work in practice, and information presented to boards on performance (including complaints and incidents) is not so

summarised that it fails to convey the experience of patients or enable non-executives to scrutinise and challenge on issues relating to patients' care.

- Senior clinical staff to be personally involved in the management of vulnerable patients and in the training of junior members of staff, who manage so much of the hour-by-hour care of patients.
- Trusts to identify and resolve shortcomings in the quality of nursing care relating to hygiene, provision of medication, nutrition and hydration, use of equipment, and compassion, empathy and communication.
- Good handovers when reorganisations and mergers occur in the NHS.
- PCTs to ensure that they have effective mechanisms to find out about the experience of patients and the quality of care in the services that they commission.

Recommendations

In this report, we have drawn together the different strands of numerous, wide-ranging and serious findings about the trust which, when brought together, we consider amount to significant failings in the provision of emergency healthcare and in the leadership and management of the trust.

We have therefore written to Monitor, the regulator of NHS foundation trusts, in accordance with the Health and Social Care (Community Health and Standards) Act 2003 (s53(6)), to highlight these significant failings. We had previously raised concerns with Monitor about the leadership of the trust, and we note that both the chairman and chief executive have left the trust in the two weeks leading up to the publication of this report.

Irrespective of the above, we expect the trust to consider all aspects of this report, including all our findings, which detail serious failings at different levels and across different parts of the trust's services. Here, we highlight where action is particularly important.

Action by the board

The trust's board must ensure that there is a systematic means of monitoring rates of mortality and other outcomes for patients. This information should inform the board's discussions about the quality of services at the trust, and also inform action taken to improve outcomes for patients.

More generally, the trust's board needs to reflect on its arrangements for overseeing the quality and safety of clinical care within the trust. In particular, how the trust:

- Develops and promotes an open, learning culture.
- Collects and reports information accurately, both internally and externally, and in sufficient detail.
- Identifies and mitigates risks to the safety of its patients.
- Identifies correctly, and then reports, investigates adequately and learns from serious incidents and unexpected deaths.
- Learns from, and ensures that necessary improvements are made following incidents, near misses and complaints.
- Engages clinicians and develops effective clinical audit.
- Considers and acts on the views and experiences of patients who use the trust's services.

A&E department

Recent improvements to the emergency department – confirmed by a recent unannounced visit we made to the trust – must be sustained and extended to ensure that the service is safe, that it meets the needs of patients, and that the department is adequately staffed and equipped at all times.

Staffing and capacity

The trust must continue the work it has started to recruit additional nursing and medical staff, to ensure that care provided to patients throughout the trust, including at night and at weekends, is safe and keeps to accepted standards.

The trust needs to review the training and supervision of its nursing staff and junior doctors, to ensure that they are undertaking appropriate roles, are confident and clear about the expectations placed on them, and are receiving all necessary support.

The trust must ensure adequate availability of theatre sessions to ensure that it is able to handle demand in an emergency without delay, and has an effective means of determining which cases requiring emergency surgery should receive priority.

The trust must ensure that there is adequate access for clinical staff to advice and support from medical staff in the critical care (intensive care) service, and ensure this is independent of the availability of beds in the critical care unit.

Standards of care

The trust must ensure that its medical and nursing staff deliver basic aspects of care, such as reviewing patients on a regular basis, monitoring their condition, and identifying and managing any complications that may arise. The trust must ensure that there is timely review of patients by senior doctors.

In the light of specific findings in this report, the trust needs to audit its arrangements for and, where appropriate, equipment used in relation to: medication (particularly on admission and for patients who are 'nil by mouth'); the resuscitation of patients; non-invasive ventilation; cardiac monitoring; and anticoagulation.

National recommendations

Analysis undertaken in this and other trusts shows worrying variations across the NHS in the quality of coding of clinical outcomes, and variations in the extent to which statistical information is used to monitor the quality of local services and inform decisions at a senior level within NHS trusts.

This is of concern in a modern, information-driven health service where the interpretation and use of data is a fundamental means of improving clinical care. We recommend formally that all NHS trust boards have access to comparative data on outcomes for patients, including mortality, that is accurate, complete and as up-to-date as possible.

While recognising the challenges in ensuring that mortality rates are accurate and expressed in a way that does not cause unnecessary alarm among patients, or lead to unhelpfully risk-averse behaviour among clinicians, we believe that mortality rates can be published in a meaningful way to help patients to make informed choices about the quality of clinical care.

Boards of NHS trusts need to be focused at all times on the safety and quality of the services provided to patients. This includes having information available to boards that properly captures the experience of patients, so that non-executives can scrutinise and challenge the care received by patients.

The NHS and appropriate professional and educational bodies need to examine why the experience of patients on general wards in trusts that we have investigated continues to be of a poor standard, and take urgent action to improve the quality of nursing care in these areas.

PCTs need to develop more effective mechanisms to learn about the quality of care, the actual experience of patients and the outcomes of care in services that they commission, and give more priority to this aspect of commissioning.

The NHS needs to ensure effective handovers when reorganisations and mergers occur, so that information on services is transferred effectively to the new organisation.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Single Tender Approval – Echocardiography Service
SPONSORING DIRECTOR:	Richard Kirby, Chief Operating Officer
AUTHOR:	Philip Thomas-Hands, DGM for Medicine B
DATE OF MEETING:	26 March 2009

KEY POINTS:

The Trust Board is requested to support a single quotation arrangement for payment of echocardiography service sessions, provided by Echotech.

The sessions are to ensure delivery against the SLA with Heart of Birmingham tPCT, agreeing that a Direct Access Echo Service would be provided for GPs.

It is regarded as cost effective to engage Echotech with the delivery of this work for a twelve month period, the cost of which is to be covered by contracted income.

The cost of the eighty sessions planned is £60,800 + VAT@15%.

PURPOSE OF THE REPORT:

◉ **Approval** ○ **Noting** ○ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

Approve a single quotation arrangement for payment for echocardiography service sessions

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

None specifically

IMPACT ASSESSMENT:

FINANCIAL	☑	Cost is £60,800 + VAT@15%
ALE	☐	
CLINICAL	☑	
WORKFORCE	☐	
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Single Tender Approval – Maintenance Contract for Imaging Equipment
SPONSORING DIRECTOR:	Richard Kirby, Chief Operating Officer
AUTHOR:	Jackie Morton, DGM for Imaging
DATE OF MEETING:	26 March 2009

KEY POINTS:

The Trust Board is requested to support a single quotation arrangement for the maintenance contract, supporting Kodak CR plate readers, master page and printers.

Current MDA, IRR and IRMER recommendations state that service should be obtained from the original equipment manufacturer/supplier wherever possible, which in this instance is Carestream Health.

The cost of the maintenance contract is £62,131.

PURPOSE OF THE REPORT:

◉ **Approval** ○ **Noting** ○ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

Approve a single quotation arrangement for the purchase of the equipment.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

None specifically

IMPACT ASSESSMENT:

FINANCIAL	☑	Cost is £62,131.
ALE	☐	
CLINICAL	☑	
WORKFORCE	☐	
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Annual Plan 2009/10
SPONSORING DIRECTOR:	Richard Kirby, Chief Operating Officer
AUTHOR:	Richard Kirby, Chief Operating Officer and Ann Charlesworth, Head of Corporate Planning
DATE OF MEETING:	26 March 2009

KEY POINTS:

The Annual Plan for 2009/10 has been developed following two Board 'Time Out' discussions and two iterations of planning with the Trust's operational Divisions.

The Plan:

- summarises our performance in 2008/9
- describes the context in which we will be operating in 2009/10
- sets 32 objectives for the Trust for 2009/10 to make progress towards our longer-term strategic objectives
- summarises the financial, activity and workforce plans that will underpin delivery of our objectives
- identifies key risks for 2009/10.

As the Trust is currently applying to become an NHS Foundation Trust, the plan has for the first time been produced in the format that would be required for an NHS FT by Monitor including sections on self-certification and membership.

In view of the fact that the plan has been prepared before the end of March, some elements relating to the final 2008/9 position, remain to be confirmed.

PURPOSE OF THE REPORT:

◉ **Approval** ○ **Noting** ○ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

1. APPROVE the Annual Plan for 2009/10

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

The Annual Plan sets the Trust's objectives for 2009/10.

IMPACT ASSESSMENT:

FINANCIAL	☑	The Annual Plan summarises the Trust's financial plan for 2009/10.
ALE	☑	A robust annual planning process is a key ALE requirement.
CLINICAL	☑	The Plan summarises our priorities for clinical service development in 2009/10.
WORKFORCE	☑	The plan summarises our workforce plan for 2009/10.
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		The main risks to delivery of our objectives in 2009/10 are summarised in the plan.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ANNUAL PLAN 2009/10

DRAFT v2.0

March 2009

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ANNUAL PLAN 2009/10

Contents

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ANNUAL PLAN 2009/10

Introduction

Sandwell and West Birmingham Hospitals NHS Trust is currently applying for Foundation Trust status with the aim of achieving this in 2009/10. The Annual Plan for 2009/10 has therefore been written to comply as far as possible with the guidance on preparation of annual plans issued by Monitor.

1. Past year performance

1.1 Chief Executive's summary of 2008/09

[This section will need final review in light of end of March position]

The previous 12 months have seen the Trust continue to make significant progress in developing our services in a number of important areas.

- Through the innovative "Listening into Action" (LiA) programme we have begun to deliver a step change in levels of staff engagement in addressing the issues facing the Trust. LiA involves staff in identifying and delivering changes in key areas to improve the services we provide and to date over 2,000 staff have taken part across the Trust.

- We have made significant progress in delivering our long-term strategy through the Towards 2010 Programme including securing approval from the Trust Board and NHS West Midlands to the Outline Business Case for the new acute hospital and working with PCTs to deliver a wider range of services closer to home.

- We have continued to maintain low waiting times for our services including achieving the national NHS 18 week referral to treatment target, whilst sustaining financial stability by delivering our planned surplus of £2.5m and treating more patients than in previous years.

- We have maintained our strong approach to infection control with further reductions in cases of MRSA and C Difficile and continued investment in ward cleaning and environmental improvements.

- We improved our ratings in the Healthcare Commission annual healthcheck achieving "good" for both quality of services and use of resources.

- We submitted our application for NHS Foundation Trust status to the Department for Health for approval to proceed to assessment by Monitor.

This level of progress by the Trust across 2008/9 represents a significant achievement on the part of all of the staff of the organisation and it is appropriate that this should be acknowledged right at the start of our Annual Plan for 2009/10.

Performance against our Corporate Objectives for 2008/09

The Trust set 25 annual objectives for 2008/9. The table below contains a summary of our corporate objectives for 2008/09 with a "traffic light" indication of their achievement.

Strategic Objective	Annual Objective	R / A/ G Rating
1. Accessible and Responsive Care	1.1 Continue to achieve national and local access targets.	
	1.2 Successfully deliver our Patient Experience Action Plan.	
	1.3 Develop and begin to deliver a Single Equality Scheme	
2. High Quality Care	2.1 Continue to reduce hospital infection rates	
	2.2.Develop our patient safety culture and systems	
	2.3 Develop and deliver Maternity Development Plan	
	2.4 Deliver improvements in the quality of nursing care	
	2.5 Deliver interim service reconfigurations	
	2.6 Take on Sandwell / Walsall breast screening service	
	2.7 Deliver improvements in cancer and stroke	
	2.8 Agree plan to ensure EWTD compliance	
3. Care Closer to Home	3.1 Deliver new models of care through exemplar projects	
	3.2 Deliver community-based dermatology service for BEN	
4. Good Use of Resources	4.1 Deliver financial plan including £2.5m surplus	
	4.2 Improve productivity through DC rates and LOS	
	4.3 Deliver service improvement programme	
5. 21st Century	5.1 Produce and secure agreement to new hospital OBC	

Strategic Objective	Annual Objective	R / A/ G Rating
Facilities	5.2 Deliver land acquisition strategy	
6. An Effective NHS FT	6.1 Achieve Healthcare Commission Healthcheck standards	
	6.2 Ensure staff receive appraisals and mandatory training	
	6.3 Achieve NHS FT status	
	6.4 Improve clinical administration and communications	
	6.5 Develop marketing and business development activity	
	6.6 Improve staff engagement through Listening into Action	
	6.7 Ensure effective emergency preparedness	

Annual Healthcheck 2007/08

The Trust's ratings in the Healthcare Commission's Annual Healthcheck (Oct 2008) are included in the table below. This year's ratings reflect the Trust's ability to maintain its quality of care, whilst continuing to improve the way in which it manages its resources.

Area	*2005/06 Rating*	*2006/07 Rating*	*2007/08 Rating*
Quality of Services	Fair	Good	Good
Use of Resources	Weak	Fair	Good

Patient Activity Performance in 2008/09

The table below summarises the Trust's high level activity for the period 2006/07 – 2008/09. Overall, admitted patient care activity increased by 4% in 2008/9 compared with the previous year including a 2.9% rise in emergency admissions and a continued shift of planned work from electives to day cases. New outpatient activity rose significantly (+16%) partly due to increases in referrals and partly due to the 18 week referral to treatment target. Rehabilitation occupied bed days fell as the Trust reduced hospital length of stay in line with Towards 2010 models of care.

Type	*2006/07 Outturn*	*2007/08 Outturn*	*2008/09 Plan*	*2008/09 Projected Outturn*	*2008/09 change from 2007/08*
Admitted Patient Care: (Spells)					
Day cases	45,850	47,198	48,287	50,668	+7.4%
Electives	13,602	13,296	13,667	13,089	-1.5%
Emergencies	65,076	67,196	67,484	69,177	+2.9%
Total	124,528	127,690	129,438	132,934	+4.1%
Outpatients (attendances):					
New	127,670	131,766	134,843	153,774	+16.7%
Review	374,844	370,285	372,340	374,833	+1.2%
Total	502,514	502,051	507,183	528,607	+5.3%
A&E	231,910	231,938	225,450	228,603	-1.4%
Rehabilitation OBDs	42,181	32,344	25,734	22,830	-29.4%
Neonatal OCDs	9,193	8,552	8,660	8,806	+3.0%
Births	5,788	6,201	n/a	6,100	-1.6%
Referrals	139,403	151,755	n/a	176,318	+16.2%

NB. Births are also included in the emergency spell totals in the first section of the table

Financial Performance in 2008/09

The Trust delivered its planned surplus of £2.5m for 2008/9 including successful delivery of a CIP of £12m. Total income rose by x% compared with 2007/8 and was x% ahead of plan mainly due to over-performance on activity targets in response to levels of demand. Total expenditure rose by x% since 2007/8 and was also x% ahead of plan mainly due to the increased cost of treating more patients than expected.

£ million	*2006/07 Outturn*	*2007/08 Outturn*	*2008/09 Plan*	*2008/09 Forecast Outturn*
Income				
NHS Clinical Income	287.4	302.5	312.3	TBC
Non NHS Clinical Income	1.7	1.6	1.5	TBC
Other Income	38.4	35.1	32.8	TBC
Total Income	327.5	339.2	346.6	348.2
Expenditure				
Pay costs	TBC	TBC	(239.3)	TBC
Non-pay costs	TBC	TBC	(80.2)	TBC

Total Costs	(301.2)	(305.2)	(319.5)	(321.1)
Operating Surplus (EBITDA)	26.3	34.0	27.1	27.1
Depreciation, Amortisation, Interest and Impairments	(14.0)	(18.7)	(15.4)	(15.4)
PDC Dividend	(8.9)	(8.8)	(9.3)	(9.3)
Net surplus/(deficit)	3.4	6.5	2.5	2.5

[section to be completed once March financial position known]

2. Future Business Plans

2.1 Strategic overview

Our planning for 2009/10 has been based on our assessment of the national and local context within which we operate. It takes account of the need to continue to make progress with the implementation of our local health economy shared service strategy, "Towards 2010".

2.1.1 National Context

The Operating Framework for the NHS in England 2009/10 (December 2008) set the national priorities, financial assumptions and national planning process for the year ahead.

Five National Priorities

Five main national priorities not changed from 2008/9.

- Infection control: achieving trajectories introducing MRSA screening.
- Improving access: maintaining 18 weeks, extending direct booking.
- Improving health / reducing inequalities: four key areas of cancer, stroke, maternity and children.
- Patient experience: improving engagement and satisfaction.
- Emergency preparedness: major incident planning / preparedness.

Other Service Priorities

Local priorities agreed by PCTs reflecting national strategies for:

- Alcohol
- Dementia
- End of life care
- Mental health
- Military personnel, their families and veterans
- Mixed-sex accommodation
- Vulnerable adults
- People with learning disabilities

Infrastructure for improving quality in three domains:

- Safety
- Effectiveness
- Patient experience

The financial context for the NHS set out in the Operating Framework reflects the increasingly challenging national economic climate.

Financial Assumptions

- *PCT allocations*
  - Allocations published for 2009/10 and 2010/11.
  - 5.5% average PCT increase in 2009/10
  - Two year increase for England = 11.3%. Sandwell = 11.3%. HoB = 10.6%.
- Adopting IFRS accounting standards bringing PFI on to balance sheets.
- Expectation of "very substantial efficiency savings" from the NHS by 2010/11.
- *Significant changes to Payment by Results*
  - HRG4 introduced includes new short stay elective tariff and wider range of outpatient with procedure tariffs.
  - Change to Market Forces Factor funding calculation.
  - Tariff uplift of only 1.7% including 3% efficiency assumption
  - Further 0.5% available through local Commissioning for Quality & Innovation (CQUIN) agreements in return for quality improvements.

Maintaining high performance on national targets whilst continuing to deliver improvements in the key clinical areas of stroke, maternity, cancer and children and continuing to improve our patient experience whilst dealing with changed financial assumptions presents a challenge for the Trust to address in our planning for 2009/10.

2.1.2 Local Context

The local context for our planning for 2009/10 remains the Towards 2010 Programme with its aim of delivering a major redevelopment of local health and social care services including a new acute hospital, the shift of care closer to home and significant investment in primary and community services.

The area that we serve continues to have significant issues of poor health that the Towards 2010 Programme aims to address. This is clearly reflected in the emphasis on health in the Local Area Agreements for Sandwell MBC and Birmingham City Council.

Sandwell MBC

Sandwell MBC LAA 2008-11. Eight priorities including: Having a Good Start in life, Improving Health and Supporting Independence LAA indicators include:

- Mortality rates (circulatory diseases)
- Smoking cessation
- End of life measures
- Delayed transfer of care
- Teenage conception rate
- Breast feeding
- People with long-term conditions living independently

Birmingham City Council

"Be Birmingham" 2008-11. Five key outcomes including "Being Healthy: enjoying long and healthy lives". The Being Healthy vision is "To reduce health inequalities, shift the emphasis over time from secondary to primary and community care with a greater focus on the customer and those with complex needs". LAA indicators include:

- Mortality rates
- Smoking cessation
- End of life measures
- Delayed transfer of care
- Teenage conception rate

The Trust's main commissioners, Sandwell PCT and Heart of Birmingham tPCT are key partners in the Towards 2010 Programme and this is reflected in their priorities. In the light of the World Class Commissioning both PCTs have reviewed their local objectives leading to a renewed concentration on population and public health issues.

Sandwell PCT

World Class Commissioning priorities:

- improving maternity & antenatal care
- young people's health
- tackling harm caused by alcohol
- improving mental health
- community diabetes services
- long-term neurological conditions
- cancer
- cardiovascular disease
- services for older people

CQUIN priorities include:

- Time to operations for fractured NoF
- Time to CT scan for stroke patients
- Reducing EL Caesarean section rate
- Extension of patient surveys
- Improved outpatient coding
- Referrals to smoking cessation service

Heart of Birmingham tPCT

New mission statement *"Eliminating health injustice for richer, longer lives"*.
World Class Commissioning priorities:

- infant mortality
- teenage conceptions
- smoking cessation
- CHD cholesterol control
- breast cancer screening uptake
- delayed transfers of care
- end of life care
- patient experience

Focus on "deadly trio" of heart failure, kidney disease and diabetes and action to reduce high cardio-vascular mortality rates.

Our plans for 2009/10 are also informed by our continuing programme of engagement with GPs and Pratice-based Commissioners to understand their views about our services and their priorities for development. The key issues arising from discussions with practices in 2008/9 included:

- Reducing new to review outpatient rates
- Ensuring that consultant to consultant referrals or tertiary referrals are only made when clinically necessary and with the knowledge of the patient's GP.
- Improving the speed and reliability of communication with GPs including further development of GP Homepage.
- Extending the range of diagnostics available on a direct access basis to support primary care.
- Increasing the range of outpatient and diagnostic services that the Trust is able to provide from its community bases (e.g. Aston HC, Rowley or Neptune).
- Supporting the development of new services in primary care (e.g. through clinical supervision of primary care practitioners)
- Ensuring that secondary care specialists are easily available for advice / guidance in addition to receiving referrals.

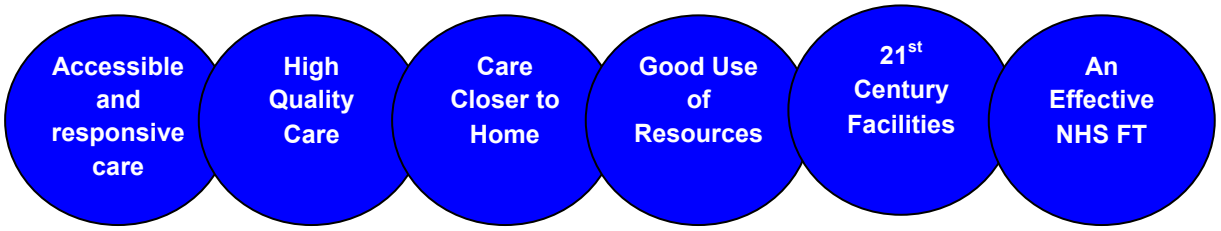
These issues along with the broader objectives for our main commissioner and national expectations form the context within which we have undertaken our planning for 2009/10.

2.1.3 Trust Strategy

The Trust has set an ambitious vision for the future of our organisation.

Our vision provides the framework for our long-term strategic objectives and the objectives that we have set for the Trust for 2009/10 in order to ensure progress towards our vision.

The Trust's six strategic objectives are set out in the diagram below.



Accessible and responsive care	High Quality Care	Care Closer to Home	Good Use of Resources	21st Century Facilities	An Effective NHS FT
We will provide services that are quick and convenient to use and responsive to individual needs treating patients with dignity and respect. Our access times and patient survey results will be amongst the best of Trusts of our size and type.	We will provide the highest quality clinical care. Our clinical outcomes will be amongst the best of Trusts of our size and type. Patients and frontline staff will be fully engaged in improving our services.	In partnership with our PCTs we will deliver a range of services outside of the acute hospital.	We will make good use of public money. On a set of key measures we will be among the most efficient Trusts of our size and type.	We will ensure our services are provided from modern buildings fit for 21st Century health care.	An effective organisation will underpin all we do. We will develop our workforce, promote education, training and research, and make good use of technologies.

To ensure that we are able to measure progress towards these strategic objectives, the Trust Board has identified a small number of medium-term measures of success. These 12 measures represent the high level objectives for the Trust over the period 2009 – 2012 and are set out below.

Strategic Objective	Medium Term Measure of Success
Accessible and Responsive Care	• Significant improvement in patient satisfaction levels demonstrated in patient survey. • In top 3 West Midlands' acute hospital trusts for IP and OP waiting times (quarterly average waiting times).
High Quality Care	• "Excellent" in Healthcare Commission ratings for Quality of Services (or equivalent system introduced by the CQC). • Achieved NHLSA Level 2 standards. • In top 3 West Midlands' acute hospital trusts for infection control (MRSA and C Diff rates).
Care Closer to Home	• Successfully delivering significant proportion of activity in line with 201o Programme service models and activity assumptions.
Good Use of Resources	• Sustained financial surplus. • Monitor Financial Risk Rating of 4.
21st Century Facilities	• Land acquisition well underway and new hospital procurement commenced.
An Effective NHS FT	• Monitor Governance and Mandatory Services ratings of "Green" • Growing FT membership and good election turnout. • Significant improvement in staff satisfaction demonstrated in staff survey.

2.1.4 Corporate Objectives 2009/10

In order to ensure continued progress towards our six strategic objectives the Trust has set 32 objectives for 2009/10. These objectives, the measures we will use to judge our success and the lead director and Divisions responsible are set out in the table below.

Strategic Objective	Annual Objective 2009/10	Measure of Success	Lead Director(s) and Responsible Divisions [to be completed]
1. Accessible and Responsive Care	1.1 Ensure continued achievement of national access targets (A&E, cancer, inpatient, outpatient and diagnostics and GUM).	• A&E 4 hour target achievement • Cancer target achievement (2 weeks, 31 days and 62 days) • 18 week referral to treatment targets • Maximum waits for IP, OP and diagnostic treatment (13 wks OP, 26 wks IP, 6 wks diagnostic) • Rapid access chest pain 2 week target achievement • GUM 48 hour access targets	
	1.2 Deliver commitments in Single Equality Scheme for 2009/10.	• Progress report to Board on actions in SES reports successful delivery of actions	
	1.3 Improve patient privacy and dignity by increasing compliance with single sex accommodation standards.	• Improvement with single sex standards demonstrated through audits	
	1.4 Improve patient experience by continuing to improve communication.	• Patient perceptions as reported through local and national surveys	
	1.5 Work with Sandwell and HoB PCTs to identify key hospital actions that will contribute to improvements in public health.	• Agreement of plan with PCTs. • Achievement of measures included in plan.	

Strategic Objective	Annual Objective 2009/10	Measure of Success	Lead Director(s) and Responsible Divisions [to be completed]
2 High Quality Care	2.1 Ensure continued improvement in infection control and achievement of national targets.	• MRSA targets achieved. • C difficile target achieved. • Compliance with Hygiene Code • Meeting national cleanliness standards	
	2.2 Complete implementation of surgical reconfiguration.	• Reconfiguration completed by June 09	
	2.3 Deliver significant improvements in quality of care for patients with stroke / TIA.	• Agreement of stroke services plan • Delivery of actions set out in plan • Improved performance on key measures (% of time on stroke unit and access to CT scan within 24 hours).	
	2.4 Deliver significant improvements in the Trust's maternity services.	• Successful delivery of action in Maternity Integrated Development Plan. • Improved performance on key measures (see monthly Performance Report).	
	2.5 Deliver the Trust's "Optimal Wards" programme.	• Ward reviews undertaken. • Results demonstrate progress in key areas. • Improvement in ward accreditation scores over the year.	
	2.6 Develop the Trust's approach to measuring and managing	• Launch of Quality Management framework	

Strategic Objective	Annual Objective 2009/10	Measure of Success	Lead Director(s) and Responsible Divisions [to be completed]
	clinical quality.	• Production of Quality Account	
	2.7 Deliver CQUIN targets: - time to surgery for fractured neck of femur; - access to CT scan for stroke patients; - reduced caesarean section rate; - improved outpatient data quality (referral source); - introduction of patient surveys; - referral of patients to smoking cessation services.	• Achievement of targets agreed in the detail of the CQUIN agreement.	
	2.8 Achieve NHSLA standards Level 2 (general)by December 2009 and Level 1 (maternity) by March 2010.	• Achievement of NHSLA standards.	
	2.9 Improve the quality of care provided to vulnerable adults (e.g. patients with mental health difficulties or learning disabilities).	• Agreement of plan for improvement including performance measures • Delivery of action in line with plan	
	2.10 Ensure the Trust fully meets the EU WTD standards for junior doctors by August 2009.	• Achieve EU WTD compliance	
3. Care Closer to Home	3.1 Ensure full Trust participation in delivery of Towards 2010 Programme exemplar projects.	• Exemplar projects achieve their targets for 2009/10	
	3.2 Make full use of outpatient facilities in Aston HC, Rowley Regis Hospital.	• Plans agreed to make maximum use of facilities • Increased volumes of outpatients delivered from these locations.	

Strategic Objective	Annual Objective 2009/10	Measure of Success	Lead Director(s) and Responsible Divisions [to be completed]
	3.3 Deliver successful community ophthalmology service for South Birmingham PCT.	• Activity delivered in South Birmingham community service.	
4. Good Use of Resources	4.1 Delivery of planned surplus of £4.3m.	• Achievement of financial target.	
	4.2 Delivery of CIP of £15m.	• Achievement of CIP.	
	4.3 Develop approach to service improvement concentrating on theatres, outpatients and bed management	• Service improvement plan agreed. • Improved theatre and outpatient utilisation.	
	4.4 Introduce routine service line reporting to support development of clinical management structure.	• Service line reporting in place. • Impact demonstrated through F&PC reviews of Divisions.	
5. 21st Century Facilities	5.1 Continue to deliver New Hospital Project as planned.	• OBC approved • Land acquired	
	5.2 Continue to improve current facilities through the delivery of the capital programme including: - replacement MRI scanner at City - upgrade of accommodation at City (MAU and D16) - new facilities for PCCU at Sandwell	• Major capital projects delivered in line with programme.	
	5.3 Fully engage with PCTs in design of major community facilities (Aston, BTC, Rowley Regis and Sandwell).	• Business case for each development agreed with PCTs through Towards 2010	

Strategic Objective	Annual Objective 2009/10	Measure of Success	Lead Director(s) and Responsible Divisions [to be completed]
		Programme.	
6. An Effective NHS FT	6.1 Achieve NHS FT status	• Authorised as NHS FT	
	6.2 Continue to achieve Annual Healthcheck Core Standards	• Core standards achieved.	
	6.3 Deliver improved uptake of annual appraisals including use of the AfC KSF and mandatory training.	• Uptake of appraisal • Uptake of mandatory training	
	6.4 Continue to spread staff engagement through Listening into Action including delivery of the LiA "Enabling Our People" projects.	• Spread of LiA projects • Progress with "Enabling Our People" • Staff views reported through staff survey	
	6.5 Establish the next stages of the Trust's clinical research strategy.	• Strategy agreed • Progress with implementation • Recruitment of patients into clinical trials	
	6.6 Improve the Trust's approach to leadership development.	• Review of current management and leadership development activity • Agreed programme of future work	
	6.7 Improve the environmental sustainability of the Trust's operations by responding to the national carbon reduction strategy.	• Agreed plan to improve sustainability • Improved performance in measures identified in the plan	

2.2 Service development plans

Our plans for 2009/10 are designed to ensure delivery of these Annual Objectives. This section provides an overview of the most significant service developments included within these plans.

2.2.1 Activity Levels

The table below sets out planned activity levels for 2009/10 – 2011/12 based on the agreed LDP for 2009/10 and the assumptions in our agreed Long-Term Financial Model.

Clinical Activity

000's of cases

	Plan 08/09	Projected Outturn 08/09	2009/10 Draft Plan	2010/11 Forecast	2011/12 Forecast
Elective	61.9	63.7	62.8	66.2	67.2
Non-elective	67.5	69.2	58.0	67.8	67.6
Unbundled HRGs	-	-	22.5		
Outpatients	507.2	528.6	532.1	467.7	431.5
A&E	225.4	228.6	230.0	235.0	244.1
Rehab OBDs	25.7	22.8	25.7	n/a	n/a
Neonatal OCDs	8.7	8.8	9.8	n/a	n/a

In 2009/10 we are therefore planning for the following changes in activity levels compared with 2008/9 outturn

- + 7.8% admitted patient care including the effect of moving to the new currency (HRG4). On a like for like comparison we are planning to deliver a similar level of admitted patient care in 2009/10 to that forecast for 2008/9;

- + 0.7% outpatients.

2.2.2 Developments

Our plan includes developments in the following services.

- Improving emergency surgical services. We will complete the changes in surgical configuration agreed in 2007/8 including investment in additional support for emergency theatres at Sandwell.

- Maternity. We plan to invest in our maternity services to continue to improve the quality of our hospital-based maternity services as well as working with PCTs to improve the quality of our community-based midwifery services.

- Stroke Services. Working with Sandwell and HoB PCTs we will develop our plans to meet the standards for stroke services set out in the local specification. This will include improving access to thrombolysis for patients with stroke.

- Ophthalmology. We are investing in additional consultants in ophthalmology to respond to rising demand and opportunities to develop new services including establishing a community service in South Birmingham.

- Infection Control. We will maintain existing levels of investment in cleaning and infection control and introduce MRSA screening for elective as well as emergency patients. Our plans are designed to ensure that we deliver our agreed infection control targets.

Infection Control Targets 2009/2010*

Target	Q1	Q2	Q3	Q4
MRSA	9	9	9	6
C. Difficile	57	56	54	53

* The above table represents the maintenance of a 60% reduction from a 2003/04 baseline in the reported incidence of MRSA bacteraemia, and a reduction of greater than 20% in the reported incidence of C Difficile cases when compared with a 2007/08 baseline.

In addition to these investments and as part of the LDP agreed with commissioners the Trust has agreed to a Commissioning for Quality and Innovation (CQUIN) Scheme that includes quality objectives in the following areas:

- reducing the Trust's caesarean section rate;
- improving the percentage of patients with fractured neck of femur operated on within 48 hours of admission;
- improving the management of stroke patients including time to CT scan after admission;
- introducing routine arrangements for monitoring patient satisfaction;
- increasing the numbers of patients who smoke referred to stop smoking services before elective operations;
- Improving the quality of coding for the source of outpatient referrals.

Full achievement of the targets included within the CQUIN Scheme will result in a payment to the Trust equivalent to 0.5% uplift on tariff income (£1.6m).

2.3 Operating resources required to deliver service developments

This section of the plan sets out the Trust's finance, workforce and capital plans for 2009/10.

2.3.1 Finance

The table below summarises the Trust's financial plan for 2009/10 – 2011/12.

Category	2006/7	2007/8	2008/9 Plan	2009/10 Plan	2010/11 Plan	2011/12 Plan
	£m	£m	£m	£m	£m	£m
NHS Clinical Income	287.4	302.5	312.3	**324.3**	329.8	335.4
Non NHS Clinical Income	1.7	1.6	1.5	**1.3**	1.3	1.3
Other Income	38.4	35.1	32.8	**39.3**	40.0	40.6
Total Income	327.5	339.2	346.6	**364.9**	371.1	377.4
Total Costs	(301.2)	(305.2)	(319.5)	**(335.0)**	(341.0)	(347.7)
Operating Surplus (EBITDA)	26.3	34.0	27.1	**29.9**	30.1	29.8
Depreciation, Amortisation, Interest and Impairments	(14.0)	(18.7)	(15.4)	**(16.2)**	(16.6)	(17.1)
PDC Dividend	(8.9)	(8.8)	(9.3)	**(9.3)**	(9.1)	(8.2)
Net Surplus / (Deficit)	3.4	6.5	2.5	**4.3**	4.4	4.4

Note. Within the £4.3m surplus planned for 2009/10, the Trust has included £2.0m of uncommitted contingency. The Trust's financial control total agreed with NHS West Midlands excludes this contingency and therefore shows a surplus of £2.3m.

The key assumptions on which the plan is based include:

- A planned surplus of £4.3m;
- Income of £364.9m, a x% increase on 2008/9 forecast outturn;
- Operating expenditure of £335.0m, an x% increase on 2008/9 forecast recognising the cost of pay awards, meeting national cost pressures, full year effect of developments in 2008/9 and developments in key priorities identified above;

- The plan incorporates the impact of moving to HRG4 and the changes to the Market Forces Factor (net loss of £3.8m income) and increases in the NHSLA premium (£3.5m increase in premium).
- A CIP of 4.5% of operating income (£15m);
- Income of £1.6m from the achievement of CQUIN targets;
- Income of £1.3m from HoB tPCT under the Towards 2010 Transitional Financial Framework to support the urgent care centre at City Hospital.

2.3.2 Workforce

WTE's have risen by c. 1% since March 2008 year to date and pay expenditure is broadly on track reflecting bank and agency use to fill vacancies. Workforce modelling for the Towards 2010 programme forecasts a stable workforce for 2009/10 at c. 5,900 WTE

WTE by Staff Group*

Category	April 2007	April 2008	April 2009	April 2010 projected
Medical	754.78	779.52	788.10	788.10
Managers	132.41	146.57	166.58	166.58
Administrative and Estates	1,153.65	1,147.39	1,065.81	1,065.81
Healthcare Assistants and Support	873.97	762.19	1,208.56	1,208.56
Nursing and Midwifery	1,969.28	2,000.40	1,673.97	1,673.97
Scientific Therapeutic and Technical	813.20	802.17	982.56	982.56
TOTAL	**5,697.29**	**5,638.22**	**5,885.58**	**5885.58**

* Figures produced from ESR using National Occupation Codes

N.B. April 09 figures differ across categories following extensive data cleansing exercise to correct historical coding errors.

[Final workforce forecasts still to be confirmed]

2.3.3 Investment and disposal strategy

The table below summarises the Trust's Capital Programme for 2009/10. The capital programme totals £19.8m including £4.1m of planned loans designed to support the purchase of land for the new acute hospital in line with the Outline Business Cases (OBC) for Land Acquisition and the New Hospital.

Capital Programme 2009/10

	£000
Capital Resources	
Internally Generated Cash (depreciation)	15,250
NHS Capital Loans	4,098
New Energy Schemes (PDC funded)	430
Total Resources	**19,778**
Capital Expenditure	
Land Acquisition	10,150
Capitalisation of Salaries	300
Medical Equipment	750
IT Programmes	910
Replacement of City MRI	2,225
Statutory Standards/Fire/ DDA Compliance	875
Estates – Plant and Building Replacement and Upgrade	1,950
Cardiology (Sandwell moves)	600
MAU Redevelopment (Exc. contribution from Statutory Standards)	375
Ophthalmology Clinics (Remaining x2)	200
Surgical Reconfiguration	100
X-ray for Aston Clinic	400
D16 Upgrade	500
Carry Forward Provisions	
Urgent Care Centre	1,017
General Slippage Carried Forward	500
Assumed slippage in 2009/10	(1,504)
New Energy Schemes	430
Total Expenditure	**19,778**
Under/(Over) Commitment against CRL	**0**

The main features of the capital programme include:

- £10m of planned expenditure on land for the new acute hospital. The exact timetable for purchase of the land will be determined by the timetable for CPO. In the event of delay in the timetable, we would reduce the value of the loans required to support land purchase in 2009/10;

- Development of new clinical facilities including a major refurbishment of ward D16 and improvements to the Medical Assessment Unit at City Hospital and investment in new facilities for cardiology at Sandwell Hospital;

- Replacement of the current MRI scanner at City Hospital with an up-to-date model with increased capacity;

- Investments to support the delivery of care closer to home including equipment for the new South Birmingham ophthalmology clinics and x-ray facilities for the outpatient and diagnostic in Aston being jointly developed with HoB tPCT.

2.4 Summary of key assumptions

The Trust's plans for 2009/10 are therefore based on continuing to develop and deliver the shared local strategy: Towards 2010. The Trust has set itself a further set of 33 annual objectives to ensure continued progress with our long-term strategic objectives.

To ensure the delivery of these objectives in 2009/10 we have produced detailed finance, activity and workforce plans for the year ahead. The financial and activity targets are fully agreed with our PCT commissioners through the LDP agreement. Successful delivery of these plans will mean that by the end of 2009/10 we have:

- delivered a CIP of £15m and a bottom-line surplus of £4.3m;

- made a number of significant capital investments including replacing the MRI scanner at City Hospital and investing in other key areas of clinical accommodation;

- made improvements in our key clinical priority areas of stroke and maternity services

- maintaining our workforce broadly stable at 2009/10 levels as developments are off-set by improvements in efficiency.

- Continued to make progress towards the new acute hospital and 2010 models of care and achieved NHS Foundation Trust status.

3. Risk Analysis

The Trust has a well-established system for identifying and managing risk to the delivery of our services and the achievement of our objectives. In line with this process a detailed review of the risks to delivery of our objectives for 2009/10 will be undertaken in April and May and included in an updated version of this plan. At this stage the plan contains a high level assessment of the major risks to delivery of our plan and compliance with the terms of our authorisation.

These risks have been scored in line with the Trust's stand approach to risk assessment based on a scale of 1-5 for impact and likelihood.

3.1 Governance Risk

There are some potential governance risks associated with our plans for 2009/10. The initial assessment of these is set out in the table below.

Risk	Potential Impact	Likelihood	Mitigating Action	Residual Risk
Failure to comply with core standard C20b – mixed sex accommodation	3	4	Trust is developing single-sex action plan to ensure progress made as far as possible within limitations of Victorian estate at City.	3x4 = 12
Failure to maintain successful engagement with FT membership.	3	3	Trust has membership strategy including clear actions planned for 2009/10.	3x2 = 6
Failure to maintain momentum with specialty engagement in improving clinical quality.	4	3	Establishment of clinical directorates and appointment of clinical directors will provide improved structure.	4x2 = 8
Failure to achieve NHS FT status	4	3	IBP agreed by Trust Board to be submitted to DH at end of March. Clear development programme underway.	4 x 2 = 8

3.2 Mandatory Service Risk

There are a number of risks to our ability to deliver services in line with commissioner, Monitor and Department of Health.

Risk	Potential Impact	Likelihood	Mitigating Action	Residual Risk
Continuing to achieve national access targets within available capacity.	4	4	Activity levels agreed with commissioners and detailed capacity plan developed.	3 x 4 = 12
Maintaining improvements in infection control.	4	3	Infection control assurance framework overseen by infection control exec committee. Regular reports to Trust Board.	4 x 2 = 8

PCT delivery of alternatives to hospital outpatients	3	3	Shared activity model agreed with PCTs. PCT plans developed through joint 2010 project groups.	3 x 2 = 6
Failure to improve maternity services.	4	3	Agreed maternity development plan supported by financial investment in 09/10.	4 x 2 = 8

3.3 Financial Risk

The Trust's financial plan identifies a number of potential financial risks for 2009/10. The most significant of these are summarised below.

Risk	Potential Impact	Likelihood	Mitigating Action	Residual Risk
Delivering the Trust's £15m CIP (4.5% of operating income).	4	3	The Trust has agreed a CIP based on a series of detailed schemes at Divisional level. The Trust will continue to operate the successful approach to CIP delivery used in previous years.	4x2 = 8
Potential loss of market share to competitors	4	3	The Trust has an established process for tracking market share and an agreed programme of business development activity for 2009/10.	4 x 2 = 8
Impact of HRG4, Market Forces Factor and NHSLA premium changes on financial plan.	4	4	The Trust's financial plan addresses these issues through agreed levels of income with PCTs and additional 1% CIP above level originally in LDP.	4 x 2 = 8

3.4 Risk of any other non-compliance with terms of authorisation

Finally, the Trust also faces two potential risks relating to our long-term plans for a new hospital.

Risk	Potential Impact	Likelihood	Mitigating Action	Residual Risk
Failure to secure approval to OBC.	4	4	OBC already approved by Trust board and SHA and submitted to DH. Trust working closely with DH to secure approval.	4 x 3 = 12
Significant delay in land acquisition strategy affecting capital programme and new hospital project.	4	4	Clear project plan and project management in place for land acquisition. Contingency plans have been developed for capital programme if no major expenditure on land in 09/10.	3 x 4 = 12

4. Declarations and Self-Certification

4.1 Self certification

As part of our preparations for the Monitor assessment stage of our application for NHS FT status, the Trust Board is developing its process for self-certification as required by Monitor. This will be undertaken initially as part of the assessment stage and subsequently as part of the annual planning process. For 2009/10 this section of the plan sets out the self-certification declarations that the Trust will make as part of the NHS FT application process.

4.2 Board statements

Clinical quality

The Board is satisfied that, to the best of its knowledge and using its own processes (supported by Healthcare Commission metrics and including any further metrics it chooses to adopt), its NHS foundation trust has and will keep in place effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

Service performance

The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) and national core standards and with all known targets going forwards;

The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with the *Health Act 2006: Code of Practice for the Prevention and Control of Healthcare Associated Infections* (the Hygiene Code).

Other risk management processes

Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the

Board is confident that there are appropriate action plans in place to address the issues in a timely manner;

All recommendations to the Board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned;

The necessary planning, performance management and risk management processes are in place to deliver the annual plan;

A Statement of Internal Control ("SIC") is in place, and the NHS foundation trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to the most up to date guidance from HM Treasury

All key risks to compliance with its Authorisation have been identified and addressed.

Compliance with its Authorisation

The Board will ensure that the NHS foundation trust remains compliant with its Authorisation and relevant legislation at all times;

The Board has considered all likely future risks to compliance with its Authorisation, the level of severity and likelihood of a breach occurring and the plans for mitigation of these risks; and

The Board has considered appropriate evidence to review these risks and has put in place action plans to address them where required to ensure continued compliance with its Authorisation.

Board roles, structures and capacity

The Board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the Board;

The Board is satisfied that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability;

The selection process and training programmes in place ensure that the non-executive directors have appropriate experience and skills;

The management team has the capability and experience necessary to deliver the annual plan; and

The management structure in place is adequate to deliver the annual plan objectives for the next three years.

5. Membership

5.1 Membership Report

In preparing for NHS FT status the Trust has had considerable success in recruiting an initial public membership from our local population. The Trust has begun to work with this membership in preparation for acquiring NHS FT status and this section provides an initial report on this activity.

The size of our membership and expected movements in 2009/10 are set out in the table below.

Membership size and movement

Public constituency	**Last Year**	**Next Year (estimated)**
At year start (April 1)	377	6,500
New members	6,333	2,324
Members leaving	210	324
At year end (March 31)	6,500	8,500
Staff constituency	**Last Year**	**Next Year (estimated)**
At year start (April 1)	6,525	6,485
New members	1,317	1,300
Members leaving	1,095	1,050
At year end (March 31)	6,484	6,400

[Need to confirm membership target of 8,500 prior to finalisation of plan]

Analysis of current membership *(based on 6,244 public members in February report)* of total public constituencies *(the wider West Midlands)* is shown in the table below.

Public constituency	**Number of members**	**Eligible membership**
Age (years):		
0-16	109	428,612
17-21	230	332,660
22+	5,610	3,768,599
Ethnicity:		
White	3,686	4,674,296
Mixed	38	73,225

Public constituency	Number of members	Eligible membership
Asian or Asian British	1,367	385,573
Black or Black British	738	104,032
Other	415	30,182
Socio-economic groupings:		
ABC1	2,385	1,913,858
C2	1,003	685,541
D	1,297	794,461
E	1,559	700,084
Gender:		
Male	2,502	2,575,111
Female	3,647	2,692,197

However, our membership rather than being from across the wider West Midlands is highly concentrated in the seven geographical constituencies in Sandwell and Birmingham (82.67% of members from this area). Analysis of current membership from those constituencies *(based on 5,162 public members in February report)* is shown in the table below. The demographic make-up of our members more closely matches the population in those areas rather than that of the whole West Midlands.

Public constituency	Number of members	Eligible membership
Age (years):		
0-16	93	57,710
17-21	179	51,905
22+	4,645	450,780
Ethnicity:		
White	2,956	444,820
Mixed	34	19,938
Asian or Asian British	1,166	140,324
Black or Black British	662	52,217
Other	344	7,686
Socio-economic groupings:		
ABC1	1,837	187,833
C2	814	82,657
D	1,097	119,569
E	1,414	109,074
Gender:		
Male	2,080	323,159
Female	3,003	341,801

The Trust's first elections have not been held at the time of this plan, but turnout at events for people interested in becoming Governors had been high for public members but relatively low for staff members.

5.2 Membership Commentary

Representation of black and minority ethnic communities in the public membership is good with membership as a proportion of the eligible membership over represented. The white population is under-represented in the membership but still makes up over half of our members. Young people are under-represented and we are working with young people in developing and implementing campaigns to increase their interest in becoming members. Young adults (22-44) and over 80 year olds are also under-represented.

Public members have been very keen to be involved and many public members who have left have done so because their circumstances have changed and they have not been able to get involved as they would have liked. Other members have asked to be taken off the list because their health has deteriorated or relatives have informed the Trust that a member has passed away.

A membership programme has been developed to ensure that members have the opportunity to play an active role in Trust activities. Over 800 members registered an interest in attending the Trust's Annual General Meeting in 2008 which had to be held on two dates and use video-conference technology to accommodate all those who attended. Seminars have been held on Allergy, Basic Life support and Resuscitation and Infection Control and a full programme for 2009 has been circulated. The topics selected are in response to member suggestions.

Members have also been involved in workshops to help plan the new hospital and have been surveyed about how they would like to be involved in other ways, such as volunteering, patient forums, reading groups etc. During 2008/09, members will have been asked for their feedback on our customer care promises and the annual report and have received copies of membership newsletters and the "Towards 2010" newsletter.

Staff are automatically members of the Foundation Trust but can opt out. To date, two members of staff have opted out.

March 2009

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	2009/10 Budget & Medium Term Financial Plan (Final Draft)
SPONSORING DIRECTOR:	Robert White, Director of Finance & Performance Management
AUTHOR:	Robert White, Director of Finance & Performance Management
DATE OF MEETING:	26 March 2009

KEY POINTS:

Provides the final draft budget plan 2009/10 (and schedules for insertion into the overall budget book) for approval by the Trust Board.

Surplus plan of £2,269,000 FIMS/ £4,314,000 LTFM in 2009/10, with a capital programme of £19,778,000 (subject to final CRL – Capital Resource Limit, confirmation from the SHA).

The Finance and Performance Management Committee considered the plan at its meeting on 19 March 2009.

PURPOSE OF THE REPORT:

☐ **Noting** ☒ **Approval**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

RECEIVE AND REVIEW the draft budget & financial plan

NOTE the recommendation from the Finance & Performance Management Committee to approve the Budget following its scrutiny process

AGREE to receive in-year monitoring of financial performance

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

- N/A

IMPACT ASSESSMENT:

FINANCIAL	☑	£4.3m surplus (which also acts as part contingency) funded in part through additional savings
ALE	☑	Presentation of medium term plan
CLINICAL	☐	
WORKFORCE	☐	
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

Sandwell & West Birmingham Hospitals NHS Trust

Paper to Trust Board

Thursday 26th March 2009

2009/10 Budget & Medium Term Financial plan

1. Introduction

This paper presents the draft budget plan for 2009/10 together with financial planning estimates for the following two years. It has been compiled in accordance with the statutory duties of an NHS Trust. All supporting schedules will be brought together in a 'Budget Book'. The financial assumptions and forecasts have been presented to F&PMC (Finance and Performance Management Committee) for scrutiny. A 'Foreword' is to appear at the beginning of the Budget Book. The suggested draft is as follows:

Foreword

The publication of this Budget Book follows another successful year both in terms of clinical and financial performance. Achievement of the planned surplus of £2,500,000 in 2008/09 within overall resources of £355,407,000 marks the 3rd successive year of positive financial results. The Trust needs to build on these results as it enters an undoubtedly more challenging financial period over the next few years. Ensuring value for money from the investments that are made is vital so as to maximise the quality of services and the experience of our patients.

At the time of writing the Trust continues to pursue Foundation Trust status. It does this in the context of ongoing development plans as part of the 2010 programme. The additional financial freedoms that self-governing status offers will help us to deliver these plans. Irrespective of our corporate form (FT vs. NHS Trust), continued strong financial management by all is needed and appreciated.

Roger Trotman
Chair
Finance & Performance Management Committee

Robert White
Director of Finance & Performance Mgt

Schedules supporting this document include:

Annex/App	Description
Annex 1	Revised Monitor guidance re: financial assumptions
Annex 2	Trust letter to SHA re: 'headroom' assurances
1	Summary I&E statement 08/09 and 09/10
2	SLA (Service Level Agreement) values
3	Divisional Startpoint Budget values *(memo CIP targets)*
4	Startpoint Workforce Budgets
5	Balance Sheet
6	Capital Programme
7	Cashflow Statement
8	Baseline Budget Reserves
9	Other Reserves
10	CIP summary
11	LTFM 3 year extracts
12	Sensitivity Analysis & Risk

1.1 High Level Control Totals

For as long as the Trust remains within the performance management remit of the SHA it must adopt high level control totals where surplus results and capital budgets are concerned. If circumstances required the Trust to deviate from SHA I&E control totals, it would negotiate a revised plan. To this end, it has been highlighted to the SHA that the FT application process encourages Trusts to pursue challenging surpluses used for:

- future investment (predominately a conversion into capital spending)
- strengthening the balance sheet of the organisation as it moves to self-governing status
- creating sufficient surpluses to counteract the effects of an adverse risk

The SHA must share out its overall underspending target and for PCTs & Trusts this is decreasing over time (£115m in 09/10 and £75m in each of 10/11 and 11/12). Consequently, there is downward pressure on surplus results.

In practice the control totals in the Long Term Financial Model can vary with FIMS (financial information monitoring system used by the SHA) to the extent that the LTFM releases uncommitted contingencies into the final I&E position. The table below summarises these positions and forms the basis of this plan.

	09/10	10/11	11/12
	£000's	£000's	£000's
I&E Surplus per LTFM	4,314	4,400	4,400
I&E Surplus per SHA FIMS	2,269	2,038	1,807
Embedded contingency	2,045	2,362	2,593

The presentation of these numbers has been discussed with the SHA and it is comfortable with this approach. The full I&E can be found at **appendix 1**.

2. LDP (Local Delivery Plan) Settlements & Financial Assumptions

Due to the delayed publication of the national tariff, the department of health moved the deadline for agreement of financial values and activity to Friday 13th March 2009. The Trust can confirm that in conjunction with its PCT partners it met this deadline and thus avoided entering into the SHA dispute resolution process. Further work is required to finalise the heads of terms during March 2009. The standard national contract governs the majority of quality and transactional issues, but specific agreement will be reached in certain areas such as:

- Waiting Times – confirmation of 18 week maximum
- Outpatients with Procedure
- Patient Transport Services
- Cancer Target – confirmation of waiting times
- HRG NZ04* - NZ09* (Pregnancy observation/investigation – formerly N12):
- Maternity Integrated Development Plan
- Regional Specialist Registrars (SPR)
- BMEC – recognition of tertiary costs
- Consultant to consultant referrals
- New to review outpatients ratios
- Urgent Care Centres with each A&E
- Infection Control
- Clinical Coding
- Stroke & Cardiovascular Disease
- Audiology
- Orthotics
- Newborn Hearing:

The changes to the national tariff made this year's negotiations particularly challenging especially the move to HRGv4 (expanded price list to take account of casemix sensitivities) and the reduction in market forces funding.

The financial settlement from the PCTs sits within two year allocation settlements of close to 11% for each our main PCTs. Reference to 'DFT' confirms the 'distance from target' that each PCT is from its targeted level of funding. The Trust's main commissioner, Sandwell PCT, is deemed to be below its targeted level (hence its higher allocation) and HoBtPCT is now above owing to changes in the funding formula.

PCT	09/10 Allocation £000s	10/11 Allocation £000s	Two year increase £000s	Two Year increase %	10/11 DFT %
Heart of Birmingham	523451	550366	52906	10.6%	10.2%
Sandwell	523488	552279	56083	11.3%	-5.4%

[source: http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/index.htm]

The table below confirms the makeup of tariff based inflation and the specific items the DH regarded as inflationary pressures prior to a 3% reduction for efficiency savings. The most significant of these is the pay settlement uplift which the Trust has reserved for.

Annex C : Tariff uplift 2009-10

	2009-10 (over 2008-09 baseline)		Assumptions	
Baseline	**64,640**	%		
Increase in pay and prices				
Pay	1,750	2.7073	Pay settlement in line with DH DDRB recommendation: 2%; NHSPRB multi-year deal: 2.54%. Also include pay drift and harmonising statutory annual leave.	
Non-pay inflation	240	0.3713	GDP deflator 1.50%	
Clinical Negligence[1]	100	0.1547	Forecast local contributions	
Secondary Care Drugs	620	0.9592	Includes NICE recommendations	
Revenue cost of capital	260	0.4022	PFI; depreciation; cost of capital	
Working Time Directive	150	0.2321	To support WTD compliance	
Beneficial impact of VAT reduction on costs	-80	-0.1238		
Efficiency	-1,940	-3.0012	3.0% in line with spending review settlement	
	1,100	***1.7017***		

As previously reported to the committee, the most significant or at least transparent change in funding concerns the market forces factor. In 2008/09, SWBH received approximately £20.7M based on an index of 9.76%. The target index has been adjusted downward to reflect, in part, that tariff prices have been inflated by 3.5%, but also to move closer to revised MFF targets.

Trust	08/09 Index	Target Index	09/10 Index
Birmingham Childrens	1.1278	1.0500	1.0697
Dudley Group	1.0577	1.0348	1.0348
Heart of England	1.1141	1.0492	1.0567
Royal Orthopaedic	1.1256	1.0430	1.0676
Royal Wolverhampton	1.0674	1.0313	1.0313
Sandwell & West Birmingham	**1.0976**	**1.0393**	**1.0411**
University Hospital Coventry & Warwickshire	1.1423	1.0638	1.0834
University Hospitals Birmingham	1.1265	1.0461	1.0685
Walsall	1.0462	1.0315	1.0315
Womens Hospital	1.1308	1.0477	1.0726

The net result of moving from 9.7% to an effective rate of 7.6% (3.5% in tariff plus 4.1% add-on) was a loss of income of £3.8m leading the Trust to push hard during negotiations in an effort to mitigate this loss. The table above confirms that the Trust was effectively moved to its target. Future year movements are immaterial at c. 0.1% of turnover. As the table shows, some Trust's will need to move by a further 2%.

The factors above, together with income generated from agreed activity levels, combine to inform the Trust's income estimate. This includes the CQUIN (commissioning for quality and innovation) additional 0.5% allocation previously presented to the F&PMC.

As in previous years, the income plan will be added to for specific allocations such as 2010 project fees and the timing of transitional financial funding allocations associated with the 2010 programme. An analysis of income by commissioning body can be found at **appendix 2.**

The activity plan supporting the income estimates sits within the Annual Plan paper submitted to the Trust Board.

2.1 Financial Assumptions

2.1.1 Income Assumptions

The Transitional Framework Framework comes into force and applies to major programme changes such as:

- Urgent Care Centre at City to have incremental costs funded with a new 4th local tariff in place

- Outpatient exemplars to be captured on hospital PAS and charged at tariff

Proposals agreed for the funding of the eye hospital (i.e. tariff-plus reimbursement) are enforceable upon associate commissioners

As modelled the 2010 Acute project fee income is available from the SHA (confirmed) and costs are kept within these sums

There is no other financial assistance other than that agreed via the Transitional Financial Framework for 2010 exemplar projects

Prudent estimate of Education levy income

Activity is delivered to at least LDP target levels

Activity associated with Income related CIPs is delivered

Current data quality will be maintained and/or improved

No major counting or coding changes are envisaged other than those arising from HRGv4 and good practice improvements

2.1.2 Expenditure Assumptions

Cost Improvement Plan savings are delivered in full

Specific reserves match the cost profile of cost behaviour

Actual payawards are contained within reserves set with reference to pay settlements

Agenda for change provision is sufficient

Contingency of c. £2m held for unforeseen events

Approved divisional cost changes remain within specific reserve values

All final budget adjustments and roll-forward budgets are sufficient to deliver contract targets

3. Cost Improvement Plans and Expenditure Budgets

The financial planning updates presented in January and February 2009 discussed the uncertainty surrounding the LDP settlement together with known cost pressures such as clinical negligence contributions. These factors forced the Trust to conclude that further savings were required. This has not changed and consequently the CIP plan has been adjusted from £12m to £15m representing an approximate programme efficiency gain of 4.5% for 09/10. This will assist in reducing the cost base of the organisation notwithstanding the specific upward cost changes funded either through LDP investments or baseline cost pressures such as CNST, pay uplifts, etc.

The F&PMC has reviewed the cost improvement scheme and has requested further work on any areas of risk within the plan. This process provides the necessary assurance that detailed schemes support the summarised monitoring reports provided each month. Delivery of the CIP remains a top financial management target especially given the more volatile and uncertain funding environment expected after 2010/11. This is best illustrated by recent guidance from MONITOR on the inflation and efficiency assumptions that Boards will need to demonstrate when seeking FT status after 1 May 2009. The Trust's recent submission deadline to the FT applications committee fell before the revised indices were issued and therefore DH/SHA sought assurances that sufficient 'headroom' exists within our plans to accommodate these new assumptions. On 2nd March 2009, MONITOR's letter to applicants stated:

> Monitor's Board has decided that for 1 May authorisations onwards new implied efficiency assumptions will take effect. These are outlined in the table below:
>
> | | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 |
> |---|---|---|---|---|---|
> | Implied efficiency assumption assessor case | 3.0% | 3.5% | 4.0% | 4.0% | 4.0% |
> | Implied efficiency assumption downside case | 3.0% | 4.0% | 4.5% | 4.5% | 4.5% |
>
> The Board additionally decided that in light of the current uncertain macro economic conditions, that a further review should be undertaken of the implied efficiency assumptions for both the assessor and downside cases following the Government's publication of its Budget in April 2009.

The full letter appears at **annex 1.** The Trust has provided the necessary assurances to the SHA **(see annex 2)**

The CIP is presented below by division and theme. The Financial Management Board will continue to review and manage progress and report to the F&PMC throughout the year. The next iteration of service line reporting will be set against these revised CIP targets in order to establish updated 'distances from target' especially in view of the changes within HRGv4.

The tried and tested process of early identification of slippage and replacement with agreed schemes will continue to ensure that rigour and strong control of the programme is maintained.

2009-2010 CIP BY DIVISION

DIVISION	£000's
Anaesthetics & Critical Care	626
Chief Executive Officer	103
Corporate	1,600
Estates	563
Facilities	698
Finance	253
Governance	122
IM&T	627
Imaging	563
Medicine A	1,817
Medicine B	1,547
Nursing & Therapies	322
Operations	682
Pathology	709
Strategy	103
Surgery A	1,978
Surgery B	779
Women's & Child Health	1,905
Workforce	78
TOTAL	**15,075**

An analysis by main theme appears below.

2009-2010 CIP BY CATEGORY

CATEGORY	£000's
Control of Pay Expenditure	2,011
General Resource Management	1,593
Income Generation	3,090
Management of Capacity	2,523
Inflation related reserves & procurement	3,027
Workforce Redesign	2,830
TOTAL	**15,075**

4.0 Financial Planning Risks

The table below contains the majority of financial risks and the way in which the Trust is managing these. The plan itself is consistent with the mitigation plans described in the corporate risk register that is regularly reviewed by the Trust Board.

Risk Factor	Approach to managing risk
Non Delivery of CIP	Contingency reserves established
PbR generally	Tariff exclusions agreed and loss of MFF incorporated into plan
PbR data challenges	Targeted review of systems to improve data quality and timeliness of submission
Practice Based Commissioners	Capacity via Business Development to respond to service offerings, marketing plan and site visits scheduled
Unforeseen events	Contingency reserves
IFRS	Balance sheet converted, IFRS conversion plan agreed, leases to be reviewed prior to commitment
Divisional/Operational underlying pressures	CIP supported by line by line schemes, reserves set aside for specific priorities
Underlying inflationary pressures	Specific reserves set aside
Regulatory Pressures	Funding secured through LDP settlement for example, infection control, screening budgets established
High Level inflationary costs	Specific reserves established for pay awards incremental drift.
Reduced Interest Earnings	Further rate reductions are unlikely to be material. Plan has been significantly changed to reflect low interest earnings
Income assumptions	Startpoint income set at LDP values

5.0 Expenditure Plans (including key schedules)

The appendices capture the current financial planning position and are described below.

Expenditure plans are made up of baseline budgets and separate planned incremental spending. An overall picture of Income and Expenditure is presented at **appendix 1.** This shows total income as £364,921,000 as offset by expenditure of £362,652,000 based on SHA control totals.

A number of reserves have been established through a combination of reinvested cost savings, inflation within tariff and non-tariff prices and discrete investment decisions by the PCTs.

Appendix 8 contains a schedule of pay settlement cost changes and other nationally directed/estimated cost pressures. These reflect known indices as part of agenda for change 3 year agreements as well as a provision for more recent pressures, e.g. the uplift to specialist and associate grades (SAS). Provision for the implementation affecting this latter group appears under '2008/09 agreed schemes'.

Baseline Budget Reserves	
	£000
Inflation and Pay Awards	
National Pay Awards	5,902
Pay settlement increments	800
Other Pay Pressures	350
NHSLA, Cap Charges	3,039
Inflation - nonpay	1,324
Surgical Reconfiguration/EWTD/MMC	813
Total	**12,228**

Specific reserves have been created relating to LDP agreements and where 2008/09 schemes require ongoing funding, e.g. MRSA screening. Funds secured via the 2009/10 LDP round have also been reserved (maternity being one such example). As some of these income streams require further justification an equal and offsetting expenditure reserve is created to offset additional incremental income. The second table captures current budget reserves and specific investment decisions for incorporation into startpoint budgets. The majority of these costs reflect changes to the recurrent cost base of the Trust and are therefore committed, e.g. energy and winter pressures.

Other Reserves	
	£000
LDP Developments & Activity Changes	
MRSA Day Case/Elective Screening	823
Stroke	352
Orthotics	280
Audiology	264
Newborn Hearing	74
Sleep Apnoea	130
Direct Access	520
RRH, UCC 2010 related	1,740
ICD's	119
High Cost Drugs/Lucentis	2,700
Maternity	660
Other activity and baseline changes	532
Total	8,194

The remaining two reserves capture other commitments. As a general point, any non-recurrent slippage owing to a delay in implementing various schemes reverts to the control of the accountable officer (CEO).

2008/2009 Agreed Schemes	
Full year effect pay changes	1,060
Quality Management Framework	252
FYE drugs	154
Surgical Reconfigeration	489
Direct access waiting times baseline	526
Hospital @ Night	380
Security	140
Winter Pressures	500
Energy	500
Operations - Waiting List Funding	500
Safeguarding Vulnerable Adults (SIRG)	77
Sickness Absence Team (SIRG)	56
Ward Housekeeping (SIRG)	215
ESR Implementation (OMB)	80
VAT movements	400
Advance maternity investment (SIRG)	400
Total	5,729

The final category of costs contains corporate issues. For example, the CfH/NpfIT monies represent an investment from PCTs at a level similar to that seen in 2008/09 and do not therefore represent a real terms increase.

Corporate Cost Pressures	
Surgical Reconfiguration - baseline provision	435
NPfIT	2,019
Deep Cleaning/PEAT	454
Bed Replacement Programme	200
Mgt of quality & LIA	123
Maternity investment schemes	531
Central mat leave budget cover	300
Divisional Cost Pressures/Cquin Issues	2,260
Total	6,322

Reserves linked to pay awards and costs occurring from 1 April 2009 onwards will be allocated to budgets from the outset. Other reserves are subject to further scrutiny and will be held in reserves pending these reviews. As divisional startpoint budgets are known, along with CIP targets, divisions and corporate areas are able to sign-off resource schedules. Budget meetings continue to enable other major allocations to be actioned in month 2/3 with strategic reserves managed during the year. The divisional budget startpoint schedules reconcile with the pay and nonpay summary (excluding category C income, also appearing on the divisional startpoint summaries).

5.1 Financial Appendices

Each of the financial appendices is described below.

Appendix 1 – Income and Expenditure

This schedule shows the financial plan in the context of prior year outturn performance. Care is required when making comparisons as 2008/09 will contain one-off income (e.g. PCT & SHA patient environment monies) not replicated entirely in 2008/09. A significant share of reserves will be allocated to the startpoint/rollover pay and nonpay positions.

Appendix 2 – Service Level Agreements

This schedule holds SLA values for PCTs and other income sources. The Sandwell and HoB figures are subject to minor adjustment following the final format of Heads of Terms (i.e. they may be adjusted further for items held in PCT reserves). However, the schedule of income does represent the latest estimate of income which in turn supports the expenditure base.

Appendix 3 – Divisional Startpoint Budgets

This schedule summarises the divisional rollover budgets as set against CIP targets. The process of sign-off of these control totals is underway.

Appendix 4 – Divisional Workforce Budgets

This schedule charts the whole time equivalent budgets contained in pay budgets prior to the allocation of in year reserves associated with developments.

Appendix 5 – Balance Sheet/Statement of Financial Position

The schedule includes new borrowings and the impact of the capital programme on fixed asset carrying values along with the main categories of assets and liabilities. It has been stated on the basis of International Financial Reporting Standards and consequently the BTC has now been capitalised (i.e. brought on-balance sheet).

Appendix 6 – Draft Capital Programme

The capital programme is heavily committed for 2009/10. The plan includes assumed borrowing for the purchase of land as part of the new hospital project. Other work continues on developing a funding strategy for equipment for the period leading up to the commissioning of 2010 estate.

Appendix 7 – Cash Flow

The cashflow reflects all movements of cash (both revenue and capital) and assumes a degree of borrowing contingent upon progress with land acquisition.

Appendix 8 – Baseline Budget Reserves

These reserves are established to meet unavoidable pressures associated with pay awards and nonpay inflation.

Appendix 9 – Other reserves

Caveats are attached to the specific reserves insofar as additional scrutiny of pay and nonpay commitments will be undertaken. The sums involved do however contain commitments under the LDP along with baseline budget adjustments to be added to divisional startpoint resources.

Appendix 10 – CIP

The CIP is £15m in 2009/10. The process of establishing the CIP was described earlier in the paper. A robust monitoring process is in place through the FMB (financial management board) chaired by the Chief Executive and reporting into the F&PMC sub-committee of the Trust Board.

Appendix 11 – Long Term Financial Model (LTFM)

A comprehensive set of financial tables is included not just for 2009/10 but for the 3 year period ending 2010/2011. The financial information has been extracted from the Trust's LTFM that is currently undergoing an update.

The appendix captures the 3 year I&E position, balance sheet and cashflow statements. Of importance is the section on Key Ratios and the indicators that inform the Risk Rating. This latter item is artificially understated due to the absence of a working capital facility. The LTFM is a dynamic tool and will be constantly updated for changes associated with the new hospital business case and transitional period.

Appendix 12 – Sensitivity

A range of potential risks and mitigating action is provided in order to demonstrate the degree of sensitivity analysis within the plan.

6. Acute Hospital Project - related costs

Income or expenditure plans are excluded at this stage for the costs associated with the 2010 acute project fees. Separate financial arrangements are in place via the SHA and PCT concerning the funding of the programme and resources are available to meet the 2009/10 forecast expenditure.

7. Capital Programme

The major components of the capital programme **(see appendix 6)** to note are:

- In 2009/10 and 2010/11 the majority of capital resources are reserved to enable the acquisition of land at Grove Lane
- The draft plan in 09/10 provides funds for completing key schemes from 2008/09, e.g. Urgent Care Centre at City Hospital. The slippage arose due to the need to avoid disruption at a time of working towards achievement of the A&E target
- Subject to a Board approved business case, replacement of the City MRI
- A scheme is being developed involving a series of moves at Sandwell to maximise clinical bed space. A Board decision is likely given the scale of the investment (e.g. likely to be above £500k)

- the MAU (medical assessment unit) at City Hospital requires modification to improve the flow of patients and key clinical adjacencies as well as improving the environment
- 2010 & community ophthalmology allocations have been reserved to ensure the devolvement of these services is successful
- Due to new accounting standards leading to the capitalisation of the BTC, there is no longer a need to build up a residual asset on the balance sheet via the annual charge to the capital budget of £500k
- Finally, the longer term plan includes significant investment in medical equipment as pressure to fund major building works reduces.

Specifically in 2009/10, pressure in the programme arises from:

- the self-financing of part of the land acquisition
- the need to renew key imaging equipment
- regular annual allocations for renewing medical equipment and IT infrastructure
- meeting statutory standards and facilities costs

The capital charge consequences of the 2009/10 plan have been incorporated into the overall financial plan.

8. Next Steps

In terms of setting budgets, the next steps include but are not limited to:

- Conversion of contract activity targets to divisional contracts
- Final prioritisation of cost pressure support
- Divisional startpoint budget and CIP sign-off
- Approval of the final draft financial plan and budget book by the Trust Board
- A refresh of the LTFM taking due regard of the regulator's revised guidance on income and efficiency assumptions

9. Conclusions & Recommendations

In setting the revenue plan and capital budget, consideration of the Trust's principal risks has been made especially where linked to the Assurance Framework (which records Trust-wide objectives and risks to achieving those objectives). As in the previous year, this is especially pertinent in terms of additional investment made in cleaning, screening and infection control. Where temporary income investment was made by PCTs in 2008/09 and not replicated in 2009/10, the Trust has ensured the underlying resources have been protected.

This financial plan and appendices (for inclusion in the final budget book) represent a challenging yet achievable plan and investment has been secured during the LDP round for key service areas. A similar structure to that seen in 2008/09 is proposed for the management and monitoring of the Cost Improvement Programme as this is crucial for the Trust's ongoing financial performance.

The Trust Board is asked to:

RECEIVE AND REVIEW the draft budget & financial plan

NOTE the recommendation from the Finance & Performance Management Committee to approve the Budget following its scrutiny process

AGREE to receive in-year monitoring of financial performance

Robert White
Director of Finance & Performance Management

18 March 2009

ANNEX 1

2 March 2009

Monitor
Independent Regulator
of NHS Foundation Trusts

4 Matthew Parker Street
London
SW1H 9NL

T: 020 7340 2400
F: 020 7340 2401
W: www.monitor-nhsft.gov.uk

To: Foundation Trust Applicants
Foundation Trust Unit

Dear Applicant,

I am writing to advise you of some changes to Monitor's financial assumptions used in assessment and in risk rating foundation trust investments. Following the Government's Pre Budget Report, we have carefully considered our financial assumptions. We have concluded that we need to change these assumptions in order to maintain Monitor's assessment bar and fully reflect the Government's current economic outlook. This letter sets out the changes that Monitor is making to both its assessor and downside assumptions. These revisions come into effect for all authorisations from 1 May 2009 onwards.

As you will be aware, our current assumptions for income inflation are based around an implied efficiency assumption for acute and mental health providers of 3% in our assessor case and 3.5% in our downside case across each of the five years in our assessment period. Our decisions on assessment are based on the downside case.

Monitor's Board has decided that for 1 May authorisations onwards new implied efficiency assumptions will take effect. These are outlined in the table below:

	2009/10	**2010/11**	**2011/12**	**2012/13**	**2013/14**
Implied efficiency assumption assessor case	3.0%	3.5%	4.0%	4.0%	4.0%
Implied efficiency assumption downside case	3.0%	4.0%	4.5%	4.5%	4.5%

The Board additionally decided that in light of the current uncertain macro economic conditions, that a further review should be undertaken of the implied efficiency assumptions for both the assessor and downside cases following the Government's publication of its Budget in April 2009.

The resulting income assumptions are as follows:

Assessor case	**2009/10***	**2010/11**	**2011/12**	**2012/13**	**2013/14**
Clinical income	2.2%	1.7%	1.2%	1.2%	1.2%

* Consistent with the assumptions used in the current operating framework and includes CQUIN at an additional 0.5%.

Downside case	**2009/10***	**2010/11**	**2011/12**	**2012/13**	**2013/14**
Clinical income	2.2%	1.2%	0.7%	0.7%	0.7%

These revised assumptions will operate for assessments with a proposed authorisation date of 1 May 2009 onwards. This includes first assessments as well as assessments of deferred or postponed applications.

Applicants will need to make their own assessment for their base case assumptions around income and cost inflation. However, they should be aware that Monitor will normally apply the assumptions detailed above when generating the assessor and downside cases. Our assessment criteria set out the requirement to deliver a sustainable surplus by year 3 after a reasonable set of downside risks. This means in order to pass our financial viability test applicants will need to be able to demonstrate sustainable surplus after applying the downside income inflation above, but after allowing credible mitigations to address this downside risk. In order to meet our assessment criteria applicants will need to focus their work on developing robust Cost Improvement Programmes which can meet the increased efficiency requirements whilst maintaining quality of care to patients.

This letter is being copied to the Foundation Trust Unit and SHA provider development leads for onward circulation to aspirant foundation trust applicants. In addition I have copied the letter to the Foundation Trust Network for circulation to their members.

Should you require any clarification on this letter please contact Jason Dorsett. Jason's email address is jason.dorsett@monitor-nhsft.gov.uk.

Yours sincerely

Stephen Hay
Chief Operating Officer

CC: SHA Provider development leads
Foundation Trust Network

ANNEX 2

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Management Block
City Hospital
Dudley Road
Birmingham
B18 7QH

Tel: 0121 554 3801
www.swbh.nhs.uk

12 March 2009

Kate Barber
Head of Provider Development
NHS West Midlands
St. Chads Court
213 Hagley Rd
Birmingham
B16 9RG

Dear Kate

As you are aware our IBP submitted on 1st March for this month's applications committee predated the letter from Monitor on 2nd March revising the modelling assumptions it expects to see in LTFMs for Trusts with an authorisation date after 1st May 2009.

We have discussed our intention to fully revise our model for Monitor - updating to the IFRS version and including outturn for 2008/09 and the LDP settlement (what is available initially will be dependent on the precise dates that Monitor start their examination). We will of course include the new assumptions (and any further assumptions that Monitor may issue post Budget) in that updated model.

The intention of this letter is to inform you of the work we have undertaken internally to assure ourselves that the fundamental assumptions behind our future plans are robust and that we are confident that when we produce the updated model it will still be within the acceptable parameters for authorisation.

We have considered across the years 2009/10 to 2017/18 what effect a reduced I&E position would have on our Financial Risk Rating. As we are modelling outside the LTFM for this purpose we have assumed as a proxy that a reduction in surplus will have an equal effect on EBITDA and the cash element of the liquidity ratio. This will not be precisely correct but should be close enough to understand what headroom we have available.

Our Turnover is £348m so reduced income growth of 1 % creates a downward impact of c.£3.5m prior to mitigation.

There are five years in our base case scenario where the inability to cover a reduction of this level via increased efficiencies would reduce our risk rating from a 4 in the current model to a 3. However, any adverse impact would need to be more than twice this amount in any year before the risk rating was reduced to a 2.

In the downside scenario (mitigated version) we remain at a risk rating of least 3 in each year except 2015/16 and 2017/18 where headroom is more limited. This arises in part from an already reduced EBITDA margin owing to the way in which the model treats PFI related expenditures. With an IFRS based LTFM model available, the next iteration of the plan will significantly improve the EBITDA parameter allowing the risk rating in those years to remain stable and at an appropriate level.

It is our intention to plan for and achieve the increased efficiencies targeted in the letter and we are confident in our ability to do so. We have increased our internal efficiency target in 2009/10 to cover the volatility in income we perceive from the introduction of HRG4 and associated MFF changes. As we discussed, these efficiencies are not yet reflected in the LTFM.

Undoubtedly, there will be challenging decisions to make in pursuing the revised efficiency levels. However, as we stated during our meeting, the Trust possesses a strong record of delivery by employing robust planning, monitoring and management techniques before and during the delivery period in question.

In the light of this and the modelling we have carried out we are confident that our next iteration of the LTFM will be within the parameters for authorisation as a Foundation Trust.

Yours sincerely

John Adler
Chief Executive

cc: Robert White
Daphne Lewsley

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Communications and Engagement Strategy 2009-2012
SPONSORING DIRECTOR:	Jessamy Kinghorn, Head of Communications and Engagement
AUTHOR:	Jessamy Kinghorn, Head of Communications and Engagement
DATE OF MEETING:	26 March 2009

KEY POINTS:

This Communications and Engagement Strategy replaces the existing Trust Communications Strategy which was a three year strategy produced in 2005.

The purpose of the strategy is to provide a framework for planning and directing communications and engagement activities across the Trust for the next three years, to set out the principles underlying communications and engagement and to set out a range of actions which can be monitored and evaluated.

The strategy has been developed in consultation with the Trust Board, Communications and Engagement team and patient and public representatives.

Of particular note is the action plan (section 8) which sets out a comprehensive list of actions required across the Trust to deliver the strategy over the first 12 months and some initial actions for the following years. Progress against this action plan will be monitored by a Communications and Engagement Governance Group that will report to the Governance Board. It is intended that the Trust Board will receive annual progress reports.

This is designed to be a Trust-wide strategy, with action required across the organisation. It will be the responsibility of the Communications and Engagement team to drive the strategy, with particular actions the responsibility of different divisions / departments. The whole organisation and each member of staff has responsibility in communicating and engaging effectively.

Following the recent publication of a Reputation Management guide for Boards by the NHS Confederation, further work will take place around the reputation management and branding actions outlined within the strategy.

PURPOSE OF THE REPORT:

To ask the Trust Board to approve the Trust's Communications and Engagement Strategy.

✓ Approval

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to APPROVE the strategy.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

The objectives within the strategy align directly to the Trust's Strategic Objectives and support delivery of the annual objectives.

The strategy also aligns to national requirements including HCC core standards, ALE requirements, CNST, Section 242 of the Health and Social Care Act

IMPACT ASSESSMENT:

FINANCIAL	☑	Cost pressures identified primarily with regard to patient information, patient surveys and Foundation membership
ALE	☑	Achievement of 5.2.7, 5.2.8, 5.2.9 (all level 4) Value for Money
CLINICAL	☑	Significant actions around clinical communication and correspondence; and around clinical information
WORKFORCE	☐	
LEGAL	☑	Equality Legislation; CNST level 2 requirements around patient information; Section 242 of the Health and Social Care Act – duty to involve;
EQUALITY & DIVERSITY	☑	Consideration of impact of approach and communications and engagement actions across all equality strands; definition of 'hard to reach' groups
COMMUNICATIONS	☑	Central to delivery of the strategy
PPI	☑	Central to delivery of the strategy. PPI representatives given opportunity to comment on strategy
RISKS		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Communications and Engagement Strategy
April 2009 – March 2012

March 2009

Contents

Executive Summary

Introduction

This document sets out the Trust's strategy for communicating and engaging with its staff, patients, stakeholders and local people in the short to medium term. It aims to put in place the foundations to meet the challenges of the next three years and will be refreshed annually.

The purpose of this strategy is primarily:

- To provide a framework for planning and directing communications and engagement activities across the Trust over the next three years
- To set out the principles underlying communications and engagement with staff, patients, stakeholders and local people
- To set out a range of actions which can be monitored and evaluated

The aims of the strategy are:

- To reinforce the values of the organisation
- To ensure the Trust is informing and involving staff, patients and local people in the business of the Trust
- To improve clinical communication between clinical staff and patients, and clinical staff and other health professionals
- To continue to build trust in the organisation by staff, users of the service and the general public
- To support and promote the strategic direction of the organisation and contribute to providing excellent patient experiences
- To improve the relationship of the Trust with staff, patients, stakeholders and local people
- To enhance the reputation of the Trust
- To play a role in educating patients and local people in their responsibilities (for example in attending appointments)

Development of the Strategy

The strategy has been developed by the Head of Communications and Engagement, in consultation with the Trust Board, Communications and Engagement team and patient and public representatives.

Definitions and approach

Good communications means messages are understood by the intended audience in the way they are meant to be understood. They give patients, staff, stakeholders and local people the information they need and enhance and protect the reputation of the Trust. Communication is delivered by everyone at all levels.

Engagement means keeping people informed, in a timely manner, about what is planned both at an individual and service level, and giving them the opportunity to share their views on our plans, asking them about their experience, being open when things don't go to plan, involving them in making improvements, giving them the opportunity to raise ideas, concerns and complaints and responding to them.

This strategy sets out our approach to staff engagement through Listening into Action (LiA) and public engagement using a three level approach:

- Day to day (service development)
- Special purpose (project based)
- Corporate (usually topic specific feedback and involvement)

The strategy also outlines the Trust's eight principles of Communications and Engagement:

- Two-way (responsive)
- Accurate
- Clear
- Open
- Honest
- Timely
- Sensitive (empathetic)
- Inclusive

Strategic Context

The Trust's Communications and Engagement Strategy is aligned to the Trust's vision, values and objectives.

The Trust's vision is:

We will help improve the health and well-being of people in Sandwell, western Birmingham and surrounding areas, working with our partners to provide the highest quality healthcare in hospital and closer to home.

The Trust's values are:

- Caring and Compassionate
- Accessible and Responsive
- Professional and Knowledgeable
- Open and Accountable
- Engaging and Empowering

The Trust's Strategic Objectives are:

- Accessible and Responsive Care
- High Quality Care
- Care Closer to Home
- Good Use of Resources
- 21st Century Facilities
- An effective NHS FT

The following table shows how the Communications and Engagement Strategy aligns with and supports the Trust's strategic objectives:

Strategic Objectives	Communications and Engagement Strategy Objectives
Accessible and Responsive Care	Our patients, their carers and the clinicians responsible for their care (including GPs), will have the information they need to understand their treatment and to improve the experience they have in hospital, and their aftercare We will ensure patients and GPs have the information they need, when they need it, in the format they need, when choosing this hospital We will listen to our patients by establishing systems to monitor levels of patient satisfaction
High Quality Care	We will uphold public confidence in the Trust and its services through managing the Trust's reputation and promoting its services and successes We will facilitate implementation of the Trust's marketing strategy through appropriate marketing to and engagement with GPs, commissioners, community and patient groups We will develop our approach to engagement with patients, carers, stakeholders and local people to improve our services and undertake meaningful consultation and involvement in relation to changes and access to services
Care Closer to Home	We will promote the concept of care closer to home, the provision of services outside the main hospitals and the Towards 2010 Programme
Good Use of Resources	We will engage with the public over our use of resources
21st Century Facilities	We will engage with staff, partners, patients, their carers and local people to develop and promote plans for the new hospital
An Effective NHS Foundation Trust	We will ensure staff have the information they need and want to carry out their work effectively and play a full part in the organisation. We will promote comprehensive staff engagement The communications crisis management and major incident response will be to a high standard We will enable our Foundation Trust members and key stakeholders play an important role in the activities and direction of the Trust, and will listen to their views and ideas We will implement a consistent brand across the organisation that reflects our values and increases awareness of the Trust

Audiences

There are five key audience groups for communications and engagement.

- Staff
- Patients and Carers
- Local people (including voluntary and community groups)
- Media
- Stakeholders

Each of these audiences has characteristics that are important to understand if we are to communicate and engage with them effectively. They include characteristics that will make it particularly challenging to engage with particular groups and audiences that are especially 'hard to reach,' such as staff that do not have access to email, staff in the community, non English speaking communities, young people, people with learning difficulties, refugees and travelling communities. Delivery of the Trust's membership strategy has identified young people and people over 80 as particularly difficult to engage with.

Strengths, weaknesses, opportunities and threats

- Strengths: the trust has an excellent track record of large-scale consultation and engagement, high levels of engagement with Foundation Trust members, good levels of patient satisfaction around levels of information received and high levels of staff engagement
- Weaknesses: The traditional approach to communications and engagement has been based on immediate priorities rather than a systematic approach with no dedicated corporate engagement or patient information support. The two local authorities have different approaches to engagement with local communities.
- Opportunities: building on the interest from our Foundation members and developing a programme of activities that maximises involvement, further increasing staff engagement, developing care closer to home and meeting the needs of a diverse population
- Threats: high levels of expectation from commissioners and local people, competition from other providers, the challenges brought by such a diverse population.

Conclusion

The opportunities presented by NHS Foundation status with an engaged membership, and Listening into Action (LiA) place the Trust in a strong position to further enhance its approach to communications and engagement. This strategy sets out that approach in detail and explains the actions that will be required to deliver such an ambitious plan.

Every member of the Trust has a part to play in delivering the Communications and Engagement Strategy and to ensure that the communications and engagement principles are embedded into the organisation.

Undertaking such comprehensive communications and engagement will require greater Governance arrangements which are outlined in section 11 of the strategy.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Communications and Engagement Strategy

April 2009 – March 2012

1. Introduction

1.1 Effective communication is about getting the right messages to the right audiences through the most appropriate channels at the most appropriate times.

1.2 It is a two-way process. As well as informing and sharing, listening and responding to incoming communications is also essential. By continuously improving what we do and the way we do it through inviting and welcoming feedback and giving staff, patients and local people opportunities to get involved with decision making, we build trust and enable the organisation to become more effective, and ultimately to provide a better service for patients.

1.3 This document sets out the Trust's strategy for communicating and engaging with its staff, patients, stakeholders and local people in the short to medium term. It aims to put in place the foundations to meet the challenges of the next three years and will be refreshed annually.

1.4 The strategy sets out principles underlying communications and engagement both within the Trust and between ourselves and our staff, patients, stakeholders and local people (our audiences are fully defined in section 6).

1.5 It sets out the strategy in the context of the Trust's vision, values and objectives, as well as other Trust policies, the Towards 2010 Communications and Engagement Strategy, Trust's marketing and membership strategies and national guidance. It includes an action plan that outlines the key activities that will be required to deliver this strategy.

1.6 The strategy outlines our strengths, weaknesses, opportunities and threats to successful delivery (section 7), including the challenging context within which we are communicating and engaging.

1.7 The purpose of this strategy is primarily:

1.7.1 To provide a framework for planning and directing communications and engagement activities across the Trust over the next three years

1.7.2 To set out the principles underlying communications and engagement with staff, patients, stakeholders and local people

1.7.3 To set out a range of actions which can be monitored and evaluated

1.8 More specifically, the aims of this strategy are:

1.8.1 To reinforce the values of the organisation

1.8.2 To ensure the Trust is informing and involving staff, patients and local people in the business of the Trust

1.8.3 To improve clinical communication between clinical staff and patients, and clinical staff and other health professionals

1.8.4 To continue to build trust in the organisation by staff, users of the service and the general public

1.8.5 To support and promote the strategic direction of the organisation and contribute to providing excellent patient experiences

1.8.6 To improve the relationship of the Trust with staff, patients, stakeholders and local people.

1.8.7 To enhance the reputation of the Trust

1.8.8 To play a role in educating patients and local people in their responsibilities (for example in attending appointments)

2. Development of the Strategy

The strategy has been produced by the Head of Communications and Engagement following the approach set out below:

Action	Date
Initial proposals created by the Head of Communications and Engagement in consideration of Trust agenda and previous communications strategy	Summer 2008
Principles and objectives debated and developed at communications and engagement team away day	22nd October
Circulated to the Trust Board for comments	12th November 2008
Presentation to Independent Patients' Forum for comments and discussed at Sandwell Patient Experience Group	25th November / 1st December 2008
Trust Board seminar to discuss and develop concepts	29th January 2009
Head of Communications and Engagement to produce first draft of strategy	19th February 2009
Further Trust Board discussion at Board away day	26th February 2009
Further discussions with patient / public groups	February/March 2009
Strategy to be approved by the Trust Board	26th March 2009

This strategy builds on the Trust's previous Communications Strategy that was launched in 2005. An update on actions is at appendix one.

3. Definitions and Approach

3.1 Communications

- *"Communication is an act by which one person gives to, or receives from, another person, information about that person's needs, desires, perceptions, knowledge, or affective states. Communication may be intentional or unintentional and may involve conventional or unconventional signals, may take linguistic or non linguistic forms, and may occur through spoken or other modes."* National Joint Committee for the Communicative Needs of Persons with Severe Disabilities, 1992 (USA)

- *"Effective communications will be critical to assessing need, planning and securing and providing services for the local population."* Department of Health Publication 'Shifting the Balance of Power – Communications,' 2002

3.1.1 Good communications are essential to ensure messages are understood by the intended audience in the way they are meant to be understood. They give patients, staff, stakeholders and local people the information they need and enhance and protect the reputation of the Trust.

3.1.2 Good communication depends on the commitment of everyone who works for the Trust to plan and prepare what they want to communicate, decide how best to get the message across and to offer opportunities for people to share ideas and concerns.

3.1.3 Communication is delivered by everyone at all levels – from corporate messages to doctors communicating directly with patients, their families and GPs, to medical secretaries requesting the correct patient notes for the right clinic.

3.2 Engagement

3.2.1 The Operating and Financial Framework for 2008 says:

- *"Everything we do in the NHS must be geared towards improving the patient's experience of NHS services and clinical outcomes of care. In order to achieve this, the NHS must get much better at listening and responding to the patients who use our services, the staff who provide them, and the citizens who fund them*

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- *"Employers who engage with their staff … tend to have higher rates of patient satisfaction with their services.*

- *"Organisations that fully involve all their communities and respond to their needs are able to make better decisions and develop services that are fit for the future."*

3.2.2 Section 242 of the NHS Act 2006 places on us a duty to involve, engage and consult.

3.2.3 People who deliver and receive the service we provide need to be at the centre of all that we plan and do. Their involvement is key to getting it right. This means:

3.2.3.1 Keeping people informed, in a timely manner, about what is planned both at an individual and service level, and giving them the opportunity to share their views on our plans

3.2.3.2 Asking people about their experience (good and poor)

3.2.3.3 Being open when things don't go to plan

3.2.3.4 Giving people the opportunity to raise ideas, concerns and complaints and responding to their comments, concerns and congratulations

3.2.3.5 Involving people in making improvements and in ensuring the improvements are sustained

3.2.3.6 Making staff feel listened to and involved so that they are more motivated and produce better results

3.2.4 There is a significant body of evidence across a variety of sectors that shows that staff who feel listened to and involved are more motivated and produce better results.

3.2.5 The Trust has developed an approach to Staff Engagement, called Listening into Action (LiA), led by the Chief Executive, which it is aiming to embed into the culture of the organisation. Together with Your Right To Be Heard in the staff newspaper (Heartbeat), where staff can write in about anything and expect to have their letter and a reply printed, LiA is the main process by which staff engagement is delivered.

3.2.6 We are developing a three level approach to public engagement:

3.2.6.1 Day to day (service development)

- Led at service level
- Engagement toolkit and best practice examples
- Advice from Communications and Engagement team

3.2.5.2 Special purpose (project based)

- Supported by Communications and Engagement team
- Major consultation is now led by the Primary Care Trusts, with key input from the Communications and Engagement team

3.2.6.2 Corporate (usually topic specific feedback and involvement)

- Primarily through Foundation Trust (FT) members
- Delivered by Communications and Engagement team
- Input from clinicians and managers
- Monitoring of FT membership and targeted recruitment (through the membership strategy) are essential to ensure the effectiveness of engagement

3.3 Principles of Communications and Engagement

Eight principles build on the Trust values and underpin communications and engagement activities at Sandwell and West Birmingham Hospitals NHS Trust. These are:

Principle	What this means
Two-way (responsive)	• We will listen and act on feedback • We will recognise that people do not always absorb information completely at first and give them the opportunity to ask questions • We will encourage bottom-up communications
Accurate	• We will ensure our communication with staff, patients, stakeholders and local people is correct • Spelling and grammar will be of high quality
Clear	• Our communications will be clear, simple and consistent • Spoken and written communications will be in Plain English standards • Our standard font will be Arial, size 12 for most documents, size 14 for publications intended for patients and local people - we will not use small or hard-to-read fonts • We will produce large-print versions of documents when appropriate • Handwritten correspondence will be legible • We will avoid information overload • We will be aware of our body language and how it might communicate to those we are talking or listening to
Open	• We will use the most appropriate form of communications, including face to face whenever possible • We will reinforce messages using a range of communication channels • We will be prepared to communicate and engage about all aspects of the Trust
Honest	• Our communications will be honest and factual • We will own up to mistakes and offer appropriate apologies • We will not mislead our audiences • We will be up front about the influence people can have when asking for their views
Timely	• Our communications will be prompt • Engagement will take place as early in the process as possible
Sensitive (empathetic)	• We will always try to put ourselves in the position of those we are communicating with and treat people how we would like to be treated • We will aim to be reassuring • We will respect the views, opinions and rights of others • We will treat others with dignity through our communications and engagement
Inclusive	• We will make appropriate efforts to include staff, patients and local people who may otherwise be excluded by conventional communications and engagement methods • We will encourage involvement • We will ensure we consider the needs and views of 'hard to reach groups' as well as those who have particular communication needs such as those who do not speak English, those who have learning difficulties, those who have a visual or hearing impairment.

4. Strategic Context

4.1 Effective communications and engagement is central to the NHS quality agenda. The Healthcare Commission assessment for Use of Resources includes several references to communication and engagement in its assessment of value for money, and two of the core standards used in determining Quality of Services are specifically around patient information and engagement.

4.2 It is important to understand the context within which the Trust is communicating and engaging with its audiences. The Trust's vision and values underpin the very fibre of the organisation and should come across in everything it does. It is especially important that the vision and values are reinforced through the Trust's communications and engagement activities and objectives. To that end, the Trust's vision, values and objectives formed the starting point for this strategy.

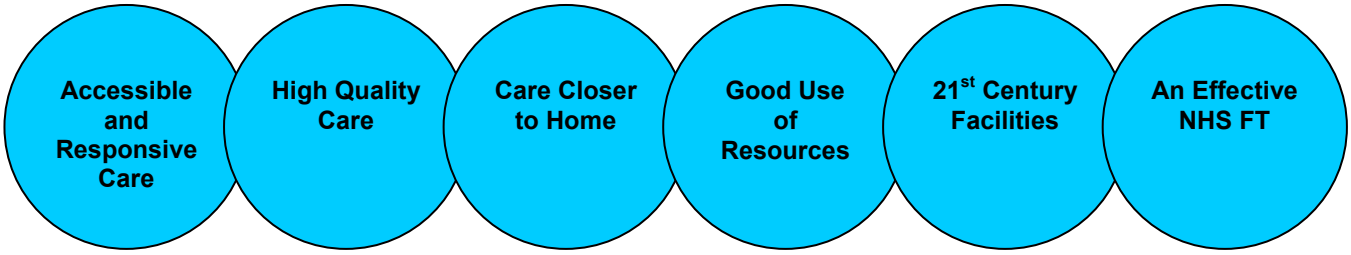
4.3 The Trust has agreed a vision for the organisation:

We will help improve the health and well-being of people in Sandwell, western Birmingham and surrounding areas, working with our partners to provide the highest quality healthcare in hospital and closer to home.

4.4 The Trust's values are:

Our Values	What this means
Caring and Compassionate	• We care for patients, their carers and relatives as they want us to. • We treat all our patients with dignity and respect.
Accessible and Responsive	• Our services are accessible to all. • We identify and respond to the diverse needs of the patients and communities that we serve. • We involve patients in decisions about their care.
Professional and Knowledgeable	• We demonstrate high levels of competence and professionalism in all we do. • We provide safe, high-quality services. • We pursue opportunities for innovation in the way we provide services.
Open and Accountable	• We are open about what we do. • We are accountable to patients and local people for the decisions we take and the services we provide.
Engaging and Empowering	• We value the experience and knowledge of all our staff and listen to their ideas. • We work together across boundaries to provide the very best care. • We provide an environment in which staff can flourish and grow.

4.5 The Trust's objectives are:



We will provide services that are quick and convenient to use and responsive to individual needs treating patients with dignity and respect Our access times and patient survey results will be amongst the best of Trusts of our size and type	We will provide the highest quality clinical care. Our clinical outcomes will be amongst the best of Trusts of our size and type Patients and frontline staff will be fully engaged in improving our services.	In partnership with our PCTs, we will deliver a range of services outside of the acute hospital	We will make good use of public money. On a set of key measures we will be among the most efficient Trusts of our size and type	We will ensure our services are provided from modern buildings fit for 21stCentury health care	An effective organisation will underpin all we do. We will develop our workforce, promote education, training and research, and make good use of technologies.

4.6 The draft key themes for the Trust's 2009/10 annual plan are Patient Satisfaction, Clinical Quality, Staff Engagement, Commercial Focus and Population Health. Whilst this strategy is a three year strategy, consideration has been given to these themes in developing the priorities for the first year of the strategy and the action plans for each objective.

5. Trust Communications and Engagement Objectives

The following table shows how the Communications and Engagement Strategy aligns with and supports the Trust's strategic objectives:

Strategic Objectives	Communications and Engagement Strategy Objectives
Accessible and Responsive Care	Our patients, their carers and the clinicians responsible for their care (including GPs), will have the information they need to understand their treatment and to improve the experience they have in hospital, and their aftercare We will ensure patients and GPs have the information they need, when they need it, in the format they need, when choosing this hospital We will listen to our patients by establishing systems to monitor levels of patient satisfaction
High Quality Care	We will uphold public confidence in the Trust and its services through managing the Trust's reputation and promoting its services and successes We will facilitate implementation of the Trust's marketing strategy through appropriate marketing to and engagement with GPs, commissioners, community and patient groups We will develop our approach to engagement with patients, carers, stakeholders and local people to improve our services and undertake meaningful consultation and involvement in relation to changes and access to services
Care Closer to Home	We will promote the concept of care closer to home, the provision of services outside the main hospitals and the Towards 2010 Programme
Good Use of Resources	We will engage with the public over our use of resources
21st Century Facilities	We will engage with staff, partners, patients, their carers and local people to develop and promote plans for the new hospital
An Effective NHS Foundation Trust	We will ensure staff have the information they need and want to carry out their work effectively and play a full part in the organisation. We will promote comprehensive staff engagement The communications crisis management and major incident response will be to a high standard We will enable our Foundation Trust members and key stakeholders play an important role in the activities and direction of the Trust, and will listen to their views and ideas We will implement a consistent brand across the organisation that reflects our values and increases awareness of the Trust

6. 'Audience'

There are five key audience groups for communications and engagement. This section defines each of these audiences and identifies characteristics about the audience that are important to understand if we are to communicate and engage with them effectively. They include characteristics that will make it particularly challenging to engage with particular groups and audiences that are especially 'hard to reach.'

6.1 Staff

6.1.1 Staff are the Trust's ambassadors. The experience and opinion of NHS staff is one of the key influencers of public opinion about local health services.

6.1.2 76% of the Trust's staff occupy positions that provide front line patient care and clinical support services. 24% of staff are employed in non-clinical support and managerial roles. Managers make up around 4% of the total numbers. *(figures taken from Workforce Strategy, 2008)*

6.1.3 Nurses make up the highest percentage of the overall workforce (39%), followed by administration and estates staff. The smallest groups are management (4%), and allied health professionals (4%). *(figures taken from Workforce Strategy, 2008)*

6.1.4 26.2% of staff work part time hours (part time is defined as less than 30 hours – 0.8WTE).

6.1.5 A number of staff work out of hours shifts only

6.1.6 The workforce is primarily concentrated on two main sites - City and Sandwell Hospitals, with a number of staff working at Rowley Regis Hospital and an increasing number staff working in the community

6.1.7 Not all staff have Trust email addresses or regular access to a computer to access their email. Nurses, estates and ancillary staff find it hardest to regularly access email.

6.1.8 Staff satisfaction with communications and engagement between senior management and staff is above the national average. Staff are less optimistic about communication between different parts of the Trust, but staff satisfaction survey results are in line with the national average. *(*based on initial findings in the 2008 staff survey and may be subject to change)*

6.1.9 Particular challenges with regard to staff communication and engagement include the nature of the estate, the number of sites run by the Trust and the number of staff working in the community

6.2 Patients and their carers

6.2.1 The Trust has around 800,000 contacts with patients each year.

Activity	Number of patients
Inpatient Elective	13,395
Inpatient non-elective	66,738
Day cases	46,304
Outpatients	493,054
A & E attendances	224,896
Births	6054

**Figures relate to 2007/08 activity*

6.2.1 The Trust runs around 300 different outpatient clinics and has more than 40 separate medical and surgical specialties.

6.2.2 The majority of our patients live in Sandwell and Birmingham, with patients from other parts of the West Midlands and beyond mainly attending for specialist ophthalmology services at the Birmingham and Midland Eye Centre.

6.2.3 Many of our patients do not speak English as their first language and a large number do not speak any English. The most common non-English language spoken and requested by patients is Punjabi. Full lists are available from the Communications Department.

6.2.4 The Trust has performed fairly well in the provisional patient survey results for 2008 compared to the national average of Trusts whose survey was conducted by the same company (27% of the total). For the questions patients were asked about patient information, communication and involvement, the Trust's performance was better than or in line with the national average. However there is room for improvement. *(*based on initial findings in the 2008 staff survey and may be subject to change)*

6.3 Local people (including voluntary and community groups)

6.3.1 The Trust serves some of the most diverse communities in the West Midlands. Both Sandwell and Birmingham have significantly higher proportions of people from black and minority ethnic groups than other parts of the West Midlands or the average for England. Ethnicity is very diverse within Sandwell and Birmingham with significant variation between Birmingham wards and Sandwell towns. There has also been significant immigration from the countries of Eastern Europe, especially Poland, which is not yet reflected in the population projections for the area.

***Figure 1:** Ethnicity in HoB tPCT Wards*

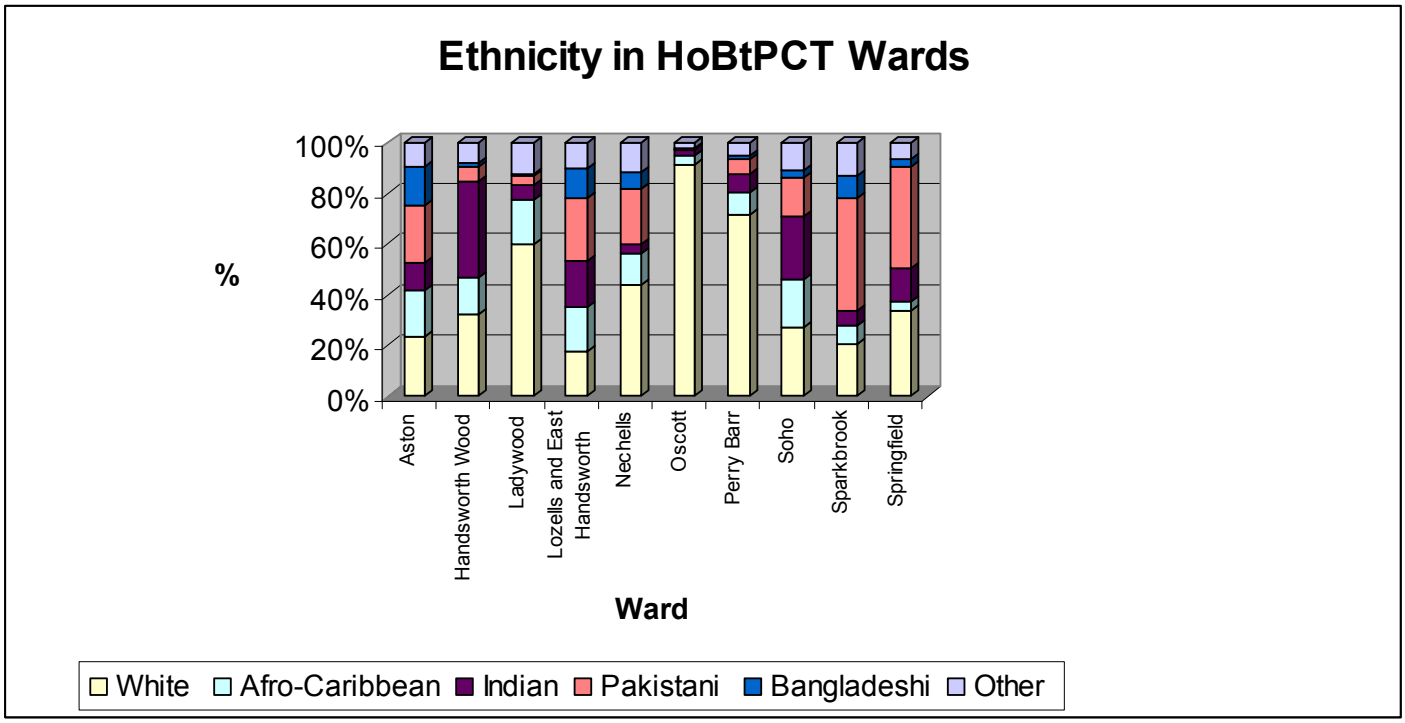
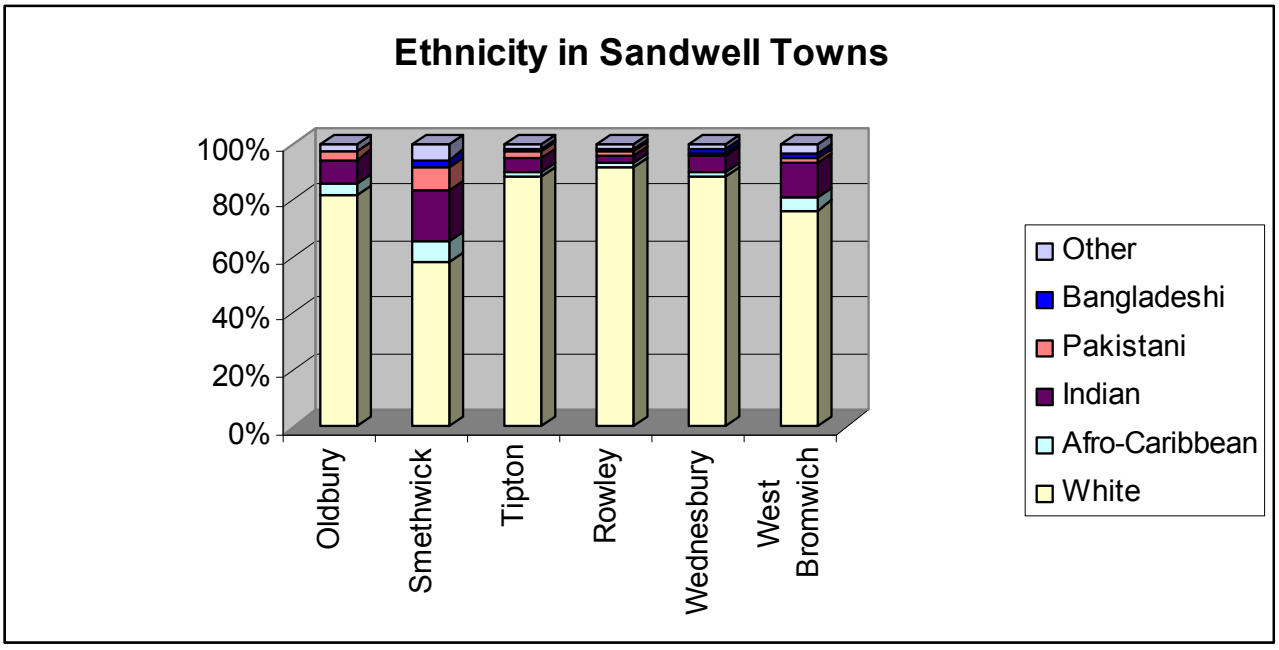


***Figure 2:** Ethnicity in Sandwell towns*



6.3.2 The area is also dominated by high levels of deprivation and poor health. Life expectancy levels are significantly lower than average, there are high levels of infant deaths in Birmingham, high levels of heart disease, stroke, diabetes and cancer, high proportions of people with unhealthy lifestyles, higher than average admissions to hospital caused by alcohol and high rates of teenage pregnancy.

6.3.3 The population in both Sandwell and Birmingham is expected to grow over the next ten years (by 6.1% and 8.7% respectively), with most of the increase in Sandwell being in the number of over 65 year olds and the increase in Birmingham in the number of young people.

6.3.4 There are large numbers of community groups and organisations within our catchment, which are particularly well structured within Sandwell Metropolitan Borough Council. Lists of these groups are available within the Communications Department and a number of key organisations are listed in the Single Equality Scheme Resource Pack.

6.3.5 The demographics of our Foundation Membership in relation to our local population are reported to the Foundation Trust Project Board. Overall, our BME representation is very good, with an over-representation of BME communities of nearly 10% of members, excluding members living in the wider West Midlands. It is harder to engage with young people. Young people aged 11-21 are under-represented by around 12% and 11-40 year olds by nearly 12%. Our male members are under-representative of the local population by around 8%.

6.3.6 Much of our public engagement is driven through our membership strategy and it is by analysing the demographics of our members in relation to the local population that we identify the particularly 'hard to reach' groups in our area (see section 6.6).

6.4 Media (including community and BME media)

6.4.1 Local print media exceed local broadcast media and national media as a source where people find out about the health service (*MORI, 2005/06),* although people do not consider it their only, or most reliable source of information.

6.4.2 The main relationships cultivated with journalists are with local press. For print media, these are mainly the Birmingham Post and Mail, Sandwell Express and Star, Sunday Mercury, Sandwell and Halesowen Chronicles, Halesowen News and Birmingham News. For broadcast media these are mainly BBC Midlands Today, BBC Radio WM and Central News, although there are a number of local radio stations that regularly cover news about the Trust. Information on circulation size is kept by the Communications Department.

6.4.3 The most significant contact with national media is with a range of women's and trade magazines (including She Magazine, HSJ, Hospital Doctor, Nursing Times) and national newspapers.

6.4.4 There are seven local BME media organisations that cover news about the Trust in English and in other languages. There are also a number of community newspapers, although many charge for editorial space.

6.4.5 There is an increasing amount of news coverage online.

6.4.6 The Communications Department analyse the amount of positive and negative media coverage about the Trust. Whilst there is a lot of positive news coverage, public expectations of the health service are very high and there is a significant market for adverse or sensational news stories.

6.5 Stakeholders (including GPs, commissioners, local NHS organisations, local authorities and politicians)

6.5.1 We are situated within the NHS West Midlands strategic health authority area

6.5.2 Our main commissioners are Sandwell Primary Care Trust and the Heart of Birmingham teaching Primary Care Trust. South Birmingham and Birmingham East and North Primary Care Trusts are also important commissioners and we treat a number of patients from other local primary care trusts.

6.5.3 Many of our ophthalmology referrals come from primary care trusts outside our main commissioners

6.5.4 Within Sandwell and Heart of Birmingham primary care trusts, there are 179 GP practices with varying numbers of GPs at each. A number of GP practices from South Birmingham Primary Care Trust and Birmingham East and North also refer patients.

Locality	Number of Practices
Sandwell	70
Heart of Birmingham	109
Birmingham East and North	107
South Birmingham	84

6.5.5 The Trust serves patients across two Local Authorities – Sandwell Metropolitan Borough Council and Birmingham City Council. Both local authorities have a Health Overview and Scrutiny Committee.

6.5.6 There are 72 Councillors in Sandwell, 120 within Birmingham. There are 11 MPs covering 39 wards in Sandwell and Birmingham, with 9 local to the immediate Trust catchment area.

6.5.7 There are two newly formed Local Involvement Networks – one for Sandwell and one for Birmingham. Sandwell are further ahead in establishing their network.

6.5.8 There are a number of acute and specialist provider organisations in close proximity to the Trust. Local Primary Care Trusts are also developing their provider services.

6.6 Hard to reach groups

6.6.1 Within our audiences there are particularly 'hard to reach' audiences that must be considered in all communications and engagement. These include staff that do not have access to email, staff in the community, non English speaking communities, young people, people with learning difficulties, refugees and travelling communities.

6.6.2 Identifying 'hard to reach' groups and our effectiveness in communicating and engaging with them is monitored through our membership strategy.

6.6.3 In December 2007, in response to the publication of 'Our Shared Future' by the Commission on Integration and Cohesion in June 2007, Secretary of State for Communities and Local Government, Hazel Blears said; *"I agree wholeheartedly with the analysis and recommendations on translation set out by the Commission… I am very clear that we should reject automatic translation in favour of a more selective approach, where translation is targeted to particular needs, and which is part of an overall local strategy to promote English."*

6.6.4 In line with the Secretary of State's recommendations, the Communications Department has been using the Government response as the basis for decisions on translation of information. The department will use this document and other available information to develop a formal policy specifically for Sandwell and West Birmingham Hospitals NHS Trust.

6.6.5 Delivery of the Trust's membership strategy suggests that some of the hardest people to engage with are young working adults who have little contact with the NHS and are not part of any religious or community groups.

6.6.6 Nationally 'young people' are perceived as a particularly 'hard to reach' group and delivery of our membership strategy reflects this.

6.6.7 We have also found older people over 80 more difficult to engage with.

6.6.8 Despite the Trust's membership reflecting high levels of engagement with black and minority ethnic communities, it should not be assumed that all black and minority ethnic groups are being reached. There needs to be ongoing efforts to engage with all communities which is delivered through our membership strategy.

6.6.9 Appropriate efforts must be made to include people who may be excluded from conventional communications and engagement methods, including the use of different formats and languages.

7. SWOT analysis

The following table shows an initial SWOT analysis of the Trust's approach to communications and engagement to date:

Strengths	• Excellent track record of large-scale consultation and engagement • High levels of engagement with Foundation Trust members • High proportion of BME Foundation members • Good levels of patient satisfaction around levels of information received • Good reputation with local journalists, in media handling and crisis management • Strong calibre of senior management as spokespeople • Recently restructured corporate communications resource • High levels of staff engagement through the Listening into Action (LiA) approach • Communications and engagement annual reports to the Trust Board • Trust commitment to communications and engagement in developing the plans for the new hospital
Weaknesses	• Traditional approach to communications and engagement based on immediate priorities rather than strategic and systematic approach • No dedicated corporate engagement support • No dedicated central patient information support • Communications and engagement not fully linked into Trust's governance structure • Split site working • Two different approaches to engagement with local communities in Sandwell and Birmingham local authorities
Opportunities	• High levels of interest from local people in Foundation Trust membership and Trust activities • Highly diverse population with differing clinical and communication needs • Towards 2010 programme – care closer to home and new hospital • Service developments • Patient satisfaction measures • Major incident handling • Listening into Action
Threats	• Plurality of providers – Competitive local market with increasing number of providers, including private practices with more opportunities to advertise their services • Media appetite for news about the health service, with some media having a particular emphasis on adverse and sensational coverage • Expectations of commissioners and local people • Highly diverse population with wide ranging communications and engagement needs / wishes • Cynicism • Increasingly young population in Birmingham (young people traditionally not interested in getting involved, but more critical than older people) • Increasing older population in Sandwell, with potential for more people with long-term illnesses which impacts on communications and engagement methods (and those with long-term illnesses tend to be more critical)

8. Action Plans

8.1 Our patients, their carers and the clinicians responsible for their care (including GPs), will have the information they need to understand their treatment and to improve the experience they have in hospital, and their aftercare

To achieve this we will…

In 2009/10:

Action		Date	Exec lead
8.1.1	Develop and introduce standards for spoken, handwritten and printed clinical communications	**End Sept '09**	**MD**
8.1.2	Establish mechanisms for monitoring standards of clinical communication with patients	**End Jan '10**	**MD**
8.1.3	Audit clinical entries in patient records	**End March '10**	**MD DoG**
8.1.4	Improve the range of information available on GP Homepage	**End Nov '09**	**COO**
8.1.5	Set and monitor standards for telephone response times	**End Oct '09**	**COO**
8.1.6	Audit existing patient information and prioritise areas of poor practice for improvement	**End May '09**	**Head of Comms**
8.1.7	Revise and impact assess the Trust's patient information policy and governance arrangements for patient information	**End June '09**	**Head of Comms**
8.1.8	Develop a Board approved formal protocol for translating clinical information and producing it in different formats, with reference to all available national guidance, and promote areas of good practice	**End Oct '09**	**Head of Comms**
8.1.9	Increase (where appropriate) the range of formats and languages in which patient information is available, in consultation with BME, deaf, visually impaired and other relevant groups	**End March '10**	**Head of Comms**
8.1.10	Review and revise the Patient Bedside Directory, ensuring it is available on all wards	**End Nov '09**	**Head of Comms**
8.1.11	Review Trust signage and develop a strategy for improved signage	**End March '10**	**Chief Nurse**
8.1.12	Make greater use of plasma screen technology	**End March '10**	**Head of Comms**
8.1.13	Develop patient information and way-finding strategies for the new hospital, in consultation with patients and visitors	**End Nov '09**	**Head of Comms**
8.1.14	Promote PALS and Complaints services more visibly	**End July '09**	**HoC/ DoG**

Beyond 2009/10:

Action	Exec lead
8.1.15 Develop further methods of improving and measuring the quality of clinical communication	**MD**
8.1.16 Review access to the Interpreting Service	**DoN**
8.1.17 Support each Division to review existing patient information and further develop a broad range of high quality information and patient treatment	**Head of Comms**
8.1.18 Use patient feedback to identify areas within outpatients where patient information can be further enhanced	**Head of Comms**
8.1.19 Ensure that a user friendly database of patient information is easily accessible to staff and patients	**Head of Comms**
8.1.20 Develop and implement a plan to improve the communications between the Trust and patients between referral and first appointment	**COO/ HoC**

8.2 We will ensure patients and GPs have the information they need, when they need it, in the format they need, when choosing this hospital

To achieve this we will…

In 2009/10:

Action		Date	Exec lead
8.2.1	Make sure information is available in libraries, health centres and other appropriate outlets	**End March '10**	**Head of Comms**
8.2.2	Work with in partnership with the Towards 2010 Programme to ensure that information about changes to services are promoted in our local communities	**Ongoing**	**Head of Comms**
8.2.3	Develop and update the information about the Trust and our services on our website	**Ongoing**	**Head of Comms**
8.2.4	Review and update Trust information on NHS Choices	**Ongoing**	**Head of Comms**
8.2.5	Monitor and respond to patient comments on NHS Choices and bring the comments to the attention of the relevant Divisional General Manager	**Ongoing**	**Head of Comms**
8.2.6	Examine the Trust internet presence and make appropriate use of external websites and facilities to promote our services	**End March '10**	**Head of Comms**
8.2.7	Run health seminars promoting our services for our Foundation members as part of our Membership Strategy	**Ongoing**	**Head of Comms**
8.2.8	Run specialty GP seminars as part of our Marketing Strategy	**Ongoing**	**Head of Comms**
8.2.9	Produce an up to date consultant directory for GPs	**End Nov '09**	**Head of Comms**

Beyond 2009/10

Action		Exec lead
8.2.10	Work with Foundation Trust members, GPs, local community groups, BME, deaf, visually impaired and other relevant groups to explore what drives their choice of hospital and the content and format of information they need to help them choose our Trust	**Head of Comms**

8.3 We will listen to our patients by establishing systems to monitor levels of patient satisfaction

To achieve this we will…

In 2009/10:

Action		Date	Exec lead
8.3.1	Implement ward based surveys of patients	**End May '09**	**Chief Nurse**
8.3.2	Make ward based patient survey information available to the wards	**End July '09**	**Chief Nurse**
8.3.3	Issue quarterly patient satisfaction reports to the Patient Experience Group and Independent Patient's Forum	**Ongoing**	**Head of Comms**
8.3.4	Develop a policy on the content of patient surveys / bank of approved questions	**End Nov '09**	**Head of Comms**
8.3.5	Run a campaign to encourage people to give us their views	**End March '10**	**Head of Comms**
8.3.6	Support and develop a 'forum' of patients and local people	**End March '10**	**Head of Comms**
8.3.7	Provide regular feedback on patient satisfaction to staff, stakeholders and local people through Heartbeat, FT newsletter, GP Focus, press releases etc.	**Ongoing**	**Head of Comms**

Beyond 2009/10:

Action		Exec lead
8.3.8	Organise Outpatient and Day Case patient surveys	**Head of Comms**

8.4 We will uphold public confidence in the Trust and its services through managing the Trust's reputation and promoting its services and successes

To achieve this we will…

In 2009/10:

Action		Date	Exec lead
8.4.1	Develop and monitor a proactive PR / media handling strategy for the Trust that sets out how we will handle adverse press enquiries, ensures we are better prepared to handle media interest following national, local or Trust publication of information or reports, outlines our approach to developing closer relationships with local media, and sets clear targets	**End May '09**	**Head of Comms**
8.4.2	Undertake a piece of work on reputation management following the NHS Confederation guide	**End July '09**	**Head of Comms**
8.4.3	Respond promptly and effectively to press enquiries, developing media handling guidelines that further enhance our reputation for dealing with enquiries openly and sympathetically	**Ongoing**	**Head of Comms**
8.4.4	Provide communications guidance and media training to senior managers	**End March '10**	**Head of Comms**
8.4.5	Enhance the media handling ability of the communications team through training	**Ongoing**	**Head of Comms**
8.4.6	Maximise positive publicity through external documentary and educational films	**Ongoing**	**Head of Comms**
8.4.7	Actively look for opportunities to promote the Trust, its services and its staff	**Ongoing**	**Head of Comms**
8.4.8	Raise awareness within the divisions of the benefits of proactive PR to encourage more staff to volunteer stories	**Ongoing**	**Head of Comms**
8.4.9	Monitor media coverage and produce quarterly reports	**End July '09**	**Head of Comms**
8.4.10	Promote the Trust's positive media coverage internally	**End Aug '09**	**Head of Comms**
8.4.11	Look for opportunities to piggy back on DH and other national news	**Ongoing**	**Head of Comms**
8.4.12	Take advantage of appropriate advertising opportunities within community press	**Ongoing**	**Head of Comms**
8.4.13	Develop a calendar of national and regional awards	**End Sept '09**	**Head of Comms**
8.4.14	Work with divisions to encourage staff to put themselves and their colleagues forward for Trust, local and national awards	**End March '10**	**Head of Comms**
8.4.15	Develop, deliver and monitor the infection control communications plan	**Ongoing**	**Head of Comms**

8.5 We will facilitate implementation of the Trust's marketing strategy through appropriate marketing to GPs, commissioners, community and patient groups.

To achieve this we will…

In 2009/10:

Action	Date	Exec lead
8.5.1 Deliver the communications and engagement responsibilities within the Trust marketing strategy	**Ongoing**	**Head of Comms**
8.5.2 Produce a schedule of content for GP Focus	**End April '09**	**Head of Comms**
8.5.3 Produce GP Focus monthly	**Ongoing**	**Head of Comms**
8.5.4 Revise the GP contacts list	**End May '09**	**Head of Comms**
8.5.5 Explore different ways of engaging effectively with GPs	**End March '10**	**Head of Comms**
8.5.6 Develop and implement communications and engagement plans for new services	**End March '10**	**Head of Comms**
8.5.7 Implement and promote the Trust's Customer Care promises	**End May '09**	**CEO / HoC**

Beyond 2009/10:

Action	Exec lead
8.5.8 Produce a calendar of lectures for GPs	**Head of Comms**
8.5.9 Develop and implement service-specific communications and engagement plans around a range of key services	**Head of Comms**

8.6 We will develop our approach to engagement with patients, carers, stakeholders and local people to improve our services and undertake meaningful consultation and involvement in relation to changes and access to services

To achieve this we will…

In 2009/10:

Action		Date	Exec lead
8.6.1	Finalise, publish and roll out involvement and consultation toolkit and best practice examples for staff	**End May '09**	**Head of Comms**
8.6.2	Promote areas of good practice, where clinicians and managers are involving staff, patients and local people in the development of services	**Ongoing**	**Head of Comms**
8.6.3	In line with our approach to engagement (3.2.5), support departments undertaking service change to develop and deliver communications and engagement plans to provide information, consult and engage patients and local people	**Ongoing**	**Head of Comms**
8.6.4	Develop and monitor communications and engagement plans for surgical reconfiguration and other service change and development	**End Sept '09**	**Head of Comms**
8.6.5	Use a variety of methods, including exploring the use of Listening into Action (LiA) methodology to effectively engage with patients and local people around service improvement and development	**End March '10**	**HoC COO / MD / CN**
8.6.6	Produce appropriate literature to explain service changes to patients and GPs	**Ongoing**	**Head of Comms**
8.6.7	Regularly survey Foundation members about plans or considerations for changes and access to services	**Ongoing**	**Head of Comms**
8.6.8	Ensure the Health Overview and Scrutiny Committees and other key stakeholders are kept appraised of service developments	**End March '09**	**Head of Comms**
8.6.9	Establish reading groups to review literature to ensure patients will be able to understand changes to services	**End May '09**	**Head of Comms**
8.6.10	Review and improve the effectiveness of mechanisms to provide feedback to staff, patients and local people	**End March '10**	**Head of Comms**
8.6.11	Participate in health promotion and public education campaigns to encourage local people to lead healthier lives and use the health service appropriately	**End March '10**	**Head of Comms**
8.6.12	Review and update the Trust's contact list for voluntary and community groups, particularly those defined as hard to reach (6.6)	**End March '10**	**Head of Comms**
8.6.13	Continue to implement the Equality and Diversity action plans and the plans of the Patient Experience and other sub-groups	**Ongoing**	**Chief Nurse**

8.7 We will promote the concept of care closer to home, the provision of services outside the main hospitals and the Towards 2010 Programme

To achieve this we will…

In 2009/10:

Action		Date	Exec lead
8.7.1	Contribute to the production of the Towards 2010 newsletter and other communications material	**Ongoing**	**Head of Comms**
8.7.2	Participate in events arrange in relation to the Towards 2010 Programme	**Ongoing**	**Head of Comms**
8.7.3	Promote the concept of care closer to home at relevant Trust events	**Ongoing**	**Head of Comms**
8.7.4	Promote and publicise Phlebotomy services moving into the community (blood tests in shopping centres)	**End March '10**	**Head of Comms**
8.7.5	Develop communications and engagement plans for pilots of services that are moving into the community (such as Ear Clinics)	**End March '10**	**HoC / COO**

Beyond 2009/10:

Action		Exec lead
8.7.6	Following evaluation of pilot moves of services into the community, evaluate effectiveness of communications and engagement plan and develop communications and engagement plans for services that are permanently moving into the community	**HoC / COO**

8.8 We will engage with the public over our use of resources

To achieve this we will…

In 2009/10:

Action		Date	Exec lead
8.8.1	Ask a sample of Foundation Trust members for their views on how we should produce our annual report and other key publications, including the language and format we should use	**End April '09**	**Head of Comms**
8.8.2	Establish an effective Governance process to ensure that Communications and Engagement activities are recorded and monitored and that engagement is taking place with diverse and hard to reach groups	**End June '09**	**HoC / DoG**
8.8.3	Present an annual report on communications and engagement activities to the Trust Board	**End March '10**	**Head of Comms**
8.8.4	Maintain effective systems to ensure patient feedback is reported to the Trust Board	**Ongoing**	**CN / HoC**
8.8.5	Audit the impact of the Communications and Engagement Strategy using staff and patient survey information and other quantative and qualitative information, paying particular attention to diverse and hard to reach groups	**End March '10**	**Head of Comms**
8.8.6	Develop and implement an engagement plan that engages with staff, patients, carers, and local people about the corporate objectives for 2010/11	**Sept '09 – March '10**	**Head of Comms**

Beyond 2009/10

Action		Exec lead
8.8.7	Audit the effectiveness of the Communications and Engagement Governance process	**HoC / DoG**
8.8.8	Develop ongoing engagement plans around the Trust's corporate objectives	**Head of Comms**
8.8.9	Continue to develop the annual report in line with public feedback	**Head of Comms**

8.9 We will engage with staff, partners, patients, their carers and local people to develop and promote plans for the new hospital

To achieve this we will…

In 2009/10:

Action		Date	Exec lead
8.9.1	Implement the new hospital Communications and Engagement plan	**Ongoing**	**Head of Comms**
8.9.2	Keep our stakeholders, staff and Foundation members up to date with our plans for the new hospital	**End March '10**	**Head of Comms**
8.9.3	Keep the Overview and Scrutiny Committee up to date with our plans for the new hospital	**End March '10**	**Head of Comms**
8.9.4	Run focus groups and workshops as part of the new hospital Communications and Engagement plan	**End March '10**	**Head of Comms**
8.9.5	Develop appropriate literature about the plans for the new hospital, including a new hospital booklet	**End March '10**	**Head of Comms**
8.9.6	Regularly update local press on progress with the new hospital	**Ongoing**	**Head of Comms**

Beyond 2009/10:

Action		Exec lead
8.9.7	Develop a plan to ensure continued communication and engagement with staff and local people after the scheme has been launched on the market	**Head of Comms**

8.10 We will ensure staff have the information they need and want to carry out their work effectively and play a full part in the organisation.

To achieve this we will…

In 2009/10:

Action		Date	Exec lead
8.10.1	Review internal communications, piloting a Listening into Action (LiA) approach with Medicine A and Facilities	**End July '09**	**Head of Comms**
8.10.2	Develop and implement a revised Internal Communications Plan, incorporating traditional communications methods including Heartbeat and Team Brief, as well as initiatives that come out of the LiA communications work	**End March '10**	**Head of Comms**
8.10.3	Establish reliable information around numbers of hard to reach staff (i.e. those working out of hours shifts only or working primarily in the community)	**End March '10**	**HoC / DoW**
8.10.4	Run a Listening into Action communications event specifically for hard to reach staff	**End Nov '10**	**Head of Comms**
8.10.5	Develop the Intranet pages as a source of information	**Ongoing**	**HoC / COO**
8.10.6	Create a pilot Communications hub for staff to access the intranet and find out about corporate activities	**End Dec '09**	**Head of Comms**
8.10.7	Provide feedback on staff and patient satisfaction and views	**Ongoing**	**HoC / DoW**
8.10.8	Introduce a policy for the use of the public folders	**End Sept '09**	**Head of Comms**
8.10.9	Continue to improve induction information	**Ongoing**	**DoW / HoC**
8.10.10	Review and improve the use of notice boards	**End Oct '09**	**Head of Comms**
8.10.11	Promote Trust expectations of staff (i.e. the code of conduct, Equality Impact Assessments and Customer Care promises)	**Ongoing**	**Head of Comms**
8.10.12	Promote key policies	**Ongoing**	**All / HoC / DoG**
8.10.13	Promote the principles of communications and engagement to staff with best practice guidance	**End Dec '09**	**Head of Comms**

Beyond 2009/10:

Action		Exec lead
8.10.14	Roll out internal communications initiatives developed through Listening into Action across the Trust	**Head of Comms**
8.10.15	Review staff access to email and the intranet	**HoC / COO**
8.10.16	Expand the Communications hub pilot	**Head of Comms**

8.11 We will promote comprehensive staff engagement

To achieve this we will…

In 2009/10:

Action		Date	Exec lead
8.11.1	Continue to roll out the Listening into Action (LiA) methodology and embed it within the culture of the organisation	**Ongoing**	**CEO / DoW**
8.11.2	Develop and implement a communications plan for LiA, regularly updating staff with progress	**Ongoing**	**Head of Comms**
8.11.3	Audit the effectiveness of LiA through staff surveys	**End March '10**	**DoW**
8.11.4	Provide senior management and/or communications input into several key corporate LiA streams	**Ongoing**	**CEO / HoC**
8.11.5	Use the LiA communications stream to improve the way we communicate about LiA and other Trust issues	**End March '10**	**Head of Comms**
8.11.6	Look for opportunities to publicise LiA outside the Trust	**Ongoing**	**All**

8.12 The communications crisis management and major incident response will be to a high standard

To achieve this we will…

In 2009/10:

Action		Date	Exec lead
8.12.1	Ensure the Communications team participate in major incident training exercises	**Ongoing**	**Head of Comms**
8.12.2	Develop a major incident communications training programme	**End June '09**	**HoC / COO**
8.12.3	Ensure Communications participation in the contingency planning group and at appropriate meetings and training programmes	**End June '09**	**Head of Comms**
8.12.4	Produce a communications plan for pandemic flu	**End May '09**	**Head of Comms**
8.12.5	Run regular designated communications exercises to test the communications response	**Ongoing**	**HoC / COO**
8.12.6	Media train appropriate staff	**End March '10**	**Head of Comms**
8.12.7	Observe other organisations' communications handling at major incident exercises	**End March '10**	**Head of Comms**

Beyond 2009/10:

Action		Exec lead
8.12.8	Provide communications major incident handling training for other organisations	**Head of Comms**

8.13 We will ensure our Foundation Trust members and key stakeholders play an important role in the activities and direction of the Trust, and will listen to their views and ideas

To achieve this we will…

In 2009/10:

Action		Date	Exec lead
8.13.1	Deliver the Foundation Trust membership strategy	**Ongoing**	**Head of Comms**
8.13.2	Monitor the demographics of our membership and target specific campaigns to engage with groups of people that are not fully represented	**Ongoing**	**Head of Comms**
8.13.3	Produce an 'evolving' annual calendar of events	**Ongoing**	**Head of Comms**
8.13.4	Give opportunities for feedback from members via written correspondence, telephone, email and at meetings	**Ongoing**	**Head of Comms**
8.13.5	Develop surveys of stakeholders and GPs	**End March '10**	**Head of Comms**
8.13.6	Provide regular feedback to members on how their comments are being used and promote examples where feedback has made a difference	**End March '10**	**Head of Comms**

8.14 We will implement a consistent brand across the organisation that reflects our values and increases awareness of the Trust

To achieve this we will…

In 2009/10:

Action		Date	Exec lead
8.14.1	Complete the Board 'Branding for Success' programme run by NHS Elect	**End June '09**	**Head of Comms**
8.14.2	Develop and consult on suggestions for a new brand for the Foundation Trust	**End Aug '09**	**Head of Comms**
8.14.3	Implement a new brand in conjunction with authorisation as a Foundation Trust	**Once FT**	**Head of Comms**
8.14.4	Review the quality, look and feel of publications for external consumption	**End July '09**	**Head of Comms**
8.14.5	Run a campaign to promote the Trust values	**End Nov '09**	**Head of Comms**
8.14.6	Develop guidelines for the production of literature and publicity materials that do not fall within the patient information policy	**End Sept '09**	**Head of Comms**
8.14.7	Develop a plan for winding down stocks of out-dated material and bringing in material with the new brand and logo	**End July '09**	**DoF / COO / HoC**

Beyond 2009/10:

Action		Exec lead
8.14.8	Audit the effectiveness of brand implementation	**Head of Comms**

9. Responsibilities

9.1 Head of Communications and Engagement

9.1.1 To lead the Communications and Engagement team
9.1.2 To oversee the development and implementation of the strategy
9.1.3 To advise the Trust Board on matters of communications or engagement
9.1.4 To advise the Trust Board with respect to communications or engagement on any issue
9.1.5 To help the Executive Team and Trust Board consider the views of staff, patients and the public
9.1.6 To use their knowledge, experience and understanding of the organisation and local environment to help the Executive Team run the Trust
9.1.7 To set a high standard for communications and engagement
9.1.8 To communicate and engage effectively
9.1.9 To embed communications and engagement in all they do

9.2 Communications Department

9.2.1 To contribute to the development and implementation of the strategy
9.2.2 To deliver the action plan
9.2.3 To provide training and support to staff to improve communications and engagement at all levels across the Trust
9.2.4 To set a high standard for communications and engagement
9.2.5 To embed communications and engagement in all they do
9.2.6 To communicate and engage effectively

9.3 Council of Governors

9.3.1 (Once established): To support the Trust's principles of communications and engagement, establishing effective links with communities and organisations in the constituencies they represent

9.4 Board of Directors (Trust Board)

9.4.1 To support the implementation of the Communications and Engagement Strategy
9.4.2 To lead by example, communicating and engaging in accordance with the Principles of Communications and Engagement
9.4.3 To embed the principles of Communications and Engagement across the Trust

9.5 Executive Team

9.5.1 To support the implementation of the Communications and Engagement Strategy, exercising leadership in delivering actions relevant to their areas.
9.4.4 To lead by example, communicating and engaging in accordance with the Principles of Communications and Engagement
9.4.5 To embed the principles of Communications and Engagement across the Trust

9.6 Clinical Directors

9.6.1 To support the implementation of the Communications and Engagement Strategy, particularly with relation to clinical staff
9.6.2 To lead by example, communicating and engaging in accordance with the Principles of Communications and Engagement
9.6.3 To embed the principles of Communications and Engagement across the Trust

9.7 Divisional Managers

9.7.1 To support the implementation of the Communications and Engagement Strategy within their division
9.7.2 To lead by example, communicating and engaging in accordance with the Principles of Communications and Engagement
9.7.3 To communicate and engage in relation to service change and access
9.7.4 To respond to patient feedback in relation to their division
9.7.5 To embed the principles of Communications and Engagement across the Trust

9.8 Ward Managers and Senior Nursing Staff

9.8.1 To support the implementation of the Communications and Engagement Strategy within their wards
9.8.2 To gather and respond to patient feedback in relation to their wards
9.8.3 To lead by example, communicating and engaging in accordance with the Principles of Communications and Engagement

9.9 Other Senior Managers

9.9.1 To support the implementation of the Communications and Engagement Strategy within their department / area
9.9.2 To lead by example, communicating and engaging in accordance with the Principles of Communications and Engagement
9.9.3 To communicate and engage in relation to service change and access
9.9.4 To respond to patient feedback in relation to their area

9.10 All Staff

9.10.1 To adopt the principles of communications and engagement
9.10.2 To support the implementation of the Communications and Engagement Strategy within their areas

10. Resources

The communications function (press office, proactive PR, internal communications, staff engagement and marketing) is at full complement subject to one appointment which is underway.

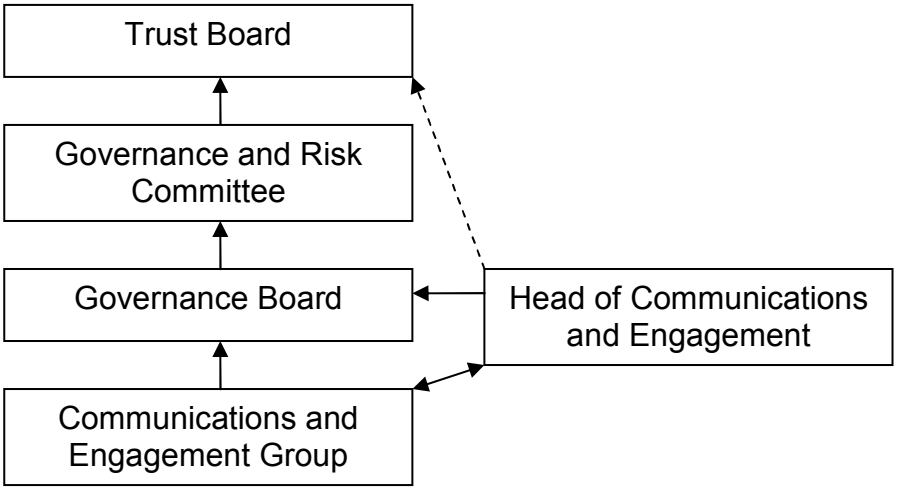
Further resource is being sought as part of the 2009/10 financial planning to support the administration of the Foundation office which is being overwhelmed by correspondence and is currently being supported by agency staff.

Admin support options are also being considered to help support the new hospital engagement programme.

There are significant resource issues for patient surveys and patient information which are being put forward as part of the 2009/10 financial planning.

11. Monitoring

A Communications and Engagement Group will be established to formally monitor progress on the action plan. This group will include staff and patient representatives. The Head of Communications and Engagement will chair this group which will report to Governance Board and send an annual report to the Trust Board.



APPENDIX ONE
UPDATE ON 2005-2008 COMMUNICATIONS PLAN

Below is an update on performance against the objectives set out in the 2005 Communications Strategy.

Developing robust GP communications	G

Since the launch of the Communications Strategy in 2005, GP Focus and GP Hotline have been launched. Email communications with GPs has improved and there have been surveys of GPs, GP open days and regular service specific learning / promotional events. All GPs in Sandwell and HOB have been visited at least twice and meetings have taken place with PBC clusters. GPs are regularly sent corporate information such as the annual report and consultation documents and receive letters and leaflets about important information such as service reconfiguration.

GP communications activities have now been incorporated into the Trust's Marketing plan.

Developing the Trust's website in support of patient choice	A

The Trust's website was launched in 2006 and redesigned and re-launched in December 2008. Some work is still outstanding on the website which comprises a range of latest news, corporate, recruitment, patient and visitor information. Information about trust services, staff and clinics is available, as well and there is a map facility which allows you to plot your route to hospital from home. It has been very challenging to get enough information on each specialty and there have been various other issues to overcome.

Improving communications with stakeholders	G

Through the database of 3,000 community and voluntary groups and venues we regularly communicate with, our 6,000+ Foundation members, implementation of the foundation membership strategy and new hospital communications and engagement strategy and three extensive public consultations, significant progress has been made to achieve this objective. A lot of focus has been placed on this and it has paid dividends.

Developing comprehensive patient information	A

A detailed audit of the state of all patient information across the Trust is underway as it was felt previous reviews did not give the whole picture. As a result, several areas of excellent practice have been highlighted but some gaps or issues with quality are also being identified. There are more than 3,000 leaflets being used within the Trust, including 200 leaflets on a system (EIDO) the Trust purchased on a two year contract. Medical Illustration has increased its staffing to help ensure leaflets don't become stuck in a queue.

The look and feel of patient information will be finalised as part of a branding exercise the Trust is in the process of undertaking. Meetings have taken place with some hard to reach communities to better understand their communications needs and some useful

feedback has been used to improve communication and engagement.

New 'welcome to hospital' leaflets include a broader range of information and larger (A4) maps, along with a membership form.

The introduction and promotion of the Health Exchange at the BTC and distribution of an external range of information to clinicians have broadened the availability of clinical information. There has also been an improvement in the amount of information available in different languages and formats and in the accessibility of telephone handsets for interpreting. Patient information is not currently resourced and progress has been difficult.

Managing the reputation and publicising the successes of the Trust	**G**

The Trust operates a daily press cuttings service and has daily contact with journalists from a broad range of local, regional, national, trade, community and BME media. Press comments, releases and statements are prepared and issued on most days. A significant increase in coverage has taken place since the communications team was restructured in September 2008.

The Communications team has started analysing the media cuttings and counting the amount of positive, neutral and negative coverage. We are also able to assess the advertising value equivalent of the cuttings. These reports will be going to the communications group from April 2009.

Since the strategy was developed in 2005, the Trust reputation appears to have improved significantly. This has corresponded with improved financial and operational performance which we have promoted through the media and through public involvement.

We are increasingly approached by trade press to share best practice in a range of specialties, have featured in research and development, information technology and Department of Health reports and have had several features during the last two years in national and local press.

The strategy from 2009 seeks to take our media handling approach further forward.

Ensuring staff are well-informed through staff communications initiatives	**G**

Heartbeat and Your Right to Be Heard, team brief and back to the floor are well established. These have all been reviewed over the last year.

A staff awards scheme and Chair's Awards have been launched and support and promotion of 'Listening into Action' to encourage greater staff engagement has become a high priority.

Providing a PR strategy in support of plans for the launch of the Birmingham Treatment Centre	**G**

A PR strategy was developed and implemented for the launch of the Birmingham Treatment Centre and various promotional activities undertaken during its first 18 months including an official opening and open day. A Birmingham Treatment Centre logo and associated literature was produced.

Several events have taken place in the Birmingham Treatment Centre, and it has been promoted in relevant Advertorial Features in local press.

Delivering the communications and engagement plan for Towards 2010	**G**

The Head of Communications chaired the 2010 communications and engagement group until the summer 2008 when the chair rotated to Sandwell PCT. Delivery of the plan included the public consultation, creation of the Towards 2010 newsletter, development and implementation of a new 2010 Communications and Engagement Strategy, new hospital Communications and Engagement Strategy and various other initiatives. Several public events have taken place around Towards 2010 and the new hospital and both are represented at most Trust events.

Supporting the Trust in gaining IWL Practice Plus accreditation	**G**

The Trust undertook extensive work to promote IWL including a creative poster campaign, regular newsletters and other internal communications initiatives.

Supporting Trust infection control initiatives	**G**

The communications team has provided ongoing support to the Be Betty's Mate and clean your hands campaigns through internal and external communications initiatives, which included the design of a mascot and a children's competition. The team is working to an infection control communications action plan for 2008/09.

Supporting the Agenda for Change/KSF process	**G**

The Trust undertook extensive work to promote Agenda for Change including regular newsletters and promotion through Heartbeat and team brief.

Supporting Trust initiatives to improve the patient experience	**G**

Reports on patient views are presented regularly to the Patient Experience group of which the Head of Communications is a member. PALS, complaints and patient survey information feeds into this report.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Review of Changes to SOs, SFIs and Scheme of Delegation
SPONSORING DIRECTOR:	Robert White, Director of Finance & Performance Management
AUTHOR:	Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	26 March 2009

KEY POINTS:

A number of changes are proposed to the Standing Orders and Standing Financial Instructions.

The Audit Committee has agreed the proposed changes.

Changes proposed are:

- An amendment to the authorisation of quotations and tenders, specifically to contracts of £1m or below, which is currently within the authorisation of the Chair to sign.
- Raising the value of single tender arrangements, requiring formal Trust Board approval from £50k to £90k.
- Addition of an additional clause to the end of section 17.5.3

It is proposed that the current authorisation levels for stock/non stock requisitions and invoices remain unchanged.

The amendments are marked in RED on paper SWBTB (3/09) 061 (a).

PURPOSE OF THE REPORT:

◉ **Approval** ○ **Noting** ○ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is recommended to ratify the Audit Committee's decision to APPROVE the proposed changes to the Standing Orders/Standing Financial Instructions.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

None specifically

IMPACT ASSESSMENT:

FINANCIAL	☑	Financial delegation limits
ALE	☑	
CLINICAL	☐	
WORKFORCE	☐	
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

STANDING ORDERS, RESERVATION AND DELEGATION of POWERS and STANDING FINANCIAL INSTRUCTIONS

Schedule of Delegated Authority and Authorisation Limits

Stock/Non Stock Requisitions and Invoices

Authorisation Level	Authorise Stock/Non Stock Requisitions and Approve Invoices for Payment
First Line Budget Managers	<= £5,000
Officers Specifically Authorised by the Director of Finance as Trust Authorised Signatories	<= £10,000
Divisional General Managers and Nominated Deputies, Deputy Divisional Directors	<= £20,000
Divisional Directors	<= £30,000
Officer and Associate Members and Other Officers Specifically Authorised by the Chief Executive and Director of Finance	<=£50,000
Chief Executive	<= £100,000
Two Officer or Associate Members (one of whom should be the Director of Finance)	<= £250,000
Chief Executive and Director of Finance	<= £500,000

It is suggested that the current authorisation levels remain fit for purpose

Authorisation of Quotations and Tenders

Formal authorisation and awarding of a contract may be decided by the following staff to the value of the contract as specified in the following table.

Authorisation Level	Value of Contract
Designated Budget Holder	<= £10,000
Divisional Director or Divisional General Manager	<= £50,000
Officer Members and Associate Members of the Trust	<= £100,000
Chief Executive	<= £250,000
Chief Executive and Director of Finance	<= £500,000
Chair **and Chief Executive**	<= £1,000,000
Trust Board	> £1,000,000

SECTION D - STANDING FINANCIAL INSTRUCTIONS

17.5.3 **Exceptions and instances where formal tendering need not be applied**

Formal tendering procedures **need not be applied** where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed £90,000 (based on a close approximation to the EU procurement limit). Any expenditure or income in excess of this level will need to be approved by the Trust Board;

(b) where the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in Standing Financial Instructions No. 25;

Formal tendering procedures **may be waived** in the following circumstances:

(d) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

(e) where the requirement is covered by an existing contract;

(f) where PASA agreements are in place and have been approved by the Board;

(g) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

(h) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(i) where specialist expertise is required and is available from only one source;

(j) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(k) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

(l) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

The Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

(m) where allowed and provided for in the Capital Investment Manual.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and periodically reported to the Audit Committee.

The provisions of this section apply equally to the requirements for competitive quotes for goods and services below £90K (see scheme of delegation) in terms of the authorisation to waive competitive tender procurement processes

SWBTB (3/09) 064

Sandwell and West Birmingham Hospitals NHS

NHS Trust

TRUST BOARD

REPORT TITLE:	Monthly Performance Monitoring Report
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance
AUTHOR:	Mike Harding, Head of Planning and Performance Mgt
DATE OF MEETING:	26 March 2009

KEY POINTS:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April 2008 – February 2009.

PURPOSE OF THE REPORT:

☐ **Approval** ☉ **Noting** ☐ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Board is asked to NOTE the report and the associated commentary.

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

None specifically. Satisfies compliance with NHS Plan and other locally agreed targets.

IMPACT ASSESSMENT:

FINANCIAL	☑	
ALE	☐	
CLINICAL	☑	
WORKFORCE	☑	
LEGAL	☑	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☑	
RISKS		

SANDWELL AND WEST BIRMINGHAM HOSPITALS PERFORMANCE MONITORING REPORT - FEBRUARY 2009

SWBTB (3/09) 064

EXECUTIVE SUMMARY

<table>
<tr><th>Note</th><th>Comments</th></tr>
<tr><td>a</td><td>The Cancer Reform Strategy published in December 2007, set new, more ambitious cancer targets. Assessment of performance by the Healthcare Commission (Annual Health Check) is likely to comprise two parts, firstly an assessment against the long standing existing commitment and secondly an assessment of performance against the new (revised) target. In particular there are a number of changes to adjustments in measuring waiting times that are no longer available, effective 1 January 2009. These are taken into account in the January data presented in the report, although this data only relates to patients referred to the Trust and treated by the Trust, excluding any patients referred elsewhere for treatment, such as Radiotherapy. such exclusions are due to national reporting mechanisms not being available until April 2009. It is acknowledged nationally that operational thresholds / tolerances for the revised targets, against which performance is assessed will require modification. Such modifications are however unlikely to be published until data for the period January to March 2009 is assessed.

In relation to the data presented. The two-week target was met in 96% of cases, breaches (17) identified all relate to patients electing for an initial outpatient appointment beyond one that was originally offered by the Trust within 2 weeks of referral. There were 4 breaches of the 62-day target, 2 each in Upper GI and Urology.</td></tr>
<tr><td>b</td><td>The number and percentage of cancelled operations reduced considerably during the month of February to 30 and 0.6% respectively. Cancellations that were reported are predominantly associated with the City site across a number of specialties.</td></tr>
<tr><td>c</td><td>Delayed Transfers of Care reduced to 2.8% during the month. Actual delays (17) reported at month end demonstrate a continued reduction in such delays throughout the month, and a considerable improvement on the number of delays at the end of January (38).</td></tr>
<tr><td>d</td><td>Accident and Emergency 4-hour waits - performance during February is reported as 99.2%, improving performance for the year to date to 97.82%. Performance during March to date (up to and including 10th) is 99.6%, further improving year to date performance to 97.88%.</td></tr>
<tr><td>e</td><td>The numbers of C Diff cases reported during February 2009 reduced to 15, against a trajectory (maximum) for the month of 26. Numbers for the year to date (148) are well within the trajectory for the period of 291. No reported cases of MRSA Bacteraemia during February 2009. Numbers for the year to date (13) remain within trajectory (31).</td></tr>
<tr><td>f</td><td>Admitted and Non-Admitted Referral to Treatment Time (RTT) performance thresholds were both met for the month of January. The assessment of the percentage of Direct Access Audiology patients with completed pathways within 18 weeks of referral, during the months of January, February and March 2009 are a component of the overall assessment by the Healthcare Commission of RTT performance. During the month of January 100% of Direct Access Audiology patients waited 18 weeks or less for treatment, with data completeness requirements also being met.</td></tr>
<tr><td>g</td><td>Activity to date is compared with the contracted activity plan for 2008 / 2009.
<table>
<tr><th></th><th>Sandwell</th><th>City</th><th>Trust</th></tr>
<tr><td>IP Elective</td><td>7.0%</td><td>-10.1%</td><td>-3.9%</td></tr>
<tr><td>Day case</td><td>5.3%</td><td>5.0%</td><td>5.1%</td></tr>
<tr><td>IPE plus DC</td><td>5.6%</td><td>1.2%</td><td>3.1%</td></tr>
<tr><td>IP Non-Elective</td><td>3.9%</td><td>0.4%</td><td>1.9%</td></tr>
<tr><td>OP New</td><td>10.0%</td><td>17.2%</td><td>14.4%</td></tr>
<tr><td>OP Review</td><td>-0.5%</td><td>0.3%</td><td>0.0%</td></tr>
</table>
Overall performance against activity plans to date remains similar to that reported last month. The differential performance against New and Review Outpatient activity plans has reduced Outpatient New : Review ratios to 2.40 for the year to date, compared with an outturn for 2007 / 08 of 2.74.

When activity to date is compared with 2007 / 08 for the corresponding period
<table>
<tr><th></th><th>Sandwell</th><th>City</th><th>Trust</th></tr>
<tr><td>IP Elective</td><td>-0.4%</td><td>-4.9%</td><td>-3.1%</td></tr>
<tr><td>Day case</td><td>8.2%</td><td>9.9%</td><td>9.1%</td></tr>
<tr><td>IPE plus DC</td><td>6.5%</td><td>6.2%</td><td>6.4%</td></tr>
<tr><td>IP Non-Elective</td><td>1.5%</td><td>4.0%</td><td>2.9%</td></tr>
<tr><td>OP New</td><td>14.0%</td><td>14.3%</td><td>14.2%</td></tr>
<tr><td>OP Review</td><td>0.8%</td><td>2.3%</td><td>1.8%</td></tr>
</table>
Overall Elective, Non-Elective and Outpatient performance remains in excess of that delivered during the corresponding period last year, as reflected in the table alongside.</td></tr>
<tr><td>h</td><td>Thresholds against which performance is assessed in Obstetrics have been identified and are now incorporated in the report.</td></tr>
<tr><td>i</td><td>The average length of queue for patients who contact the Elective Access Centre has reduced during the year, but the maximum length of queue remains well in excess of the target set.</td></tr>
<tr><td>j</td><td>Across the Trust during February 20% of ambulance turnaround times were in excess of 30 minutes, with 16% delayed at Sandwell and 24% at City. The West Midlands average was 22%. 13 delays in excess of 60 minutes were reported by the West Midlands Ambulance Service.</td></tr>
<tr><td>k</td><td>Average income per wte and average income per open bed for 2008 / 09 to date is 0.9% and 3.8% higher respectively, than 2007 / 08 outturn. Average total income per spell is 0.8% higher than average total cost per spell for the year to date.</td></tr>
<tr><td>l</td><td>Overall expenditure on Bank and Agency staff during February is similar to that incurred during January. Of note is the reduction in Nurse Agency costs within the month.</td></tr>
<tr><td>m</td><td>PDRs reported during February were 71 in total, representing an overall compliance rate for the Trust of 84% for the Trust, when assessed against the target to date. Almost 700 PDRs will need to be undertaken and reported during March if a trust-wide target of 90% is to be achieved.</td></tr>
</table>

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Financial Performance – Month 11
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Management
AUTHOR:	Robert White/Tony Wharram
DATE OF MEETING:	26 March 2009

KEY POINTS:

The report is provided to update the Trust Board on financial performance for the period to 28th February 2009.

In-month surplus is £120k against a target surplus of £169k; £49k below plan.

Year to date surplus is £2,652k, £267k ahead of plan.

In-month WTEs are 135 below plan.

Cash balance is £3.8m above revised plan at 28th February.

PURPOSE OF THE REPORT:

☐ **Approval** ☉ **Noting** ☐ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

To receive and note the monthly finance report.

To approve the amendment to the Trust's capital programme (Medical illustration camera).

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

4.1- Deliver the financial plan including achieving a financial surplus of £2.5m and a CIP of £11m.

IMPACT ASSESSMENT:

FINANCIAL	☑	Trust has a target surplus for the year of £2.5m in line with requirement to repay the residue of its working capital loan.
ALE	☐	
CLINICAL	☐	
WORKFORCE	☐	
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – February 2009

EXECUTIVE SUMMARY

• At the end of February, the Trust had a surplus of £2,652k, £267k ahead of plan and £152k ahead of the target for the year end.

• The in-month surplus is £120k against a target surplus of £169k, £49k lower than plan.

• A significant improvement in activity and patient related income in January has improved performance across several divisions and for the Trust as a whole.

• At month end WTE's (whole time equivalents) were 135 below plan.

• The cash balance is £3.8m above revised plan at 28th February.

•Divisional performance has generally been positive in month, in part linked to the improved activity position, and almost all divisions have returned to a positive "bottom line" position at the end of February and expect to deliver at least break even by the year end.

•CIP performance is in line with plan for February and the programme remains on course to deliver the required savings by the year end.

Financial Performance Indicators

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	-49	267	> Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	19	323	> Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	-323	-410	< Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	-633	-3,050	< Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	135	173	< Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	3,793	3,793	> = Plan	> = 95% of plan	< 95% of plan
CIP Actual v Plan £000	0	5	> 97½% of Plan	> = 92½% of plan	< 92½% of plan

Note: positive variances are favourable, negative variances unfavourable

Performance Against Key Financial Targets

Target	Year to Date Plan £000	Year to Date Actual £000	Forecast Outturn Plan £000	Forecast Outturn Forecast £000
Income and Expenditure	2,385	2,652	2,500	2,500
Capital Resource Limit	15,439	0	16,843	15,863
External Financing Limit	---	---	(3,894)	(3,894)
Return on Assets Employed	2.70%	2.70%	3.50%	3.50%

2008/2009 Summary Income & Expenditure Performance at February 2009	Annual Plan £000's	CP Plan £000's	CP Actual £000's	CP Variance £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's	Forecast Outturn £000's
Income from Activities	314,242	26,177	27,082	905	288,051	291,116	3,065	317,581
Other Income	36,902	3,034	3,104	70	33,956	34,674	718	37,826
Operating Expenses	(324,100)	(26,993)	(27,949)	(956)	(297,162)	(300,622)	(3,460)	(329,136)
EBITDA	27,044	2,218	2,237	19	24,845	25,168	323	26,271
Interest Receivable	1,164	90	22	(68)	1,109	1,053	(56)	1,073
Depreciation & Amortisation	(16,343)	(1,362)	(1,362)	0	(14,981)	(14,981)	0	(15,478)
PDC Dividend	(9,258)	(771)	(771)	0	(8,486)	(8,486)	0	(9,257)
Interest Payable	(108)	(6)	(6)	0	(102)	(102)	0	(108)
Net Surplus/(Deficit)	**2,499**	**169**	**120**	**(49)**	**2,385**	**2,652**	**267**	**2,500**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

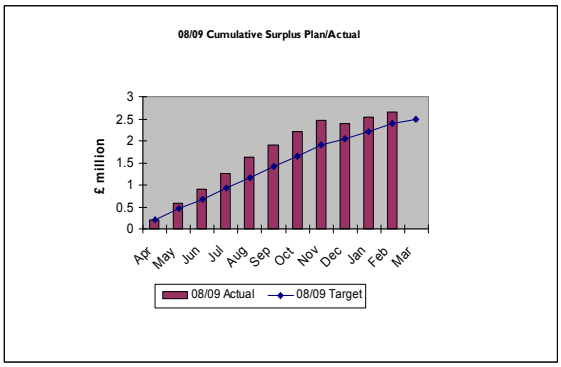
Financial Performance Report – February 2009

External Perspective

• Both Sandwell and Heart of Birmingham PCTs continue to report strong financial positions and are expecting to achieve their financial targets at the year end.

•Ongoing StHA promoted reconciliation exercises have not revealed any significant discrepancies between the Trust and its commissioners and it not expected that this position will change significantly for the year end.

•Heart of Birmingham PCT continues to experience over performance against its acute Service Level Agreements for all providers although it expects to manage this over performance within its contingencies.



Performance of Major Commissioners

• Fully coded activity data is available up to 31st January and this, and its related income, is incorporated into the financial position reported this month. A summary of key admitted care and out-patient data is shown in the table below. However, it should be noted that there is significant SLA activity and income not covered by these categories.

•In month (January) activity has improved in many areas and across most commissioners. This has played a significant part in maintaining the overall financial performance of the Trust and has improved the overall position of most bed holding divisions.

•The high level of over performance in new out-patients continues although it remains weighted more towards the Sandwell site rather than City.

•Agreement of activity data via the CBSA has led to an increasingly certain income position for the year to date. As the year progresses and more output from the CBSA becomes available, the Trust will be in a better position to firm up views on outturn income levels.

Year to Date Key Activity Performance
Performance Against SLA

	Activity			Value of Variance		
ACTIVITY UP TO JANUARY	Sandwell PCT	Heart of Birmingham PCT	Overall	Sandwell PCT	Heart of Birmingham PCT	Overall
				£000	£000	£000
Admitted Care						
Elective	3.7%	-11.4%	-4.2%	146	-542	-976
Non Elective	2.6%	3.1%	2.6%	-1,069	1,537	665
Day Case	7.5%	2.9%	5.0%	799	133	1,290
Out-Patients						
New	13.7%	4.9%	14.0%	1,325	230	1,787
Follow Ups	10.0%	-5.3%	0.4%	269	-286	401

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – February 2009

Divisional Performance

• Overall performance in-month is slightly worse than plan although this level of performance is required if the Trust is not to exceed its control total surplus at the year end. In month performance has still generated an I&E surplus and the Trust remains slightly ahead of its year end target surplus of £2.5m.

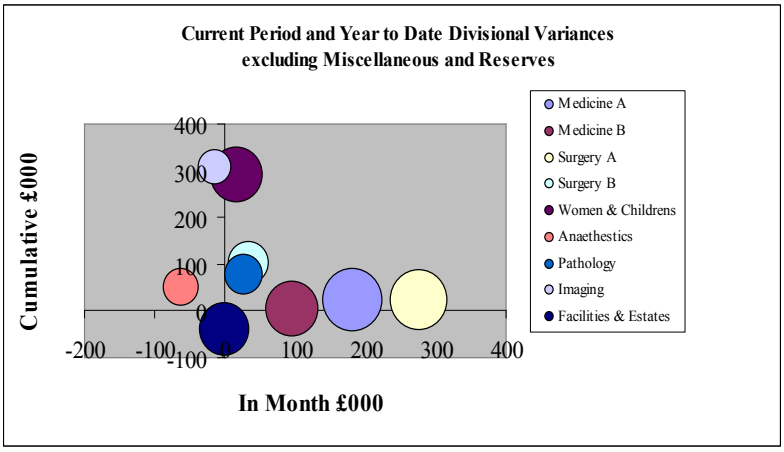
•For the year to date, with one exception, all operational divisions have generated a bottom line surplus (the only minor exception being Facilities and Estates which has a net year to date deficit of £40k). The improved activity and income performance has made a significant contribution to this improvement particularly for Medicine A, Medicine B and Surgery A. All divisions are now forecasting a year end position of break even or better.

•A degree of prudence continues to be reflected in Miscellaneous and Reserves Divisions reflecting uncertainties towards the year end and particularly with regard to activity and income which has not yet been validated by the CBSA.

•Net income performance has improved by almost £1m in month with almost £900k being generated by patient related SLAs.

• Expenditure on pay exceeded planned levels by £323k during February reflecting ongoing agency spend not wholly offset by savings in permanent workforce costs.

• Overall non pay expenditure was £633k higher than plan in February. The major areas of additional spend were linked with medical and surgical consumables and minor equipment (at least in part linked to higher than planned activity levels), hotel services costs (mainly connected with ongoing infection control and deep cleaning programmes and some delays in bringing Rowley cook chill facilities on line) and printing and stationery (mainly one off charges for advertising, books and general stationery).



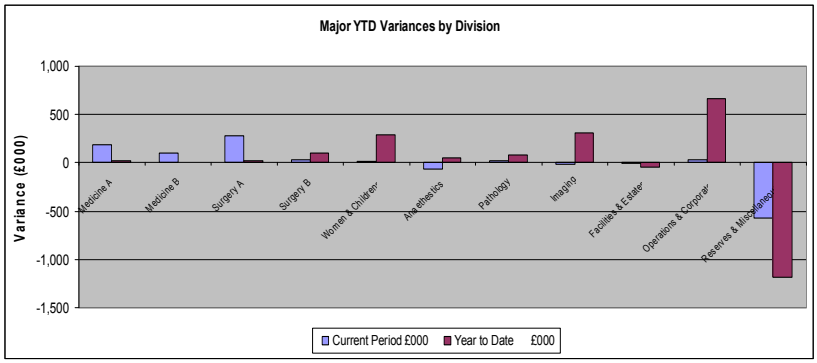
The tables adjacent and overleaf show a generally improved position for most divisions. Relatively small in month deficits were posted by Anaesthetics and Critical Care (primarily related to ongoing high staff costs including agency cover), Imaging (primarily driven by non recurrent equipment purchases) and Corporate Services.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – February 2009

Divisional Variances from Plan

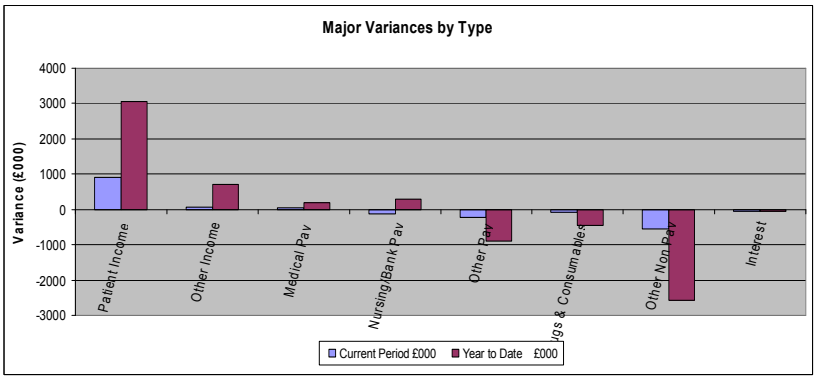
	Current Period £000	Year to Date £000
Medicine A	182	22
Medicine B	96	5
Surgery A	277	24
Surgery B	33	103
Women & Childrens	17	291
Anaethestics	-63	50
Pathology	27	77
Imaging	-15	308
Facilities & Estates	-1	-40
Operations & Corporate	33	669
Reserves & Miscellaneous	-568	-1,184



The tables below illustrate that income continues to perform better than plan for the year to date. Pay and non pay are above plan and sharp falls in interest rates have caused a dramatic downturn in the levels of interest earned over the last few months.

Variance From Plan by Expenditure Type

	Current Period £000	Year to Date £000
Patient Income	905	3065
Other Income	70	718
Medical Pay	53	190
Nursing/Bank Pay	-139	287
Other Pay	-237	-887
Drugs & Consumables	-73	-459
Other Non Pay	-560	-2591
Interest	-68	-56

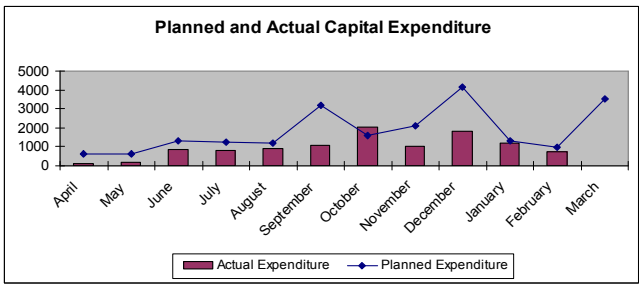


Capital Expenditure

• Planned and actual capital expenditure by month is summarised in the adjacent graph. Year to date expenditure by February has risen to £10,778k, an increase in month of £764k, with a significant spend on statutory standards and medical equipment.

•The forecast outturn for capital expenditure for the year remains almost £1m below plan.

•The capital programme has been amended to include a replacement printer for Medical Illustration at £13k.



Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – February 2009

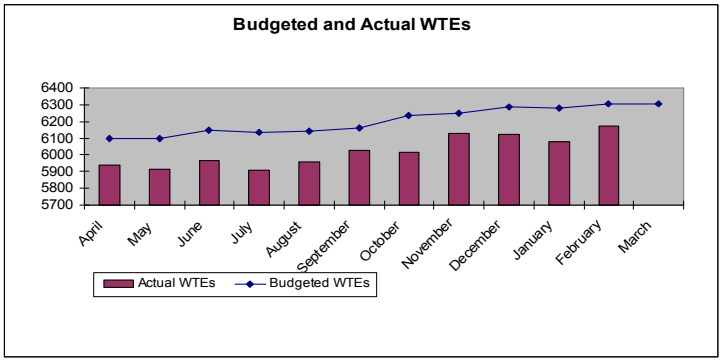
Paybill & Workforce

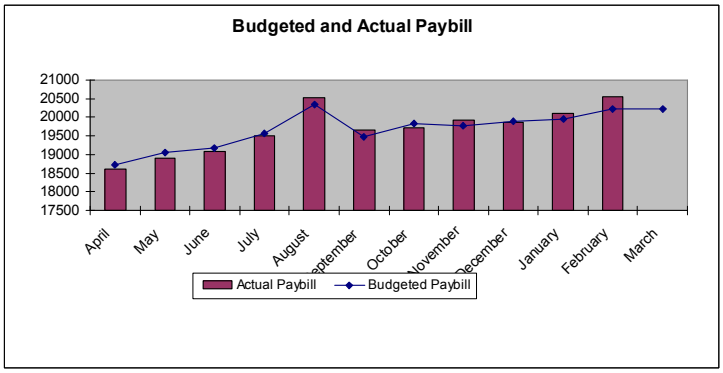
• Overall workforce numbers (wte's) are 135 below plan for February with absolute numbers in post increasing by 93 wtes to 6170. With the exception of January, there has been a fairly steady growth in actual workforce numbers (including bank) with an increase since September of 141 wtes. This does reflect the financial plan of the Trust which at the start of the year included a significant number of service developments incorporated within the LDP with local commissioners.

•Paybill (including agency staff) is £323k above budgeted levels for the month.

•Excluding the cost of agency staff, the paybill would be £60k below budget in month and £3,879k for the year to date.

•Agency spend in month was £580k with the monthly average for the year rising to £494k.





Balance Sheet

• The opening balance sheet for the year at 1st April reflects the final audited accounts.

•Changes in fixed asset values are largely a consequence of the estimated value of indexation of existing assets at 1st April 2008 along with depreciation charged between April and February. New capital expenditure in 2008/2009 continues to progress and now adds almost £11m to the fixed asset values. However, it should be noted that, given the current market conditions and the absence of any formal NHS policy on indexation in 08/09, only equipment has been indexed.

•There has been a further improvement in cash balances in month compared with the revised forecast with cash balances at the month end being approximately £3.8m above revised plan. The major reason for the improved position is the receipt from HoB PCT of an additional £2m earlier than planned.

•Cash balances are expected to remain reasonably positive throughout the next 12 months although the planned falls in March 2009 (in part linked with payment of dividends and loan repayment) will mean that balances for much of the next financial year are expected to be at lower levels than experienced in 2008/09. This forecast will be updated as further information becomes available particularly through the forthcoming financial planning process.

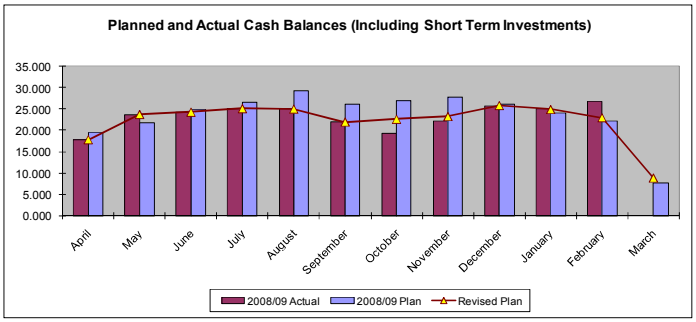
•Forecast interest earnings continue to be significantly reduced as a result of the continuing reductions in base rates and this downturn in performance is reflected in earnings for the current month.

Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – February 2009

Sandwell & West Birmingham Hospitals NHS Trust
BALANCE SHEET

		Opening Balance as at March 2008 £000	Balance as at February 2009 £000	Forecast at March 2009 £000
Fixed Assets	Intangible Assets	373	275	250
	Tangible Assets	274,392	270,734	274,572
	Investments	0	0	0
Current Assets	Stocks and Work in Progress	3,649	3,478	3,550
	Debtors and Accrued Income	19,508	15,555	16,500
	Investments	0	0	0
	Cash	8,285	26,728	8,715
Current Liabilities	Creditors and Accrued Expenditure Falling Due In Less Than 1 Year	(27,172)	(40,398)	(27,174)
	Loan Repayments Due in Less Than 1 Year	(2,500)	(1,250)	0
Long Term Liabilities	Creditors Falling Due in More Than 1 Year	0	0	0
Provisions for Liabilities and Charges		(5,571)	(3,446)	(3,750)
		270,964	271,676	272,663
Financed By				
Taxpayers Equity	Public Dividend Capital	162,296	160,231	161,331
	Revaluation Reserve	83,147	83,692	83,692
	Donated Asset Reserve	2,669	2,324	2,368
	Government Grant Reserve	2,163	2,088	2,083
	Other Reserves	9,058	9,058	9,058
	Income and Expenditure Reserve	11,631	14,283	14,131
		270,964	271,676	272,663



Risk Ratings

Measure	Description	Value	Score
EBITDA Margin	Excess of income over operational costs	8.4%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	101.3%	5
Return on Assets	Surplus before dividends over average assets employed	4.1%	3
I&E Surplus Margin	I&E Surplus as % of total income	0.8%	2
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	2.1	1
Overall Rating			**2.5**

Risk Ratings

•The adjacent table shows the Monitor risk rating score for the Trust based on performance at February.

•Currently, the only significant weak area is the liquid ratio which will only be improved by the introduction of a working capital facility under FT status or sizeable net inflows of cash from another source.

Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – February 2009

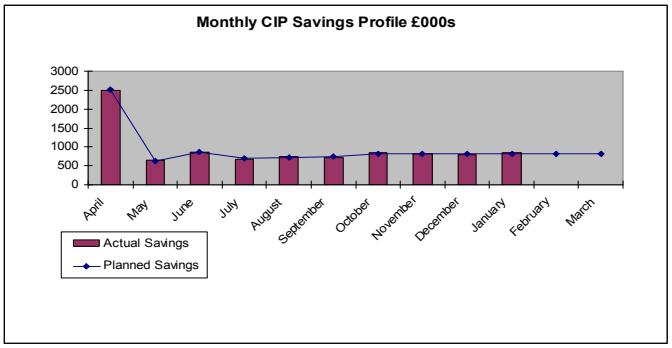
The tables below shows the summary forecast cash position over the next 12 months, including the remainder of the current financial year. The position at February reflects actual cash balances held by the Trust.

Sandwell & West Birmingham Hospitals NHS Trust
CASH FLOW
12 MONTH ROLLING FORECAST AT February 2009

ACTUAL/FORECAST	February 2009 £000s	March 2009 £000s	April 2009 £000s	May 2009 £000s	June 2009 £000s	July 2009 £000s	August 2009 £000s	September 2009 £000s	October 2009 £000s	November 2009 £000s	December 2009 £000s	January 2010 £000s	February 2010 £000s
Receipts													
SLAs: Sandwell PCT	**11,183**	11,183	12,514	12,514	12,514	12,514	12,514	12,514	12,514	12,514	12,514	12,514	12,514
HoB PCT	**7,132**	6,936	7,761	7,761	7,761	7,761	7,761	7,761	7,761	7,761	7,761	7,761	7,761
South Birmingham PCT	**1,182**	1,095	1,225	1,225	1,225	1,225	1,225	1,225	1,225	1,225	1,225	1,225	1,225
BEN PCT	**1,556**	1,556	1,741	1,741	1,741	1,741	1,741	1,741	1,741	1,741	1,741	1,741	1,741
Pan Birmingham LSCG	**1,156**	1,160	1,298	1,298	1,298	1,298	1,298	1,298	1,298	1,298	1,298	1,298	1,298
Other	**1,819**	1,950	2,182	2,182	2,182	2,182	2,182	2,182	2,182	2,182	2,182	2,182	2,182
DoH Market Forces Factor	**1,729**	1,729	0	0	0	0	0	0	0	0	0	0	0
Over Performance Payments	**0**	750	0	0	0	0	0	0	0	0	0	0	0
Education & Training	**1,276**	1,326	1,356	1,356	1,356	1,356	1,356	1,356	1,356	1,356	1,356	1,356	1,356
Loans	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Interest	**36**	25	10	11	11	11	11	9	5	4	4	5	6
Other Receipts	**5,874**	2,850	2,800	2,800	2,800	2,800	2,800	2,800	2,800	2,800	2,800	2,800	2,800
Total Receipts	**32,943**	30,560	30,888	30,889	30,889	30,889	30,889	30,887	30,883	30,882	30,882	30,883	30,884
Payments													
Payroll	**11,988**	12,268	12,454	12,454	12,454	12,454	12,454	12,454	12,454	12,454	12,454	12,454	12,454
Tax, NI and Pensions	**8,218**	8,287	8,413	8,413	8,413	8,413	8,413	8,413	8,413	8,413	8,413	8,413	8,413
Non Pay - NHS	**1,853**	2,500	500	2,200	2,200	2,200	2,200	2,200	2,200	2,200	2,200	2,200	2,200
Non Pay - Trade	**7,872**	15,713	7,300	7,250	5,800	7,250	5,800	7,250	7,250	7,250	5,800	5,800	5,800
Non Pay - Capital	**935**	3,422	1,500	500	500	500	750	750	750	750	750	750	750
PDC Dividend		4,629						4,700					
PDC Repayment													
Repayment of Loans		1,250											
Interest		34											
BTC Unitary Charge	**360**	370	389	389	389	389	389	389	389	389	389	389	389
Other Payments	**40**	100	100	100	100	100	100	100	100	100	100	100	100
Total Payments	**31,266**	48,573	30,655	31,305	29,855	31,305	30,105	36,255	31,555	31,555	30,105	30,105	30,105
Cash Brought Forward	**25,051**	26,728	8,715	8,948	8,532	9,567	9,151	9,936	4,568	3,897	3,224	4,002	4,780
Net Receipts/(Payments)	**1,677**	(18,013)	233	(416)	1,034	(416)	784	(5,368)	(672)	(673)	777	778	779
Cash Carried Forward	**26,728**	8,715	8,948	8,532	9,567	9,151	9,936	4,568	3,897	3,224	4,002	4,780	5,560

Cost Improvement Programme

- The adjacent table shows actual performance of CIP schemes against plan.
- In February, actual performance was in line with plan delivering an in month performance of £829k and a year to date actual of £10,260k which is £5k above plan.
- The forecast outturn is that the programme will be fully delivered at the year end.



Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – February 2009

Forecast Outturn and Forward Look

•The forecast outturn position for the Trust currently remains at £2.5m which is in line with its target required to repay the residue of the working capital loan.

•Activity and income performance has improved significantly in January and across most commissioners and specialties. This has led to an improved position particularly for Medicine A, Medicine B and Surgery A. All operational divisions are now forecasting a year end position of break even or better.

•Performance against pay budgets has continued to deteriorate and year to date spend is now £410k higher than planned levels. It is anticipated that for the year end, there will be a noticeably higher level of spend than is included in the plan although this will include any one off costs which will not carry forward into the new financial year. Although wte numbers continue to be significantly lower than planned, ongoing high levels of spend on bank and agency has resulted in the erosion of the pay under spend of earlier periods. Agency expenditure continues to grow and for the forecast outturn is expected to represent around 2.5% of the total paybill. A significant amount of actual and potential volatility exists in the use of bank and agency staff and the Trust will need to continue to closely monitor and manage all pay spend both for the remainder of the year and for future years.

•Non pay expenditure in month is significantly higher than plan. Some of this can be attributed to increased activity levels and non recurrent items but close control will need to be maintained in all areas as the Trust moves into a new and financially more demanding year.

•Recent announcements by Monitor and the DoH have confirmed views of increasing financial pressure on the whole of the NHS with an expectation of reducing inflation on clinical income and increases in the level of CIP requirements. These changes are considered in more detail in the paper presenting the Trust's financial plan for 09/10 and beyond.

Conclusions

Overall, the Trust has delivered a bottom line year to date surplus of £2,652,000 which is £267,000 ahead of plan for the 11 months to 28th February. The Trust continues to forecast a bottom line surplus of £2.5m at the year end. There has been a further improvement in income levels (based on January data) in month although this does remain an area of volatility and will need to be closely monitored in February and March.

Although capital expenditure continues to be lower than plan, a further £0.8m of expenditure was incurred in month. The forecast year end capital position remains an undershoot of almost £1m.

Cash balances have exceeded planned levels at 28th February by almost £3.8m.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – February 2009

Recommendations

The Trust Board is asked to:

i. NOTE the contents of the report; and

ii. APPROVE the amendment to the capital programme outlined above.

Robert White

Director of Finance & Performance Management

SWBTB (3/09) 054

Sandwell and West Birmingham Hospitals NHS

NHS Trust

TRUST BOARD

REPORT TITLE:	Foundation Trust Service Performance Report
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of Performance Management and Kam Dhami, Director of Governance
DATE OF MEETING:	26 March 2009

KEY POINTS:

Part of the calculation of the Trust's Governance Risk Rating under Monitors Compliance Framework is dependent on a Service Performance Report.

The Governance Risk Rating is based on a combination of self certification, information from the Trust, exception reports and reports from third parties.

It is important both to the prospects for authorisation as an NHS FT and to the level of monitoring which will be applied subsequently.

The current status of the Trust's Governance Risk Rating is Green.

PURPOSE OF THE REPORT:

☐ **Approval** ☉ **Noting** ☐ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to NOTE the report

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

Compliance with the Foundation Trust application process

IMPACT ASSESSMENT:

FINANCIAL	☑	
ALE	☑	
CLINICAL	☐	
WORKFORCE	☐	
LEGAL	☑	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

SANDWELL AND WEST BIRMINGHAM HOSPITALS - KEY PERFORMANCE INDICATORS - 2008 / 2009 (February 2009)

INDICATOR	WEIGHT		Q1 2008 / 09	Q2 2008 / 09	Q3 2008 / 09	January 2008 / 09	February 2008 / 09	NARRATIVE
Clostridium Difficile	1.0	Actual	45	33	38	17	15	The numbers of C Diff cases reported during February 2009 reduced to 15, against a trajectory (maximum) for the month of 26. Numbers for the year to date (148) are well within the trajectory for the period of 291.
(Number of Infections)		[Target]	[81]	[80]	[78]	[26]	[26]	
			■	▲	▼	▼	▲	
MRSA Bacteraemia	1.0	Actual	2	6	3	2	0	No reported cases of MRSA Bacteraemia during February 2009. Numbers for the year to date (13) remain within trajectory (31).
(Number of Infections)		[Target]	[9]	[9]	[9]	[2]	[2]	
			■	▼	▲	▼	▲	
18-weeks RTT (Admitted)	1.0	Actual	94.6	95.0	94.5	93.4		Admitted patients commencing treatment with 18 weeks of referral has been maintained in excess of 90% throughout the first 10 months of the reporting year.
(% patients)		[Target]	[90]	[90]	[90]	[90]	[90]	
			■	▲	▼	▼	■ (projected)	
18-weeks RTT (Non-Admitted)	1.0	Actual	93.3	95.7	96.2	97.4		Non-admitted patients commencing treatment with 18 weeks of referral has now been in excess of 95% since the onset of Quarters 2.
(% patients)		[Target]	[95]	[95]	[95]	[95]	[95]	
			■	■	▲	▲	■ (projected)	
A/E Waits less than 4-hours	0.5	Actual	98.4	98.1	96.3	98.4	99.2	Performance during the month (February) further improved the performance for the year to date to 97.82%. Continued improvement is seen during March (up to 10th) to date.
(% patients)		[Target]	[98.0]	[98.0]	[98.0]	[98.0]	[98.0]	
			■	▼	■	■	▲	
Cancer - 2 weeks	0.5	Actual	99.1	99.9	99.8	99.4		**Please see note below**: January 2009 - the two-week target was met in 96% of cases. Breaches (17) all relate to patients electing for an initial outpatient appointment beyond one that was originally offered by the Trust within 2 weeks of referral. It is projected that this performance will meet a modified (yet to be determined) operational standard for this indicator.
(Urgent GP Referral to first OP App't)		[Target]	[98.0]	[98.0]	[98.0]	[]	[]	
(% patients)			■	▲	▼	■ (projected)	■ (projected)	
Cancer - 31 days	0.5	Actual	100	100	100	100		**Please see note below**: 100% compliance with this indicator has been maintained throughout the year to date. It is projected that performance will continue to meet a modified (yet to be determined) operational standard for this indicator.
(Diagnosis to Treatment)		[Target]	[98.0]	[98.0]	[98.0]	[]	[]	
(% patients)			■	■	■	■ (projected)	■ (projected)	
Cancer - 62 days	0.5	Actual	99.6	100	100	91.7		**Please see note below**:January 2009 - There were 4 breaches of the 62-day target, 2 each in Upper GI and Urology. It is projected that this performance will meet a modified (yet to be determined) operational standard for this indicator.
(Referral to Treatment)		[Target]	[95.0]	[95.0]	[95.0]	[]	[]	
(% patients)			■	▲	■	■ (projected)	■ (projected)	
National Core Standards	0.4	Actual	2	2	0	1	1	Non-compliance identified relates to Core Standard C13a '*Healthcare Organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect'.*
(not met)		[Target]	[0]	[0]	[0]	[0]	[0]	
			▲	■	■	■	■	
Overall Score for Period			1.8	0.8	0.5	0.4	0.4	***Please Note**: The **Cancer** Reform Strategy published in December 2007, set new, more ambitious cancer targets. Assessment of 2008 / 09 performance by the Healthcare Commission (Annual Health Check) is likely to comprise two parts, firstly an assessment against the long standing existing commitment and secondly an assessment of performance against the new (revised) target. In particular there are a number of changes to adjustments in measuring waiting times that are no longer available, effective 1 January 2009. These are taken into account in the January data presented in the report, although this data only relates to patients referred to the Trust and treated by the Trust, excluding any patients referred elsewhere for treatment, such as Radiotherapy. Such exclusions are due to national reporting mechanisms not being available until april 2009. It is acknowledged nationally that operational thresholds / tolerances for the revised targets, against which performance is assessed will require modification. Such modifications are however unlikely to be published until data for the period January to March 2009 is assessed.*
Overall Governance Rating (after trend assessment)			■	▲	▲	▲	■	

Basis of RAG rating:

Indicators with a weighting of 1.0 will be either GREEN or RED, while those with a weighting of 0.5 / 0.4 will be either GREEN or AMBER. If there are 3 successive AMBER ratings, the third will be shown as RED. For the incomplete quarter, the projected risk rating is based on the months to date. Overall RAG is based on Monitor Compliance Framework.

Trends are shown as:	▲	Improving
	■	Staying the same
	▼	Getting worse

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Integrated Risk and Complaints Report: 2008/09 Quarter 3
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Ruth Gibson, Head of Risk Management Dally Masaun, Head of Health & Safety Debbie Dunn, Head of Complaints & Litigation
DATE OF MEETING:	26 March 2009

KEY POINTS:

This revised report combines information on risk, incidents and complaints in line with integrated governance principles.

Key incident statistics:

- There were 1860 reported incidents (1886 in Q3 2007/8).
- Reported clinical incidents rose from 1393 in Q3 2007/8 to 1448 in Q3 2008/9.
- Reported health & safety incidents fell from 493 in Q3 2007/8 to 412 in Q3 2008/9.
- There were 33 incident forms received relating to red incidents (1.8% of the total), compared with 50 in Q3 2007/8 (2.6% of the total).
- Top 3 incident types
    - Patient accident (195),
    - Organisational issues
    - Aspects of clinical care (190),

Key complaints statistics:

- Total complaints: 187 (166 in Q3 2007/08), an increase of 13%
- Red complaints: 1 (2 in Q2 2008/9)
- Top 3 categories of complaint
    - Dissatisfied with clinical treatment (43%)
    - Delays/cancellations (16%)
    - Staff attitude (8%)

PURPOSE OF THE REPORT:

○ **Approval** ◉ **Noting** ○ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

Relevant to the following 2008/09 corporate objectives:

2.2 Develop and begin delivery of a plan to enhance the safety culture and systems of the Trust

6.1 Continue to achieve Healthcare Commission Health Check standards

IMPACT ASSESSMENT:

FINANCIAL	☐	
ALE	☐	
CLINICAL	☑	
WORKFORCE	☐	
LEGAL	☑	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

Integrated Risk and Complaints Report: Quarter 3 2008/9

1. Overview

This report highlights key risk activity including:

- Summary incident data and details of lessons learned
- Summary complaints data and details of lessons learned
- Aggregated analysis of incidents and complaints, and lessons learned.

2. Introduction

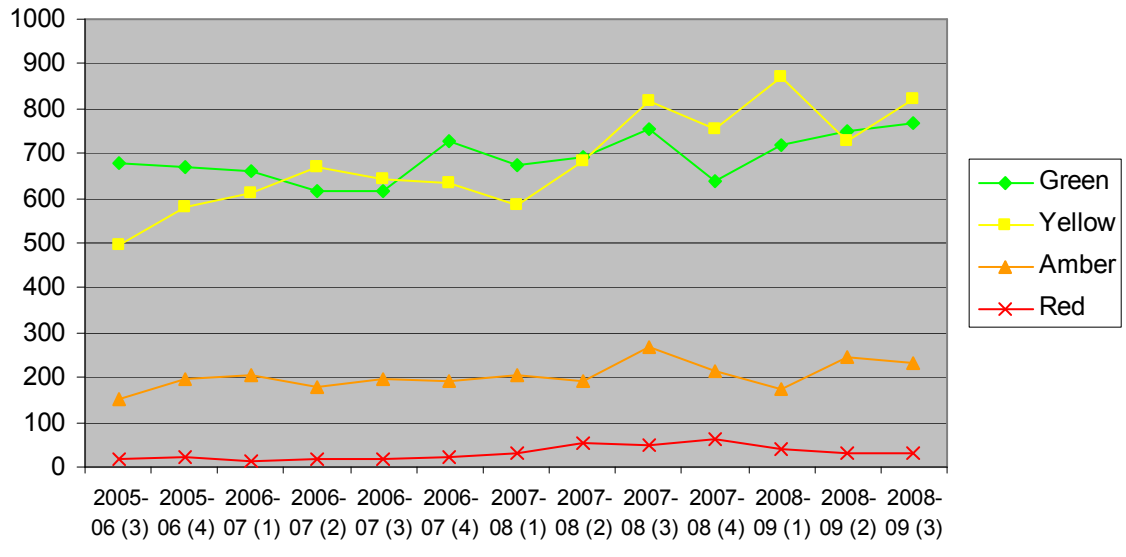
This report combines previous quarterly reports on incident/risk and complaints to implement the Policy for the Investigation, Analysis and Learning of Lessons from Adverse Events and meet NHS Litigation Authority assessment requirements. Where possible, comparisons across these areas of activity will be made to try to identify common trends and actions. Future reports will also include claims and inquest data.

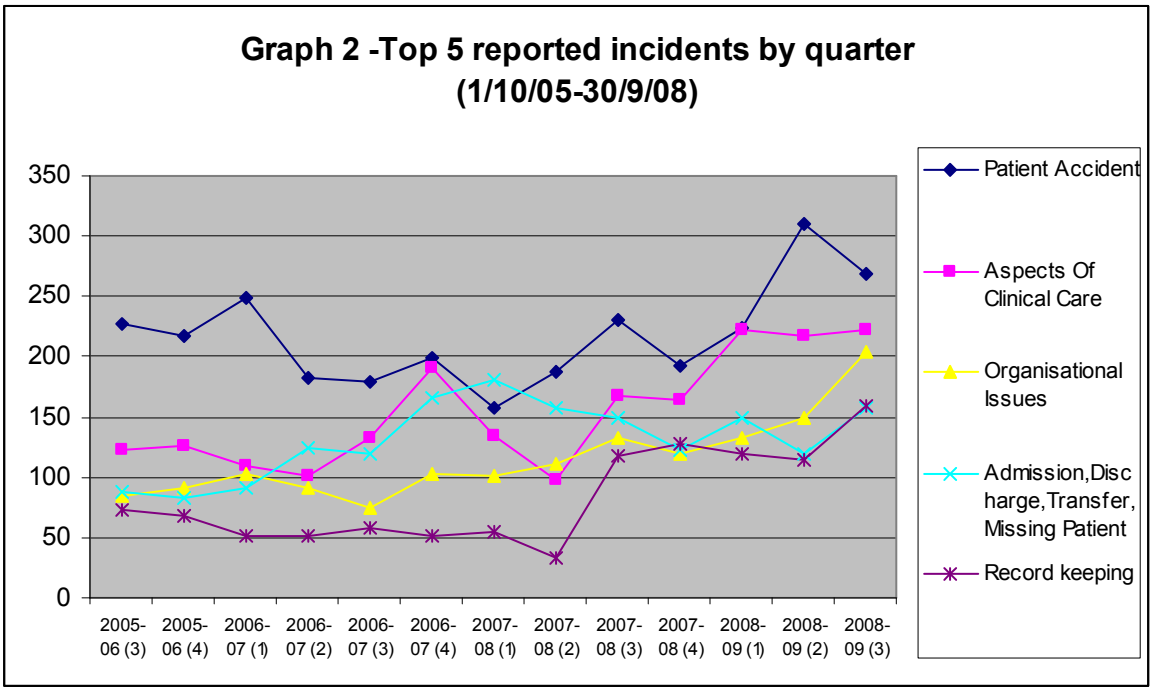
3. Key Issues

3.1 Review of Quarter 3 Incident Data

- There were 1860 reported incidents (1886 in Q3 2007/8).
- Reported clinical incidents rose from 1393 in Q3 2007/8 to 1448 in Q3 2008/9.
- Reported health & safety incidents fell from 493 in Q3 2007/8 to 412 in Q3 2008/9.
- There were 33 incident forms received relating to red incidents (1.8% of the total), compared with 50 in Q3 2007/8 (2.6% of the total).

Graph 1 Incident trends by risk score 1/10/05 - 31/12/08





3 of the top 5 most frequently reported categories (patient accident, admission etc and aspects of clinical care) are the same as in Q3 2007/8. In Q3 2007/8 the top 5 included medical equipment (ie Bbraun issues) and verbal abuse instead of organizational issues (ie staffing) and record keeping (ie missing records).

More detailed analysis of incident data has been considered by the Risk Management Group, Governance Board and Governance and Risk Management Committee. Examples of lessons learned from root cause analysis and incident reviews are attached at **Appendix 1.**

3.2 Complaints

The Trust received 187 complaints, compared with 166 in the same quarter in 2007/08, an increase of 13%. The target response time was achieved in 83% of complaints, compared with 81% in the same quarter in 2007/08.

The 187 complaints were graded as follows:-

Grade	October – December 2008	October – December 2007
Red	1 (1%)	2 (1%)
Amber	21 (11%)	24 (14%)
Yellow	113 (60%)	41 (25%)
Green	52 (28%)	99 (60%)

To date, 4% of the complaints have been re-opened and either a further response has been sent or a meeting has been held. This is consistent with previous quarters.

The main areas of concern are:-

Area of concern	October – December 2008	October – December 2007
Clinical treatment	43%	49%
Delays/cancellations	16%	16%
Staff attitude	8%	6%
Communication	4%	9%
Hotel services/food	3%	2%

More detailed analysis of complaints data has been considered by the Risk Management Group, Governance Board and Governance and Risk Management Committee. Examples of lessons learned from root cause analysis and incident reviews are attached at **Appendix 1**.

3.3 Aggregated analysis

The second most reported incident category (aspects of clinical care) correlates with the most frequently recorded complaint category (dissatisfaction with clinical treatment).

Surgical specialties have shown both a fall in numbers of incidents reported and a rise in complaints. Both factors are relevant to the safety culture of an area.

Incidents and complaints are categorized using the same grading system. 1.8% of incidents and 1% of complaints received during Q3 were red.

Details of key lessons learned are included at appendix 1.

4. Recommendations

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

Appendix 1

Lessons Learned from Incidents Q3 2008/9

30 red incidents were reported via incident forms during this period. Table top reviews have been held for each and an action plan developed, which is monitored through the Adverse Events Committee, chaired by the Chief Executive.

All amber incidents should be monitored at Divisional Groups, with green and yellow incidents being reviewed and fed back at a local level.

Examples of some of the red incidents and key actions taken/lessons learned:

Incident type	**Lessons Learned/ Improvements/Actions taken**
Delay in attending cardiac arrest by member of staff going to wrong ward	**Root cause** – intermittent transistor failure resulting in poor sound quality in bleep message **Good practice** – daily checks by Telecoms introduced, replacement and upgrading programme underway, wireless system being reviewed. **Action taken / lessons learned:** Email sent to warn staff Survey of theatres to be undertaken to check for other faults Switchboard procedures modified to include checks on comprehension
Attempted self-harm by patient jumping from fire escape	**Root cause** – no contributory factors identified **Good practice** – patient had been referred to and seen promptly by psychiatric team and was waiting for discharge home. **Action taken/lessons learned :** Guidance to be given to staff on self-harm Review of external fire escapes to be undertaken Trust policy to be reviewed to ensure EMRT calls outside the core building are appropriately covered Staff to ensure actions are appropriately documented
Delay in eye surgery – deterioration in condition	**Root cause** – no clear link between the delay and deterioration could be made. **Action taken/lessons learned:** Admin manager to be appointed for on call rotas Include VR pathway in Fellows local induction to Trust Development of VR service to be pursued by division Staff to ensure actions are appropriately documented
Maternal Death – Guillain Barre Syndrome in pregnant patient who had severe learning difficulties	**Root cause –** no clear contributory factors identified **Good practice –** vulnerable adult issues well managed. On discovery of non-viable pregnancy there was good involvement of Trust solicitors to manage consent issues. **Action taken/lessons learned:** To be presented at Grand Round Admission clerking by junior doctors to be reviewed by senior staff Guideline for maternity patients on medical wards to be reviewed and publicised to staff Staff to ensure actions are appropriately documented
Needlesticks to non-clinical workers	Potential weaknesses in: • local Infection risk assessment (wrt these particular incidents) • quality of local sharps safety induction • provision of safer generic sharps

Key lessons learned from complaints during Quarter 3

The complaints received cover a wide range of issues and are spread over many wards/departments. Following investigation, the complaints are reviewed to identify any required action. Examples of actions arising from upheld complaints are as follows:-

- Additional orthopaedic theatre sessions introduced
- Attitude and general approach to the management of the patient discussed with the junior doctor
- Care discussed with the junior doctor and explained that a further specialist medical opinion should have been obtained
- Failure to follow the correct procedure discussed with member of staff and work to be monitored
- Attitude discussed with receptionist and work to be monitored
- Additional sessions introduced for the reporting of x-rays

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	2008/09 Core Standards
SPONSOR:	Kam Dhami, Director of Governance
AUTHOR:	Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	26 March 2009

KEY POINTS:

The report presents the outcome of the work undertaken to assess the Trust's compliance with the core standards component of the Annual Health Check for 2008/09.

The self-assessment has identified that compliance against the requirements of C20b have not been fully met. Specifically, issues in achieving the requirements for mixed sex accommodation, especially in light of recent press statements and correspondence from the Department of Health, have been highlighted via a Trust-wide audit of its accommodation. Although plans are in place to address the findings of the audit and to achieve compliance (Appendix 3), this standard will need to be declared as 'not met' this year.

Action plans for the standards against which the Trust reported non-compliance in 2007/08 (C7e and C8b) have been achieved. Despite this and because full-year compliance has not been achieved, they must be declared as 'not met' in 2008/09.

In summary, 3 out of 24 core standards will be declared as 'not met' in the 2008/09 declaration to the Healthcare Commission.

The draft declaration has been considered by the Governance and Risk Management Committee

PURPOSE OF THE REPORT:

◉ **Approval** ○ **Noting** ○ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The proposed compliance levels are being presented to the Trust Board for APPROVAL.

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

6.1 - Continue to achieve Healthcare Commission Health Check standards

IMPACT ASSESSMENT:

FINANCIAL	☐	
ALE	☑	Linkage to the 2008/09 ALE assessment as this also forms part of the overall HCC standards for better heath assessment
CLINICAL	☑	Many of the core standards are clinically focused
WORKFORCE	☑	Third domain focuses on managerial and clinical leadership and accountability
LEGAL	☐	
EQUALITY & DIVERSITY	☑	
COMMUNICATIONS	☑	
PPI	☑	Fourth domain focuses on patient well-being
RISKS		

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

TRUST BOARD

2008/09 Annual Health Check – Core Standards Assessment

26th March 2009

1. Introduction

The Annual Health Check is the approach used by the Health Care Commission to assess and report on the performance of the NHS and independent healthcare organisations. To do this, the Annual Health Check has several components that are used to assess different aspects of performance. A key part of this is the annual rating of every NHS organisation that provides healthcare. The rating is separated into two parts: 'quality of services' and 'use of resources'.

The process for approving and submitting the 2008/09 core standards declaration to the Healthcare Commission was presented to, and endorsed by, the Governance and Risk Management Committee in November 2008.

The purpose of this report is to present to the Trust Board the outcome of the work undertaken to assess the Trust's compliance with the core standards and the proposed declaration status for the same.

2. The core standards declaration

The declaration is intended to confirm that the Trust Board has received reasonable assurance that the Trust has complied with the core standards without any significant lapses. In considering significant lapses the Healthcare Commission expects the Trust Board to consider the extent of risk presented to patients, staff and the public and the duration and impact of any lapse. The assessment is not intended as a medium for reporting isolated, trivial or purely technical lapses.

Where there are exceptions there is a requirement to report these as (a) standards that are not met or (b) standards that lack assurance. For both an action plan is required to rectify the lapses.

The declaration must be approved by the Trust Board to acknowledge their accountability for the standards of care provided.

3. The self-assessment process

Executive Directors have undertaken a self-assessment on the extent to which the Trust has met the core standards for the period 1st April 2008 to 31st March 2009. Given the 2007/08 declaration, this work has focussed on whether compliance has been maintained. With reference to the information submitted to the Trust Board that informed the previous declaration, Executive Directors have revisited the relevant standards to:

a) identify **recent developments** that further strengthen the already compliant position; e.g. the introduction of new technology, improvements in working practices.

b) establish if there is **information that was not included** in the previous position statement to the Trust Board but should have been as it reinforces the declaration of compliance.

c) ascertain all relevant **national publications and guidance** issued since the last declaration and ensure that these have been considered and, where necessary, implemented. Changes in legislation also needed to be taken into account.

d) scrutinise the **information sources** that the Commission will refer to when cross-checking declarations.

e) produce a portfolio of evidence – including documents referred to in the position statement. This information may be requested by the Commission's assessors if the Trust is selected for inspection.

The Commission will again be inspecting a selection of trusts against their core standards declaration this year. When carrying out these inspections, the assessment managers use inspection guides. Whilst these are a resource for use by the Commission's staff, the "lines of enquiry" provide useful indicators for what should be included in the self-assessment process. For this reason the local process undertaken has included reference to the inspection guides.

The findings of the interim self-assessment were presented to the Governance and Risk Management Committee in November 2008. Continued compliance was reported against all standards, apart from standard C5c – *clinical care and treatment are carried out under supervision and leadership*, which was identified as requiring further assessment, principally because of concerns that the evidence so far presented might not establish full compliance with the standard. This work has now been completed by the Chief Nurse and Medical Director and the necessary assurance gained to declare compliance against this standard.

Recent developments have required compliance against the requirements of C20b to be revisited. Specifically, issues in achieving the requirements for mixed sex accommodation, especially in light of recent press statements and correspondence from the Department of Health, have been highlighted via a Trust-wide audit of its accommodation. Although plans are in place to address the findings of the audit and to achieve compliance (Appendix 3), this standard will need to be declared as 'not met' this year.

4. Proposed declaration

The self-assessment is complete and the findings are provided in the appended documents. Appendix 1 summarises the proposed compliance status (the options available on the Healthcare Commission's on-line declaration form are 'compliant', 'not met' or 'limited assurance'). Appendix 2 is designed to provide Trust Board members with sufficient information to make an informed declaration.

Action plans for the standards against which the Trust reported non-compliance in 2007/08 (C7e and C8b) have been achieved in-year and were presented to the Governance and

Risk Management Committee in November. Despite this and because full-year compliance has not been achieved, they must be declared as 'not met' in 2008/09.

The draft declaration was approved by the Governance and Risk Management Committee on 19 March 2009.

In summary, 3 out of 24 core standards will be declared as 'not met' in the 2008/09 declaration to the Healthcare Commission.

5. Third Party Commentary

The Trust is required to seek commentaries from the following:

- Overview and Scrutiny Committees
- Local Involvement Networks (LINks)
- Strategic Health Authority
- Local Child Safeguarding Board

The comments received from each of these will form part of the final declaration submitted to the Healthcare Commission in May.

6. General Statement of Compliance

It is proposed that the following statement is included in the relevant section of the declaration form:

> "Other than the exceptions noted on the domain forms, the Trust Board has reasonable assurance that there have been not significant lapses in meeting the core standards during the period 1st April 2008 to 31st March 2009. The Trust Board is confident that sufficient action has been taken to correct the recorded exception".

7. Recommendation

The proposed compliance levels are being presented to the Trust Board for APPROVAL.

The final declaration must be submitted to the Healthcare Commission by 1st May.

Kam Dhami
Director of Governance

Sandwell and West Birmingham Hospitals NHS
NHS Trust

STANDARDS FOR BETTER HEALTH

2008/09 Core Standards – Self-Assessment

	Standard	Lead	Compliance Status *MET/NOT MET/LIMITED ASSURANCE*	Comments
C1	Health care organisations protect patients through systems that:			
a)	identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents; and	KD	MET	
b)	ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required time-scales.	KD	MET	
C2	Health care organisations protect children by following national child protection guidance within their own activities and in their dealings with other organisations.	RO	MET	
C3	Health care organisations protect patients by following NICE Interventional Procedures guidance.	KD	MET	
C4	Health care organisations keep patients, staff and visitors safe by having systems to ensure that:			
a)	the risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in MRSA;	RO	MET	
b)	all risks associated with the acquisition and use of medical devices are minimised;	KD	MET	
c)	all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed;	GS	MET	
d)	medicines are handled safely and securely; and	RK	MET	
e)	the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and safety of the environment.	RO	MET	
C5	Health care organisations ensure that:			
a)	they conform to NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care;	KD	MET	
b)	clinical care and treatment are carried out under supervision and leadership;	RO & DOD	MET	
c)	clinicians continuously update skills and techniques relevant to their clinical work; and	RO & DOD	MET	
d)	clinicians participate in regular clinical audit and reviews of clinical services.	KD	MET	

	Standard	Lead	Compliance Status *MET/NOT MET/LIMITED ASSURANCE*	Comments
C6	Health care organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met.	RK	MET	
C7	Health care organisations:			
a)	apply the principles of sound clinical and corporate governance;	KD	MET	
b)	actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources;	CH	MET	
c)	undertake systematic risk assessment and risk management;	KD	MET	
d)	ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources;	RW	Measured through ALE process	
e)	challenge discrimination, promote equality and respect human rights; and	RO & CH	NOT MET	Compliance achieved in July 2008
f)	meet the existing performance requirements	RW	Measured through existing national targets assessment	
C8	Health care organisations support their staff through:			
a)	having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services; and	CH	MET	
b)	organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups.	CH	NOT MET	Compliance achieved in August 2008
C9	Health care organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.	RK	MET	
C10	Health care organisations:			
a)	undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies; and	CH	MET	
b)	require that all employed professionals abide by relevant published codes of professional practice.	CH	MET	
C11	Health care organisations ensure that staff concerned with all aspects of the provision of health care:			
a)	are appropriately recruited, trained and qualified for the work they undertake;	CH	MET	

	Standard	Lead	Compliance Status *MET/NOT MET/LIMITED ASSURANCE*	Comments
b)	participate in mandatory training programmes; and	CH	MET	
c)	participate in further professional and occupational development commensurate with their work throughout their working lives.	CH	MET	
C12	Health care organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied.	DOD	MET	
C13	Health care organisations have systems in place to ensure that:			
a)	staff treat patients, their relatives and carers with dignity and respect;	RO	MET	
b)	appropriate consent is obtained when required for all contacts with patients and for the use of any patient confidential information; and	DOD	MET	
c)	staff treat patient information confidentially, except where authorised by legislation to the contrary.	RK	MET	
C14	Health care organisations have systems in place to ensure that patients, their relatives and carers:			
a)	have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services;	KD	MET	
b)	are not discriminated against when complaints are made; and	KD	MET	
c)	are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.	KD	MET	
C15	Where food is provided, health care organisations have systems in place to ensure that:			
a)	patients are provided with a choice and that it is prepared safely and provides a balanced diet; and	RO	MET	
b)	patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day.	RO	MET	
C16	Health care organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after-care.	JK	MET	
C17	The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health care services.	JK	MET	

	Standard	Lead	Compliance Status *MET/NOT MET/LIMITED ASSURANCE*	Comments
C18	Health care organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.	RO	MET	
C19	Health care organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services.	RK	Measured through existing and new national targets assessment	
C20	Health care services are provided in environments which promote effective care and optimise health outcomes by being:			
a)	a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation; and	GS	MET	
b)	supportive of patient privacy and confidentiality.	GS	NOT MET	Full year non-compliance being declared
C21	Health care services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.	RO & GS	MET	
C22	Health care organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by:			
a)	co-operating with each other and with local authorities and other organisations:	RK	MET	
b)	ensuring that the local Director of Public Health's Annual Report informs their policies and practices; and	RK	MET	
c)	making an appropriate and effective contribution to local partnership arrangements including Local Strategic Partnerships and Crime and Disorder Reduction Partnerships.	RK	MET	
C23	Health care organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service Frameworks and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections.	DOD	MET	
C24	Health care organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services.	RK	MET	

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

ANNUAL HEALTH CHECK

Core Standards Self-Assessment: 2008/09

First domain: safety

Elements	Position Statement	Key Evidence
Core standard C1a **Healthcare organisations protect patients through systems that identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents.**		
Element one Incidents are reported locally, and nationally via the appropriate reporting route/s to the National Patient Safety Agency (NPSA), Health and Safety Executive, Medicines and Healthcare products Regulatory Agency (MHRA), Health Protection Agency, Healthcare Commission, the Counter Fraud and Security Management Service and all other national organisations to which the healthcare organisation is required to report incidents.	▪ The Trust has an Incident & Hazard Reporting Policy. This was approved by the Trust Board in September 2006 and is currently being reviewed. This was assessed by the NHSLA in January 2008 at level 1. The Trust is working towards a level 2 assessment Q3 in 2009. ▪ The Trust is continuing to build a safety culture which is open and fair by stating in the policy what staff should do following an incident, how it should be investigated and what support should be given to patients, families and staff. ▪ To simplify the system the Trust has one form for reporting all risks including clinical and non clinical. ▪ The Ulysses (Safeguard) database was purchased by the Trust in 2005 to be compliant with NPSA National Reporting and Learning System (NRLS) reporting requirements. This also has the capacity to capture reporting to other external agencies including HSE, MHRA, CFSMS, HCC and HPA (the last two via free text searches) ▪ Work is underway to allow staff to report incidents electronically into the Ulysses database. A pilot is planned for early 2009/10.	• Incident & Hazard Reporting policy updated September 2006 • A revised incident reporting form which includes clinical and non clinical risks

Elements	Position Statement	Key Evidence
	▪ Completed forms are entered onto the database; this captures trends and frequency of risks occurring, together with details of action taken. ▪ In the interest of patient safety and openness, constructive criticism of clinical care is actively encouraged through a blame free culture. ▪ Patient safety incidents are reported externally on a regular basis to the NPSA (National Patient Safety Agency) via the NRLS ▪ The organisation has a close working relationship with the local Patient Safety Manager, who has attended red incident reviews. ▪ The organisation supplies further information regarding incidents to help develop understanding of incidents within the NPSA ▪ Incidents are routinely reported to the Strategic Health Authority, CFSMS, HSE, MHRA and HPA, in line with the requirements of the Incident & Hazard Reporting Policy and requirements of the agencies in question.	• Incidents reported externally to the NRLS following the NPSA mapping to the database
Element two Individual incidents are analysed rapidly after they occur to identify actions required to reduce further immediate risks, and where appropriate individual incidents are analysed to seek to identify root causes, likelihood of repetition and actions required to prevent the reoccurrence of incidents in the future.	▪ Quarterly reports with trends and analysis are presented to divisions/directorates, specialist committees, the Risk Management Group, Health & Safety Committee, Governance Board and to the Trust Board. ▪ A monthly report is provided to the Governance Board and Trust Board for all clinical incidents reported to the Strategic Health Authority via STEIS. ▪ The organisation has approved a policy to formalise the analysis of incidents, complaints and claims, in line with the NHSLA Risk Management Standards. This was approved by the NHSLA at level 1 assessment in January 2008 and evidence provided of implementation for level 2 was supported by the assessor during an in-year interim visit. ▪ The Incident and Hazard reporting policy sets out a mechanism for investigating incidents. This includes a template report format. A modified	• Quarterly risk management reports to the Governance Board and Trust Board • Monthly reports to Governance Board and Trust Board • Incident and Hazard Reporting Policy – report template • MRSA bacteraemia RCA template

Elements	Position Statement	Key Evidence
	template has been developed for RCA of MRSA bacteraemia cases. ▪ It is expected that a root cause analysis will be carried out for all red incidents. Root causes should also be identified for amber incidents. ▪ Training in incident reporting and investigation of red/amber incidents is offered. This is provided to all staff on Induction to the Trust. The Corporate Risk and Health & Safety Teams also provide more specific training for staff. This includes root cause analysis techniques. ▪ All red incidents are considered to identify immediate actions to prevent recurrence when they are reported. ▪ Amber incidents are reviewed by divisions on a regular basis to ensure action plans have been put in place to address issues identified.	• Presentation for Incident training session
Element three Reported incidents are aggregated and analysed to seek to identify common patterns, relevant trends, likelihood of repetition and actions required to prevent the reoccurrence of similar incidents in the future, for the benefit of patients / service users as a whole.	▪ The Corporate Risk Team along with the divisional/directorate risk co-ordinators are involved in investigating all Red incidents. Tabletop reviews are held to discuss the serious incidents and an action plan is formalised for the division/directorate to monitor. ▪ Action plans from Red incidents are monitored through the bi-monthlyAdverse Events Committee (AEC) chaired by the Chief Executive. Action plans ensure lessons are learnt from serious incidents, embedding lessons through changes to practice, processes or systems. ▪ Minutes of the AEC are forwarded to the Trust's Governance Board ▪ Amber Incidents are investigated by the divisions/directorates and discussed at a divisional/directorate risk meeting and at their own Governance Group meetings. Lessons learnt are shared through the minutes of the risk meeting. ▪ Green and Yellow incidents (low risk incidents) are investigated locally and feedback is provided to staff by matrons, managers, etc ensuring local lessons are learnt.	• All red (serious) incidents investigated via a tabletop review with a subsequent action plan, file maintained for each red incident • All red incidents monitored via the Adverse Events Committee chaired by the CEO with actions minuted • Amber risk groups at divisional level to review local processes with minutes from meetings • Minutes of Risk Management Group and Governance Board

Elements	Position Statement	Key Evidence
	▪ The Governance Board monitors progress and implementation of all National Confidential enquiries. This process was seen as good practice by CNST in March 2005 Assessment report. ▪ Reports from the NRLS observatory are considered at key internal committees, including the Risk Management Group and Governance Board ▪ Observatory reports are circulated within the organisation to inform operational decisions. ▪ Details of red incident action plans are circulated to staff involved in the incident and to other relevant staff ▪ Amber action plans are circulated to relevant staff within the division ▪ Learning from green and yellow incidents is fed back to staff locally by the area risk leads ▪ Each division has a clinical risk lead and a risk co-ordinator who ensures incidents are escalated, followed up and fed back appropriately ▪ The Risk Department is working to develop an internal newsletter to feed back further information to staff ▪ An integrated risk report now compares trends from incidents with those raised in complaints	• List of risk leads • Evidence of feed-back of actions
Element four Demonstrable improvements in practice are made to prevent the reoccurrence of incidents based on information arising from the analysis of local incidents and the national analysis of incidents by the organisations stated in	▪ All red incident actions must be supported by evidence of change implemented before the action can be closed off ▪ Amber and red incident action plans are monitored by relevant divisions to ensure improvements are implemented ▪ Changes in practice have been implemented in the light of NPSA feedback reports and other documentation (In-Patient Falls Policy revised to ensure near	• Red incident action plans and files • 'Lessons learned' section of the quarterly Integrated Risk and Complaints report

Elements	Position Statement	Key Evidence
element one (above).	misses reported, pressure sores to be reported in the light of amended guidance, never events incorporated into Trust incident database) ▪ Incident forms capture improvements in practice	
Core standard C1b **Healthcare organisations protect patients through systems that ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required time-scales.**		
Element one All communications concerning patient safety issued from the National Patient Safety Agency (NPSA) and the Medicines Healthcare products Regulatory Agency (MHRA) via national distribution systems, including the Safety Alert Broadcast System (SABS), the Central Alert System (CAS) the UK Public Health Link System (UKPHLS), are implemented within the required timescales.	▪ Patient safety notices, alerts are received by the Trust's Health & Safety Department, The organisation has approved a systematic process to ensure that the recommendations contained in patient safety notices, safety alerts and other communications are implemented within the required timescale, in accordance with national guidance and Standard 1 (1.5.7) of the NHSLA Risk Management Standards for Acute Trusts. E-mail returns from specific mailbox are accepted in place of a signature. ▪ NPSA warnings are received by the risk leads and distributed through various routes of communications and meetings i.e. the Risk Management Group, Health & Safety Committee, Governance Board and G&RMC. ▪ The Trust Policy on the Distribution and Management of Safety Alert Notices has been developed and implemented to allow both corporate and divisional/directorate management of safety alert notices sent via the Safety Alert Broadcast System (SABS). It also allows the management of Safety Alerts produced within the Trust. Key features of the system are; early assessment of relevance of alert to the Trust by corporate leads for each type of alert (form SABS 3); method of implementation (corporately or divisionally lead); cascading the information through the divisions/directorates, employing nominated key staff and receiving information on action carried out back up the cascade on standard forms (SABS 1, SABS 2). ▪ The SABS system is updated with a reason if the alert is not relevant to the Trust	• Policy On The Distribution And Management Of Safety Alert Notice • SABS record folder – SABS memo 1,2 & 3 and e-mail correspondence • Reports to G&RMC, H&SC, DGGs. • York University Report – Work commissioned by the HPA • SABS system

Elements	Position Statement	Key Evidence
	▪ The system is managed by the Health and Safety Department, here the SABS webs site is updated ▪ A quarterly report on action taken by the Trust on these alerts is presented to the Divisional Governance Groups and the Trust Governance and Risk Management Committee ▪ Not all alerts are implemented within the required timescales, this is particularly true for the NPSA alerts which sometimes have unrealistic timescales when applied to a large organisation. However, in most cases the key actions are taken immediately and the corporate lead for the alert ensures sustained progress. ▪ The SABS system is updated on completion.	• Reports to G&RMC, H&SC, DGGs. • Reports to G&RMC, H&SC, DGGs.
Core standard C2 **Healthcare organisations protect children by following national child protection guidance within their own activities and in their dealings with other organisations.**		
Element one The healthcare organisations have made arrangements to safeguard children under Section 11 of the Children Act 2004 having regard to statutory guidance entitled *Statutory Guidance on making arrangements to safeguard and promote the welfare of children under section 11of the Children Act 2004*.	▪ The Trust has a named nurse for child protection ▪ The Trust has a named midwife for disadvantaged women and children ▪ The Trust has a named doctor for City Hospital and a named doctor for Sandwell Hospital. ▪ The Trust has a designated doctor for Safeguarding ▪ The Chief Nurse is the executive lead and sits on the Sandwell Safeguarding Board. ▪ The HoB tPCT represent health on the Birmingham Safeguarding Board. ▪ The Trust has a safeguarding committee for children	• JDs • Minutes of meetings • • Safeguarding Children policy • Training records

Elements	Position Statement	Key Evidence
	▪ Safeguarding Board for adults and children – this reports to the Governance Board and the Trust Board receives reports. ▪ The Trust has a Safeguarding Children policy. ▪ Level 1 training is provided to all staff during Trust induction and includes distribution of written information and contact details ▪ Level 2 training is provided to staff who have direct contact with women and children. ▪ Level 3 training is directed at staff who have a specialist role with women and children ▪ All training is supported by a training pack ▪ Level 2 and 3 training is provided with the support of the PCT and Mental Health Trusts. ▪ The Trust has a domestic violence policy and training is delivered for staff likely to come into contact with those subjected to violence. ▪ Training needs are identified through PDRs and detailed in the training plans ▪ The Trust has a CRB policy and all new staff are checked via HR. ▪ Volunteers are checked via the volunteer manager ▪ Bank and locum staff are checked via the Trust bank. ▪ Students are checked by the relevant university ▪ Enhanced CRB and POCA checks are undertaken where necessary.	• Resource packs • Domestic Violence Policy • PDRs and training plans • Evidence of CRB checks • CRB Policy
Element two The healthcare organisation works	▪ Key members of Trust staff sit on the relevant stakeholder groups and safeguarding boards.	• Minutes of Safeguarding Boards

Elements	Position Statement	Key Evidence
with partners to protect children and participate in reviews as set out in *Working together to safeguard children* (HM Government, 2006).	▪ The Trust takes part in management reviews and provides detailed investigations where required. ▪ The Trust participates actively in any serious case reviews ▪ Findings from management reviews and serious case reviews are reported to the Trust Governance Board. ▪ Multi agency training is participated in by Trust staff ▪ Child protection web page is available to all staff. ▪ Both A+E departments have RSCN trained nurses although this is insufficient to have one on every shift. ▪ Safeguarding procedures and contact numbers are readily available in relevant departments. ▪ Key members of Trust staff sit on the relevant stakeholder groups and safeguarding boards. ▪ The Trust takes part in management reviews and provides detailed investigations where required. ▪ The Trust participates actively in any serious case reviews. ▪ Findings from management reviews and serious case reviews are reported to the Governance Board. ▪ Multi agency training is participated in by Trust staff ▪ Child protection web page is available to all staff. ▪ Both A+E departments have RSCN trained nurses although this is insufficient to have one on every shift.	• Evidence of management reviews • Evidence of case reviews • Governance board minutes

Elements	Position Statement	Key Evidence
	▪ Safeguarding procedures and contact numbers are readily available in relevant departments. ▪	
Element three The healthcare organisation has agreed systems, standards and protocols about sharing information about a child and their family both within the organisation and with outside agencies, having regard to *Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11of the Children Act 2004*.	▪ Agreement with Sandwell Safeguarding board partners are in place. ▪ Agreement with Birmingham Safeguarding partners. ▪ Evidence that partners actively share information is available via training materials, case reviews, meetings etc.	• Agreements
Core standard C3 **Healthcare organisations protect patients by following NICE Interventional Procedures guidance.**		
Element one The healthcare organisation follows NICE interventional procedures guidance in accordance with *The interventional procedures programme* (Health Service Circular 2003/011). Arrangements for compliance are communicated to all relevant staff.	▪ There is a Trust policy (Policy and process for the introduction of new clinical techniques and procedures (SWBH\ORG\ 056)) that sets out the approach to be taken over the introduction of new clinical techniques and procedures within the Trust. It aims to protect the safety of patients and to support clinicians and the Trust in managing clinical innovation responsibly. ▪ The policy covers the situations where the proposed new technique is the subject of NICE guidance and also where it has not yet been considered. It also covers the situation of use of a new technique in a clinical emergency. ▪ There is also a Trust policy for the dissemination and implementation of NICE Guidance. In summary, this requires lead clinicians to provide assessments of the implications for the Trust of the guidance, which is recorded and then reported within the governance framework. This includes the introduction of Interventional Procedure Guidance.	• Policy and process for the introduction of new clinical techniques and procedures (SWBH\ORG\056) • Policy for disseminating and implementing guidance from NICE (SWBH\Clin\026) • Examples of applications made to the Governance Board under the new techniques policy. • NICE Implementation reports to the Governance Board and G&RMC

Elements	Position Statement	Key Evidence
Core standard C4a **Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in Methicillin-Resistant Staphylococcus Aureus (MRSA)**		
Element one The healthcare organisation has systems to ensure the risk of healthcare associated infection is reduced in accordance with *The Health Act 2006 Code of Practice for the Prevention and Control of Healthcare Associated Infections* (Department of Health, 2006 revised January 2008). To note: the measurement of the MRSA target is undertaken through the 'national priorities' component of the annual health checks.	▪ The Trust continues to give a high profile to reducing the risk of HCAI. ▪ The Trust is well within its targets for MRSA and C Difficile, which indicates that the Trust action plan is having an effect. ▪ The Trust Board monitors progress via the Assurance Framework, action plan and a quarterly suite of reports. ▪ The Executive Infection Control Committee ensures that the action plan is progressed. ▪ Audit results show good progress in key areas, such as saving lives, hand hygiene, antimicrobial prescribing. ▪ The Trust has recently reviewed all of its policy documents and is satisfied that relevant policies exist and are in date. ▪ All staff have access to training via taught sessions, induction programmes and CDROM.	• IC Assurance framework • Action plan • Minutes of infection control exec committee • Minutes of Operational Infection Control Committee • Trust Board reports • Reports to TMB, and Governance Board. • Divisional performance reports • Trust Board performance reports • Audit reports • Training data • Data highlights
Core standard C4b **Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all risks associated with the acquisition and use of medical devices are minimised.**		
Element one The healthcare organisation has systems in place to minimise the risks associated with the	▪ The Medical Devices Committee (MDC), chaired by the Director of Estates, reviews the systems for the development, monitoring and review of safe systems for medical devices, including approving procedures for their procurement, standardization, use, decontamination and training. The MDC	• Risk based training needs analysis procedure • Corporate Competency database

Elements	Position Statement	Key Evidence
acquisition and use of medical devices in accordance with guidance issued by the Medicines Healthcare Products Regulatory Authority.	reports to the Governance Board. ▪ Processes for the development, monitoring and review of safe systems for medical devices, including approving procedures for their procurement, standardisation, use, decontamination and training exist. ▪ The Control of Infection Department provides advice on the cleaning, disinfection, decontamination and, where appropriate, the method of sterilisation of medical devices. ▪ Medical equipment maintenance duties, including the provision of a 24-hour on-call service for emergency breakdowns, are carried out. ▪ A corporate register of medical equipment is maintained. ▪ All purchases of medical equipment satisfy the essential requirements of the Medical Device Directive (MDD 93/42 EEC). ▪ A process of standardisation of common medical devices/equipment is in place to minimise the number of makes and models of similar devices in clinical areas. This work is on-going ▪ Systems exist for the delivery, acceptance, commissioning and storage of medical equipment/devices. ▪ The Trust operates a system of decontamination of medical equipment ▪ The Trust has appointed a substantive lead Decontamination Manager ▪ Records are kept of maintenance and repair of medical equipment ▪ Adverse incidents relating to medical devices are reported in accordance with the Trust Incident Reporting Policy. ▪ Safety Alert Notices issued by the Medicines and Healthcare products Regulatory Agency (Medical Device Alerts only), DH Estates & Facilities, the	• Local competency database • Policy and Procedure for Ensuring Competence in Medical Devices • Policy for the Management of Medical Devices • Trust-wide Medical Equipment Register (database) • SABS System • Decontamination Manager's job description • Terms of reference and minutes of the Medical Devices Committee

Elements	Position Statement	Key Evidence
	National Patient Safety Agency and NHS Litigation Authority are sent to the Trust electronically using the Safety Alert Broadcast System (SABS), indicating importance and type of action to be taken. ▪ Arrangements are in place to ensure the co-ordination and effective reporting of incidents involving medical devices and the dissemination of MHRA Hazard and Safety Notices. This ensures that necessary actions are completed within the designated time frame. ▪ All single use items purchased and used throughout the Trust are not reused or reprocessed under any circumstances. ▪ Medical equipment libraries at both acute hospital sites exist. Construction work to improve the Sandwell site facility has been undertaken this year. ▪ Records of staff training in the use of medical equipment are held at departmental/ward level. ▪ Annual training needs analysis/ competency in the use of medical devices undertaken to support corporate competency recording. ▪ Training provided by a range of systems and appropriately competent specialist staff including resuscitation team and IV team ▪ Training recorded centrally on Safeguard database	
Element two The healthcare organisation has systems in place to meet the requirements of the Ionising Radiation (Medical Exposure) Regulations 2000 [IR(ME)R] and any subsequent amendment.	▪ The Trust has in place an IRMER policy available to all staff on the Imaging intranet ▪ The Trust has an RPA and also has appointed RPS personnel for all areas where ionising radiations are used. Local rules and systems of work are in place for all controlled areas. ▪ A Radiation safety committee and also an IRMER committee meet to review and discuss appropriate radiation safety issues.	• IRMER policy • Minutes of Radiation Safety Committee • Training course outlines • Annual Trust Board report

Elements	Position Statement	Key Evidence
	■ IRMER training courses are held regularly for staff. ■ All staff radiation film badge doses are reviewed centrally and there is a policy for review of results. ■ A report is presented annually to the Trust Board by the RPA	
Core standard C4c **Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed.**		
Element one Reusable medical devices are properly decontaminated in accordance with *The Health Act 2006 Code of Practice for the Prevention and Control of Healthcare Associated Infections* (Department of Health, 2006 revised January 2008).	■ Decontamination of the Trusts medical devices transferred to an off-site service provider Bbraun Sterilog. ■ The Trust has no bench top Steriliser & Washer Disinfectors within the Trust ■ The Trust belongs to the "Pan Birmingham Consortium for Sterile Services" who monitor and oversee the decontamination service that Bbraun provide to SWBH NHS Trust. The Consortium keeps a comprehensive Risk Register to ensure all eventualities are covered. ■ Both Hospital sites have Endoscopy units with HTM compliant disinfectors and instrument trace-ability systems in place. ■ A substantive Lead Decontamination Manager has been appointed. ■ There is a Sterile Services Contact Manager appointed by the Trust to manage the day-to-day use of the off-site service provided by Bbraun Sterilog. ■ The Trust has both a Medical Devices Committee and a Decontamination of Medical Devices Sub-committee to ensure that all medical devices processed both of –site and on-site in preparation for re-use, are done so effectively and in accordance with the European Directive 93/42/EEC.	• Copy of Bbraun's registration certificate with a notified body (BSI). • Equipment tested and maintained in accordance to HTM2010 & HTM 2030. Operating Policy, Work Instructions and Trace-ability documentation available. • Decontamination Service Agreement with Bbraun Sterilog. • Copy of Pan Birmingham Risk Register. • Risk Schedule • Disinfectors maintained to HTM2030. • Trace-ability records maintained. • Internal Audit of Endoscopy decontamination procedures. • Medical Devices Policy • Decontamination Manager JD • Terms of reference

Elements	Position Statement	Key Evidence
		• Decontamination Service Agreement with off-site service provider Bbraun Sterilog • Decontamination Sub Group • Decontamination Sub Group Minutes • Medical Engineering Workplan • Service Review Committee • Service Review Committee Minutes • Defects Reports • Weekly turnaround performance reports • Pan Birmingham Action Plan
Core standard C4d **Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that medicines are handled safely and securely.**		
Element one Medicines are safely and securely procured, prescribed, dispensed, prepared, administered and monitored, in accordance with the Medicines Act 1968 (as amended, and subsequent regulations, including the Medicines for Human Use (Prescribing) Order 2005), the Health and Safety at Work Act 1974, as amended, and subsequent regulations including the Control of Substances Hazardous to Health Regulations 2002; and the good practice	▪ The Trust has good systems in place, which are measured against national standards and are regularly audited. ▪ Audits and external reviews have provided a high level of satisfaction with the service and the meeting of the national standards. There are areas in need of improvement and new standards to achieve. Actions plans are in place or are being developed to support this. ▪ The 2006 Acute Hospitals Medicine Management review gave a 'Good' rating. ▪ The Trust has an effective Drugs and Therapeutics Committee (DTC) with representatives from the local PCTs. The DTC has completed a full review of the Trust drugs formulary and the revised formulary has been fully implemented.	A wide of range evidence is available including internal and external audits. These include: • 2006 Acute Hospitals Medicine Management review gave a 'Good' rating. Action plan from this review • Building a safer NHS – Pharmacy action plan • Policies and procedures • Drugs and Therapeutics Committee meeting papers • Governance Board – quarterly Pharmacy update • Medicines safety and non-medical prescribing is reported

Elements	Position Statement	Key Evidence
identified in *The safe and secure handling of medicines: A team approach* (RPS, March 2005) should be considered and where appropriate followed.	▪ The Pharmacy team is continuing to develop and implement a revised single set of policies and procedures across all the Trust pharmacy services. This is being supported by a new management structure. ▪ Single Trust wide pharmacy computer system implemented. ▪ Pharmacy Aseptic Services unit within BTC. The facility has been licensed by the MHRA. ▪ New drug prescription / drug administration sheet has been developed and is being implemented. ▪ Trust wide medicines management policy implemented; Controlled Drugs medicines management policy is being developed ▪ NPSA alerts, actions in progress to achieve requirements stated within alerts	on to the Trust Risk Management Committee • All adverse drugs reactions are monitored by internal and external agencies. • External inspection by MHRA: minor issues identified – no major/critical issues • External audit of SAB re oral methotrexate • External audit Dangerous Goods Safety • Audits of staff dispensing • The Trust is training centre fir Pharmacist staff which ensures staff are being trained to and monitored against the latest standards
Element two Controlled drugs are handled safely and securely in accordance with the *Misuse of Drugs Act 1971* (and amendments), *Safer Management of Controlled Drugs: Guidance on strengthened governance arrangements* (Department of Health, Jan 2007) and *The Controlled Drugs (Supervision of Management and Use) Regulations 2006.*		
Core standard C4e **Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the**		

Elements	Position Statement	Key Evidence
safety of the environment.		
Element one The prevention, segregation, handling, transport and disposal of waste is properly managed to minimise the risks to patients/service users, staff, the public and the environment in accordance with all relevant legislative requirements referred to in Environment and Sustainability: Health Technical Memorandum 07-01: Safe management of healthcare waste (Department of Health, November 2006) and Environment and sustainability: Health Technical Memorandum 07-05: The treatment, recovery, recycling and safe disposal of waste electrical and electronic equipment (Department of Health, June 2007).	▪ The Trust has arrangements in place to discharge its responsibility to ensure that all waste is managed in accordance with: o Health and Safety Executive o Safe Disposal of Healthcare Waste HTM 07-01 o The environment Protection Act 1990 o The Hazardous Waste Regulations 2005 o The Carriage of Dangerous Goods & Use of Transportable Pressure Equipment (ADR) Regulations 2007 ▪ In addition the Trust is has appointed a Waste Minimisation Manager to lead in implementing the changes in HTM 07 -01 and ensure conformity. This will be done in conjunction with the waste management group that reports the facilities Governance. ▪ The Trust has a comprehensive Waste Policy which is reviewed on an annual basis ▪ The Trust has a responsibility to ensure that all waste transported off site is incinerated and disposed of correctly. ▪ Regular planned audits are undertaken inclusive of: o Waste transportation o Incineration procedures o Incineration facility	• Environment agency external audit reports • Carriage of Dangerous Goods training records • Up to date copies of legislation- • Management and staff training records • Waste carriers licence • Waste Transfer Station Licenses • Department Risk register • Trust Waste Policy • Dangerous Goods Safety Advisor(DGSA) • Environment Agency External reports • Team Brief April 08 • Waste Action Plan • Updated Waste Policy • Waste Posters • Para 27 Exemption • Waste Group • Waste Group minutes • Trust DGSA audit

Second domain: clinical and cost effectiveness

Elements	Position Statement	Evidence
Core standard C5a **Healthcare organisations ensure that they conform to NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care.**		
Element one The healthcare organisation ensures that it conforms to NICE technology appraisals where relevant to its services. Mechanisms are in place to: identify relevant technology appraisals; take account of clinical views and current practice in decision-making; and where necessary assess costs, and develop, communicate, implement and review an action plan for relevant technology appraisals.	▪ The process for the management of NICE Guidance within the Trust is set out in the NICE Implementation Policy. This details the responsibilities for determining whether new guidance is relevant to the Trust and for obtaining an assessment of current practice against the key recommendations. Also, the Trust is a member of the Sandwell and West Birmingham (Health Economy) NICE Implementation Group. Details of the implementation process are identified in section 4.1.of the group's operational policy. ▪ As part of the implementation policies (SWBH & SWB), clinicians are asked for a baseline assessment of the implications. The SWB Group has also conducted a number of assessments of the potential impact of draft guidance on the local health economy. ▪ When providing their baseline assessment, Lead Clinicians are requested to indicate whether implementation plan is required. ▪ For many of the cancer related therapies implementation is managed through the Cancer Network. ▪ Where in the opinion of the lead clinician there is only partial compliance with a technology appraisal guidance, implementation is reviewed by the NICE Implementation Groups ▪ A regular report is presented to the Governance Board which indicates guidance published. ▪ Guidance published is downloaded onto the Trusts Intranet Site.	• Policy for disseminating and implementing guidance from NICE (SWBH/Clin/026) • Policy for NICE Implementation ;- Sandwell and West Birmingham Health Economy NICE Implementation Group (SWB NICE Group) • Minutes from NICE implementation group meetings • Examples of baseline assessments • Example of an Implementation plan • NICE reports to the Governance Board • Example of dissemination letter as per NICE Implementation Policy • Report to a Divisional Governance Group • Trust Clinical Audit Forward Plan 2008/09 • Governance Board Minutes

Elements	Position Statement	Evidence
	▪ Divisional Governance Groups also consider relevant NICE Guidance. ▪ In addition, the SWB Group has developed a Health Economy Database. This is being populated with data and when completed full access will be provided from the Trusts' Intranet Site. ▪ Audits of NICE Guidance are included in the Trusts Clinical Audit Forward Plan on an annual basis. ▪ If audit results show areas for improving compliance then an action plan is required to be developed. ▪ The Trust's NICE Implementation Policy incorporates best practice guidance contained in ' *How to put NICE guidance into practice'*	
Element two The healthcare organisation can demonstrate how it takes into account nationally agreed guidance where it is available as defined in National Service Frameworks (NSFs), NICE guidelines, national plans and nationally agreed guidance, when delivering care and treatment. The healthcare organisation has mechanisms in place to: identify relevant guidance; take account of clinical views and current practice in decision-making; and where necessary assess costs, and develop, communicate, implement and review an action plan for appropriate guidelines.	▪ The Trust has a formal policy for handling nationally agreed guidance within the organisation. The policy applies primarily to recommendations made in national reports e.g. those arising from National Service Frameworks, the National Confidential Enquiries, Royal Colleges; the Healthcare Commission (national reviews of clinical services).and National Patient Safety Agency (excludes alerts). It also applies to similar guidance contained in reports produced on a region wide basis. ▪ Where nationally produced guidance is relevant to the organisation the appropriate Executive Director, clinical and operational leads are requested to provide an assessment of compliance against the identified best practice. ▪ Under the 'Towards 2010' Implementation programme, working groups (SMOCS) are required to consider best practice as defined in nationally produced guidance when developing service models for the 'health economy' ▪ The Trust also participates in many National Audits which measure compliance with national guidance in particular with milestones contained in the NSF's e.g. MINAP	• Policy for the Management of Nationally Agreed Clinical Guidance and Governance Reports (ORG/088) • Examples of baseline assessments and action plans developed in line with the policy • NSF action plan 2009/10

Elements	Position Statement	Evidence
Core standard C5b **Healthcare organisations ensure that clinical care and treatment are carried out under supervision and leadership.**		
Element one The healthcare organisation ensures that appropriate supervision and clinical leadership is provided to staff when delivering clinical care and treatment. Where appropriate, staff also have the opportunity to receive 'clinical supervision'; and where appropriate, this is in accordance with requirements from relevant professional bodies. Arrangements for clinical leadership and supervision (including 'clinical supervision') are communicated to all relevant staff. The effectiveness of these arrangements is monitored and reviewed on a regular basis and action is taken accordingly.	▪ A revised clinical supervision policy has been developed that includes a continuum of supported practice from qualification to expert i.e. preceptorship – clinical supervision – mentorship – coaching. ▪ All non-medical clinical professionals have access to supervision. ▪ Clinical leadership has been strengthened through: o Matrons development programme o Restructure of senior nursing team o MD ward leadership event o Numerous trust clinical leadership conferences o Support for team leaders on the ILM programme ▪ Supervision for therapists and midwives is in accordance with their professional bodies. ▪ Supervision arrangements for midwives are reviewed annually by the LSA and the Trust receives their report via the trust maternity taskforce. ▪ Training for supervision is available for both supervisors and supervisees. ▪ Funding has been approved for preceptorship posts ▪ All posts have leadership duties outlines in JDs and KSF ▪ Medical leadership has been strengthened through the development of directorates with clear accountability for clinical supervision at the specialty level. ▪ All clinical staff in training have a named educational supervisor. ▪ All training posts are regularly reviewed by the post-graduate tutors and external organisations.	• Leadership programmes • Attendance on ILM • Conference details • LSA officer reports • Clinical Management Structure • Deanery and SAC reports

Elements	Position Statement	Evidence
	▪ The induction process for medical trainees includes the completion of a competency document which is then discussed with the supervising consultant.	
Element two The healthcare organisation ensures that it provides opportunities for clinicians to develop their clinical leadership skills and experience.	▪ There are regular leadership events with required attendance for all consultants. ▪ External courses are regularly circulated to clinical staff and funded through a robust CME process ▪ Senior clinicians strongly encouraged and supported in gaining formal qualifications in clinical leadership	
Core standard C5c **Healthcare organisations ensure that clinicians continuously update skills and techniques relevant to their clinical work.**		
The healthcare organisation ensures that clinicians from all disciplines participate in activities to update the skills and techniques that are relevant to their clinical work in accordance with relevant guidance and curricula. This includes identifying and reviewing skills needs and skills gaps; providing and supporting on the-job training and other training opportunities; and where appropriate working in partnership with education and training providers to ensure effective delivery of training.	▪ The Trust has a dedicated Learning and development dept who are responsible for meeting the training needs of staff. ▪ To this end a Trust training plan is developed, populated from department and divisional training needs assessments and production of training plans. ▪ Training needs are identified via PDRs which are undertaken at least annually. ▪ Numerous teaching materials and courses are utilised to develop the skills of staff including: o Taught programmes in house o External programmes o Specialist members of staff o CDROMs o Virtual packages o Cascade training o Induction programmes o Leadership programmes o NVQs o Foundation degrees	• Training programmes and prospectus • Trust training plan • Dept training plans • PDRs and KSF outlines • Various packages • Training attendances • Minutes and outcomes of bids

Elements	Position Statement	Evidence
	▪ The Trust has good relationships with providers and also sits on the Workforce locality Board. ▪ 2010 programme and exemplar projects have also been instrumental in reviewing staff skills and shifting the emphasis of where skills are required. ▪ Medical CPD is discussed in detail during structured appraisal discussions. ▪ Identified gaps in skills are addressed through agreed personal development plans.	• Appraisal documentation
Core standard C5d **Healthcare organisations ensure that clinicians participate in regular clinical audit and reviews of clinical services.**		
Element one The healthcare organisation ensures that clinicians are involved in prioritising, conducting, reporting and acting on regular clinical audits.	▪ The Clinical Effectiveness Department (CED) provides support for audits that are prioritised by the specialties/divisions and included in the Trusts Clinical Audit Forward Plan. ▪ The CED offer advice to clinicians about the audit process for both forward and non forward plan topics. ▪ A programme of Clinical Governance Afternoons provides many clinical staff with protected time for the planning, presenting and discussion of clinical audits. ▪ Included in the Trusts Forward Plan are a number of audits that have been designated as 'Corporate Clinical Audits' e.g. Healthcare Records Audit. These require participation of many staff. ▪ The Trust also participates in many national clinical audits which involve staff from a variety of disciplines. ▪ There is a Trust policy covering the conduct of clinical audit. This identifies the system for prioritising clinical audit projects. ▪ The clinical audits that are prioritised for each financial year and included in a Trust Clinical Audit Forward Plan. This includes audits from many specialties.	• Clinical Audit and Effectiveness Strategy 2009/10 • Policy for undertaking a clinical audit (ORG/103) • Trust Clinical Audit Forward plan 2008/09 • Examples of action plans developed • Clinical Governance Afternoon programmes

Elements	Position Statement	Evidence
	▪ Following the presentation of clinical audit projects, when indicated, action plans are required to be developed and this can involve a number of staff from different disciplines. ▪ A summary of audits is also fed back to staff attending Divisional Governance Group meetings. ▪ In addition, audits are presented through 'Grand Round' events at City Hospital.	
Element two The healthcare organisation ensures that clinicians participate in regular reviews of the effectiveness of clinical services through evaluation, audit or research.	▪ A programme of Clinical Governance Afternoons provides many clinical staff with protected time for the presentation and discussion of relevant clinical information. ▪ The Trust has commenced service line reporting on a range of indicators for selected directorates as part of the development of a Quality Management Framework. ▪ Benchmarked data is also available from Dr Foster and alerts that are generated are reported to the Governance Board. Data is also available to clinical management teams through the 'Hospital Activity Tracker' which has also been developed through the Dr Foster organisation. ▪ There is also a dashboard of performance indicators that are presented on a regular basis to the Operational Management Board and to the Trust Board ▪ A programme of Divisional and Ward Reviews is ongoing. These reviews include the discussion of information on performance and target setting.	• Clinical Governance Afternoon agendas and feedback. • Quality Management Framework reports • Dr Foster Reports to the Governance Board • Divisional Governance Group reports to the Governance Board • Ward review template

Core standard C6
Healthcare organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly

managed and met.		
Element one The healthcare organisation works in partnership with other health and social care organisations to ensure that the individual needs of patients / service users are properly managed and met: • Where responsibility for the care of a patient is shared between the organisation and one or more other health and/or social care organisations. and/or • Where the major responsibility for a patient's care is moved (due to admission, referral, discharge or transfer) across organisational boundaries. Where appropriate, these arrangements are in accordance with: • Section 75 partnership arrangements of the National Health Service Act 2006 (previously section 31 of the Health Act 1999). • The Community Care (Delayed Discharges etc.) Act 2003 and Discharge from hospital pathway, process and practice (DH, 2003). Where appropriate, these arrangements are in accordance with the relevant aspects of the following guidance or equally	▪ There are joint arrangements with social care regarding discharge processes as well as the use of the (deferred) reimbursement funding. The use of this resource is monitored on a regular basis by senior mangers within the Trust, as are the numbers of delayed discharges. ▪ At all sites within the Trust there are posts/structures which have been jointly funded and which aim to reduce delays in patients moving out of the acute sector. ▪ The Discharge policy for the trust was circulated to PCT and social services representatives to enable them to comment prior to its approval. The policy contains letters to patients which have been jointly agreed with social services and the Trust. ▪ The work around the exemplar sites for intermediate care has involved multi-agency working and agreements over joint use of resources. The Rowley Regis exemplar model for example involves the PCT funding beds in social services facilities at Knowle House. The recently opened Norman Power Centre is a further example of joint working. ▪ Recently there have been discussions between the Trust, Sandwell PCT and Sandwell social services regarding processes for Continuing Care Assessments. It has been agreed that SWBHT staff will be trained in undertaking these and that they will be accepted by the social services and the PCT funding panel. Joint awareness training has already taken place regarding the CCA. ▪ Staff are aware of the joint working and new care pathways that are being developed as part of the 2010 exemplars/modeling as they are regularly informed about these schemes via Team Brief ▪ There are regular meetings of senior managers at both the City and Sandwell sites with their counterparts in health and social care to review how the system is dealing with patients.	• Copy of Discharge Policy on intranet • Notes from joint meetings between the partner agencies regarding delayed transfers of care or joint planning Minutes from the intermediate care exemplar groups • Notes from meetings • Team Brief • Notes from meetings

effective alternatives: • *Guidance on the Health Act Section31* partnership agreements (DH, 1999). • Guidance on partnership working contained within relevant National Service Frameworks and national strategies (for example, the National Service Framework for Mental Health (DH, 1999), the National Service Framework for Older People (DH, 2001) and the Cancer Reform Strategy (DH, December 2007). • The National Framework for NHS Continuing Healthcare and NHS funded Nursing Care (DH, 2007).		
Element two Staff concerned with all aspects of the provision of healthcare work in partnership with colleagues in other health and social care organisations to ensure that the needs of the patient / service user are properly managed and met.		

Third domain: governance

Elements	Position Statement	Evidence
Core standard C7a&c **Healthcare organisations:** **a) apply the principles of sound clinical and corporate governance; and** **c) undertake systematic risk assessment and risk management.**		
Element one The healthcare organisation has effective clinical governance arrangements in place to promote clinical leadership and improve and assure the quality and safety of clinical services for patients / service users.	The Trust has a well established integrated governance framework, the key components of which are: ▪ Clear lines of accountability at Board and divisional level ▪ Organisation wide Governance committees, e.g. Drugs & Therapeutics, Resuscitation, reporting to the Governance Board ▪ Planned reporting requirements from Divisional Governance Groups and organisation-wide committees ▪ Annual reports covering the main governance components e.g. risk management, infection control, safeguarding ▪ Clinical performance and quality monitoring reports ▪ Arrangements for ensuring governance policies are approved, effectively promulgated and monitored. ▪ Process for ensuring the findings and recommendations arising from external visits, peer review assessments, accreditations are acted upon	• Organisational Governance Framework • Role specifications • Terms of reference • Regular reports/updates from divisions and organisation wide committees • Clinical performance/monitoring reports • Annual reports • Action plans developed in response to external reports
Element two The healthcare organisation has effective corporate governance arrangements in place that where appropriate are in accordance with *Governing the NHS: A guide for NHS boards* (Department	▪ Accountability arrangements for corporate governance have been clearly set out. ▪ The accountability of the Board and the Chief Executive are clearly defined. ▪ Governance arrangements, key documentation and committee arrangements have been established and approved by the Board.	• Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions • Trust Board Sub-Committees – Terms of Reference

Elements	Position Statement	Evidence
of Health and NHS Appointments Commission, 2003), and the *NHS trust model standing orders, reservation and delegation of powers and standing financial instructions March 2006* (DH, 2006).	▪ The Board has defined a set of key objectives for the organisation that have been approved by the Board. ▪ The Board has defined a Performance Assessment Framework to meet the needs of its objectives and monitor its progress against NHS targets. ▪ Committee and management structures are in place to support the Board ▪ The Board has delegated responsibility for overseeing aspects of corporate and clinical governance to supporting committees (e.g. Finance & Performance Management, Audit, Governance & Risk) ▪ The arrangements, responsibilities and membership of committees are clearly defined through the Terms of Reference (as approved by the Board). ▪ The Board and its Committees have in place a clear annual cycle of business ▪ Cross-reporting between committees takes place where agendas cross-over. ▪ Specific responsibilities for corporate and clinical governance are defined in job descriptions. ▪ Risks relating to governance are included on the Trust-wide Risk Register ▪ Corporate governance documents (Standing Orders, Standing Financial Instructions and the Scheme of Delegation) are based on DoH models. ▪ Corporate governance arrangements have been developed in accordance with the relevant DoH guidance ▪ Corporate governance arrangements have been reviewed in the light of future plans for the Trust	• 2008/09 Trust Objectives and quarterly updates • 2008/09 Assurance Framework and quarterly updates on progress to address gaps • Trust Risk Register and quarterly updates • Corporate objectives risk register and quarterly updates • Executive Director Job Descriptions • Non Executive Director appointment documentation • Organisational Framework for Governance • Audit Committee Cycle of business • Trust Board cycle of business • Governance reporting cycle • KPMG Board development reports • IBP (Chapter 9)
Element three	▪ The Trust has a Trust Risk Management Strategy which is approved by Trust	• Risk Management Strategy

Elements	Position Statement	Evidence
The healthcare organisation systematically assesses and manages its risks, both corporate/clinical risks in order to ensure probity, clinical quality and patient safety.	Board and which is reviewed annually by the Governance and Risk Management Committee. ■ The Strategy includes a description of the organizational risk management structure detailing all those committees/sub-committees/groups which have some responsibility for risk. The key Trust-wide policies supporting this Strategy are: - Risk Assessment Policy - Incident and Hazard Reporting Policy (updated in September 2006) ■ The Governance and Risk Management Committee, on behalf of the Trust Board, sets the strategic direction for governance and risk management within the Trust. ■ The Trust has an approved organizational wide high level risk register which includes source of risk, description of risk, risk score, summary risk treatment plan, target date for completion, date of review, residual risk rating, trends, critical incidents and significant new risks. The Register is populated from a wide range of sources including corporate objectives, incident reports, risk assessments, significant risks from directorate risk registers. ■ Risk Management is included in all corporate induction programmes. ■ Training workshops are provided for risk Assessment, Incident reporting and incident investigation. ■ Divisions have almost all developed a local register showing all risks and a divisional risk register showing high risks. It is expected these registers will cover all categories of risk (ie clinical, H&S, organizational, information governance etc) ■ Key projects within the Trust have risk registers which feed into the Trust system (i.e. Foundation Trust, Acute Hospital Project) ■ Quarterly updates are obtained for all risk registers and reported to corporate	• Risk Assessment Policy • Incident & Hazard Reporting Policy • Local Risk assessments • Corporate Risk Register • Divisional Risk Registers • Risk Assessment/Incident Reporting Training Registers

Elements	Position Statement	Evidence
	committees and Trust Board. ▪ The Corporate Risk Register is presented to Governance and Risk Management Committee and Trust Board together with the Corporate Objectives risk register and Assurance Framework to ensure an overview of all risks is achieved. ▪ Individual full risk assessments take place using the designated risk assessment report form/documentation.	
Core standard C7b **Healthcare organisations actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources.**		
Element one The healthcare organisation actively promotes openness, honesty, probity and accountability to its staff and ensures that resources are protected from fraud and corruption in accordance with the *Code of conduct for NHS managers*(Department of Health, 2002), *NHS Counter fraud & corruption manual third edition* (NHS Counter Fraud Service, 2006), and having regard to guidance or advice issued by the CFSMS.	▪ The standard statement of main terms and conditions of employment document includes a clause [para 28] which requires all staff to abide by the provisions of Standards of Business Conduct. ▪ These are also included in Trust Standing orders. ▪ Para 28 also requires all staff to notify the Chief Executive of any potential conflicts of interest or other financial interests which may impinge on Trust contracts/business. ▪ Para 29 requires all staff to adhere to the Code of Conduct. ▪ Para 30 explains the responsibilities of employees with regards to gifts and hospitality. ▪ There is a local Code of Conduct and Employment charter which reinforces standards of behavior. ▪ The Trust has in place an annual appraisals and PDRs process ▪ Regular corporate induction programmes are run ▪ The Trust has a Code of Conduct, which has been disseminated to all staff	• Standard Statement of main terms and conditions of employment • Code of conduct and employment charter • Standing Orders • Corporate induction programme outlines • Code of Conduct leaflet

Elements	Position Statement	Evidence
	▪ The Trust has a Counter Fraud and Corruption Policy available to all staff on the intranet ▪ The Trust has a Whistleblowing Policy available to all staff on the intranet	• Counter Fraud and Corruption Policy • Whistleblowing Policy
Core standard C7d **Healthcare organisations ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources**		
This standard will be measured through the use of resources assessment.		
Core standard C7e **Healthcare organisations challenge discrimination, promote equality and respect human rights.**		
Element one The healthcare organisation challenges discrimination and respects human rights in accordance with the: • Human Rights Act 1998. • *No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse* (Department of Health, 2000). • The general and specific duties imposed on public bodies in relation to race, disability and gender (including, among other things, equality schemes for race,	▪ The Trust has in place a Single Equality Scheme agreed by the Trust Board, which is supported by an improvement plan. ▪ The Trust has invested in three new posts to support the implementation of the action plan. ▪ The Trust has a web page that can be accessed by members of the public detailing its arrangements for equality and diversity. ▪ The Trust has an Adult Safeguarding Steering Group (and Senior representation on Local Authority Safeguarding Boards). Membership is multi-disciplinary. Reports are received from sub-groups regarding Mental Capacity /DOL and Mental Health. ▪ The Trust has recruited a Safeguarding Lead post to assist with Adult Protection alerts and investigations. ▪ The Trust has a Vulnerable Adult Protection Policy (mental Capacity and	• SES scheme • Action plan and progress reports to the TB • Web page • HR/workforce data and action plans • Minutes

Elements	Position Statement	Evidence
disability and gender, along with impact assessments) under the "public body duties"*. • "Employment and equalities legislation"** including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part-time workers, fixed term employees, flexible working and working time. *"Acting in accordance with 'public body duties'" means: Acting in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under the following statutes: • Race Relations (Amendment) Act 2000. • Disability Discrimination Act 2005. • Equality Act 2006. And, where appropriate, having due regard to the associated codes of practice. **"Acting in accordance with 'employment and equalities legislation'" means: Acting in accordance with relevant legislation including: • Equal Pay Act 1970 (as amended). • Sex Discrimination Act 1975 (as amended). • Race Relations Act 1976 (as amended). • Disability Discrimination Act 1995. • Employment Equality (Religion or Belief) Regulations 2003. • Employment Equality (Sexual Orientation) Regulations 2003. • Employment Equality (Age) regulations 2006.	Mental Health Act policy) based on the local Multi-agency guidelines and No Secrets. ■ Training is available at level 1 – raising awareness and levels 2 and 3 – investigations and decision making, internally, externally and via classroom and electronic mediums. Level 1 is provided on induction and up-date sessions. ■ Patient/staff information is available on induction and via websites. ■ A data collection tool is being piloted. ■ Lessons learnt are disseminated via the Governance framework, senior meetings and Governance newsletter. ■ The Trust produces workforce data and shares this with the Trust Board ■ The Trust has a steering group in place and a sub structure for monitoring the SES and ensuring the individual workstreams are implemented. ■ The sub groups structure includes: o Patient experience o Workforce o Policies and impact assessment o Independent living ■ The Trust has an active diversity staff group. ■ The Trust has a good database and network of diverse community groups with whom to consult. ■ The Trust has a programmes of impact assessments planned. ■ Training has been provided for the TB and senior managers and is available via L+D for other staff groups.	• Training data and resource packs • Safeguarding Leaflet • Audit tool/database

Elements	Position Statement	Evidence
• Part Time workers (Protection from Less Favourable Treatment) Regulations 2000. • Fixed Term Employees (Protection from Less Favourable Treatment Regulations 2002). • Employment Rights Act section 80F-I (relating to the right to request flexible working). • Working Time Regulations 1998 (as amended). And, where appropriate, having due regard to the associated codes of practice	▪ Relevant HR policies exist and are monitored for adverse effects on race etc. ▪ The Trust monitors DDA compliance and reports this through the Independent living group. ▪ Equal opportunities legislation is included in all management training.	
Core standard C7f **Healthcare organisations meet the existing performance requirements**		
This standard will be measured through the existing national targets assessment		
Core standard C8a **Healthcare organisations support their staff through having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services.**		
Element one Staff are supported, and know how, to raise concerns about services confidentially and without prejudicing their position including in accordance with The Public Disclosure Act 1998: Whistle blowing in the NHS (HSC 1999/198).	▪ These matters are dealt with in the Trusts Whistleblowing Policy. Mention is made of this and its purpose at corporate induction There are a number of mechanisms available for staff to use , these include o Whistleblowing Policy o Team briefing sessions/'Hot Topics' o Incident reports o Availability of a non executive Director o Annual appraisals o 'Your right to be heard' letters ▪ The standard terms and conditions of employment contain no "gagging"	• Whistleblowing Policy

Elements	Position Statement	Evidence
	clause. ▪ The Trust asks appropriate questions in the annual survey, all leavers are asked to complete an exit questionnaire and they are able to request a face to face interview.	• Exit interview questionnaire • Copy of 2006/2007 opinion survey action plan
Core standard C8b **Healthcare organisations support their staff through having organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups.**		
Element one The healthcare organisation supports and involves staff in organisational and personal development programmes as defined by the relevant areas of the Improving Working Lives (IWL) standard at Practice Plus level and in accordance with "*employment and equalities legislation*"* including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part-time workers, fixed term employees, flexible working and working time; and in accordance with its "*public body duties*"* in relation to employees, including, but not restricted to, its monitoring duties in relation to race, disability and gender; and where appropriate, having due regard to the associated codes of practice. * The phrases "*public body duties*" and "*employment and equalities legislation*"	▪ An appraisal reporting and monitoring process is in place and results are fed back to Divisional ▪ Managers via regular meetings with L&D ▪ Out comes of PDR and personal development planning processes feed the annual training needs analysis for planning of development activity ▪ The Trust is committed to staff development and has comprehensive L&D and study leave policies in place. Management and Leadership development opportunities are available internally and external to the Trust. Leadership Conferences are held for managers.	• PDR monitoring process • Personal development plans/portfolios • Training Programmes • Adverts for training – internal and external • L&D Opportunities, L&D Policy, Study Leave Policy • L&D evaluation • SWBH Leadership Conference papers • Nurse Leaders' Conference papers

Elements	Position Statement	Evidence
are defined in C7e		
Element two Staff from minority groups are offered opportunities for personal development to address under-representation in the workforce compared to the local population in accordance with "*employment and equalities legislation*"* including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part-time workers, fixed term employees, flexible working and working time; and in accordance with its "*public body duties*"* in relation to employees, including, but not restricted to, its monitoring duties in relation to race, disability and gender. * The phrases "*public body duties*" and "*employment and equalities legislation*" are defined in C7e.	▪ The appraisal process includes the identification of development needs against the KSF and requirements of the role for all employees ▪ A wide range of internal and externally provided development opportunities are available and training taken up is monitored ▪ Where feasible internal training programmes are offered at a variety of times/venues/days of the week etc and/or adjustments are made to suit individual learners ▪ Learners are able to access external programmes to suit their attendance needs ▪ A network group exists to enable support for BME staff ▪ All staff have access to development regardless of their ethnic group which includes both personal development and professional training. ▪ Study Leave applications include questions to monitor ethnic group.	• Appraisal process & policy • Study leave policy and records • CRT and Mandatory training programmes & records • L&D evaluation report • L&D opportunities document • Study Leave policy, process & records • Commissioning process • Study Leave Forms
Core standard C9 **Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the orgainsation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.**		
The healthcare organisation has effective systems for managing records in accordance with *Records management: NHS code of practice* (Department of	▪ Annual NHS Information Governance Healthcare Records Standard and action plan. ▪ CNST Healthcare Records Standard met.	• Healthcare Records Group action plans, minutes, terms of reference. • Data Quality monitored monthly.

Elements	Position Statement	Evidence
Health, April 2006), *Information security management: NHS code of practice* (Department of Health, April 2007) and *NHS Information Governance* (Department of Health, September 2007). The healthcare organisation complies with the actions specified in the NHS Chief Executive's letter of 20 May 2008 (Gateway reference 9912); and with supplemental mandates and guidance if they are introduced during the assessment period.	▪ Healthcare Records Group in place. ▪ Trust Data Quality Group in place.	
Element two The information management and technology plan for the organisation demonstrates how a correct NHS Number will be assigned to every clinical record, in accordance with *The NHS in England: the Operating Framework for 2008/09* (Department of Health, December 2007).		
Core standard C10a **Healthcare organisations undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies.**		
Element one The necessary checks are undertaken in respect of all applications for NHS positions (prospective employees) and	▪ The Trust has three departments responsible for recruitment within the Trust, as given below, and all are trained and are aware of the required pre-employment checks that need to be followed. ▪ The Trust has in place a Centralised Recruitment Office; a Medical staffing	• Recruitment and selection policy

Elements	Position Statement	Evidence
staff in ongoing NHS employment in accordance with the NHS Employment Check Standards (NHS Employers) 2008)	Department; and a Nurse Bank ■ Recruitment responsibilities are outlined within the Trust's Recruitment and Selection Policy, CRB Policy and Recruitment of Ex-Offenders Policy. ■ The Trust does not make unconditional employment offers until receipt of two satisfactory references, which is in accordance with Dept of Health guidelines and Trust policy. ■ This is implemented as standard in accordance with Trust policy. Pre-employment assessments are undertaken by the Trust's Occupational Health Department. ■ The Trust complies with these requirements as stipulated with its Professional Registration Policy. ■ The procedure for dealing with lapsed registrants is detailed within the policy. Line managers are sent reminders of registrations that are due for renewal and we follow a system of escalating the problem to more senior management and HR for action as appropriate. ■ Escalation of 'red' issues presented to the Trust Management Board ■ The Trust complies with this requirement as detailed within its CRB Policy. ■ The Trust complies with this requirement as detailed within its CRB Policy. ■ The Trust's manager responsible for the appointment process for volunteers has been trained with respect to CRB requirements and is now a Trust counter-signatory for completion of CRB forms. ■ This is covered within the Trust's CRB policy and the Trusts contract under the Framework agreement for agency selection	• TMB paper from March 09 • CRB policy
Core standard C10b **Healthcare organisations require that all employed professionals abide by relevant published codes of professional practice.**		

Elements	Position Statement	Evidence
Element one The healthcare organisation explicitly requires all employed healthcare professionals to abide by relevant codes of professional conduct. Mechanisms are in place to identify, report and take appropriate action when codes of conduct are breached.	▪ Para 23 of the Statement of main Terms and Conditions of employment require all staff as appropriate to comply with relevant Codes of Conduct and to be registered as appropriate at all times. Proof of registration is obtained on appointment and at regular intervals thereafter. ▪ Job descriptions and person specifications include specific requirements as appropriate. ▪ Failure to abide by codes etc would ideally normally be picked up by regular supervision, if this does not happen then such failures would be identified at regular appraisals. ▪ On occasion issues may arise as the result of a complaint or a recorded incident. ▪ All investigations of this nature are dealt with using the Trusts investigation policy. Future management of the issues would depend on the detail but could include retraining, a period of supervised practice and/or disciplinary action.	• Protocol for checking registrations • Investigations Policy
Core standard 11a **Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare are appropriately recruited, trained and qualified for the work they undertake.**		
Element one The healthcare organisation recruits staff in accordance with "employment and equalities legislation"* including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part time workers, fixed term employees, flexible working and working time; and in accordance with its "public body duties" * in relation to employees, including, but not	▪ All Trust recruitment activity is monitored and with the exception of medical recruitment is recorded on NHS Jobs and ESR systems. Information is therefore available to confirm why candidates were either not short listed or appointed. ▪ All Recruitment Office staff are provided with training to understand the reasons behind and the importance of recording data with respect to equalities legislation. ▪ The Trust monitors all employed staff and is able to report on ethnic minority information (subject to the short-term data transfer problem identified above). ▪ The Trust uses NHS Jobs for recruitment into the Trust as its standard approach. Alternative methods of application are available upon request.	• Interview criteria form • Applicant pack

Elements	Position Statement	Evidence
restricted to, its monitoring duties in relation to race, disability and gender; and where appropriate, having due regard to the associated codes of practice. * The phrases "public body duties" and "employment and equalities legislation" are defined in C7e.	▪ All candidates are asked if they need any specific provisions to be made for them to enable them to attend for interview. ▪ The Trust is not currently recruiting applicants from overseas, but in the event of needing to do so, would comply with the Code of Practice.	
Element two The healthcare organisation aligns workforce requirements to its service needs by undertaking workforce planning, and by ensuring that its staff are appropriately trained and qualified for the work they undertake.	▪ Detailed workforce plans have been developed for the Trust's 'Towards 2010' Programme and in accordance with local SHA requirements. These plans are being developed and are integrated with the business plans within the organization. ▪ Currently the Trust is developing a Workforce Planning tool, to enable line managers to effectively and consistently develop workforce plans that will feed into the Trust's 2010 workforce planning requirements. These plans will require both wte numbers but also the collection and analysis of competency requirements to support training and development requirements. ▪ The tool currently under development will be based on the 'six step' model and is designed to encourage managers to think creatively about their future workforce requirements rather than within the constraints of existing traditional professional roles. ▪ Individuals employed by the Trust are required to undertake an annual Performance Development Review with their line manager which is designed to identify their specific development needs. These needs are collated into a Divisional/Trust wide development plan that are used to inform the Trust's commissioning process and the development of local training provision. ▪ Based on the current needs of the service the Trust is currently developing plans for the creation of an ' Assistant Practitioner' role and is providing in-house NVQ training in Customer Care, Admin and Care ▪ Bespoke facilities are available via L&D, Medical Education Centre, Post-	• Policies and procedures • Training programs • Skills lab programs • IT open learning packs • Professional re-registration checked • Performance appraisal documentation • Re-registration process linked to CPD • Professional body/council websites • Codes of conduct for all professionals • Professional journals • British Medical Council sties • Professional chat lines and email networks • Conferences, seminars and teaching tutorials Trust intranet access • Study Leave records • University Brochures • List of programmes • Publicity material for NHS • Learning accounts and records of uptake

Elements	Position Statement	Evidence
	graduate Centre. ▪ The Trust has invested in clinical skills laboratories on the two main Hospital sites. This has an extensive program of activity for all clinical staff including medical and nursing staff. To supplement this on line learning packages and tailor made training programs exist which are delivered by clinical specialists. ▪ Multiple training programs are available for clinical staff to access to their renew skills e.g. CPR, drug administration venepunture, medical device training, lifting and handling, food hygiene etc. ▪ To assist the problem of staff release IT learning/assessment packages are available that enable staff access via the intranet, within wards, departments or onsite IT cafes ▪ In accordance with the Trust induction and CPD Policy staff are monitored in their attendance of mandatory and clinical training annually by managers and the Learning and Development Department. ▪ Staff have an annual performance appraisal with their line manager and identify appropriate training needs, which is captured on their development plans. ▪ Further development identified as part of the Learning Needs Analysis is supported through the study leave procedure. Through this process staff have equity of access to development opportunities that are appropriate to their role and career progression. Statistics to demonstrate the number of staff accessing development is contained in the annual L&D evaluation report. ▪ Staff responsible for mentoring, assessing/supporting students in the workplace are trained via appropriate assessor and mentorship programmes provided by local universities ▪ Staff on NVQ programes are supported by qualified NVQ assessors ▪ A variety of NVQ programmes are available to staff e.g. Healthcare,	• Various evaluation reports • Ofsted Report • NVQ Accreditations

Elements	Position Statement	Evidence
	Customer Service, Administration, Allied Healthcare Support NVQs. ▪ NHS learning accounts were widely publicised whilst they were still available ▪ The Trust has maintained Investor in People status since 1999. ▪ Basic Skills, Key Skills and ESOL programmes are available internally delivered by qualified trainers. These are advertised via the Learning Needs Analysis, L&D opportunities and bespoke publicity. They are also included in other development programmes that are offered to staff. ▪ A Skills for Life Action Plan is in place	
Core standard 11b **Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in mandatory training programmes.**		
Element one Staff participate in relevant mandatory training programmes as defined by the relevant sector-specific NHSLA Risk Management Standards.	▪ A programme is in place which provides different modules to meet the needs of different staff groups. Staff attend as part of their induction to the Trust and are also required to attend regular updates (annually for clinical staff and bi-annually for non-clinical staff). ▪ Staff are required to provide information that they are up to date with their mandatory training requirements before they are able to access other development opportunities. ▪ Mandatory training is provided within working hours on a 24 hour basis relevant to the needs of divisions.	• Training programme/modules • Registers of attendance • Study leave process • Induction and Mandatory training policy • Training programmes and registers
Element two Staff and students participate in relevant induction programmes	▪ New staff all attend mandatory training as part of their induction	• Induction and Mandatory Training Policies • Record of induction attendance • Local induction checklists and 3 monthly auditing

Elements	Position Statement	Evidence
Element three The healthcare organisation verifies that staff participate in those mandatory training programmes necessary to ensure probity, clinical quality and patient safety (including that referred to in element one). Where the healthcare organisation identify non-attendance, action is taken to rectify this.	▪ A blended learning system of mandatory training supports a competency based approach and regular updates and on-line assessments are delivered in accordance with the Mandatory Training Policy ▪ Attendance is monitored by L&D and reported to the Trust Board and senior managers within the organisation. ▪ Training content is updated as needed e.g.: recent changes in infection control procedures and energy efficiency ▪ Staff are also required to attend regular updated (annually for clinical staff and bi-annually for non-clinical staff) and training is provided within working hours on a 24 hour basis relevant to the needs of divisions ▪ A blended learning system of mandatory training is in place with sessions being offered across sites, on a 24 hour basis and at different locations within the Trust. ▪ All new staff and students attend a 3 day corporate induction programme plus local induction is provided within the workplace to cover work area and job specific requirements.	• Training Programmes • Health and Safety and Risk Assessment training programme attendance sheets and checklists • Monthly reports • Training Programmes • Monthly reports • Attendance records
Core standard 11c **Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in further professional and occupational development commensurate with their work throughout their working lives.**		
Element one The healthcare organisation ensures that all staff concerned with all aspects of the provision of healthcare have opportunities to participate in professional and occupational development at all points in their career in accordance with "employment and equalities legislation"*. This includes legislation regarding age,	▪ The appraisal process includes the identification of development needs against the KSF for all employees ▪ A wide range of internal and externally provided development opportunities are available and training taken up is monitored ▪ Where feasible internal training programmes are offered at a variety of times/venues/days of the week etc and/or adjustments are made to suit individual learners ▪ Learners are able to access external programmes to suit their attendance	• Appraisal process & policy • Study leave policy and records • CRT and Mandatory training programmes & records • L&D evaluation report • L&D opportunities document • IT training programmes • Attendance records

Elements	Position Statement	Evidence
disability, gender, race, religion and belief, sexual orientation, part time workers, fixed term employees, flexible working and working time; and in accordance with its "public body duties"* in relation to employees, including, but not restricted to, its monitoring duties in relation to race, disability and gender; and where appropriate, having due regard to the associated codes of practice; and in accordance with the relevant aspects of Working together – learning together: a framework for lifelong learning for the NHS (Department of Health 2001) or an equally effective alternative. * The phrases "public body duties" and "employment and equalities legislation" are defined in C7e	needs ▪ Library facilities are available to staff at City and Sandwell Hospital sites ▪ A range of IT skills training is offered on a regular basis and/or at drop-in sessions ▪ Contract and Agency staff all complete the Trust mandatory training and local induction.	
Core standard C12 **Healthcare organisations which either lead or participate in research have systems in place to ensure that the principles and requirement of the research governance framework are consistently applied.**		
Element one The healthcare organisation has effective research governance in place, which complies with the principles and requirements of the *Research governance framework for health and social care, second edition* (DH 2005).	▪ Confirmation of Sponsorship is required for all studies as part of the R&D Approval Process ▪ A copy of the Ethics Approval Letter(s) (and CTA from the MHRA where applicable) are required for all studies as part of the R&D Approval Process ▪ All research undertaken within the Trust is subject to formal R&D Approval as signed by the Director of R&D.	• R&D Approval Process (& Applicant's Checklist) as appended to the R&D Policy. • R&D Policy • PI Agreement • R&D Policy • R&D Constitution

Elements	Position Statement	Evidence
	▪ In accordance with the R&D Approval Process, a Principal Investigator (PI) is identified for each study and a PI Agreement which outlines the PI's responsibilities is signed and held on file in the R&D Department study files. Site Agreements are also negotiated and held on file to define responsibilities held by each party where applicable. ▪ Signed Site Agreements are in place as applicable; SWBH Trust accepts the Commercial and Non-Commercial mCTA unmodified. ▪ Consumer involvement in the design, conduct, analysis and reporting of research is encouraged wherever possible in accordance with the R&D Policy. ▪ In accordance with the R&D Constitution, a lay member sits on the R&D Committee to provide input regarding consumer issues in research. ▪ All studies that are registered with the R&D Department are recorded on a database. Applicable studies have previously been submitted quarterly to the National Research Register (NRR) in compliance with requirements; we await instruction as to the replacement mechanism following the disestablishment of the NRR. Commercial studies are recorded on the database but not submitted to a national register. ▪ The requirement for adverse events reporting is outlined in the Trust's Procedure for Safety Reporting in Research. This includes a requirement to report the clinical incident/hazard in accordance with the Trust Clinical Incident Procedure if the adverse event in question occurred as a result of an error of failure in a study or other related procedure. ▪ Systems to address and learn from complaints are covered in the Trust's Policy on the Handling of Complaints. Complaints and resolutions are monitored and reported to the Governance and Trust Board regularly. ▪ The Trust has a Policy which governs the management of Intellectual Property generated by Trust employees. The management of intellectual property has	• Procedure for Safety Reporting in Research • Policy on the Handling of Complaints • Managing Intellectual Property • Trust Employment Contracts • MidTECH Agreement • Misconduct & Fraud in Research • R&D Policy

Elements	Position Statement	Evidence
	also been included in its employment contracts for staff. The Trust is also a full member of MidTECH, the Innovations Hub for the West Midlands who provide advice and assistance in the protection and exploitation of our intellectual property. ▪ The Trust has a Misconduct & Fraud in Research policy. In addition, the R&D Department undertake random research governance audits of active studies to ensure compliance and as part of the requirements of R&D Approval; all PIs undertaking clinical trials must produce a recently obtained GCP certificate.	

Fourth domain: patient focus

Elements	Position Statement	Evidence
Core standard C13a **Healthcare organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect.**		
Element one The healthcare organisation ensures that staff treat patients / service users, carers and relatives with dignity and respect at every stage of their care and treatment, and, where relevant, identify, and take preventive and corrective actions where there are issues and risks with dignity and respect.	▪ The Trust has a privacy and dignity policy in place. ▪ The Trust has a patient experience plan in place which identifies privacy and dignity as a specific work stream. ▪ The plan is overseen by the patient experience group and reports to the TB on a regular basis. ▪ Trust induction includes confidentiality and privacy and dignity at work. ▪ There are numerous training opportunities for staff that include privacy and dignity. ▪ NVQ programmes include privacy and dignity ▪ The Trust has identified customer care as an improvement project and is actively working towards improving communications with service users ▪ The Trust has a mixed sex accommodation action plan and has been working towards improving standards ▪ Audits of essence of care standards are undertaken ▪ Ward reviews consider issues of privacy and dignity	• Policy • Action plan • Minutes • Training packages • Ward review tool and results • Essence of care audits
Element two The healthcare organisation meets the needs and rights of different patient groups with regard to dignity including by acting in accordance with the Human	See standard C7e	

Elements	Position Statement	Evidence
Rights Act 1998 and the general and specific duties imposed on public bodies in relation to race, disability and gender (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under the following "public body duties"* statutes • the Race Relations Amendment) Act 2000 • the Disability Discrimination Act 2005 • the Equality Act 2006. And where appropriate, having due regard to the associated codes of practice. The healthcare organisation should act in accordance with the requirements in the National Service Framework for older people (Health Service circular 2001/007), to ensure that older people are not unfairly discriminated against in accessing NHS or social care services as a result of their age. * The phrase "public body duties" is defined in C7e.	▪ The Trust has an NSF Older people resource pack ▪ The Trust employs a practice development nurse who leads on the NSF standards ▪ The Trust monitors all falls and has a falls reduction action plan. ▪ The Trust has a published bereavement strategy and end of life care plan.	
Core standard C13b **Healthcare organisations have systems in place to ensure that appropriate consent is obtained when required for all contacts with patients**		

Elements	Position Statement	Evidence
and for the use of any patient confidential information.		
Valid consent, including from those who have communication or language support needs, is obtained by suitably qualified staff for all treatments, procedures (including post-mortem) investigations and decisions in accordance with the Human Rights Act 1998, the *Reference guide to consent for examination or treatment* (Department of Health 2001), *Human Tissue Authority: a code of practice* (July 2006), and having regard to the *Code of Practice to the Mental Health Act 1983 and 2007* and the *Code of Practice to the Mental Capacity Act* 2005.	▪ Trust has a 'Consent for Examination or Treatment Policy' in place including Delegated Consent. ▪ There is a corporate group looking at consent issues including use of interpreters, consent forms, delegated consent training packs and arrangements. ▪ An audit of consent has been carried out and is an ongoing process. Areas for further improvement have been identified and an action plan is to be developed. ▪ An audit of delegated consent has taken place to determine the use of the delegated consent process and the level of support required. ▪ Training packs have been developed for identified areas of delegated consent in 5 areas of the Trust. ▪ Some patient information contains risks benefits and alternatives to treatment. ▪ There is a Trust wide patient information group looking at the patient information processes with the Executive lead for PALS and patient information reporting progress. ▪ There is intranet access for staff to patient information leaflets with explanation of risks, benefits and alternatives. ▪ There are some pre-assessment clinics where initial explanations are provided and information is given to patients by the practitioner co-ordinating the clinic. This gives the patient time to consider the risks, benefits and possible alternative including no treatment option. ▪ There is a Policy for Consent for Hospital Post Mortems, Retention and the Respectful Disposal of Human Tissues.	• Consent for Examination or Treatment Policy • Video/photography policy • Delegated consent training packs for identified procedures and staff • Bespoke delegated consent forms for gynae oncology • Patient information leaflets • Audit of delegated consent procedures

Elements	Position Statement	Evidence
	▪ There is a Policy covering the procedure for obtaining consent for examination and subsequent disposal of tissues from early pregnancy loss (EPL). This includes a consent form and patient information.	
Element two Patients/service users, including those with language and/or communication support needs, are provided with appropriate and sufficient information suitable to their needs, on the use and disclosure of confidential information held about them in accordance with *Confidentiality: NHS code of practice*(Department of Health 2003).	▪ The Trust has a dedicated interpreter service available to all staff ▪ The Trust has a telephone language line service which is available to all staff ▪ Patient information is made available in a number of languages ▪ An audit of patient information is being carried out to ensure the provision is appropriate to meet users with diverse needs	
Element three The healthcare organisation monitors and reviews current practices to ensure effective consent processes.	▪ An annual audit of consent has been carried out and the results reported to Governance Board. ▪ A consent group, chaired by the Trust Clinical Risk Lead, meets every two months to consider issues around consent.	
Core standard C13c **Healthcare organisations have systems in place to ensure that staff treat patient information confidentially, except where authorised by legislation to the contrary.**		
Element one When using and disclosing patients/service users' personal information staff act in accordance with the Data Protection Act 1998, the Human Rights Act 1998, the Freedom of Information Act 2000 and	▪ Patient confidentiality is a core element in all NHS staff training and included in a variety of standards including CNST and Essence of Care. ▪ The Trust is monitored annually against a number of relevant Information Governance Standards included Healthcare Records, Data Protection and Freedom of Information.	• Confidentiality Code of Practice adopted by Trust

Elements	Position Statement	Evidence
Confidentiality: NHS code of practice (Department of Health 2003), *Caldicott Guardian Manual 2006* (Department of Health 2006). The healthcare organisation complies with the actions specified in the NHS Chief Executive's letter of 20 May 2008 (Gateway reference 9912); and with supplemental mandates and guidance if they are introduced during the assessment period.	▪ The key areas for development are to improve the patient information on confidentiality and to improve Freedom of Information standards on non-patient information. ▪ Freedom of Information requests and responses are now all logged electronically ▪ An Executive Director deals with ALL Confidentiality & Data Protection requests, issues and advice, supported by the Trust Caldicott Guardian. ▪ Information Governance Action Plans are in place. Progress is monitored by the Information Governance Group. These plans have been reviewed by Internal Audit.	
Core standard C14a **Healthcare organisations have systems in place to ensure that patients, their relatives and carers have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services.**		
Element one Patients / service users, relatives and carers are given suitable and accessible information about, and can easily access, a formal complaints system, including information about how to escalate their concerns; and the healthcare organisation acts in accordance with the NHS (Complaints) Regulations 2004 (as amended) in so far as they are relevant to the healthcare organisation.	▪ Detailed policy on handling complaints ▪ 'Your views matter' leaflet available throughout the Trust and sets out how patients, relatives and carers can tell us what they think about our services ▪ A form is available if the complainant does not want to write a formal letter ▪ A complaints page is available on the website and includes an on line form for making a complaint ▪ Complaints can also be made by e-mail (to a designated e-mail address) or by telephone ▪ Information can be provided in a format that meets the individual needs of the complainant e.g. sending letters on CD ▪ Translators have been used to assist people in pursuing their complaints and letters have been translated into the preferred language	• Policy on the Handling of Complaints • Leaflet/form • Website

Elements	Position Statement	Evidence
	▪ Support is available via PALS and ICAS	
Element two Patients / service users, relatives and carers are provided with opportunities to give feedback on the quality of services.	▪ The 'Your views matter' form tells patients, relatives and carers how they can tell us what they think about our services. The form can also be used to register comments, not just complaints ▪ Details are also kept of the number of 'thank you' letters received and figures are included in the quarterly and annual reports to the Trust Board ▪ Complainants are sent a questionnaire asking for their views on the way that their complaint was handled and details are included in the annual report ▪ Feedback can also be given via PALS	• Leaflet/form • Trust Board reports • Questionnaire
Core standard C14b **Healthcare organisations have systems in place to ensure that patients, their relatives and carers are not discriminated against when complaints are made.**		
Element one The healthcare organisation has systems in place to ensure that patients / service users, carers and relatives are not treated adversely as a result of having complained.	▪ The Policy on the Handling of Complaints has the following objective – "To reassure patients that their treatment will not be affected and that they will not be discriminated against in any way as a result of having made a complaint ▪ Within the Policy the roles and responsibilities of the Complaints Manager, Complaints Department, Investigating Officers, Staff and Divisional General Managers/Executive Directors include the commitment to ensure that patients/relatives/carers are not treated differently as a result of having made a complaint and that in the event of any unfavourable treatment being discovered this is escalated and managed appropriately.	• Policy on the Handling of Complaints
Core standard C14c **Healthcare organisations have systems in place to ensure that patients, their relatives and carers are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.**		
Element one	▪ Policy on the Handling of Complaints includes the following objectives –	• Policy on the Handling of

Elements	Position Statement	Evidence
The healthcare organisation acts on, and responds to, complaints appropriately and in a timely manner; and acts in accordance with the NHS (Complaints) Regulations 2004 (as amended) in so far as they are relevant to the healthcare organisation.	"To ensure that minor complaints are handled by front line staff responding sensitively, courteously and promptly to the complainant's needs" "To ensure that all complaints are treated seriously and sympathetically and actioned within set timescales ▪ A detailed file is maintained for each complaint ▪ All complaints are logged onto a computerised database ▪ Complaints are investigated in line with the requirements of the Policy on the Handling of Complaints and this includes keeping complainants informed of progress ▪ The Policy includes the provision that the Complaints Manager will consider the use of conciliation to resolve a complaint ▪ Detailed responses are sent, addressing the points raised by the complainant ▪ The standard ending for all complaint responses advises the complainant of their right to refer their concerns to the Healthcare Commission and gives the relevant contact details ▪ Quarterly and annual reports are submitted to the Trust Board giving the timescales for responding to complaints, the range of issues complained about, the outcomes and examples of actions arising	Complaints • Quarterly and annual reports
Element two Demonstrable improvements are made to service delivery as a result of concerns and complaints from patients / service users, relatives and carers.	▪ Following the investigation of a complaint an action plan is completed, showing the action to be taken as a result of the complaint. Monitoring is undertaken via the Governance framework ▪ Complaints are graded according to their severity and future risks to patients and/or the Trust. Action plans for red complaints are monitored by the Adverse Events Committee (which is chaired by the Chief Executive) ▪ Details of the actions arising from complaints are included in the quarterly reports to the Trust Board and in the annual report	• Action plans • Complaint files • Adverse Events papers • Quarterly/annual reports
Core standard C15a **Where food is provided, healthcare organisations have systems in place to ensure that patients are provided with a choice and that it is prepared safely and provides a balanced diet.**		

Elements	Position Statement	Evidence
Element one Patients/service users are offered a choice of food and drink in line with the requirements of a balanced diet reflecting the rights (including the rights of different faith groups), needs (including cultural needs) and preferences of its service user population. **Element two** The preparation, distribution, delivery, handling and serving of food, storage, and disposal of food is carried out in accordance with food safety legislation including the *Food Safety Act 1990* and the *Food Hygiene (England) Regulations2006.*	Legislation: All Sandwell and West Birmingham Hospitals NHS Trust patient food is prepared, distributed, handled and served in accordance with: o Better Hospital Food (NHS Estates 2001) o Food Safety Legislation and National Guidelines o Food Safety Act 1990 o Food Safety (Temperature Control) Regulations 1995 o Food Safety (General Food Hygiene) Regulations 1995 o Food Premises (Registration) Regulation 1991 o Workplace (Health, Safety and Welfare) Regulations 1992 o EC Regulations 852/2004 Menu Selection: ▪ All patients are offered a choice of meal and portion size from a multi-choice, menu range inclusive of vegetarian, halal and puree. This reflects the needs of the local community. BHF: ▪ The six key requirements for BHF are adhered to.	• Environmental Health Officer (EHO) audit inspections • Better Hospital Food audits (PEAT)2007 • Departmental Controls Assurance • Departmental Risk Assessments • Audit Commission Catering Review 2001 • 3-Week menu cycle • Hotel Services audits • Hotel Services patient questionnaire • Healthcare Commission young persons patient survey • Acute Hospital Portfolio • Department of Health PEAT BHF audit scores • Acute Hospital Portfolio • Better Hospital Food Audit (2008) • Environmental Health Report (July 08)
Core standard C15b **Where food is provided, healthcare organisations have systems in place to ensure that patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day.**		
Element one Patients/service users have access to food and drink that meets the individual needs of the patients / service users 24 hours a day. **Element two** The nutritional, personal and clinical dietary requirements of	▪ Nutritional assessment is an integral element of the admission process and results are recorded within the initial assessment documentation in the patient's health care records. ▪ The nutritional assessment tool completed on admission would identify any support needs require for patients. The trust has implements the RED TRAY scheme to highlight patient who need assistance with feeding. ▪ As above and in addition the trust are exploring the possibility of formulating a	• Initial assessment record • Nutritional assessment tool • Red Tray Scheme • Food Policy • Initial assessment record • Red Tray Scheme • Initial Assessment Record • Bed Plans for menu • Nutritional Team Meeting

Elements	Position Statement	Evidence
individual patients/service users are assessed and met, including the right to have religious dietary requirements met at all stages of their care and treatment. **Element three** Patients/service users requiring assistance with eating and drinking are provided with appropriate support including provision of dedicated meal times, adapted appliances and appropriate consistency of food where necessary.	Volunteer group to support patients to eat and drink at meal times ■ As above and in addition the trust are exploring the possibility of formulating a Volunteer group to support patients to eat and drink at meal times ■ All health care staff are trained in the holistic care of patients. Each patient's personal preferences are recorded within the initial assessment records and staff form relationships by talking to their patients to become familiar with their likes and dislikes. Meals are served in accordance with trust policies by catering staff or nurses ■ The trust has implemented the RED TRAY scheme to highlight patient who need assistance with feeding. Any patient who needs additional specialist equipment would have this identified on admission through the nutritional assessment process	• Nutritional Team Meeting minutes • Nutritional Team priorities • JD for mealtime volunteers • Food Service Training Presentation
Core standard C16 **Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after-care.**		
Element one The healthcare organisation has identified the information needs of its service population, and provides suitable and accessible information on the services it provides in response to these needs. This includes the provision of information in relevant languages and formats in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for	■ The Trust has a wide range of literature, using both internally produced information and reputable external information. We also have around 300 EIDO leaflets that are used across the Trust. ■ *We are currently undertaking a comprehensive 3-month audit of patient information across the Trust to ensure that the quality is consistent across the organisation.* ■ Information is produced electronically and in hard copy. Black font on yellow paper is used for some visually impaired patients. Some video information is also available. ■ The Health Exchange Kiosk within the Patient Support Centre at the	• Medical Illustration library • Intranet • EIDO • Patient Satisfaction Survey results • Patient Information Audit (incomplete) • Literature Library • www.swbh.nhs.uk

Elements	Position Statement	Evidence
race, disability and gender, along with impact assessments) under the following "public body duties"* statutes: • the Race Relations Amendment) Act 2000 • the Disability Discrimination Act 2005 • the Equality Act 2006. And where appropriate, having due regard to the associated codes of practice. * The phrase "public body duties" is defined in C7e.	Birmingham Treatment Centre provides a comprehensive range of information in a variety of languages with support workers on hand to help guide patients and visitors through the system. ■ Welcome to hospital leaflets are sent to all new outpatients. This year we have increased the size map in response to patient needs. ■ We have re-launched our website with a much wider range of information for patients. We also have speech enablement on our website. ■ We provide an interpreting service and telephone language line, offering over 30 languages. Minicom and deaf loops are also available. The Trust has purchased a portable deaf loop to take to public meetings and events. ■ The Trust has a Single Equality Scheme and the Patient Information Policy is assessed for its impact on each of the six equality strands as outlined in the document. ■ Our patient survey results for patient information are above average *(2008 inpatient survey results to be included here but not yet available)*. This information is analysed by gender, age, ethnicity, site and specialty and reported to the Patient Experience Group. ■ Trust-run patient surveys are sent to patients accompanied by a leaflet explaining how patients could receive the information in 31 different languages. ■ Public consultation is accompanied by offers of translation or interpreters. For the consultation on becoming a Foundation Trust at the start of the year, documents, summaries and membership forms were produced in Punjabi, as well as membership forms in other languages such as Arabic and Farsi. The membership forms asked people to indicate if they had a preferred language or format for communication with them and we now produce a summary newsletter about Trust information and activities in six different languages.	• Single Equality Scheme • FT consultation analysis • Consultation document - Punjabi • FT membership forms
Element two	■ The Trust has a wide range of literature, using both internally produced	

Elements	Position Statement	Evidence
The healthcare organisation provides patients / service users and, where appropriate, carers with sufficient and accessible information on the patient's individual care, treatment and after care, including those patients / service users and carers with communication or language support needs. In doing so healthcare organisations must have regard, where appropriate, to the *Code of Practice to the Mental Capacity Act 2005* (Department of Constitutional Affairs 2007) and the *Code of Practice to the Mental Health Act* (Department of Constitutional Affairs 1983).	information and reputable external information. We also have around 300 EIDO leaflets that are used across the Trust. The patient information policy makes specific mention of using simple language and ensuring accessibility. ▪ *We are currently undertaking a comprehensive 3-month audit of patient information across the Trust to ensure that the quality is consistent across the organisation.* ▪ Information is produced electronically and in hard copy. Black font on yellow paper is used for some visually impaired patients. Some video information is also available. ▪ The Health Exchange Kiosk within the Patient Support Centre at the Birmingham Treatment Centre provides a comprehensive range of information in a variety of languages with support workers on hand to help guide patients and visitors through the system. ▪ We provide an interpreting service and telephone language line, offering over 30 languages. Minicom and deaf loops are also available. ▪ Infection control information is available on patient line.	

Fifth domain: accessible and responsive care

Elements	Position Statement	Evidence
Core standard C17 **The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services.**		
Element one The healthcare organisation seeks and collects the views and experiences of patients/service users, carers and the local community, particularly those people who are seldom listened to, on an ongoing basis when designing, planning, delivering and improving healthcare services as required by Section 242 of the *National Health Services Act* 2006 in accordance with *Strengthening Accountability, patient and public involvement policy guidance – section 11 of the Health and Social Care Act 2001* (Department of Health 2003) and any subsequent statutory guidance introduced in the assessment year. In doing so the healthcare organisation acts in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under the following "public body	▪ The Trust has a dedicated new hospital engagement manager to ensure that the views and experiences of patients, carers and the local community, including 'hard to reach' groups, are considered in the planning and design for the new hospital. The engagement manager leads an action plan with activities including focus groups, workshops, public meetings, communication etc. that is reported each month to the Project Board which is a sub-group of the Trust Board. ▪ There is a Towards 2010 Communications and Engagement Group with representation from SWBH and its partner organisations that instigates and monitors communication and engagement activities associated with the Towards 2010 programme, which is the Trust's long term vision. ▪ Trust services starting outpatient clinics in the community, run engagement activities (ENT, Paediatrics, Ophthalmology, Sickle Cell etc.) such as focus groups and workshops. ▪ Stroke and Ophthalmology have piloted a new approach to patient and public engagement based on a model the Trust has tested with staff. This has proved very successful at providing direction for the service. ▪ Service specific surveys are carried out to establish how effective changes to services are. 717 parents responded to a survey about children's inpatient facilities. ▪ 2000 local people were surveyed about the introduction of customer care promises (results pending). ▪ Maternity and surgical surveys are being carried out in March.	• New Hospital Communications and Engagement Plan • Public meeting feedback • Reports from workshops on waiting areas and arts in hospital • Communications and engagement group minutes • Towards 2010 Programme Director's report • Service specific engagement reports • LiA information • Paediatric survey report

Elements	Position Statement	Evidence
duties" *statutes: • the Race Relations Amendment) Act 2000 • the Disability Discrimination Act 2005 • the Equality Act 2006. And where appropriate, having due regard to the associated codes of practice * The phrase "public body duties" is defined in C7e.	▪ Much of the Trust's engagement is carried out through its membership and membership recruitment strategies. The recruitment strategy targets areas that are under represented and hard to reach. Specific campaigns have been developed to target young people and certain geographical areas. The campaigns have been developed with the help of young people and people living in those areas. Membership recruitment is reported to the Project Board which is a sub group of the Trust Board. It monitors recruitment against the demographics of the local population, including age, gender, ethnicity and socio-economic status. ▪ The Trust's membership strategy identifies who our hard to reach groups are and outlines activities to involve members in the business of the Trust. A calendar of events has been prepared in response to the interests of local people. So far this has included well attended events on allergy, patient experience, infection control, stroke, new hospital and cpr. The membership newsletter is produced in size 14 font and summaries are available in six additional languages. An audio recording of our plans is available. Over 800 people requested to come to our AGM which was held over two dates with two overflow rooms on each day. Over 500 people are known to have attended and there was opportunity for questions and answers with Board members.	• Membership strategy • Recruitment strategies • Calendar of events
Element two The healthcare organisation demonstrates to patients/service users, carers and the local community, particularly those people who are seldom listened to, how it has taken their views and experiences into account in the designing, planning, delivering and improving healthcare services, in accordance with *Strengthening Accountability, patient and public involvement policy guidance – section 11*	▪ Feedback is provided to patients and local people through press releases, the website, the membership newsletter etc. ▪ Those participating in focus groups and workshops about the new hospital receive feedback once the information has been disseminated to the project team and responses made to the points raised. Those taking part in other focus groups receive feedback in a similar way. ▪ Senior members of the Trust attend various ward, community or other public meetings – providing updates on plans discussed previously and answering questions about any other matters.	

Elements	Position Statement	Evidence
of the Health and Social Care Act 2001 (Department of Health 2003) and any subsequent statutory guidance introduced in the assessment year. In doing so the healthcare organisation should act in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under the following "public body duties"* statutes: • the Race Relations Amendment) Act 2000 • the Disability Discrimination Act 2005 • the Equality Act 2006. And where appropriate, having due regard to the associated codes of practice * The phrase "public body duties" is defined in C7e.		
Core standard C18 **Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.**		
Element one The healthcare organisation enables all members of the	▪ The Trust continues to work to ensure that all members of the population it serves are able to access its services equitably and that we meet the needs of individuals. Accessible and responsive care is one of our key objectives.	• Our Strategic Direction 2008/9

Elements	Position Statement	Evidence
population it serves to access its services equally, including acting in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under the following "public body duties"*statutes: • the Race Relations Amendment) Act 2000 • the Disability Discrimination Act 2005 • the Equality Act 2006. And where appropriate, having due regard to the associated codes of practice * The phrase "public body duties" is defined in C7e	▪ In July 2008 the Trust Board approved our Single Equality Scheme(SES) which incorporates all elements of equality legislation and outlines how we will meet our public duties. ▪ The Trust has an ongoing DDA work programme led by Head of Estates to ensure that access and environment are compliant with the DDA requirements. ▪ One of the subgroups reporting to the Equality and Diversity steering group is the Independent Living group, members of this group are PPI representatives from voluntary and public bodies such as Blind and Deaf associations. They work with staff members to monitor our DDA elements of the SES action plan. ▪ The Trust has established a designated Equality and Diversity team who have undertaken in depth studies into our local community demography. Linking with teams from the 2010 project the organisation now has reliable information of the six equality strands to assist in planning future services and acting as a baseline to identify if there are health inequalities in accessing services. ▪ Following the launch of the SES the diversity team are supporting the operational managers in completing a trust wide equality impact assessment work schedule across all services, functions and policies. This work will be monitored by the Service and policy assessment group (SES subgroup). ▪ If users of the service are dissatisfied with access to services we have a PALS and Complaints service where they can raise their concerns. The Trust board has this feedback presented quarterly within the Patient views report	• Single equality scheme(SES)2008 • DDA environmental changes action plan • Terms of reference &minutes of SES group E&D,ILG • Demography report • SES action plan • Terms of reference SPAG • Patient Views report
Element two The healthcare organisation offers patients/service users choice in access to services and treatment, and those choices in access to services and treatment are offered on a fair, just and	▪ The Trust provides a range of services to support our diverse community from interpreting services to BME menu options, chaplaincy services and multilingual patient information. ▪ Considerable investment has been made over the last few years to create a Central call centre and Choose and book service to offer patient choice in	• Access and delivery of Interpreting services(SWBH/ORG/076 • Responding to Patient

Elements	Position Statement	Evidence
reasonable basis, including to disadvantaged groups and including acting in accordance with the general and specific duties imposed on public bodies as in element one and including, where appropriate, having due regard to the associated codes of practice.	line with national policy. ▪ Patients with disabilities can use email to book direct appointments via the internet as part of Choose and book. This is also accessed by GPs who can trigger a request for Interpreting Services at the first appointment. ▪ The appointment requests are triaged by Consultants and timed according to clinical priority. A directory of services is available to the public which includes type of service and location. ▪ In line with 2010 programme the Trust is supporting the launch of more community based clinics to meet strategic objective of care closer to home. There are operational guidelines for the Contact Centre and clinic matrix available of the Intranet that reflects the wealth of choice our patients now have. ▪ In addition to Interpreting service each reception and patient support centre has minicom loops for deaf patients. Our recently launch visitors posters state that Guide dogs are allowed and we are continually exploring ways to ensure that Information for patients is available to users who English is not their first language or who cannot read.	choice(March 2007) • Directory of services • 2010 programme • Clinic locality matrix
Core standard C19 **Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services.**		
This standard will be measured under the existing national targets and new national targets assessment	▪ The Trust continues to meet the national targets for A&E waiting times. ▪ The Trust continues to achieve other national access targets (including 18 weeks, cancer and GUM targets.)	• Trust performance reports.

Sixth domain: care environment and amenities

Elements	Position Statement	Evidence
Core standard C20a **Healthcare services are provided in environments which promote effective care and optimise health outcomes by being a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation.**		
Element one The healthcare organisation effectively manages the health, safety and environmental risks to patients/service users, staff and visitors, in accordance with all relevant health and safety legislation, fire safety legislation, the *Disability Discrimination Act 1995*, and the *Disability Discrimination Act 2005*; and by having regard to *The duty to promote disability equality: Statutory Code of practice* (Disability Rights Commission, 2005). It also acts in accordance with the mandatory requirements set out in *Firecode – fire safety in the NHS Health Technical Memorandum (HTM) 05-01: Managing healthcare fire safety* (Department of Health, 2006), in so far as the requirements are relevant to the healthcare organisation, and follows the guidance contained therein, or equally effective alternative means to achieve the same objectives. It also considers, and	**Organisational Accountability** ▪ Chief Executive has overall responsibility for ensuring health, safety and environmental risks are managed effectively so as to protect staff, patients and visitors who access the trust. ▪ Director of Human Resources has board level responsibility for overseeing the management of health and safety risks. ▪ Director of Estates has Board level responsibility for overseeing the management of environmental risks ▪ The Trust has only two full time Health and Safety Managers, the lead officer is a Graduate, with a Post-Graduate qualification in occupational health and safety and is also a Charted member of the Institute of Occupational Health and Safety ▪ The following topics are subject to corporate risk assessment ○ **Manual handling** Following a corporate assessment of moving and handling activity, specific training modules were developed and are being delivered to staff appropriately. ○ **Violence and aggression** Following a corporate security assessment engineering (electronic locks, CCTV etc) have been installed (see later), all frontline staff must attend the CFSMS training programme, some staff (local RA) receive additional training such as MAPA and breakaway. ○ **Slips, trips and falls**	• Health and Safety Policy • Job Descriptions • Risk Assessment Policy • Risk Registers • Manual handling Policy • Violence and aggression Policy • Sips, trips and falls Policy • Patient Falls Policy • HSN (Towels) • Snow policy • Window survey • Occupational health procedure for managing blood borne contamination incidents • Stress at Work Policy • Sickness Absence Policy • PDR Policy • Fire Safety Policy • HTM Library • External Fire Safety Advisor • Organisational Structure • Fire Safety Committee • Fire Safety Audits • Local Fire Plans • Local Fire Manuals • Fire Safety Training • Additional Fire Safety Trainers

Elements	Position Statement	Evidence
where appropriate follows, the good practice guidance referred to in *The NHS Healthy Workplaces Handbook* (NHS Employers 2007) or equally effective alternative means to achieve the same objectives.	A corporate assessment of all bathroom flooring has been carried out. Bathroom flooring must now meet a minimum trust standard. Staff have been told not to use secondary material between the patients feet and safety flooring (Internal Safety Alert). Other high risk areas have been identified – kitchens, entrances etc. The Trust has a protocol for adverse weather. All trust window have been audited wrt risk of fall **Needlestick injuries** Patient records o Safer needles o Training o All staff are screened on appoint by Occupational Heath, those that need to be seen by a Occupational Health Doctor or Nurse are referred and appropriate inoculations are administered. The risk of HIV has been planned. **Stress** The trust is currently participating in "Creating Safe Places Project", A project plan is being developed to carry out organisational stress assessment based on the HSE's "Healthy Workplace Solutions" initiative. **Fire** <u>Responsibility:</u> The Trust has a duty to comply with all statutory requirements. These include – o Regulatory Reform Order (Fire Safety) Policies and Principles o The Firecode suite of documents Furthermore, the Trust will foster a culture which recognises the importance of effective fire safety measures and in which all Staff, without exception understand what is expected of them and co-operate fully with Trust management to reduce the risk of a fire occurring and thus make the Trust premises a safer place for all. <u>Policy:</u> The Trust has a comprehensive Fire Policy in place and procedures for each of its	• External Inspection • External Reporting • Capital funding for Statutory Standards • Post Incident Reviews • Portable Appliance Testing policy • Generator Risk Assessment • Electrical Safety Risk Assessments • Control of substances hazardous to health (COSHH) Policy • Infection control policy • Cleaning Policy • Waste Policy • Draft Revision of Waste Policy • DSE Policy • Training Records • Eye Centre arrangement • Management of Contractors Policy • Confined spaces • Working at height Policy • Permit to Work Policy Permits • Major Incident Plan • Pandemic Flu Plan • Radiation Committee • Tool Box Talks for Trade Staff • Contractors Induction Standard Operating Procedure (Dec 08 +) • Contractors database

Elements	Position Statement	Evidence
	three sites. Fire Safety Management: The Trust has clearly defined roles and responsibilities in accordance with the Department of Health Fire Code HTM 05 -01. Fire Safety Committee Monthly meetings to discuss fire safety with key members of the organisation Fire Safety Audit: Fire Safety audits have been completed for all areas. These are updated annually. An action plan exists which identifies all outstanding works. Statutory Standards Projects are being undertaken to invest to reduce the residual risk raised from fire safety audits. Such as fire stopping , fire detection upgrades and fire compartment works **Electrical Risk and power loss** Purchasing standards Provision of adequate sockets where possible Tests: (portable appliances electrical installation, generator auto start. **Control of substances hazardous to health (COSHH)/Infection Control** The principal hazardous substances within the organisation are micro-organisms which are managed through good clinical practice (universal protection), infection control policy and the initiatives by the infection control team. Chemicals used in the laboratories, estates and facilities are subject to local COSHH assessments and procedures. **Waste Management** **DSE** Bespoke risk assessment form, training for managers/assessors, minimum standards for workstations, eye/eyesight tests	

Elements	Position Statement	Evidence
	Contractors o The risk presented by contractors (building/maintenance) are managed in accordance to the Management of Contractors Policy o Working at height, Confined Spaces, Hot working, Electrical work and Working on Medical Gas Supplies are all managed by a Permit to Work System. **Transport** Following a corporate traffic assessment, the Trust has invested considerable time and resources into improving the segregation between pedestrian and road traffic. **Radiation** Radiation Protection Adviser, **Emergency Planning** Emergency Planning Committee: **General** The trust has developed a risk assessment process. All significant risks are assessed and graded with current controls in place. Where residual risks are deemed still to be significant additional controls are identified and implemented. The Trust advocates the HSE hierarchy for risk control actions. Serious (Red) risks are placed on the Trust risk register Policies and reports under development or review:- o Maintenance Policy (Draft) o Asbestos Policy (Draft) o Electrical Policy (Draft) o Medical Gas Policy (under consultation) o Legionella Policy (under consultation) o Dept Health and Safety manuals (Building only Feb 09) o Estates Backlog Maintenance Report (Mar 09)	

Elements	Position Statement	Evidence
Element two The healthcare organisation provides a secure environment which protects patients/service users, staff, visitors and their property, and the physical assets of the organisation, including in accordance with *Secretary of State directions on measures to tackle violence against staff and professionals who work in or provide services to the NHS* (Department of Health 2003, as amended 2006) and *Secretary of State directions on NHS security management measures* (Department of Health 2004, as amended 2006)	<u>Responsibility:</u> ▪ The Trust has in place a robust structure relating to the management and control of security, overall responsibility at Executive Director level and dedicated Security Advisor who is also the Local Security Management Specialist (LSMS). Provision of additional LSMS resources is currently under review. The Security Advisor is a member of the NHS SMS Secure by Design and Security Strategy Implementation groups. ▪ An in-house security department is established with 24 hours security presence. The Trust employs forty-nine full-time staff who perform a core or mixed security/portering roles to assist with the management of security including violent and aggressive incidents covering 24/7 period all the year round. The establishment of a dedicated Security Department operating 24/7 to assist with security and car parking at Sandwell Hospital is currently under review. ▪ The Trust uses the services of 3 x Counter Fraud Specialists. ▪ The Trust has proactive and reactive initiatives for the protection of its staff and patients from the inevitable risk of violence and aggression. It has placed a high priority on preparing staff to manage potentially violent situations by ensuring that front line staff receive conflict resolution training and refresher conflict resolution training which includes corporate induction elements on violence and aggression and customer care. ▪ Wherever possible physical assaults are reported to the police and are reported annually to the Counter Fraud Security Management Service (CFSMS). The Chief Nurse (Security Management Director) is the principle contact point with the CFSMS. However, the Director of Workforce is the Executive Lead on violence. ▪ The Trust's Staff Survey for 2008 indicates that physical violence from patients/service users has increased from 8% in 2006 to 12% in 2008 (+4%) and from relatives of patients/service users from 5% in 2006 to 7% in 2008 (+2%). Reporting of incidents of violence has increased from 23% in 2006 to 67%	• Organisational Structure • Trust Violence and Aggression Policy • Trust Security Policy • Trust Lone Worker Policy • Trust Control and Restraint Policy • Trust Deployment of Armed Police Policy • Trust Missing Patient Policy • Trust Procedure following Baby/Child Abduction or Missing Child • Protocol of Standing Arrangements between HM Prison Birmingham and City Hospital for the Treatment of Prisoners • Trust Policy for the Confiscation of Illegal Drugs found on Patients or Visitors on Trust Premises • Maintenance records/contracts. • Training Records • Listening to Staff - Trust Staff Survey 2008. • NHS SMS statistics – Violence Against Staff • Trust H&S Report – Reported RED Violence & Aggression Incidents • Capital Projects Programme of Security Work – 2008/09. • LSMS Workplan (as updated).

Elements	Position Statement	Evidence
	(+44%) in 2008, however, this is a reduction of 6% against the 2007 survey. There has been an increase in staff perception that the Trust takes effective action if they are physically assaulted by patients from 51% in 2006 to 58% in 2008 (+7%). Trust scores compared to other similar Trusts on issues relating to violence are generally about the same. ▪ The overall number of assaults reported against Trust staff has decreased against the previous year. This may be due to a number of factors: the Trust-wide roll out of protocols to sedate alcohol or drug dependent patients, the impact of conflict resolution training for staff, advance identification of patients that may cause harm to staff, proactive management following an assault on a member of staff, and it is also possible that the deterrence message is getting through to the public as evidence indicates that the number of patients/ service users etc., with capacity assaulting staff is reducing. Assaults against staff were as follows: o 07/08 – 108 (of these, 71 were deliberate assaults against staff) o 06/07 – 117 o 05/06 – 100 o 04/05 – 102 ▪ It is anticipated that current and further planned work in improving psychiatric support/liaison and care pathways for those suffering with alcohol or drug dependence and confusion will further decrease the numbers of assaults on staff in the future. ▪ CCTV, access controls, building alarms, panic alarms, considerable external lighting, secure parking, staff ID and baby tagging systems are all in place across certain areas of the Trust. The Trust has in excess of 130 CCTV cameras on its three sites. The Trust has an annual programme to improve physical security based on risk assessment and available resources - £650k has been expended in FY 2008/09 to upgrade the Security CCTV system, to ensure that access controls are installed on all ward doors across all 3 hospital sites, to improve security within the 2 Maternity Units and to enable the A&E Department at City Hospital to achieve a 'lock down' capability to improve the safety of staff and patients.	

Elements	Position Statement	Evidence
	▪ Assurance: o All security staff receive appropriate training – however, further training is required in security operations and CCTV operation. Currently this training has been provided to Security Team Leaders at City Hospital only. Further rollout of this training is planned in 2008/09. o Security staff also receive Management of Actual and Potential Aggression training (4 day course – 1 day annual refresher) to equip them to deal with patients and others with mental health issues that require restraint. o All front-line staff (Including Security staff) receive the one-day conflict resolution course, delivered by a dedicated in-house Conflict Resolution trainer	
Core standard C20b **Healthcare services are provided in environments which promote effective care and optimise health outcomes by being supportive of patient privacy and confidentiality.**		
Element one The healthcare organisation provides services in environments that are supportive of patient privacy and confidentiality, including the provision of single sex facilities and accommodation, access to private areas for religious and spiritual needs and for confidential consultations. This should happen at all stages of care and during transfers	<u>Privacy & Dignity:</u> ▪ The Trust has in place a Privacy & Dignity (P&D) Policy which recognises the needs of patients ▪ The Trust has in place local audits, patient surveys , PPI feedback and complaints as a mechanism to review and implement change. ▪ The Trust has undertaken a formal audit of all sleeping accommodation in accordance with The NHS Institute for Innovation and Improvement- The Elimination of Mixed Sex accommodation, this has shown that the trust has weaknesses in some of its accommodation. ▪ Following the issue of letter Privacy and Dignity: Drive to Eliminate "Mixed Sex Accommodation" the trust undertook a further accommodation audit of its accommodation against the definitions and implications of that letter. ▪ Currently the Trust's accommodation does not fully comply with The NHS	• Privacy and Dignity Policy • Confidentiality Policy • Curtain Replacement Programme • Appropriate Clothing Project • Clinical Practice Reviews • Essence of Care • PALS Website • Patient Surveys • PPI Forum • Board Paper • NHS IIIP audit • Capital project work details • Privacy and Dignity Audit (Feb 09) • Bid for DOH monies (Feb 09)
Element two Healthcare organisations have systems in place to ensure that		

Elements	Position Statement	Evidence
preventive and corrective actions are taken in situations where there are risks and/or issues with patient privacy and/or confidentiality	Institute for Innovation and Improvement- The Elimination of Mixed Sex accommodation and letter Privacy and Dignity: Drive to Eliminate "Mixed Sex Accommodation" . to improve its position DOH monies have been applied for. Also in recognition of its poor quality estate the trust has developed an OBC to replace its current two hospitals with new estate. This OBC has been approved by the SHA and is currently being considered by the DH	
Core standard C21 **Healthcare services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.**		
Element one The healthcare organisation has systems in place and has taken steps to ensure that care is provided in well designed and well maintained environments, including in accordance with all relevant legislative requirements referred to in Health Building Notes (HBN) and Health Technical Memoranda (HTM), and by following the guidance contained therein, or equally effective alternative means to achieve the outcomes of the HBNs/HTMs. The healthcare organisation should also act in accordance with the *Disability Discrimination Act 1995*, the *Disability Discrimination Act 2005*; and have regard to *The duty to promote disability equality: Statutory Code of practice* (Disability Rights Commission,	▪ A condition survey has been carried out in relation to physical condition of the Estate, this has been updated in line with risk adjusted very high backlog maintenance methodology. The Trust has a very high backlog maintenance figure (upper quartile ERIC returns ▪ Risk assessments have been carried out against key Estates functions: ○ Legionella ○ Asbestos ○ Medical Gases ○ Working at Height ○ Inclement Weather ○ HV/LV Electrical Systems ○ PAT Testing ○ Fire ○ Site Plant (eg Tractors) ○ DDA ○ Emergency Generators ○ Ventilation ○ Lifts ○ Safe Hot Water ○ Pressure Systems	• Condition Surveys • Estates Risk Register • Estates Risk Assessments • Schedule of works undertaken • Site Surveys • Cleaning schedules • Departmental risk registers • Portering procedures • Audit scores • PEAT • Training manuals • Departmental Controls Assurance • E.H.O Reports • Hotel Services Questionnaire • Infection control policy • Compliance Audits • Monthly Reports on works relating to Fire to Fire Consultant • Monthly Reports on works relating to macerators to infection Control

Elements	Position Statement	Evidence
2005). **Element two** Care is provided in clean environments, in accordance with the relevant requirements of duty four of *The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections* (Department of Health, revised 2008).	○ Roof Systems ○ Slips Trips and Falls ▪ Compliance Manager employed to assist with Risk Management of Estates functions ▪ The Trust recognises its responsibilities in relation to Disability Discrimination Act 1995. A complete audit of all properties has been undertaken 2001/02. Various works have been carried out to date to improve accessibility for the disabled and an ongoing programme is continuing to make improvements ▪ The Trust has policies and procedure for the cleaning of trust premises and monitoring regimes both for internal and external inspection ▪ The Trust has policies and procedure for the cleaning of trust premises and monitoring regimes both for internal and external inspection ▪ The Trust has policies and procedure for the cleaning of trust premises and provision of food ▪ Monitoring regimes both for internal and external inspection ▪ The Trust has policies and procedure for the cleaning of trust premises and monitoring regimes both for internal and external inspection	• Emergency Planning

Seventh domain: public health

Elements	Position Statement	Evidence
Core standard C22a&c **Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by: a) co-operating with each other and with local authorities and other organisations; and c) making an appropriate and effective contribution to local partnership arrangements including Local Strategic Partnerships and Crime and Disorder Reduction Partnerships.**		
Element one The healthcare organisation actively works with other healthcare organisations, local government and other local partners to promote, protect and demonstrably improve the health of the community served and narrow health inequalities, such as by working to improve care pathways for patients / service users across the health community and between the health, social care and the criminal justice system, and/or participating in the JSNA and health equity audits to identify population health needs.	▪ The Trust actively co-operates with partners in both health and social care in order to pursue the health economy's strategy. ▪ The Trust is a key member of the "Towards 2010" local health economy partnership comprising the Trust, its two main PCTs and two main local authorities. Towards 2010 is an ambitious programme to redevelop health and social care services in Sandwell and the Heart of Birmingham. ▪ The Trust's staff are involved in a wide range of local partnerships including the Cancer Network, Diabetes Network and CHD Local Implementation Team. The Trust has undertaken a stocktake of all its partnership activity to ensure it is properly co-ordinated. ▪ The Trust is represented on it two Local Strategic Partnerships. The Chief Executive is a member of the Sandwell Partnership (LSP) and the Health Partnership and Health Partnership Executive. The Chair is a member of the Birmingham LSP's Health Partnership.	• Towards 2010 Partnership Terms of Reference [need to get from Prog Office] • Towards 2010 Partnership Board Minutes (Aug – Oct 07 as an example) [need to get from Prog Office] • Towards 2010 Programme public consultation document (November 2007) • Stocktake of Trust Partnership Activity (March 2007) • Sandwell LSP and Health Partnership Minutes and Birmingham LSP Health Partnership Minutes.
Element two The healthcare organisation contributes appropriately and effectively to nationally recognised and/or statutory partnerships, such as the Local Strategic Partnership, children's partnership arrangements and, where appropriate, the Crime and		

Elements	Position Statement	Evidence
Disorder Reduction Partnership.		
Element three The healthcare organisation monitors and reviews their contribution to public health partnership arrangements and takes action as required.		
Core standard C22b **Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by ensuring that the local Director of Public Health's Annual Report informs their policies and practices.**		
Element one The healthcare organisation's policies and practice to improve health and narrow health inequalities are informed by the local director of public health's (DPH) annual public health report.	▪ The Trust works to improve the health of the local population in line with local public health priorities. o The Trust's strategic direction is based on an assessment of the health of the local population developed from public health reports identifying the key issues. o The Towards 2010 Programme is a response to significant local health issues identified by the Trust's two main PCTs. ▪ The Trust Board has received a presentation from its main commissioner's Director of Public Health on the Sandwell Public Health report. Further annual presentations on both the Heart of Birmingham and Sandwell public health reports will be arranged.	• Our Strategic Direction (March 2007) • Towards 2010 Programme public consultation document (November 2007) • Sandwell and Heart of Birmingham PCT • Public health reports • Minutes of Sandwell PCT presentation to Trust Board
Core standard C23 **Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service Frameworks and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections.**		
Element one	▪ Data collection on relevant health promotion areas	

Elements	Position Statement	Evidence
The healthcare organisation collects, analyses and shares data about its patients/service users and services, including where relevant data on ethnicity, gender, age, disability and socio-economic factors, including with its commissioners, to influence health needs assessments and strategic planning to improve the health of the community served	▪ Details of the patient's weight, smoking status, alcohol intake and mental well being are collected on the patient's admission to hospital or attendance at pre-assessment clinics either on the Single Patient Record documentation or on the initial medical clerking. ▪ In addition, data is collected for specific audits both nationally and locally e.g. on 'smoking status' for the National Audit of Cardiac Rehabilitation and locally through the Essence of Care Audits. ▪ In a survey of Lead clinicians responders indicated that smoking status, weight and alcohol intake were routinely recorded and onward referral was made if indicated.	
Element two Patients/service users are provided with evidence-based care and advice along their care pathway in relation to public health priority areas, including through referral to specialist advice/services.	▪ Clinical coders record when patients are documented as smokers ▪ Continuing development of dietetic and fitness services & development and investment in Bariatric surgery ▪ A 'snapshot' audit has revealed that 'smoking status' is recorded in the majority of cases and with evidence of onward referral of those cases where it was documented that the patient was interested in giving up	
Element three The healthcare organisation implements policies and practices to improve the health and wellbeing of its workforce.	▪ The introduction of a "Stop before the Op" project aimed at offering smoking cessation services to all smokers prior to surgery – in association with PCT partners ▪ Sharing information on relevant health promotion areas ▪ The trust is working with PCT partners and has undertaken a major assessment of the health needs of the local population as part of developing long-term plans through the 'Towards 2010 Programme' ▪ Participation in specialty SMOCS around specific health themes & Needs of the local population ▪ There is sharing of relevant information at NSF Local implementation Teams	

Elements	Position Statement	Evidence
	(LIT's) e.g. on smoking prevention at the CHD LIT ■ The Trust has a series of programmes for working with patients to improve their health including the services provide to patients with key long term conditions such as CHD an diabetes ■ The Trust has agreed policies for the management of patients with alcohol drug and obesity problems. ■ A directory of local support services for people with substance misuse problems. These are available on the intranet, in wards and in the Trusts information centres ■ The Trust is member of the local health Exchange project which provides easily accessible multi-lingual public health information and advice to patients ■ The Trust also has dietetic and nutritional teams to support patients and lead midwives for public health who provide a range of educational classes, clinics and public health events ■ GP's and Health Centres hold disease prevention days and events supported by CNS's from the Trust. ■ Pathways developed for 2010 should take account of relevant NICE Guidance ■ Local obesity strategy is under development ■ The Trust has a systematic process for the implementation of NICE guidance. ■ Cancer Services are developed in line with 'Implementing Outcomes Guidance' and assessed through peer review. ■ The Trust participates in a number of national Clinical Audits which have built in measures.	

Elements	Position Statement	Evidence
	▪ As a result of monitoring for EOC and 'snapshot' audits a strategy for health promotion will be formulated in relation to areas identified. ▪ There are also some audits which have made recommendations for a change e.g. obesity screening in paediatrics and nutrition screening in adults at Sandwell The Trust provides numerous examples:- o Activ Health Club o Access to smoking cessation o Stress Management workshops o Health assessments o 'Walking lunch' o Shuttle Bus o Car sharing schemes o 'Back to fitness' courses ▪ The Medical Director and Chief Operating Officer link with the Directors of Public Health in the two main local PCTs as required. Infection Control may do this directly should the need arise.	
Core standard C24 **Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services.**		

Elements	Position Statement	Evidence
Element one The healthcare organisation protects the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations (including control of communicable diseases), which includes arrangements for business continuity management, in accordance with the Civil Contingencies Act (2004), The NHS Emergency Planning Guidance 2005, and associated supplements (Department of Health, 2005, 2007) and Pandemic Influenza: A National Framework for Responding to an Influenza Pandemic (Department of Health November 2007).	▪ Sandwell and West Birmingham NHS Trust has a number of emergency plans in accordance with its requirements under the applicable legislation. Its generic Emergency plan was significantly updated in 2008 and reissued on 1st December, accompanied by a rolling programme of awareness and exercising. The Trusts Pandemic plan was revisited in line with the internal amendment cycle, key elements are being developed continuously in line with government guidance as it becomes available. The Trust business continuity plan is being reviewed as part of its ongoing validation cycle and is expected to be compliant with BS25999. ▪ The Trust has also played a significant part in the production of the West Midlands LRF strategic coordination group plan for pandemic flu strategic management, this is compliant with Cabinet office and Department of Health Guidance. ▪ The Trust has also planned and managed a significant 'flu outbreak in an enclosed community with its Mental health trust colleagues and PCT and shows a high level of commitment to training and mutual response as evidenced by flu awareness sessions in all the partner organisations run as a joint venture between the trust, Sandwell PCT, Sandwell Metropolitan borough council and Sandwell metal health Trust. Training and exercising in Pandemic flu has also been held with Birmingham City Council, Birmingham Social services and independent care homes.	• Generic Major Incident plan 2008, version 5 final and managers briefing pack • Pandemic Influenza plan 2009 final version going to trust management Board 17 03.09 • Safeguarding Children policy
Element two The healthcare organisation protects the public by working with key partner organisations, including through Local Resilience Forums, in the preparation of, training for and annual testing of emergency preparedness plans, in accordance with the *Civil Contingencies Act 2004*, *The NHS Emergency Planning Guidance 2005 and associated annexes*	▪ During 2008 and in January 2009 the Trust has carried out a number of exercises and tests in partnership with its local LRF organisations and its key stakeholders, this has included Table top exercises (exercise Vengeance on the City Site and exercise Trident on the Sandwell site) these were multi-agency table tops testing the plans and arrangements to deal with a bomb threat to the trust and required active management and recovery phases for the trust, exercise trident focused on flooding and power failure, essential systems Business continuity and recovery, all were externally facilitated and reports were used to review existing plans and arrangements. The trust carried out 2 live casualty exercises during this period, Exercise Deep Freeze in November at the Rowley Regis Site, utilising 10 casualties and multi-agency response from the Fire Service and Police and exercise Phoenix in January a large scale multi-agency live casualty exercise at the Sandwell site involving	• Reports on exercise Vengeance • Exercise Trident, exercise deepfreeze and exercise phoenix. • External reports on exercise performance from multi agency colleagues. • Expected external auditors review of emergency planning progress due end March 2009 • Feedback from pandemic awareness training sessions

Elements	Position Statement	Evidence
(Department of Health 2005, 2007) and *Pandemic Influenza: A National Framework for Responding to an Influenza Pandemic* (Department of Health November 2007).	26 fire appliances from 3 counties, 39 live casualties, a bus, West Midlands Police, Local authority, Ambulance service and a full trust response including Gold and Silver management. This was externally validated by referees from other agencies and health organisations. ▪ The Trust has played a leading part in facilitating and leading exercises on behalf of multi-agency partners in the region for Pandemic Flu, Tactical operational management of a terrorist attack, communications management of an incident. the trust has also responded to two significant incidents including a HAZMAT and Flu outbreak. ▪ The Trust has carried out two communications cascade tests in 2008.	

March 2009

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

Core Standards Declaration 2008-09

Action plan for non-compliant standard

Standard	Description of the issue [lapse identified or lack of assurance in compliance]	Summary of actions planned
Core standard C20b **Heathcare services are provided in environments which promote effective care and optimise health outcomes by being supportive of patient privacy and confidentiality** **Executive Lead:** Director of Estates/New Hospital Project Director	Latest guidance and instruction from the Department of Health requires higher standard of sleeping and sanitary accommodation to achieve compliance	Review existing operational and nursing practice and where necessary improve to achieve compliance. Upgrade existing arrangements for sleeping and sanitary accommodation to achieve compliance. This will require significant capital funding and safe access to wards to undertake works

Specific corrective actions planned	Timescale	Lead	Progress report	Evidence of achievement
1. Review nursing and operational practices to comply with standard *1-9, 14, 16, 26-31*[#]	June 2009	COO, CN and MD		
2. Reconfigure wards around single sex accommodation. Standards *10,11,12,13* 2.1 Identify wards to be single sex based on clinical and operational suitability 2.2 Complete implementation of single sex wards- for this plan assumed all City spine wards	April 2009 June 2009	COO, CN and MD		

 # Relates to standards within the NHS Institute for Improvement and Innovation – Privacy and Dignity the Elimination of Mixed Sex Wards

Standard	Description of the issue [lapse identified or lack of assurance in compliance]	Summary of actions planned
Core standard C20b **Heathcare services are provided in environments which promote effective care and optimise health outcomes by being supportive of patient privacy and confidentiality** **Executive Lead:** Director of Estates/New Hospital Project Director	Latest guidance and instruction from the Department of Health requires higher standard of sleeping and sanitary accommodation to achieve compliance	Review existing operational and nursing practice and where necessary improve to achieve compliance. Upgrade existing arrangements for sleeping and sanitary accommodation to achieve compliance. This will require significant capital funding and safe access to wards to undertake works

and all wards at SGH except eight wards.				
3. Plan and implement modifications to non single sex wards - *Standards 10,11,12,13* 3.1 Based on solution 2.1identify estates solution for remaining wards 3.2 Secure funding for remaining ward conversion 3.3 Start decant wards for works 3.4 Complete scheme (4 wards @SGH)	 April 2009 April 2009 April 2009 June 2009	 DE/NHPD FD COO DE/NHPD		
4. improve toilet/ bathroom provision to comply - *Standards17 -25* 4.1 Identify estates solution 4.2 Secure funding for solution 4.3 Implement solution	 April 2009 April 2009 June 2009	 DE/NHPD FD DE/NHPD		
5. upgrade signage - *Standard 15*				

Standard	Description of the issue [lapse identified or lack of assurance in compliance]	Summary of actions planned
Core standard C20b **Heathcare services are provided in environments which promote effective care and optimise health outcomes by being supportive of patient privacy and confidentiality** **Executive Lead:** Director of Estates/New Hospital Project Director	Latest guidance and instruction from the Department of Health requires higher standard of sleeping and sanitary accommodation to achieve compliance	Review existing operational and nursing practice and where necessary improve to achieve compliance. Upgrade existing arrangements for sleeping and sanitary accommodation to achieve compliance. This will require significant capital funding and safe access to wards to undertake works

5.1 Identify solution 5.2 Secure funding 5.3 Implement solution	April 2009 April 2009 May 2009	DE/NHPD FD DE/NHPD		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Assurance Framework 2008/09
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	26 March 2009

KEY POINTS:

This report is provided to update the Trust Board on progress with actions undertaken to address the gaps in control and assurance against corporate objectives, which were identified in the Assurance Framework.

Progress with plans to address the gaps is on track for the majority of actions.

Progress is amber (some delay, but expected to be completed as planned) with actions planned to address gaps identified against the achievement of objective 4.2, further improve productivity by improving day case rates and reducing average hospital length of stay, and 6.1, continue to achieve Healthcare Commission Core Standards.

PURPOSE OF THE REPORT:

○ **Approval** ◉ **Noting** ○ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is recommended to note the progress with actions to address the gaps in assurance and control.

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

Relevant to all corporate objectives

IMPACT ASSESSMENT:

FINANCIAL	☑	
ALE	☑	
CLINICAL	☑	
WORKFORCE	☑	
LEGAL	☑	
EQUALITY & DIVERSITY	☑	
COMMUNICATIONS	☑	
PPI	☐	
RISKS		None identified.

Sandwell and West Birmingham Hospitals
NHS Trust

ASSURANCE FRAMEWORK 2008/09: Q4 UPDATE

March 2009

PROGRESS REPORTING

Reference is made within the Assurance Framework to the action plans that are in place to address the identified gaps in control and/or assurance in relation to the principal risks that threaten the achievement of the Trust's objectives for 2007/08. Regular reports are presented to the Board to update members on the progress made in implementing the plans e.g. the monthly performance report, the monthly Interim Reconfiguration update etc. In addition, this report captures within one document all the identified gaps in controls and assurance and provides a brief summary of the progress made to date.

CATEGORISATION

Progress with the actions in the plan has been assessed on the scale set out in the table below.

Status	
5	Complete
4	On track
3	Some delay – expect to be completed as planned
2	Significant delay – unlikely to be completed as planned
1	Not yet commenced
0	Objective revised

Ref	Lead Director	Objective	Identified gaps in control/assurance	Summary of actions planned to address gaps, including timescales	Progress against actions planned	Status
1	**Accessible and Responsive Care**					
1.1	Chief Operating Officer	Continue to achieve national targets (18 weeks, cancer, A & E and GUM)	**Gap in control** Need to improve the data reporting systems to support meeting the new cancer targets. This will be aided by a new IT system that is being procured. **Gap in assurance** None identified	Improvements to the 18-week reporting systems to be identified and actioned Additional staffing required to meet new December cancer targets	Improvements to 18-week system in place and further developments underway. Revised systems for cancer waiting times targets being introduced from December 2008 to ensure achievement of this target. There has been an increase in non-elective activity, which has had an adverse impact on performance against the 98% A & E target. At the end of December 2008 this had slipped to 97.62% year to date. A rectification action plan has been developed which will require the Trust to achieve 99% throughout the whole of Q4.	**4**

Ref	Lead Director	Objective	Identified gaps in control/assurance	Summary of actions planned to address gaps, including timescales	Progress against actions planned	Status
1.2	Chief Nurse/Head of Communications	Successfully deliver our Patient Experience Action Plan in response to patient survey results	**Gap in control** None identified **Gap in assurance** Patient surveys are not routinely carried out at a local level	Establish a mechanism for routinely carrying out patient surveys Establish reporting methodology	A patient view report has been developed and presented to the Patient Experience Steering Group. This reflects the five key indicators of the Patient Experience Action Plan. Surveys have also been conducted in A & E and PALS/Complaints. Patient surveys will be undertaken twice per year (April and September) on all adult inpatient areas. A mixed sex accommodation survey has been undertaken.	**4**
1.3	Chief Nurse	Develop and begin to deliver a Single Equality Scheme for the Trust	**Gap in control** Staff not yet recruited **Gap in assurance** None identified	Recruit a Trust lead for Equality and Diversity	All posts now filled.	**4**

Ref	Lead Director	Objective	Identified gaps in control/assurance	Summary of actions planned to address gaps, including timescales	Progress against actions planned	Status
2	**High Quality Care**					
2.1	Chief Nurse	Continue to reduce hospital infection rates achieving national and local targets for MRSA and clostridium difficile, including introducing MRSA screening in line with national guidance	**Gap in control** None identified **Gap in assurance** Audit returns not always completed	Instil more rigour and discipline into completion of audits. Revise infection control policies to reinforce requirement to complete audits	Audits now routinely completed to a high standard. MRSA and C diff policies revised and approved by TMB/Gov Board	**4**
2.2	Director of Governance	Develop and begin delivery of a plan to enhance the safety culture and systems of the Trust	**Gaps in control** Gaps in systems around training (NHLSA assessment action plan) and divisional/directorate governance structures **Gaps in assurance** None identified	Patient Safety Development Plan approved by Trust Board and monitored quarterly at Governance Board.	Plan continues to be implemented and reviewed on quarterly basis at Governance Board. Survey of patient safety structures has been undertaken and the results presented to the December Governance Board. A training needs analysis for incident/risk management has been undertaken. Action plans to address gaps in structures have been prepared by the majority of divisions.	**4**
2.3	Medical Director	Develop and begin to deliver the Maternity Development Plan in light of local reviews and national guidance	**Gaps in control** Infra structure improvements not yet delivered	Develop an integrated maternity services development plan.	Implementation of the integrated maternity services development plan began in September.	**4**

Ref	Lead Director	Objective	Identified gaps in control/assurance	Summary of actions planned to address gaps, including timescales	Progress against actions planned	Status
			Gaps in assurance None identified		The plan is a live document, which will need constant review and development. The plan is intended to be monitored by the Clinical Quality Review Committee, which has been established by Sandwell PCT.	
2.4	Chief Nurse	Deliver plans to improve the quality and consistency of nursing	**Gaps in control** None identified **Gaps in assurance** Some quality data not currently available.	Establish and embed ward review process and optimal ward initiative	Second round of Ward reviews has now been completed and the optimal ward programme, arising from the Listening into Action initiative is underway, which has been expanded to include 13 wards currently.	**4**
2.5	Chief Operating Officer	Deliver service reconfiguration changes in neo-natal services, surgery and pathology	**Gaps in control** None identified **Gaps in assurance** Process for formal review after implementation yet to be agreed by project board	Agree and implement process for formal review of impact of changes 12 months after implementation	HSMC external review of paediatrics underway. The possibility of using neonatal network review process to evaluate neo-natal changes is being explored. Approach for surgery and pathology to be agreed once	**4**

Ref	Lead Director	Objective	Identified gaps in control/assurance	Summary of actions planned to address gaps, including timescales	Progress against actions planned	Status
					changes are completed.	
2.6	Chief Operating Officer	Take on Walsall and Sandwell breast screening service as part of a larger Walsall/Sandwell/City breast screening service	**Gaps in control** None identified **Gaps in assurance** None identified		Service went live as planned on 1 April 2008	**5**
2.7	Chief Operating Officer/Medical Director	Deliver improvements in national clinical priorities of cancer (Cancer Reform Strategy) and stroke (Stroke Strategy)	**Gaps in control (cancer)** None identified once the planned changes to the structure of the MDT management arrangements have been delivered **Gaps in assurance (cancer)** None identified **Gaps in control (stroke)** Appropriate long term performance management and control systems have not yet been established **Gaps in assurance (stroke)** Much of the Stroke pathway on both sites needs further development of reporting, audit, and	Implement changes to MDT management structure by the end of September 2008 Establish robust performance management and control systems. Establish mechanism for wider engagement of plans. The plan includes the development of appropriate audit and reporting tools	The changes to the structure for managing the Trust's MDTs were completed by the end of September. Trust cancer strategy was presented to the Trust Board in December 2008 and is being updated following consultation. Stroke sponsor group is now in place and has developed a plan for service improvement. This plan has been shared with commissioning PCTs and is expected to be delivered throughout 2009/10	**4**

Ref	Lead Director	Objective	Identified gaps in control/assurance	Summary of actions planned to address gaps, including timescales	Progress against actions planned	Status
			control systems			
2.8	Medical Director/Director of Governance	Agree a clear plan to ensure EWTD (48 hr) compliance by August 2009, including continued development of Hospital at Night	**Gaps in control** More structured reporting required with greater Divisional level input **Gaps in assurance** None identified	Position statement of 2009 EWTD Compliance as at 28 February 2009 circulated to Divisional Directors and Divisional General Managers in March 2009. Meetings (and follow up meetings) have been organised with Divisional Directors and Clinical Directors in specialties where 2009 compliance not yet achieved. Where the issues in the specialty are more difficult to solve the Deputy Medical Director has become involved Speciality working groups to address EWTD issues have been set up in Ophthalmology, Radiology and Trauma and orthopaedics. Deanery action team to visited the Trust on 28 November 2008 to assess Trust position and were assured that Trust was developing plans to ensure EWTD	A number of meetings with Divisional Directors, Clinical Directors and lead clinicians have taken place to develop action plans in specialities not yet compliant with the August 2009 targets. Follow up meetings continuing to take place where there are outstanding issues	**4**

Ref	Lead Director	Objective	Identified gaps in control/assurance	Summary of actions planned to address gaps, including timescales	Progress against actions planned	Status
				Compliance.		
3	**Care Closer to Home**					
3.1	Chief Operating Officer	Deliver new models of care through the first wave 2010 exemplar projects (urgent care, intermediate care, dermatology and diabetes) and begin to deliver new models of care for community-based outpatients in the second wave 2010 exemplar specialities (cardiology, orthopaedics, rheumatology, ophthalmology, respiratory and gynaecology)	**Gaps in control** Lack of consistency in project management approach across the projects. This is being developed by the Programme following the SHA review **Gaps in assurance** None identified	With 2010 programme, agree framework to ensure future consistency	Trust 2010 Implementation Board reviewed progress project by project in November 2008 and action agreed to address the outstanding issues. Overall 2010 exemplars expected to deliver end of year targets.	**4**
3.2	Chief Operating Officer	Successfully deliver a community-based dermatology service for Birmingham North East PCT	**Gaps in control** None identified **Gaps in assurance** The Trust needs to develop systems for capturing patient and GTP satisfaction with the service	Establish appropriate internal arrangements for ensuring successful delivery of the service from June 2008. Ensure that commissioners, GPs and patients are satisfied with the service by March 2009	Project team structure now fully established. BEN commissioners confirmed their satisfaction with provision to date. Will now develop arrangements for ensuring reporting on GP and patient satisfaction by March 2009. Patient survey now commenced in clinics.	**4**
4	**Good Use of Resources**					

Ref	Lead Director	Objective	Identified gaps in control/assurance	Summary of actions planned to address gaps, including timescales	Progress against actions planned	Status
4.1	Director of Finance	Deliver the financial plan including achieving a financial surplus of at least £2.5m and a CIP of £11m	**Gaps in control** None identified **Gaps in assurance** None identified			
4.2	Chief Operating Officer	Further improve productivity by improving day case rates and reducing average hospital length of stay	**Gaps in Control** Need to improve the Theatre Management reporting to demonstrate improvements. New reports are in place from April and these will be developed further **Gaps in assurance** None identified	Complete implementation of Theatre System by April 08 New Theatre utilisation reports in the monthly performance pack by June 08	Complete The theatre utilisation reports have been developed but it is recognised that a dedicated programme of work needed to be undertaken to ensure that further improvements in theatre productivity result.	**3**
4.3	Chief Operating Officer	Deliver the next stages of the Trust's Service Improvement Programme	**Gaps in control** None identified **Gaps in assurance** Do not currently have a formal process for post-project evaluation. Will see to introduce this during 2008/09.	Develop formal process for post-project evaluation by January 2009. Have used the process by March 2009.	Arrangements for post project evaluation now agreed and have been used for the latest round of projects.	**5**
5	**21st Century Facilities**					
5.1	New Hospital Project Director	Produce and secure agreement to the Outline Business Case for the new acute hospital	**Gaps in control** None identified **Gaps in assurance**	Internal audit receive monthly Project Board meetings. This group will review OBC drafts at key	Internal Audit now attend meetings and are shortly due to be engaged with some	**4**

Ref	Lead Director	Objective	Identified gaps in control/assurance	Summary of actions planned to address gaps, including timescales	Progress against actions planned	Status
			Monthly progress reports are based on self assessment against plan. Trust Board may wish to consider requesting a more objective view (e.g. from internal audit) as work progresses in addition to the regular PFU reviews	stages prior to and including final submission to the DOH	specific assurance exercises in connection with the project OBC submission version now developed and considered at the December 08 Trust Board	
5.2	New Hospital Project Director	Agree and begin to implement land acquisition for the new hospital	**Gaps in control** None identified **Gaps in assurance** Monthly progress reports are based on self assessment against plan. Trust Board may wish to consider requesting a more objective view (e.g. from internal audit) as work progresses in addition to the regular PFU reviews	Internal audit receive Land Acquisition Group on biweekly basis	Land business case approved by the Strategic Health Authority. Being considered by the Department of Health. Voluntary land acquisition has commenced.	**4**
6	**An effective NHS FT**					
6.1	Director of Governance	Continue to achieve Healthcare Commission Health Check Standards	**Gaps in control** None identified **Gaps in assurance** Electronic system to centrally capture evidence to support compliance	Establish a mechanism for electronically capturing all evidence to support the annual core standards declaration	Shared folder set up on S drive, structured in line with the annual heathcheck core standards. Executive and operational leads assigned to each	**3**

Ref	Lead Director	Objective	Identified gaps in control/assurance	Summary of actions planned to address gaps, including timescales	Progress against actions planned	Status
					core standards to ensure clarity of responsibility for providing supporting evidence. Although much of the evidence is easily available, further work needs to be undertaken to collect and organise it into an electronic portfolio available for inspection if required.	
6.2	Chief Executive	Achieve NHS Foundation Trust status	**Gaps in control** None identified **Gaps in assurance** None identified			
6.3	Chief Operating Officer	Using the Trust's new patient information systems, improve clinical administration and clinical communications	**Gaps in control** None identified **Gaps in assurance** None identified			
6.4	Chief Operating Officer/Head of Communications	Develop further our approach to marketing and business development activity	**Gaps in control** None identified **Gaps in assurance** Business development group only reports to executive committees i.e. no structure for NED oversight of this activity. Will need to agree how this can best be delivered (e.g.	Agree how to ensure appropriate level of NED input to and oversight of this agenda	Discussions taken place at FT Seminar, at which Non Executive Directors are engaged. Marketing and Business Development Strategy now finalised for formal agreement. Progress with actions	**4**

Ref	Lead Director	Objective	Identified gaps in control/assurance	Summary of actions planned to address gaps, including timescales	Progress against actions planned	Status
			through Trust Board or sub-committee, such as F & PMC)		reviewed at Business Development Group and FMB.	
6.5	Director of Workforce	Improve staff engagement through implementation of the 'Listening into Action' programme	**Gaps in control** None identified **Gaps in assurance** None identified			
6.6	Chief Operating Officer	Ensure effective emergency preparedness	**Gaps in control** Robust monitoring of emergency preparedness training in all areas More exercises required around the CBRN decontamination facilities **Gaps in assurance** This is being identified as part of the self audit against BSI 25999	Exercises on emergency preparedness to be undertaken. CBRN processes at City Hospital to be reviewed and training needs addressed. Major incident plan to be developed and training provided to staff. BSI 25999 to be undertaken.	An Emergency Planning Officer has been in post since March 2008. The Major Incident Plan was comprehensively revised in September 2008 to ensure compliance with DoH guidance, the Civil Contingencies Act 2004 and the NHS West Midlands ERMA arrangements. There are generic common command and control arrangements for the Trust with site-specific annexes for the City, Sandwell and Rowley Regis Hospital sites. Revised MIP was presented to OMB in September 08.	**4**

Ref	Lead Director	Objective	Identified gaps in control/assurance	Summary of actions planned to address gaps, including timescales	Progress against actions planned	Status
					Further associated plans/policies have been developed/reviewed during the year. These include: Influenza pandemic contingency plan (Dec 08); Bomb threat policy (June 08); Hospital evacuation plan (Dec 08); Heatwave plan (July 08); Emergency supply of fuel plan (July 08); CBRN arrangements at City have been revised and the tent area made more secure, which further training has been undertaken. There have been a number of live and table top tests undertaken over the last 12 months, which all involved testing all or some elements of the trust emergency plans. The latest actions around emergency	

Ref	Lead Director	Objective	Identified gaps in control/assurance	Summary of actions planned to address gaps, including timescales	Progress against actions planned	Status
					planning include: Exercise Phoenix (10th January 2009) SGH: Live CBRN casualty exercise involving police, Fire Service, WMAS, 40 volunteers. Simulated a chemical release requiring decontamination (both at SGH A&E and with WMFS mass decontamination facility) Influenza Pandemic Plan to be presented for approval at March TMB Briefing sessions on Influenza Pandemic have been held for trust staff (March 2009)	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Quarterly Infection Prevention and Control Report October – December 2008
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Dr Beryl Oppenheim, Director of Infection Prevention and Control
DATE OF MEETING:	26 March 2009

KEY POINTS:

- Organisational structures continue to work well and we anticipate the opportunity to further harmonise our efforts across the wider healthcare community
- Numbers of cases of MRSA bacteraemia and Clostridium difficile infections remain low in comparison with previous years, the focus now remains on sustaining these over time
- The focus at a national level remains on driving the implementation of MRSA screening programmes and we are pleased to be developing a strategy to implement a common pathway for screening across the healthcare economy and working with the Department of Health to evaluate the impact of rapid screening initiatives
- Audit and directed training continue to be prioritised as a means of delivering continuous improvements

PURPOSE OF THE REPORT:

☉ **Approval** ○ **Noting** ○ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to receive and note the Quarterly Report for October to December 2008

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

2.1 - Continue to reduce hospital infection rates achieving national and local targets for MRSA and *clostridium difficile* including introducing MRSA screening in line with national guidance.

IMPACT ASSESSMENT:

FINANCIAL	☐	
ALE	☐	
CLINICAL	☑	
WORKFORCE	☐	
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quarterly Infection Prevention and Control Report
October to December 2008

Executive Summary

Organisational structures continue to work well and we anticipate the opportunity to further harmonise our efforts across the wider healthcare community

Numbers of cases of MRSA bacteraemia and Clostridium difficile infections remain low in comparison with previous years, the focus now remains on sustaining these over time

The focus at a national level remains on driving the implementation of MRSA screening programmes and we are pleased to be developing a strategy to implement a common pathway for screening across the healthcare economy and working with the Department of Health to evaluate the impact of rapid screening initiatives

Audit and directed training continue to be prioritised as a means of delivering continuous improvements

Management and Organisation

The existing structures are working well and allow engagement of staff at all levels. With the filling of a vacant Antibiotic Pharmacist post within our Trust and the appointment to an equivalent position within Sandwell PCT there should be excellent links to enhance prudent prescribing across the primary: secondary care interface. Similar arrangements are in progress with the appointment of a data analyst in both organisations to maximise the provision of information for action on all aspects of HCAI, but particularly focussing on MRSA and C. difficile. Negotiations are progressing well to develop a formal service level agreement to provide infection control doctor support and advice to Heart of Birmingham PCT, and this will harmonise arrangements between the acute Trust and all the major community partners.

The first major piece of work of this health economy wide group has been to develop a strategy to implement MRSA screening across all of our areas according to joint protocols and this strategy has been presented to the Strategic Health Authority.

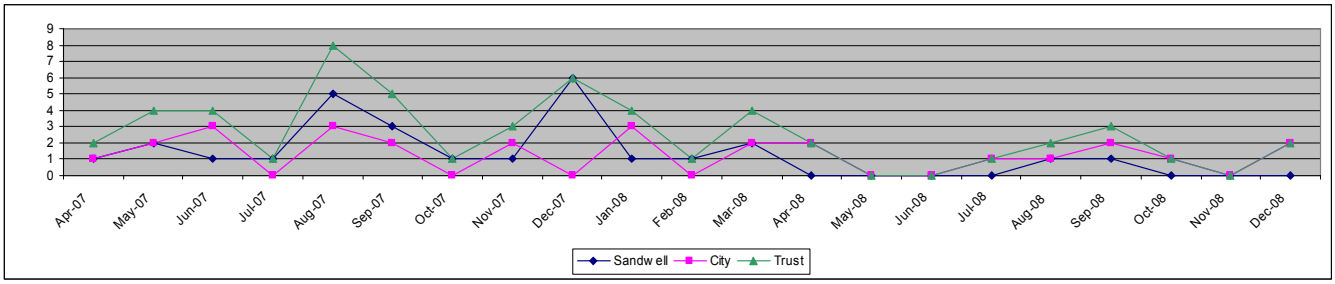
The Infection Control Team continue to monitor progress against the Infection Control Programme with the majority of the work on track and plans to develop many areas further in the next financial year.

MRSA

Mandatory Reporting of MRSA bacteraemia

For the quarter October to December 2008 there were 3 MRSA bacteraemias against a target of 9 and compared to 9 bacteraemias in the equivalent period in 2007 (Figure 1)

Figure 1. No of MRSA Bacteraemia cases.



MRSA Screening and Decolonisation Therapy

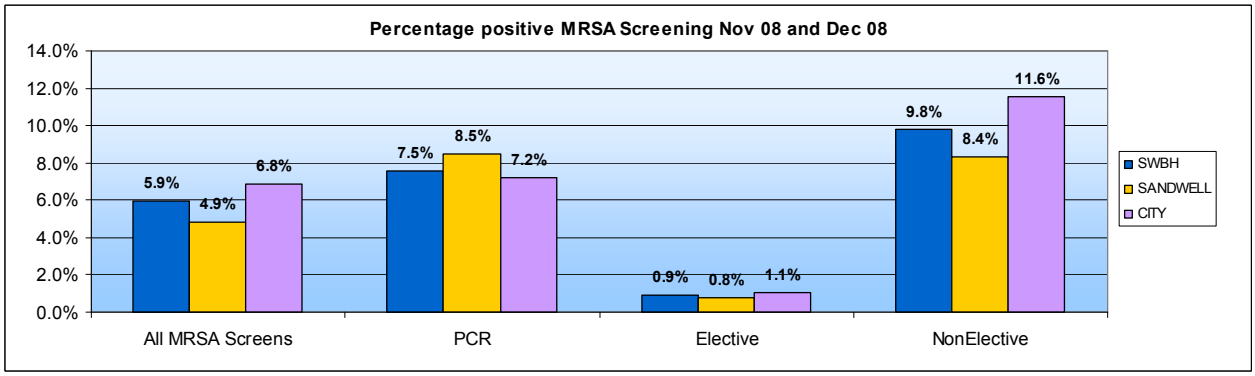
Further guidance issued by DH late in 2008 reinforced the requirement to have in place MRSA screening for all elective admissions including day cases by end March 2009, but the detail of how this was to be achieved was noted to be left for individual organisations to decide, and in some cases the wording was felt to be ambiguous.

It was felt that some consistency, at least at a regional level, would be desirable, and we have assisted in the organisation of a meeting under the umbrella of the Strategic Health Authority and the development of a document drawing together both those aspects of a screening programme where there was significant agreement and those where a national steer or further research might be required. This document is now out for consultation among infection control teams throughout the Region.

In the interim the SHA was required to scrutinise individual organisations' implementation plans to provide assurance that they were able to meet their objectives within the required timescale. To ensure a consistent approach within our own healthcare community, we have put together an implementation strategy encompassing Sandwell and West Birmingham Hospitals NHS Trust, Sandwell PCT, Heart of Birmingham PCT and Sandwell Mental Health and Social Care NHS Foundation Trust.

The current programme of screening elective inpatients and emergency admissions is progressing well and yielding interesting results with major differences in positivity rates between emergencies and elective patients (figure 2), adding evidence to our decision to prioritise screening of emergency admissions in advance of the timescales required nationally. Screening emergency admissions by using a rapid test at the point of entry to hospital remains a novel approach and we are delighted to have been commissioned by the Department of Health to undertake an evaluation of the impact of this screening programme.

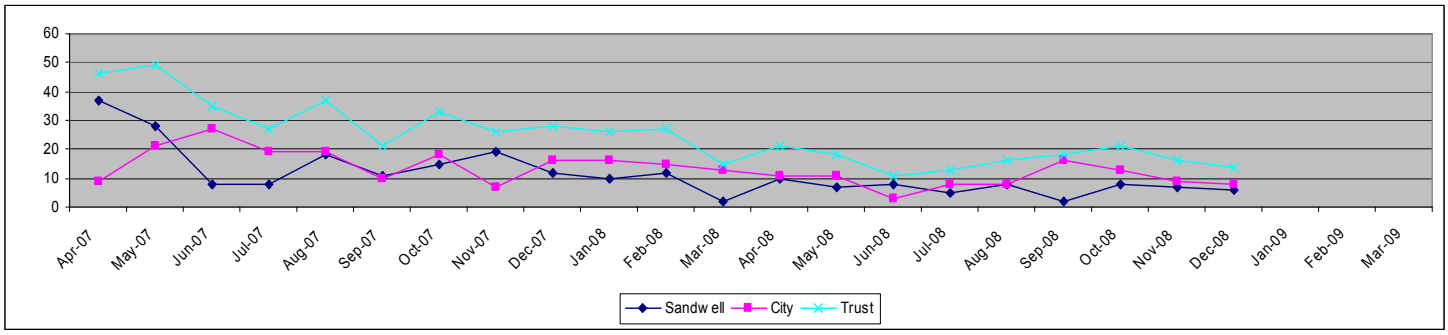
Figure 2. Screening results November/December 2008



Clostridium difficile infections (CDI)

There were 51 cases of CDI in patients admitted to the Trust in the quarter October to December 2008 which compared to 87 in the comparable quarter of 2007 (Figure 3). 38 occurred more than 48 hours after admission and are attributable to the Trust trajectory.

Figure 3: Total number of *C difficile* cases admitted to SWBH NHS Trust



Particular interest has focussed in recent months on the potential value of new generation tests to identify patients with CDI. While in the past the diagnosis of CDI was limited to identifying the toxin of *C. difficile* in stool samples, these newer assays are able to identify carriage of *C. difficile*, carriage of toxin producing *C. difficile* strains, and carriage of the potentially more virulent 027 strain. While it is likely that these advances in diagnosis will require workers in the field to re-define the precise circumstances in which a diagnosis of CDI should be made, it appears sensible to assume that ascertaining symptomatic individuals who are carrying toxin-producing strains of *C. difficile* could be an important aspect of the control of the infection. We are currently completing an evaluation of a number of the newer diagnostic tools and an interim analysis has suggested that our current tests may delay or, in a small number of cases, miss the diagnosis of infection. Over the next few weeks we intend to complete the analysis of the evaluation and develop a new algorithm for testing of patients with CDI.

Norovirus outbreaks

The current winter season has seen major problems with community and hospital outbreaks of norovirus infection both nationally and regionally, however we have been able to limit these within the Trust with only a single ward closure due to norovirus occurring during the quarter October to December 2008. Rapid and highly sensitive testing and an extremely proactive approach to control measures may have assisted in this but hospitals are always vulnerable to new introductions of the infection from patients, visitors and staff. For the future we are planning joint publicity campaigns across the healthcare community to remind the public of the risks of introducing infection into healthcare premises.

Antimicrobial stewardship

With the appointment of a replacement antimicrobial pharmacist to our own team and a new post to Sandwell PCT we are now well placed to develop a coherent antimicrobial stewardship programme across the healthcare economy. A new and more restrictive antibiotic formulary is now out for consultation among general practitioners which would bring their prescribing more into line with that in the hospitals. A number of audits of antibiotic prescribing within our hospitals have been undertaken and while broadly favourable have highlighted areas for further improvement particularly in providing assurance that antibiotic courses are being regularly reviewed and that antibiotics are discontinued as soon as they are no longer necessary.

Audit and training

Saving Lives audits continue to be performed regularly and provide assurance of excellent clinical practice across all areas. A similar new on – line data base has been developed for hand hygiene audits which will allow wards, departments and divisions to be responsible for inputting and monitoring their own data and will also allow monitoring of hand hygiene compliance in specific staff groups. Bi-monthly hand hygiene workshops are now being held where the team undertake individual hand hygiene assessments using a newly developed assessment tool. These assessments have been well received and it is hoped will feed in to improved compliance with hand hygiene in the clinical areas.

Bi-monthly Infection Control Champion workshops continue and have also been supplemented by workshops for Cleanyourhands champions to assist in driving the campaign forward. A study day on *Clostridium difficile* infection was well attended and included speakers from around the Region on a variety of aspects which we hope will allow staff to better understand this important infection.

As part of the infection control programme the team have undertaken a number of audits of practices and facilities and this year we intend to spend time scrutinising each audit and developing an action plan to ensure continual improvements which will feed into next year's programme.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Infection Control Assurance Framework
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Rachel Overfield, Chief Nurse
DATE OF MEETING:	26 March 2009

KEY POINTS:

The current infection control assurance framework was produced in response to the 2006 Health Act – Code of Practice for the Prevention and Control of Healthcare Associated Infections.

The attached revised Assurance Framework has been produced in response to the recently published 2008 Health Act and includes reference to the new regulations that come into force in April 2009. These regulations require the Trust to register with the Care Quality Commission and declare compliance, or otherwise, with the regulation standards. (refer to TB paper January 2009).

The 'duties' incorporated in to the 2006 Health Act have been replaced with 'Criterion' in the 2008 Act and as these are quite different to each other the document required rewriting.

Amber items:

Criterion 1e – An Infection Control team audit programme exists and is robustly undertaken and reported. It does not, however, cover all key policies as detailed within the health Act 2008. A programme is due to be reported to the Executive Infection Control meeting in April.

2e – Due to the age of the Trust estate it is very difficult to maintain environments to modern healthcare standards. Cleaning standards in non patient areas need to be improved.

2f – As for 2e. Identified in HCC report (duty 4 breach).

2g – Handgel is widely available but due to the age of the buildings it is not possible to have handwash facilities in every ideal location. An audit is currently being undertaken.

8 – All policies are in place but are not all included in an audit programme.

PURPOSE OF THE REPORT:

☐ **Approval** ☉ **Noting** ☐ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to note the Health and Social Care Act 2008 (published January 2009). The Trust Board are asked to note the changes as a result of the above to the Trust Infection Control Assurance Framework.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

2.1 - Continue to reduce hospital infection rates achieving national and local targets for MRSA and clostridium difficile including introducing MRSA screening in line with national guidance.

IMPACT ASSESSMENT:

FINANCIAL	☐	
ALE	☐	
CLINICAL	☑	
WORKFORCE	☐	
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

5th March 2009

Infection Control and Cleanliness Trust Board Assurance Framework – Version 10

The following provides a framework in which assurance can be gained that the Trust understands the risks associated with infection control and cleanliness: has actions in place or planned to mitigate risk: assigned individuals and expected outcomes from each action and appropriate monitoring structures.

The document takes into account standards from the following key documents:

- Health Act 2008 – Code of Practice for the prevention and control of healthcare associated infections.

The document is overseen by the Executive Infection Control Committee and owned by the Trust Executive Lead, Chief Nurse.

Status	
Green	Complete/compliant
Light Green	On track/compliant
Amber	Some delay/partial compliance
Red	Significant delay/non compliance

Compliance Criteria		Outcome required	Action required/to have in place	Who By/Exec Lead	Status
1 *Have in place and operate effective management systems for the prevention and control of HCAI which are informed by risk assessments and analysis of infection incidents* Overall Status: 'MEETS'	1a	A Board level agreement outlining the boards collective responsibility for minimizing the risks of infection and the general means by when it prevents and controls such risks.	• Board level agreement • Risk assessment and incorporation of risks into the Trust Risk Register • System of risk and incident reporting and investigation • Appropriate structures in place for managing risk.	Chief Nurse	Green
	1b	The designation of an individual as Director of Infection Prevention and Control, accountable to the Chief Executive and the Board.	• Appoint a DIPC • Provide system for reporting to TB	Chief Executive	Green
	1c	A mechanism that ensures sufficient resources are available to secure the effective prevention and control of HCAIs.	• Trust Assurance Framework • Infection Control Action Plan • Infection Control Programme • Infection Control team and information infrastructure • Infection Control Operational Committee and Executive Committee	Chief Nurse	Green
	1d	Ensuring that relevant staff, contractors and others who are directly or indirectly concerned with poatient care reeciove suitable and sufficient information on infection prevention and control.	• Training programmes for all staff and evidence of attendance. • Specific induction for contractors.	Director of Workforce	Green
	1e	A programme of audit to ensure key policies and practices are being implemented appropriately.	• Develop a programme of audit against all key policies • Identify resources and timescales • Identify reporting cycle	DIPC	Amber
	1f	A policy addressing the admission, discharge, transfer and movement of patients between departments and health care facilities.	• Develop an all encompassing bed management policy • Develop and deliver relevant training and awareness raising	Chief Operating Officer	Amber

	1g	Designation of Decontamination Lead	• Appoint a Decontamination Lead	Chief Nurse	Green
2 *Provide and maintain a clean and appropriate environment which facilitates the prevention and control of HCAI.* Overall Status: 'PARTLY MEETS'	2a	The Trust has policies for the environment that make provision for liaison between members of the ICT and facilities management.	• Senior Nurse Forum and Facilities • Chief Nurse role • PEAT visits • Infection Control Operational Committee and Executive Committee	Chief Nurse	Green
	2b	The Trust designates lead managers for cleaning and decontamination of equipment.	• Appoint Decontamination Manager • Establish a Decontamination Committee • Regular reports against a work plan	Director of Estates	Green
	2c	Chief Nurse, Matrons and ICT involve in all aspects of cleaning	• Chief Nurse role to include facilities management • Joint Forums • PEAT • Infection Control Operational Committee • Executive Infection Control Committee	Chief Nurse	Green
	2d	Matrons have personal responsibility for delivering safe and clean care environment and the nurse in charge of a shift is responsible for standards throughout the shift.	• Job Descriptions for Matrons and shift leaders • Matrons report • PEAT visits • Environment audits • Cleaning audits • Cleaning matrix	Chief Nurse	Green
	2e	All parts of the premises in which the Trust provides care are suitable for purpose, clean and well maintained	• Cleaning standards • Maintenance programme • PEAT • Cleaning audits • Environmental audit • TB reports	Chief Nurse and Director of Estates	Amber
	2f	Cleaning arrangements detail the standards of cleanliness required in each part of the premises	• Cleaning schedules detailing the frequency of cleans • Cleaning audits • Cleanliness TB report	Chief Nurse	Amber
	2g	There is adequate provision of suitable hand-washing facilities and antibacterial handrubs	• Handwash facilities at entrance to the wards • Sufficient handwash facilities throughout the wards • Handwash facilities in sluices	Chief Nurse and Director of Estates	Amber

			• Handwash facilities in siderooms • Hand gel at entrance to the wards and siderooms • Hand gel at the end of beds • Appropriate policies		
	2h	There are effective arrangements for the decontamination of instruments and other equipment.	• Decontamination and disinfectant policy • Decontamination work plan • Decontamination Committee	Director of Estates	Green
	2i	The supply and provision of linen and laundry reflects the HSG (95) 18	• Linen and laundry contract compliant with the HSG standards • Report to Executive Infection Control Committee quarterly. • Linen and laundry policy in place	Chief Nurse	Green
	2j	Uniform policies ensure that clothing worn by staff is clean and fit for purpose.	• Uniform policy in place • Uniform audits take place twice a year • Included in PEAT	Chief Nurse	Green
3 *Provide suitable and sufficient information on HCAI to the patient, the public and other service providers when patients move between health and social care providers* Overall status: 'MEETS'	3a	Provides information on prevention and control of HCAI and key asopects of the providers policy on infection prevention and control.	• Infection control policy widely published • Various leaflets available • Posters and signage • Visitors Policy	DIPC	Green
	3b	Information on the role and responsiblities of individuals in the prevention and control of HCAI to support them when visiting patients.	• As per 3a	DIPC	Green
	3c	Information to support vigilance in patients.	• As per 3a	DIPC	Green
	3d	Information to stress the importance of compliance by visitors with hand hygiene and visiting restrictions.	• As per 3a	Chief Nurse	Green
	3e	Information on how to report breeches in hygiene and cleanliness	• As per 3a	Chief Nurse	Green
	3f	Information re incident/outbreak management	• Policy widely available • As per 3a	DIPC	Green
	3g	Feedback that is focused on the patient pathway.	• Bed Management Policy • Divisional reports • Ward review process	Chief Nurse	Green
	3h	Information is provided across boundaries	• Health economy wide committee • Screening action plan	DIPC	Green
4		Prevention and control of HCAI should be	• Job descriptions of all staff include control	Chief Nurse	Green

Ensure that patients presenting with an infection or who acquire an infection during care are indentified promptly and receive appropriate management and treatment to reduce the risk of transmission. Overall Status: 'MEETS'		such as to demonstrate responsibility is devolved to: • All professional groups • All specialties	and prevention of infection • Division performance reviews • Division governance groups • Division reports to Infection Control Operational Committee • Ward reviews • Incidence reports by Division • Saving Lives/Hand Hygiene audits by ward		
5 *Gain the co-operation of staff, contractors and others involved in the prevention and control of infection.* Overall Status: 'MEETS'		Providers should ensure that staff, contractors and others co-operate to meet obligations under this code.	• PDR's • Performance reviews • Infection Control and Prevention included in SLA's and contracts with others	Chief Nurse	Green
6 *Provide or secure adequate isolation facilities.* Overall Status: 'MEETS'		Providers should ensure that adequate isolation facilities are provided including facilities for day care. Policies should be in place for risk assessment and allocation of isolation facilities. Sufficient staff should be available to care for patients in isolation.	• Review of facilities • Facilities in 'control' of Infection Control team • Isolation policy and risk assessment tools in place • Staffing assessments undertaken	DIPC	Green
7 *Secure adequate access to laboratory support.* Overall Status: 'MEETS'		Providers should ensure that laboratories used to provide microbiology services have in place appropriate protocols and that they operate according to the required accreditation standards – CPA (UK) Ltd.	• Labs are CPA accredited	DIPC	Green

8 *Have and adhere to appropriate policies and protocols for the prevention and control of HCAI.* Overall Status: 'MEETS'		Providers have a list of core policies in place (List ref Act 2008 p15)	• All listed policies are in place • An audit programme exists to audit compliance • Policies are widely available • Policies are included in staff training	DIPC	Amber
9 *Ensure as far as practicable that healthcare workers are free of and protected from exposure to infections during the course of their work and that all staff are suitably educated in the prevention and control of infection.* Overall Status: 'MEETS'	9a	All staff can access relevant occupational health services	• Manual of services • Service advertised widely • Referral system	Director of Workforce	Green
	9b	Policies are in place for prevention and management of communicable diseases including immunisations.	• Policy documents	Director of Workforce	Green
	9c	Prevention and control of infection is included in the induction programme for new staff and in training programmes for all staff.	• Training prospectus • Registers • Training packages • Report to Executive Infection Control Committee	Director of Workforce	Green
	9d	There is a programme of ongoing education for existing staff	As per 9c	Director of Workforce	Green
	9e	There is a record of relevant immunisations	• Records are in place • Report to Executive Infection Control Committee	Director of Workforce	Green
	9f	There is a record of training and updates for all staff.	As per 9e	Director of Workforce	Green
	9g	The responsibilities of each member of staff for the prevention and control of infection is reflected in their job descriptions and in PDRs.	• All job descriptions reflect this • Audit of Job descriptions • Audit of PDRs • Report to Executive Infection Control Committee	Director of Workforce	Green

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Cleanliness/PEAT Report
SPONSORING DIRECTOR:	Rachel Ovefield, Chief Nurse
AUTHOR:	Steve Clarke, Deputy Director of Facilities
DATE OF MEETING:	26 March 2009

KEY POINTS:

The report is provided to report to the Board the results from the National Standards of Cleanliness and PEAT audits and give an update on the PEAT inspections for 2008.

PURPOSE OF THE REPORT:

☐ **Approval** ☉ **Noting** ☐ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked receive and note the report.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

2.1 - Continue to reduce hospital infection rates achieving national and local targets for MRSA and *clostridium difficile* including introducing MRSA screening in line with national guidance.

IMPACT ASSESSMENT:

FINANCIAL	☐	
ALE	☐	
CLINICAL	☑	
WORKFORCE	☐	
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

TRUST BOARD REPORT

26TH MARCH 2009

National Standards of Cleanliness (NSoC)

The Trust is maintaining its overall level in the NSoC audit scores in the critical areas for 'very high' and 'high' level cleaning.

However, following the Healthcare Commission visit further improvements have been made to ensure 'closed areas' such as sluice rooms, cleaning cupboards etc. meet the required standards. An additional internal audit system has been introduced by Hotel Services with the Supervisors physically checking all areas weekly.

Audit Scores

The following audit scores are for the first 9 months of 2008/09 with a comparison against the overall scores for 2007/08.

	Overall 07/08 Very high	Overall 07/08 High	April - Dec 08 Very high	April - Dec 08 High
City	92	90	94	94
Sandwell	95	91	95	95
Rowley	N/A	95	N/A	97
BTC	98	97	98	97
Overall %	**95**	**93**	**96**	**96**
Target %	**98**	**95**	**98**	**95**

Environmental Ward/Department Assessment Tool

To further enhance the NSoC and Patient Environment Action Team (PEAT) audit inspections an environmental self-assessment tool has been designed to capture the current environmental status of each ward/department.

The assessments will be undertaken on each ward/department by the relevant matron, ward manager or designated lead officer. The assessments will be reviewed by the relevant Divisional General Managers and Matrons and an action plan developed prioritising risk.

The PEAT management team will then assess/QA the action plans and prioritise the available funding/workforce accordingly. The plans and inspections will then be reviewed on a quarterly basis and will be discussed as part of the Divisional Review process.

PEAT Internal Inspections 2009/10

Weekly PEAT management inspections have been on-going for the last 12 months; the inspections have contributed greatly to the improvement in the general ward/departmental environment. The PEAT funding has enabled the team to action a lot of the outstanding issues immediately, an example being the replacement of general ward furniture issued from the trust's stock holding.

Again in response to the comments from the Healthcare Commission with regards to the ward/department audits, from February 2009 the inspections have increased to twice weekly with dedicated teams undertaking the inspections. The inspections will consist of:

- To visit 2 wards/departments on each audit.
- Teams to be escorted by relevant Matron/Ward Manager
- For each inspection the PEAT team will:
    - Review the ward/departmental assessment tool.
    - Check the ward/department procedures against the agreed pro-forma.
    - Undertake a visual inspection of the general environment.
- Action plans will be developed from each inspection.
- A combined Facilities, Estates and Nursing team will meet on a monthly basis to review action plans against available funding/resources.

PEAT External Inspections 2009

The national PEAT assessment program for the Trust has been completed for 2009. The assessments covered City Hospital, Eye Hospital, Sandwell Hospital and Rowley Regis.

The score for all the individual units and overall rated as good. There was some excellent feedback on the improved standard of Patient Food especially the service presentation and the use of red trays. It was also noted that the general environment had improved in both cleanliness and maintenance.

The Trust assessment team was again supported by members of the Trust Patient Representative Group. An external validator joined the team for the inspection at Sandwell.

The scores will now be submitted for validation to the National Patients Safety Agency.

Additional Information

- **Discharge Cleaning Teams**
  The overall view is that the service is delivering in terms of cleanliness and in general the beds are available within a relatively short time from discharge and the overall presentation of the beds and patient furniture has improved dramatically. However the bed cleans recorded for January has reduced due to the number of wards closed for D&V and vacancies within the discharge team, although the requests are still being actioned by the domestic department. These figures are not recorded by Bed Management; this shortfall will be addressed for February.

City	Bed Cleans	Average per day
September 08	970	35
October 08	1094	35
November 08	999	33
December 08	884	29
January 09	709	23

Sandwell	Bed Cleans	Average per day
September 08	1082	40
October 08	1145	37
November 08	1024	34
December 08	1077	35
January 09	747	24

- **Ward Service Officers**
  Phases 1 – 4 have now been successfully implemented. Phase 5 is in the process of being implemented on Wards D5, D7 & D8. Phase 6 to be implemented commencing February 09. The implementation programme is on target to be complete by 31st March 2009.

Environmental Developments

- The redecoration programme is on-going.

- New flooring has been completed on:

  - Sandwell
    All link areas on 2nd, 3rd, 4th & 5th floor, Dartmouth Clinic, Elizabeth Suite, OPD Entrance & lobby, 1st floor lobby area

  - City
    A&E, Maternity, Neurophysiology side rooms, D15, Main Corridor 2nd floor, Sheldon corridor 2nd floor skin ward, front of hospital staircase landing, Urodynamics

- New nursing stations have been fitted on D21, D24, D7, Labour Ward (City) and a refurbishment of the nurses station on Priory 5

Recommendation

To receive and note the cleanliness report.

STEVE CLARKE
DEPUTY DIRECTOR - FACILITIES

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Single Equality Scheme (SES) Progress update
SPONSORING DIRECTOR:	Rachel Stevens, Chief Nurse
AUTHOR:	Pauline Richards, Head of Equality & Diversity
DATE OF MEETING:	26 March 2009

KEY POINTS:

The report is intended to share with the Trust Board the progress achieved against the Single Equality Scheme Action plan during quarter 3.

Key to the successful delivery of the action plan is the four subgroups; Workforce Monitoring, Independent Living, Service and Policy Assessment and Patient experience. All groups are in place and functioning as the operational arm of the Equality and Diversity Steering Group, which reports to the Trust Board.

The Head of Equality and Diversity for the Trust is now in post to complete the E&D Team.

PURPOSE OF THE REPORT:

To provide the Trust Board with an update on progress in relation to achieving its obligations under the equality legislation and objectives.

◉ Noting

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is recommended to note the progress to date

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

The action plan aligns with the Trust Strategic Objectives No. 4 – Respond to our patients No. 5 – Improve quality and standards of care No. 7 – Promote education, training and research HCC core standards Essence of Care standards

IMPACT ASSESSMENT:

FINANCIAL	☑	None known currently although may be some as action plan implemented
ALE	☐	
CLINICAL	☐	
WORKFORCE	☐	
LEGAL	☐	Equality Legislation
EQUALITY & DIVERSITY	☑	Single Equality Scheme (SES)
COMMUNICATIONS	☑	Public dates for publishing and access to information under equality legislation
PPI	☑	Consultation and engagement active as required under public duties of equality legislation.
RISKS		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Trust Board Update Report March 09

IMPLEMENTATION OF THE SINGLE EQUALITY SCHEME (SES)

1.0 Introduction

This report is intended to inform members of the Trust Board of the progress achieved since the presentation of the updated SES action plan (SWBTB (11/08) 126 (b)) in November 2008.

2.0 Implementation Process

The Head of Equality & Diversity (Pauline Richards) commenced her role on 2nd March 2009. She will lead the team and be responsible for the operational management and coordination of the SES and will work closely with the subgroups and key departmental leads.

3.0 Reporting and Monitoring Framework

The Equality & Diversity Steering Group receives progress reports from the four sub-groups as part of its monitoring function. The reports include key achievements, issues raised and action plans within the last quarter in each of the groups. A summary of the Equality and Diversity Steering group and each subgroup progress is outlined below:

3.1 Equality & Diversity Steering Group (E&D)

Equality Works was commissioned to deliver a series of E&D Master classes for Senior Managers and members of the E&D Committee. The classes were delivered during the 3 months period from November 2008 to January 2009 by management consultants from Equality Works.

Three cohorts of two workshops were provided with a 64.68% attendance rate. 66 managers attended, however, key Divisional General Managers and committee leads still need to undertake Equality Impact Assessment training. Future training will be provided in-house by the E&D team with 1:1 coaching on Impact Assessments.

3.2 Workforce Monitoring Group

The provision of in-house diversity training has been reviewed. A revised programme is now in place as part of the Trust induction programme and specific diversity training has been made available via e-learning for all Trust employees.

To raise the profile of the Workforce Monitoring Group a communications programme is being developed. This will commence with an article in the March edition of 'Heartbeat' concentrating on the role of the group, staff networks and introducing plans for a forthcoming workforce information census in May/June 2009.

Plans are being developed to consider the implementation of a volunteer harassment advisor network. This would support staff to respond effectively in cases of alleged harassment and thereby informally resolve concerns early.

The existing staff networks (BME, LGBT and Disability) are being 're-energised' with plans underway to increase membership. The development of revised terms of reference will improve the effectiveness of the groups as a mechanism for peer support and an effective means of influencing/supporting Trust policy/direction.

An Equal Pay Audit examining whether there are any gender specific material pay differences that require remedial action is being undertaken.

Workforce monitoring data is under review to consider whether there are any underlying adverse trends that require specific action. Information on actions being taken will be published on the Trust's website to support compliance with the Trust's statutory duty.

Impact assessments of recruitment and learning & development functions are now being undertaken with progress reports due to be received at the April meeting of the Workforce Monitoring Group.

3.3 Independent Living Group

Recruitment of external public representatives onto the group has been slow. However, we now have colleagues from the Blind and Deaf Association, mental Health and are lobbying for more PPI delegates.

A Focus group has been identified to undertake an internal signage and access audit, coordinated by the Diversity Advisor and Estates lead.

A community engagement register has been expanded and, working with the communication department, there is now a wealth of contacts willing to assist in user involvement and consultation exercises.

A poster campaign has commenced within the Trust to improve Ethnicity disclosure.
A time limited group including members of the chaplaincy and users has been identified to produce a Sandwell & West Birmingham Equality and Diversity Resource pack for staff, once completed this will be accessible via the intranet.

3.4 Service & Policy Assessment Group

Executive Directors are being supported to review and identify policies likely to have potential equality impact issues. Divisional Management teams have been asked to complete two impact assessments on their services by the end of Q4. Work is underway and will be monitored via divisional performance reviews.

Work has begun to provide updated information of the local population demography to enable effective comparison with service user and employment monitoring information

3.5 Patient Experience Group

The Equality and Diversity issues relating to Patient Experience focuses on the new meal service at the City site; development of E&D website, reviewing the interpreting service and patient information.

The new meal service is now fully implemented on the city site with the implementation of the new al a carte menus to follow. The E & D website has been launched and publishing duties have been achieved. The site is benefiting from ongoing expansion and maintenance. Work has commenced on reviewing the interpreting service and improving patient information.

4.0 Conclusion

During this quarter work has focused on building awareness and in particular on Equality Impact assessment through the training of E&D committee members and senior managers. The Equality team has begun working with Divisional teams as part of their service impact assessment work program.

5.0 Further Work Areas

- Equality is integrated into procurement contracts
- IT systems are improved to capture all equality strands for staff and patients. The patient system is extended to capture patients who are from hard to reach groups such as asylum seekers and migrant communities
- Patient Information is translated into multiple languages or alternative media formats in order to provide material for non English reading patients or individuals with learning disabilities
- Training and Awareness for all staff

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Update on Mixed Sex Accommodation
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Rachel Overfield, Chief Nurse
DATE OF MEETING:	26 March 2009

KEY POINTS:

The Department of Health guidance for Trusts states that men and women should not share sleeping accommodation or toilet/bathroom facilities. This message was recently emphasised in a Department of Health letter to Chief Executives from the Director General and Chief Nursing Officer. The letter detailed a six-month intensive improvement plan to deliver on the secretary of state's pledge to move towards eliminating mixed sex accommodation.

This report details the specific requirements, results of recent audit and plans to improve the Trust's position.

PURPOSE OF THE REPORT:

☐ **Approval** ☉ **Noting** ☐ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to note the content of the report, the change to the core standards declaration and the proposed actions to improve the current position.

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

None specifically, although is a requirement of recent Department of Health guidance

IMPACT ASSESSMENT:

FINANCIAL	☐	
ALE	☐	
CLINICAL	☑	
WORKFORCE	☐	
LEGAL	☐	
EQUALITY & DIVERSITY	☑	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

TRUST BOARD REPORT

Update on Mixed Sex Accommodation

Rachel Overfield

Introduction

The Department of Health (DoH) guidance for Trusts states that men and women should not share sleeping accommodation or toilet/bathroom facilities. This message was recently emphasised in a Department of Health letter to Chief Executives from the Director General and Chief Nursing Officer. The letter detailed a six month intensive improvement plan to deliver on the secretary of state's pledge to move towards eliminating mixed sex accommodation.

What Is Required

- The need for mixed sex accommodation must be taken to the lowest possible level, recognising that it can never be fully eliminated and acknowledging justified clinical need.

- A risk assessment and audit of the current position

- Detailed action plans for improvement including investment plans and timescales up to the end of June when plans are expected to be completed.

- SHA's will be responsible for co-ordinating Trust actions and monitoring progress. The DoH will require a report from each SHA by the beginning of July.

A DoH improvement team will be established to:

- Raise the focus
- Identify and spread good practice
- Provide metrics and assurance
- Target support

A national Taskforce will be established to steer and advise actions within the DoH and the NHS. Their role will be as 'critical friend'.

Withholding payment from poor-performing Trusts

The 2009/10 contracts do not contain any specific financial sanctions on mixed sex accommodation but they do:

- Require mixed sex reduction plans
- Give Commissioners the option to apply sanctions to providers who do not report their performance against a reduction plan
- Provide an opportunity for parties to set local goals and earn incentive payments

For 2010/2011 the intention is to include within contracts financial sanctions on organisations that fail to deliver improvements where it is not clinically justified.

The Current Position

The Trust Board received a report on the elimination of mixed sex accommodation in July 2008. The report detailed the Trusts's progress against Good Practice Guidance using a Self Assessment Checklist.

Much of the action required as a result of this assessment was incorporated into the Privacy and Dignity section of the Patient Experience Action Plan which also came to the Trust Board in 2008. At the time of the assessment it was noted that due to the age of the estate it would be very difficult without considerable investment to improve against some standards.

As a results of the DoH correspondence and further clarification of definitions a full audit of all adult in patient areas has been undertaken to establish our current position, taking into account recent reconfigurations and capital schemes. As a result a bid for funding to the SHA has been submitted and a milestone action plan is currently being developed. This will include both capital and operational measures required to improve the Trust's position.

A comparison of the Trust position in July 08 to February 09 is attached as Appendix 1.

Summary of Audit Results

- It is not common practice to mix patients of the opposite sex in bedded areas.
- Patients of the opposite sex are mixed in very specialised areas eg Poisons Unit and BTC Surgical Hub
- Patients commonly at City Hospital have to pass through bays of the opposite sex to access/egress the ward
- Patients do have to pass by patients of the opposite sex at Sandwell to access toilets/bathrooms and to access/egress the wards
- Generally signage is satisfactory but could be improved
- Privacy curtains and bed curtains are generally adequate but could be improved
- There are very few unisex toilets/bathrooms in use
- Privacy signage is good
- Rowley Hospital provides good compliance

NB: iTU and High Dependency areas were excluded from the audit. Day case and assessment units were excluded but new definitions from the DoH state that even in these areas best endeavours must be made to segregate sexes.

Proposed Plans

- Increase bay partitioning at Sandwell on all wards
- Move towards increased single sex wards at City Hospital including specialist areas
- Improve curtaining and signage where required

- Emphasise the need to segregate the sexes wherever possible in assessment and day units
- Move towards single sex days in the BTC surgical hub
- Develop a mixed sex accommodation reduction plan and milestone action plan by the end of March to deliver on plans by the end of June.
- Monitor progress against plan at Patient Experience Group and Exec Team

HCC Core Standards Declaration

C20b – The Trust has previously declared full year compliance against this standard but as a result of the detailed trustwide audit and greater widening and clarity of definitions by the DoH it is proposed to declare unmet for this standard.

The Recommendation

The Trust Board are recommended to note the content of this report; The summary of the audit findings (details are available for Board members) and the proposed plans.
The reduction and milestone action plans will be available for April Trust Board should the Board wish to see it.

PRIVACY & DIGNITY – THE ELIMINATION OF MIXED SEX ACCOMMODATION ACTION PLAN
(Comparison of the Trust position in July 08 to Feb 09)

Standard	July 08 RAG	Feb 09 RAG	Comment
1. Mechanisms are in place to provide the Board of Directors with regular information on the views of patients and service users	Green	Green	
2. The Board receives regular reports on the Trust's progress in eliminating mixed-sex accommodation	Green	Green	
3. The Board receives information from patient complaints and incidents, categorised on the basis of mixed-sex accommodation issues.	Amber	Amber	Current coding of complaints/incidents does not allow this. Mixed sex accommodation breeches will be reported as incidents under the new MSA policy, currently going through approval.
4. The Board reviews and amends policies on mixed-sex accommodation in light of experience, incidents and changes to the service.	Red	Amber	TB do not see policies of this kind currently. Will go to Governance Board in April.
5. The Board sets annual measurable targets for improvement	Red	Amber	TB to approve milestone plan in April.
6. The Trust considers the elimination of mixed-sex accommodation in any refurbishment or new-build capital development schemes	Green	Green	
7. The Trust provides training to support the elimination of mixed-sex accommodation and promote the protection of privacy and dignity	Amber	Green	
8. Public and patient areas are consistently clean.	Green	Amber	Not consistent in public areas. Action plan in place to improve this.
9. Patient and public areas are well maintained and in a state of good repair.	Green	Amber	Poor estate and backlog maintenance makes this difficult to fully achieve.
10. Unconverted Nightingale wards accommodate either men or women, but not both	Green	Green	

11. Partitions separating men and women are robust enough to prevent casual overlooking and overhearing	Amber	Amber	Some in place but not everywhere.
12. Curtains are long enough, thick enough, and full enough	Amber	Amber	Generally in place but could improve.
13. Patient groups who particularly value separation (eg older people, women and those with a gender-related condition) are prioritised when planning the elimination of mixed-sex accommodation	Amber	Amber	Policy stresses this.
14. Private spaces are available for use by patients to talk to staff or visitors.	Amber	Amber	Some areas have these but it is not consistent.
15. Private signs are available to be attached to curtains and doors	Red	Green	
16. Separate treatment areas are available, for care to be provided away from the bedside.	Red	Amber	Some areas have these but it is not consistent.
17. Separate, clearly labelled, male and female toilets and washing facilities (other than assisted or accessible facilities) are available within the ward or department.	Amber	Amber	Generally in place but could improve.
18. Toilet and washing facilities are located within, or close to, the patient's room or bay.	Green	Green	
19. Patients can reach toilets and washing facilities without the need to pass through areas occupied by members of the opposite sex.	Amber	Amber	Very variable across the Trust.
20. Where patients pass near to areas occupied by members of the opposite sex, adequate screening such as opaque glazing or blinds/curtains at windows and doors are used.	Red		Some partitioning is available but not in all areas.
21. Toilets and washing facilities are fitted with internal privacy curtains where necessary.	Amber	Amber	Generally ok but could be improved.

22. Toilets and bathroom doors are lockable from the inside, and are accessible to staff in the vent of an emergency.	Green	Green	
23. Toilets have nurse-call systems.	Amber	Amber	Variable across the Trust.
24. Where assisted bathrooms remain unisex, appropriate facilities are provided to uphold the privacy and dignity of all patients who use them	Green	Green	
25. Where the use of mixed-sex accommodation is unavoidable, the patient is moved to single-sex accommodation within a specified time limit, ideally within 24 hours, but in any event within 48 hours. (Please note this excludes patients in ICU, CCU and HDU as outlined on page 4).	Green	Green	
26. Except in an emergency patients are told in writing, prior to admission if any parts of the ward are shared between men and women. (If the patient is unable to read written information they are advised verbally and this is documented).	Green	Green	
27. Patients are able to request alternative accommodation or, where the accommodation offered is mixed, ask for an alternative admission date.	Green	Green	
28. Patients who ask for an alternative admission date receive the offer of a date within one month of the original date.	Green	Green	
29. Elective patients are accommodated in either single rooms, single-sex wards or single-sex bays/rooms within mixed wards.	Green	Amber	Except in the BTC Surgical Hub.
30. Patients admitted as an emergency are accommodated in either single rooms, single-sex wards or single-sex bays/rooms within mixed wards.	Green	Green	

31. Episodes of mixed sex accommodation are reported in accordance with locally determined exception reporting arrangements.	Red	Amber	Included in MSA policy.
32. Where possible, patients are encouraged to receive visitors in day rooms or other communal spaces.	Amber	Green	
33. Patients are given privacy during treatment, consultation and when receiving personal care.	Green	Green	
34. Staff ensure that patients remain properly clothed/covered at all times.	Green	Green	
35. Staff respond effectively to concerns expressed by patients or their visitors about privacy and dignity and mixed-sex accommodation.	Green	Green	
36. Clear information is provided for patients, relatives and carers on the arrangements made and the standards they should expect to ensure their privacy and dignity is maintained. This must include who to contact if necessary to raise queries or concerns.	Red	Amber	Patient information is currently under review.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Progress Report – Ward Reviews, March 2009
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Linda Pascall, Assistant Director of Nursing and Rachel Overfield, Chief Nurse
DATE OF MEETING:	26 March 2009

KEY POINTS:

This report details the Ward Review process and a summary of results from the most recent reviews. It also outlines which areas meet or exceed the requirements and which areas need attention.

The Trust Ward Review process was established in Summer 2008 and identified a range of criteria against which wards would be assessed. Results are triangulated with other sources of information and a RAG rating is attributed to each criteria. The aim of the Ward Review process is to identify areas of good practice, share results and to target areas of poor practice to improve them.

The recent reviews appear to show improvement in many key areas and ward Managers and Matrons have fully engaged in the process. Adding additional criteria and changes in some wards/departments involved in the review has meant that this round of reviews is difficult to do – but individual wards have been able to compare their results and generally this has shown improvement.

The results do suggest that standards of care are generally satisfactory and safe. However there remains room for improvement – this will be driven through the optimal wards and leadership development. The report also details an accreditation process to be applied following these reviews where wards will receive gold, silver or bronze status.

PURPOSE OF THE REPORT:

☐ **Approval** ☉ **Noting** ☐ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to note the results of the Ward Review summary.

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

Deliver plans to improve the quality and consistency of nursing.

IMPACT ASSESSMENT:

FINANCIAL	☐	
ALE	☐	
CLINICAL	☑	
WORKFORCE	☐	
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

Progress Report – Ward Reviews
March 2009

Introduction

Standards of nursing care at ward level have an immediate and lasting effect on both patient outcomes and experience and therefore systems should be in place to ensure standards are consistently met. The Trust Ward Review process was established in Summer 2008 and identified a range of criteria against which wards would be assessed. Results would be triangulated with other sources of information and a RAG rating attributed to each criteria. The aim being to identify areas of good practice, share results and to target areas of poor practice and improve.

The first Ward Review was completed between May – July 2008. The results identified a range of development issues to be addressed by nursing teams but also revealed examples of good care.

Upon completion of the first review the tool was revised following consultation with Matrons, Ward Managers, Assistant Directors of Nursing and Therapies, L&D and Risk colleagues. A copy of the revised tool is attached as appendix A.

Additional criteria have been applied and the number for review have increased from 35 to 60.

This report describes the outcome of the second review including a comparison, where possible, with Round 1.

The Process

The methodology of the review remains the same, with each Ward Manager and their Matron invited to attend a review session with the Chief Nurse or Assistant Director of Nursing (Workforce and Strategy). The invitation is also extended to any other member of the Divisional Team, i.e. the General Manager, HR and Finance Representative but their attendance is optional.

The tool not only makes reference to all the audits currently in use, nationally and locally, but it also includes requirement for non clinical performance budget and HR issues etc. New areas have been included that relate to the ward as an educational environment, patient experience and communication.

Although the ethos of the review remains the same with clinical teams RAG rating each target, the targets have become more focussed and evidence to support their rating is required.

Results

52 wards/departments have been reviewed. The RAG rating report is attached as Appendix B.
The themes and trends have been compared with the results in the first review where possible.

Areas Where Performance Meets or Exceeds Requirements

- Grievance/Disciplinary Issues
  No major trends were identified.

- Cross Infection Control
  Positive feedback has been received revealing the robust processes in place to manage MRSA and C.Diff.

- Hand Hygiene
  Significant progress in compliance continues. Compliance has improved in all staff groups.

- Patient Meals
  The use of the 'red – tray' scheme continues with the recent addition of Blue Beakers for patient's with a need to have special attention to their hydration. The introduction of the Ward Service Officers to assist with meals has had a positive impact on the workload of nurses but has also further improved the patient experience with nurses being able to spend more time with patients who need assistance.

  There was clear evidence that 'Protected meal times' were in place in most areas.

- Privacy and Dignity
  Although Ward Managers reported being able to maintain single sex facilities where appropriate, recent changes to guidance will require changes in the models of care. In the interim there was evidence that any incidents were swiftly addressed. Further details on this issue are contained in separate reports.

  From the previous review the 'respect my privacy' signs are in use and can be seen attached to curtains to avoid patients being unnecessarily disturbed.

- Monitoring Vital Signs
  In the main Ward Managers reported compliance with the standards relating to this aspect of care although there are still reports of instances when this fell short of what is required. There continues to be a disparity between the competency based training for Health Care Assistants in relation to recording vital signs. A competency trawl is to be undertaken with education programmes being introduced to address any training needs.

- Patient Experience
  This tests how we seek patient views and it was found that some areas have introduced feedback systems themselves but there is now a corporate approach to patient surveys which is being coordinated by the nursing division and which will ensure all wards have feedback from their patients twice yearly.

- Meet and Greet
  Again this was an area where improvement was noted. Ward Managers reported back an improvement in 'Meet and Greet' and the introduction of a new Ward Clerk uniform is expected to improve this further.

- Initial Assessment Documentation
  Performance varied but the overall view was that this had improved. The introduction of the MUST (Malnutrition Universal Screening Tool) was seen as positive and compliance was good.

- Team meetings
  This was a new standard and questioned the attendance at Team Brief (Hot Topics) and the number of ward meetings held. Managers reported that they did try and send representation to the Team brief but did find the time of day challenging. The timing has been altered in an attempt to help with this issue.

  Many wards reported regular team meetings with relevant agenda items.

- Slips, Trips and Falls
  In the first round it was noted that only major falls were reported. Since then recording of all 'slips, trips and falls' has commenced which has allowed trends to be spotted and acted upon.

- Complaints/Clinical Incidents
  At the last review Ward Managers had reported they did not always get feedback from complaints they had been involved in and similarly for clinical incidents they had reported. Since the last review many wards have put systems in place to collate complaints and incidents locally and these are discussed at the review.

Areas Where Performance Needs Attention

- Mandatory Training
  This continues to be an area that causes concern. The current modular system is still in use, requiring staff to attend on several different days for each component. The update is not complete until all of the modules are complete. Managers have difficulty in monitoring an individual's progress. This issue is being addressed in the medium term through the Listening into Action "Time to Learn" project but better recording systems are to be introduced more urgently to ensure compliance with NHSLA and Core standards. In addition an e-learning approach is also being explored for feasibility.

  The revised tool explored the way staff were prepared to use Medical Devices. Limited evidence of formal training was produced and this is an area being addressed corporately through work on the relevant core standard.

- Education Environment
  Another new standard aimed at ascertaining if the ward environment was conducive to learning. Managers gave a mixed response to most of the criteria – they were unsure if they had an educational audit and confirmed that there was work to be done around having Mentors available. However most had induction/welcome packs and students generally could access policies/guidelines.

- Patient Information
  There is still room for improvement in the amount of information for patients with sensory impairment or whose first language is not English.

There is still an issue concerning access to the interpreter service and range of languages covered. A review of the Trusts Interpreter service has commenced.

- Mental Health Capacity/Safeguarding
  The review sought evidence on how wards were meeting the needs of our most vulnerable groups of patients. In the first review it was recognised this was an issue that needed to be addressed by the Trust as a matter of urgency. There is now evidence that Safeguarding training is being cascaded throughout the Trust so improvement has been made however more is required.

Limited or No Data Available At Local Level

- Sickness/Absence
  There continues to be a lack of information for some Ward Managers to enable them to effectively manage sickness absence. HR has commenced work on a corporately agreed template spreadsheet for local recording. In the meantime good practice is being shared for local systems that Ward Managers could use.

- Turnover/Exit Interviews
  Ward Managers continue to report that they have no data regarding turnover or feedback from exit questionnaires.

- Tissue Viability
  A Tissue Viability reporting mechanism has been introduced since the last audit but the flow of reports has yet to commence fully. Initial findings suggest that tissue damage rates are within national norms.

Accreditation

An accreditation system has been introduced for the first time with this round of reviews. This provides the opportunity for wards to be recognised for the level of care they are providing and gives a very visual tool for use with patients and visitors. It gives a simple overview of where wards are in terms of their standards and enables targeted support to struggling areas.

To achieve Gold accreditation wards must have no red ratings and must achieve green, ie meet the target standard in the following areas:

Hand Hygiene
Saving Lives
IV Scores
Quality scores – Essence of Care, ie nutrition, TV, continence, hygiene, privacy and dignity
Sickness Absence Level
PDR Rates
Mandatory Training Target

To achieve Silver - again no reds in the key areas as above and at least 80% green throughout.

To achieve Bronze - no reds in key areas and at least 70% green throughout.

Wards who cannot achieve Bronze standards will be coached by the Turnaround team that is being developed who will work more closely with the ward managers to improve their standards of care.

Ward Staffing Levels

Standards of care are influenced by levels of staffing at ward level. There is a Nursing Workforce Strategy which has been well publicised and is currently being implemented. Part of the strategy is to review staffing levels on every ward. This work is due for completion by mid April and a report will be generated as a result.

Next Steps

The Review tool will be revised for the next round to include more clearly stated targets and Ward Managers will be required to qualify their answers with evidence. In the future the process will arranged to coincide with Quality [Essence of care audits] and patient surveys. It will also focus on the patient safety bundle around observations and failure to rescue.

The tool had once again been used in specialist areas but it is anticipated that this will be revised for the next round for Maternity, OPD, ITU and Paediatrics.

CONCLUSION

The Ward Reviews have become an accepted means of gauging the standard of nursing care in the Trust and Ward Managers and Matrons have responded very well to the process. The conclusion reached is that overall a satisfactory level of care is being delivered and in some places excellent care is being achieved. The aim is to share this good practice across the Trust – using the 'Optimal Ward' process and continuing the work on clinical leadership so that excellent care is the norm.

Ward/Department Review Tool

Ward/Dept:		Matron:	
Ward/Dept Manager:		Division:	
Date of Review:			

RAG
Red
Amber
Green

You are not expected to fill the RAG scores.

Objective	Target/Standard to be achieved (where identified)	Evidence supplied by others	Evidence supplied by Matron/Ward Manager (to be completed prior to review and any supporting evidence attached)	Target/Standard actually achieved	RAG Rating
1. Matrons and ward managers are responsible for their clinical areas and the standard of cleanliness within the environment. This includes the processes and systems that are in place for infection control and prevention e.g. • Implementation of ward managers checklist • Evidence that Equipment is cleaned regularly • Cleaning is audited weekly • Hand hygiene is audited at least fortnightly • Uniform policy is audited monthly • Grey areas are allocated and cleaned • Visitor policy is adhered to • Aseptic technique is practiced and especially protocols re lines etc are adhered to. • Patients are offered chance to wash hands prior to meals. • Bed spaces are correctly cleaned between patients	30% reduction in CDiff cases.	Infection rates CDiff (previous 3 mths). c.diff proforma complete where required			
	MRSA cases.	Number of MRSA cases (previous 3 mths).			
	100% compliance with hand hygiene and audit.	% result hand hygiene audits and evidence of monthly audit.			
	100%great compliance with Saving Lives audit.	% return Saving Lives audit.			
	Isolation facilities are used at all times for appropriate cases	Incidence forms			
	No Red Alerts on PEAT visits.	Key actions PEAT visits.			
	Incidence of Phlebitis is less than 1%	IV team audit VIP score			
	Equipment is cleaned daily	Record of ward checklist			
	100% compliance with Visitors policy	PPI Audit			

	100% staff are compliant with the Uniform policy	Uniform audit			

Objective	Target/Standard to be achieved (where identified)	Evidence supplied by others	Evidence supplied by Matron/Ward Manager (to be completed prior to review and any supporting evidence attached)	Target/Standard actually achieved	RAG Rating
2. All patients can expect to have their basic care needs met whilst a patient of the Trust. Matrons and ward managers are responsible for ensuring patients basic care needs are met. These include needs around e.g. • Nutrition – Protected meal times – Preparation of patients for eating – Assistance with eating Assessment of nutritional needs and care planned to address these needs. • Continence – Toileting philosophy/care – Numbers of catheters – UTIs – Equipment • Tissue viability – **incidence rates (monthly)** • Patient safety – especially falls – Falls rates – Local falls policies – Equipment – Training • **End of Life /Palliative care** - **implementation of SCP**	Protected meal policy implemented.	Annual EOC audit data.			
	Patients will be properly prepared to eat 100% of the time.	PEAT Inspections.			
	Volunteer 'Feeder' in use	**Observations of care twice yearly**			
	Red Tray/Blue beaker system in use when required	Feedback ward service officer audit			
	100% completion of MUST tool	Audit of completion.			
	Incidence of UTI is within acceptable parameters	UTI rates			
	Incidence of slips trips and falls has reduced	**Falls rates monthly report Annual EOC annual data Evidence of Reporting of falls and risk assessment Care planning process in use.**			
	All patients have up to date falls assessment in place	**Notes audit**			

- **syringe driver training** - **breaking bad news/communication** • **Pain Control** - **Patients individual needs are met** - **Pain control measures are evaluated.**	Tissue damage rates ***is* within 4- 10% [NHS Indicator]**	Tissue damage rates and incidence data. ***Evidence that risk assessment and care planning are in use***			
	All appropriate patients have access to end of life/palliative care to meet their needs.	**Availability of Palliative Care patient information leaflets.** **Attendance at syringe driver training** **Implementation of SCP as per Trust project plan.** **SCP lead** **PAL's feedback**			
	EOC action plans are monitored and reported quarterly to SNF	Quality reports (EOC)			

Objective	Target/Standard to be achieved (where identified)	Evidence supplied by others	Evidence supplied by Matron/Ward Manager (to be completed prior to review and any supporting evidence attached)	Target/Standard actually achieved	RAG Rating
3. Matrons and ward managers will be expected to deliver a balanced budget and make effective use of resources e.g. • Process for bank and agency staff bookings • Rostering practices • Monitoring • Sickness absence management • Developing and maintaining a local risk register and keeping risk assessments up to date • Non stock management • Annual Leave management • Recruitment and retention practices • All staff have PDR • All staff have current NMC registration • There are effective staff communication systems in place.	Balanced pay and non-pay budget.	Budget reports and finance.			
	Bank/Agency use does not exceed budget. No 3rd party agency use.	Bank/Agency reports.			
	Sickness absence rate of no greater than 4%	Sickness absence data.			
	Risk Register is current	Audit of risk register			
	All staff to have annual PDR	PDR rates			
	100% staff registration status known	Staff registration data			
	100% staff attended Mandatory training	% staff attending training			
	Recruitment into vacancies no greater than 15 weeks from notice being given.	Current vacancies/ recruitment position.			
	At least one team member attends team brief every month	Feedback recorded in ward team meetings			
	A team meeting is held every month	Audit of team meeting minutes			

Objective	Target/Standard to be achieved (where identified)	Evidence supplied by others	Evidence supplied by Matron/Ward Manager (to be completed prior to review and any supporting evidence attached)	Target/Standard actually achieved	RAG Rating
4. Matrons and ward managers will ensure effective admission and discharge planning processes are in place for their areas: • Admission protocols • Discharge planning • Predicted discharge dates • Care pathways • Transfer handover and documentation • Tracking of medical records	All patients will have an estimated discharge date.	LOS information.			
	All patients will have a completed-**Patient assessment record.**	**Annual EOC audit** **Monthly record keeping audits.**			
	All patients will have a discharge plan.	Documentation audit			
	MDT board in use for all patients	Bi annual quality check			

Objective	Target/Standard to be achieved (where identified)	Evidence supplied by others	Evidence supplied by Matron/Ward Manager (to be completed prior to review and any supporting evidence attached)	Target/Standard actually achieved	RAG Rating
5. Matrons and ward managers should ensure that systems are in place to ensure that patients receive the best experience possible during their hospital stay. This will include the reception they receive on admission; the way staff communicate with them and their relatives; the way staff present themselves; general meal and drink services etc. e.g. • Patient information • Notice boards • Communication strategy • Professional standards • Matron/ward manager accessibility and visibility e.g. ward rounds/clinics • Surveys/open mornings • PALS/complaints data • Effective management of Clinical incidents	• The ward/dept 'meet and greet' standard is adhered to • ~~P~~atients receive information regarding the Ward procedures on admission etc.	PALS data. **Observations of care twice yearly**			
	Service improvements are made following PAL's concerns	Examples			
	The number of complaints is reducing.	Complaints data.			
	The number of **red / amber** incident are reducing.	Incident data.			
	There is Local follow up of incidents and feedback to staff	Minutes of meetings			
	A patient survey is conducted at least twice a year and an action plan produced.	Patient survey information.			
	Ward Website completed and Online [New standard for spring 09]	Able to access site			

Objective	Target/Standard to be achieved (where identified)	Evidence supplied by others	Evidence supplied by Matron/Ward Manager (to be completed prior to review and any supporting evidence attached)	Target/Standard actually achieved	RAG Rating
6. Matrons and ward managers are responsible for maintaining privacy and dignity for patients in their clinical area. This includes ensuring the environment, as far as possible, protects patient privacy and dignity; ensuring staff communicate with patients in a manner that is respectful; ensuring genders are not mixed and that consideration is given for individuals diverse needs e.g. • Signage of single sex accommodation • Mixed sex issues • Dignity curtains/equipment • Equality and diversity measures • Addressing of patients	Patients are never nursed in mixed sex bays/wards (except ITU, HDU, CCU and assessment areas)	**Observations of care twice yearly** **Bed management team data Monthly monitoring**			
	100% bathrooms and toilets are clearly labelled Male/ Female.	PEAT inspections			
	No patient should have to walk past a patient of the opposite sex to use the bathroom, toilet or enter/exit the ward.	**Observations of care twice yearly** **PEAT** inspections			
	100% bed spaces have adequate curtains to protect patient dignity.	**observations of care twice yearly** **PEAT**			
	Privacy signs are in use	**observations of care twice yearly** **PEAT**			
	The Ward has completed an equality impact assessment. [New standard for Spring 09]	**Audit of records**			

	Patient information is available in a format and language that meets individuals needs	**Annual EOC audits**			
	100% staff have attended diversity awareness training [New standard for spring 09]	**Audit of records**			
	Patients receive meals appropriate to their personal needs.	Feedback Ward service officers			
	Patients can get access to facilities to meet their spiritual needs.	Patient survey			

APPENDIX A SWBTB (3/09) 071 (b)

Objective	Target/Standard to be achieved (where identified)	Evidence supplied by others	Evidence supplied by Matron/Ward Manager (to be completed prior to review and any supporting evidence attached)	Target/Standard actually achieved	RAG Rating

7. **Matrons and Ward Managers will ensure the Safeguarding agenda is met in line with Trust policies** **Attendance at training:** • **Vulnerable Adult Abuse** • **Mental Capacity Act** • **Mental Health**	**The mental health needs of patients are met in all aspects of safe guarding appropriate to their individual needs**	**Evidence of monitoring of VAP referrals , Mental Capacity tests and IMCA referrals** **Quality data** **Training numbers** **Availability of patient information regarding VAP, MCAct and MH conditions**			
Objective	**Target/Standard to be achieved (where identified)**	**Evidence supplied by others**	**Evidence supplied by Matron/Ward Manager** (to be completed prior to review and any supporting evidence attached)	**Target/Standard actually achieved**	**RAG Rating**

8. Area is suitable for Healthcare students	Audit is in date	PPM Team			
	Mentors are qualified	100% of qualified staff are Mentors and have relevant qualification Mentors have attended an annual update			
	Educational Link Nurse	100% attendance at quarterly meetings			
	Induction / Welcome Pack is available	PPM Team			
	Students have access to Trust policies / guidelines	PPM Team			

Objective	Target/Standard to be achieved (where identified)	Evidence supplied by others	Evidence supplied by Matron/Ward Manager (to be completed prior to review and any supporting evidence attached)	Target/Standard actually achieved	RAG Rating
9. All patients can expect that their condition will be effectively monitored and that in the event of change or deterioration in their condition that it is managed safely. Matrons and ward managers are responsible for ensuring patient's acute needs are met.	100% staff understand the role of Outreach team, EMT and calling criteria.	Oxygen therapy audit data.			
	100% registered staff are able to administer O_2 therapy safely and effectively.	**Training records list RN who are competent to administer O2 therapy**			
	100% registered staff are able to accurately record and monitor patients vital signs.	Audits of shaded charts.			
	Non registered staff have completed the appropriate competency to be able to undertake the recording of vital signs.	**Training records include list of HCA's who are competent to perform temp, BP, pulse and resps**			
	100% registered staff are able to use the shaded observation chart, documents accurately and respond appropriately.				
	100% of staff have had medical equipment training needs assessed and training is up to date	Audit records			

Appendix B

WARD REVIEW PERFORMANCE SCORES

SWBTB (3/09) 071(c)

Question	Round 1			Round 2		
	R	A	G	R	A	G
Q1 Environmental Cleanliness						
C.Diff	1	8	40	1	5	42
MRSA	1	10	39	1	1	46
Hand Hygiene	11	31	12	4	22	26
Saving Lives Audit	1	15	35	1	3	43
PEAT Visits (Red Alerts)	3	20	31	2	13	31
Q2 Patient Basic Care Needs						
EOC Audit Data	7	11	23	1	16	23
PEAT Visits	4	15	24	0	1	41
Falls Rate	7	11	7	1	11	35
Tissue Damage Rates	5	9	22	0	13	32
Q3 Resource Management						
Financial Management	1	8	41	1	7	44
Bank/Agency Use	1	10	41	1	8	44
Sickness Absence	2	14	26	3	17	31
Q4 Admission/Discharge Planning						
Average Length of Stay	3	13	31	5	10	20
Initial Assessment Form	4	19	4	1	14	28
Discharge Plan	3	13	32	2	9	27
Q5 Patient Experience						
PALS Data	6	23	24	0	15	35
Complaints Data	4	13	32	2	10	40
Patient Survey	28	13	12	22	11	10
Q6 Privacy & Dignity						
Religious Needs	6	19	26	0	4	45
Single Sex Accommodation	5	5	33	1	2	34
Clear Signage	5	7	36	2	1	44
Bed Space	6	14	31	3	7	35
Multi Lingual Info	25	10	18	4	25	24
Q7 Mental Health Needs						
Patient Assessment	34	5	14	15	25	13
Q8 Condition Monitoring						
Oxygen Admin Use & Safety	3	15	29	0	14	34
Recording Vital Signs	3	17	27	0	14	34
Observation Chart Usage	2	11	35	2	5	37

Please note that some standards do not apply to some of the areas reviewed, therefore evidence was not supplied for these.
A&E/EAU were not included in Round 2 and other areas, eg colposcopy have been included.
Until the process is fully implemented it is difficult to provide a Trust comparison but comparison for individual wards that have taken part in each round is possible and has been done.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Finance and Performance Management Committee – v0.2

Venue Executive Meeting Room, City Hospital **Date** 19 February 2009; 1430h – 1630h

Members Present

Mr R Trotman [Chair]
Mrs S Davis
Mrs G Hunjan
Ms I Bartram
Dr S Sahota
Miss P Akhtar

In Attendance

Miss R Overfield
Mr M Dodd
Mr T Wharram
Mr M Harding
Mrs K Olley [Item 2 only]
Mr V Munsami [Item 2 only]

Secretariat

Mr S Grainger-Payne [Minutes]

Apologies

Prof D Alderson
Mr J Adler
Mr R White
Mr R Kirby

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received apologies from Professor Derek Alderson, Mr John Adler, Mr Robert White and Mr Richard Kirby.	
2 Presentation by the Surgery B Division	**SWBFC (2/09) 012** **SWBFC (2/09) 012 (a)**
Mrs Olley advised the Committee that as at the end of January, the division was £69k underspent and it fully anticipated delivering a balanced financial position at the year-end. The division has significantly overperformed against outpatient contracts, largely attributed to general ophthalmology work. Spend on pay however is higher than expected, mainly due to premium pay rates required to fund initiatives undertaken to reduce waiting times. In the future, there is a possibility that substantive appointments may need to be made to undertake this work on a longer-term basis. Mr Trotman noted the reported risk in relation to market share as a consequence of the introduction of the drug Lucentis causing a reduction in Photo Dynamic Therapy (PDT) work. Mrs Olley explained that although Lucentis is now the treatment of choice, the cost base is different to that of PDT. Activity levels are being maintained however as a fast track system may now be offered, clinical networks are good in this area and service managers are efficient. It is hoped that these measures will ensure the Trust's market share is maintained. Mr Trotman asked whether there was an expectation that further ophthalmology work is expected from Heart of England FT. He was advised that extra session have	

been requested through SIRG and employment contracts for consultants due to undertake the work are being drawn up by the Trust's solicitors, Mills and Reeve LLP. Activity associated with emergency ophthalmology work is presently strong. In terms of pay costs, nursing costs have increased due to the need for extra shifts and theatre sessions recently. Theatre utilisation has not improved significantly in the division and there have been issues with cancelled sessions. There are plans in place now which should address the situation, involving creation of designated theatre slots for VR work and emergencies. This will eliminate the need to cancel elective sessions, should an emergency arise. Non-pay expenditure is currently below plan. Drugs costs are running below budgeted levels, in particular. Mrs Olley was asked what plans were in place to achieve the additional 1% CIP now required of the division. She advised that there will be a greater focus on surgery and ENT efficiencies, which should provide the additional savings needed. Mr Trotman asked what the effect of the recommendations arising from the external review of BMEC had realised for the division. He was advised that the division's surplus has improved. Mr Trotman suggested that it would be interesting for the Non Executive Directors to review the current position against the KPMG report on BMEC. Mrs Davis suggested that if there was potential for growth in audiology, then this should be pursued. Mrs Olley explained that the current lack of physical space and suitability of premises was currently a limiting factor in this area. It was suggested that a proactive approach should be undertaken, negotiating with PCTs if required. Mrs Olley advised that ENT and oral surgery had been given some challenging targets to achieve as part of the additional CIP required. Mr Dodd suggested that the plans for audiology should be revisited in the new financial year, therefore it was agreed that an update should be presented at the April meeting of the Finance and Performance Management Committee. Mrs Olley reported that work has been undertaken to improve the outpatient reception area in BMEC. Part of the previous reception area has been converted into clinical space. Other improvements include the introduction of evening and weekend clinics. A Listening into Action event has also been held where patient feedback suggested that the clinical service provided by the division was good, although the administration required improvement. Partial booking is now in place, which will streamline some of the administration processes. Mr Dodd added that partial booking for follow up appointments is due to be implemented as part of the IT development plan. Dr Sahota asked what the division's position was with DNA rates. He was advised that overall, this is currently 16.2%. Further examination of this situation is underway. Mrs Olley and Mr Munsami were thanked for their informative presentation.	
ACTION: **Kathy Olley to provide an update on plans for audiology to be discussed at the April meeting of the Finance and Performance Management Committee** **ACTION:** **Kathy Olley to provide an update on the current position against the recommendations in the KPMG review of the BMEC by May 09**	
3 Minutes of the previous meeting	**SWBFC (1/09) 010**
The minutes of the last meeting were agreed as an accurate reflection of	

discussions held on 22 January 09.	
AGREEMENT: The minutes of the previous meeting were approved	
4 Matters arising from the previous meeting	**SWBFC (1/09) 010 (a)**
The Committee noted the updated action log. In connection with action SWBFCACT.040, the Committee was advised that the leasing arrangements for the MRI at Sandwell Hospital are not due to be renewed until January 2010.	
5 Trust Board performance management reports	
5.1 2008/09 month 10 financial position and forecast	**SWBFC (2/09) 013** **SWBFC (2/09) 013 a)** **SWBFC (2/09) 013 (b)**
Mr Wharram reported that the original forecast surplus of £2.5m had been slightly exceeded, being £315k ahead of plan. The in-month surplus however was below plan at £134k, against a target of £179k. The Committee was informed that there had been some realignment of some income targets, which had changed the financial position of some of the divisions. The dip in income during December has been recovered during the month and the cash position is broadly in line with plan at £0.2m above as at 31 January 09. Mrs Davis asked whether there were any measures that could mitigate the reduced income from interest payments seen recently. Mr Wharram advised that there are limited investment options available, however it is likely that there would be greater freedoms available should the Trust be authorised as a Foundation Trust. In terms of the divisional performance, three divisions reported deficits: Medicines A & B and Surgery A, although a breakeven position is forecast for the year end. Mr Trotman asked on what the optimism for a recovered position by year end was based. He was advised that income and activity levels increase at the end of the year, although it was noted that this is not a guaranteed situation. An adjustment has been made to the BTC unitary charge. A one off payment of £300k has been made, which reflects the lower capitalised costs resulting from a reassessment of the residual value as part of the IFRS restatement exercise. Mrs Davis asked how often a revaluation was performed. She was advised that this is usually undertaken every five years, however a routine review will be performed sooner than this. It was noted that although the financial downturn is likely to have reduced the value of the estate overall, depreciation will also have reduced. Capital expenditure year to date is £10,014k, although an underachievement against plan of c. £1m is expected at the year end. In relation to the public sector payments policy, Mr Wharram was asked whether the required invoices will be paid by the year end. He advised that this is in hand and every effort is being made to ensure that a satisfactory percentage of invoices paid on time is maintained.	
5.2 Performance monitoring report	**SWBFC (2/09) 014** **SWBFC (2/09) 014 (a)** **SWBFC (2/09) 014 (b)**

Mr Harding presented the Trust's summary performance.

Two breaches of the standard 14-day waiting time for cancer services were reported in December, both of which related to Upper GI cases. It is not anticipated that these breaches will impact on the overall target, however.

In terms of stroke care, an error in the calculation of previous performance has been detected and rectified, meaning that the performance against the target has now improved. Mrs Davis asked for further detail about the correction of the error. Mr Harding reported that correction of the situation now means that performance is based on identification of one of the eleven diagnoses within the target on admission. As such, performance is now more in line with clinical expectation. Mr Harding was asked to report back at the next meeting on the process by which the error was detected and current performance is validated.

The maximum number of breaches permissible to ensure that the year-end Accident and Emergency waiting times target is achieved, has now been identified. Breaches to date have remained less that the threshold, therefore there is optimism that the Trust can still achieve this target.

Sandwell Social Services has been engaged to provide a more focussed approach to delayed transfers of care.

The *C difficile* trajectory has been revised downwards, although there is anticipation that the required performance can still be achieved.

Information from the maternity dashboard has now been incorporated into the performance report and will continue to be populated as further information is obtained from EVOLUTION. It was noted that there has been a downward trend in caesarean section rates, as a result of closer focus in this area.

The number of completed PDRs submitted was noted to be very low at 47. Mr Trotman suggested that this situation should be escalated to the CEO and Head of Workforce.

It was noted that inpatient elective activity was low, although this is reflective of a change to the day patient admissions, as more are now admitted for care in the Birmingham Treatment Centre.

In connection with the GUM target, there are plans to recruit a second consultant into this area, although until this person is in post, there is a likelihood that this target will not be achieved. Much improved performance is expected from the beginning of the next financial year.

It was noted that the extra beds opened to handle the winter operational pressures are still open. Mr Dodd was asked whether there were plans to shut these beds in the near future. He advised that there were no plans to close these beds until the end of March, to ensure that the A & E target is achieved.

Mrs Hunjan highlighted that the workforce numbers in the performance report were inconsistent with those in the financial performance report. Mr Wharram and Mr Harding were asked to ensure that future reports are harmonised.

ACTION:	**Mike Harding to provide further details of the process by which the the stroke target performance error was detected and current performance is verified**
ACTION:	**Mike Harding and Tony Wharram to ensure duplicate information in the finance and performance reports is harmonised**

5.3 Foundation Trust compliance report	**SWBFC (2/09) 019** **SWBFC (2/09) 019 (a)**
Mr Harding presented the updated FT compliance report. He highlighted that the non-compliance with core standards relates to the standard concerning privacy and dignity. A Trustwide audit has been conducted into mixed sex accommodation and issues have been identified particularly with access and egress to wards. A bid has been submitted for funds to assist with resolving these issues.	
5.4 Financial planning update	**SWBFC (2/09) 018** **SWBFC (2/09) 018 (a)** **SWBFC (2/09) 018 (b)**
Mr Wharram presented the second financial planning update and highlighted that a more detailed report will be presented at the next meeting. The biggest issue currently being handled relates to the settlement of contracts with PCTs for 2009/10. The deadline for the agreement of the contracts has been extended recently. A prudent view has been taken in relation to the tariff expected next year. The business plan as part of the FT application will need to be updated to reflect this and resubmitted. Changes include the loss of income in respect of market forces factor and the impact of the implementation of HRG4. CQUIN funding represents 0.5% of the tariff uplift for 2009/10. The draft capital plan for 2009/10 was reviewed, much of which is to be taken up by proposed land acquisition for the new hospital site.	
6 Cost improvement programme (2008/09)	
6.1 CIP delivery report	**SWBFC (2/09) 016** **SWBFC (2/09) 016 (a)** **SWBFC (2/09) 016 (b)** **SWBFC (2/09) 016 (c)**
Mr Wharram reported that the CIP for month 10 was in line with plan and the Trust is expected to achieve its target by the year end.	
7 Minutes for noting	
7.1 Minutes of the Strategic Investment Review Group	**SWBSI (1/09) 001**
The Committee noted the minutes of the SIRG meeting held on 13 January 09.	
7.2 Actions and decisions from the Strategic Investment Review Group	**SWBFC (2/09) 017**
The Committee noted the actions and decisions arising from the meeting of SIRG meeting held on 10 February 09.	
8 Any other business	**Verbal**
There was none.	
9 Details of next meeting	**Verbal**
The next meeting is planned for 19 March 2009 at 1430h in the Executive Meeting	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Room, City Hospital.	

Signed .....

Print .....

Date .....

MINUTES

Audit Committee – Version 0.1

Venue Executive Meeting Room, City Hospital **Date** 5 February 2009; 1030h – 1230h

Members		In Attendance	Secretariat	
Mrs G Hunjan	[Chair]	Mr R White	Mr S Grainger-Payne	[Minutes]
Mr R Trotman		Mr T Wharram		
Ms I Bartram		Ms R Chaudary		
Dr S Sahota		Mr P Westwood		
Prof D Alderson		Ms S-A Moore		
Miss P Akhtar				

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received apologies from Mr Paul Dudfield and Mr Mike McDonagh.	
2 Minutes of the previous meetings	**SWBAC (12/08) 055**
Subject to slight amendment, the minutes of the meeting held on 12 December 08 were agreed to be a true and accurate reflection of discussions held.	
AGREEMENT: The minutes of the previous meetings were approved	
3 Matters arising from the previous meetings	**SWBAC (12/09) 055 (a)**
It was noted that there were no actions overdue.	
3.1 Charge exempt overseas visitors	**SWBAC (2/09) 012** **SWBAC (2/09) 012 (a)**
Mr White presented the guidance in place in the Trust for members of 'front line' staff to assess whether patients may be eligible for treatment under reciprocal arrangements. PCTs are responsible for funding the treatment, with the charges assumed to be made to the PCT with responsibility for the place of residency of the patient. Mr White agreed to check that this was the case.	
ACTION: Robert White to determine whether the PCT invoiced for treatment under reciprocal arrangements is that with responsibility for the patient's place of residency	
4 External Audit matters	

4.1 Progress report	**Verbal**
Mrs Moore reported that KPMG was currently on site undertaking interim work. Progress with the ALE submission is virtually complete, with evidence to be reviewed shortly.	
4.2 Assessment of external audit services questionnaire	**SWBAC (2/09) 013** **SWBAC (2/09) 013 (a)**
Mrs Moore presented the external audit assessment questionnaire, which had been tailored from the initial version presented at the December meeting, to a short list of potential questions which could be meaningfully scored. In connection with the question 'Is the external audit plan agreed with the Committee?', Mr Trotman questioned whether the plan is noted or agreed. Mrs Moore highlighted that there is ample opportunity for the members of the Audit Committee to debate the plan before it is presented for approval formally. Mr White asked whether the audit process would be different following authorisation as a Foundation Trust. He was advised that the Trust's red risks will be used as a guide for the audit programme and there is greater flexibility around the Audit Commission's guidance currently adopted. It was noted that in relation to the question 'Is the external audit fee reasonable given the scope of the external audit and how does the fee compare with other similar Trusts?', that the current arrangements mean that as there is no means to select the auditors used, there is no flexibility to negotiate the fees. Mr White suggested that effectiveness of communication between internal and external audit should be added into the assessment. The Committee debated the question 'Does the nature of non-audit services provide any potential to impair independence?'. It has been noted during the recent historic due diligence exercise, that the Trust had used KPMG for Board Development work and questioned whether there was a potential for this engagement to impair the impartiality of the routine audit work. The Committee agreed however that this did not compromise the independence of the auditors, on the following basis: the proposition to use KPMG for the work had been agreed by the Trust Board with full cognisance of the auditing role that KPMG fulfils; a separate team within KPMG had been engaged to undertake the Board development work; the Non Executive Directors all sit on both the Audit Committee and the Trust Board and therefore would have raised a concern, should there have been a question of impropriety; the board development work was a special one-off consultancy and is not a regular arrangement. Mrs Moore offered to share an example of a policy governing the use of external audit for non-audit related work, such as consultancy. Mrs Hunjan proposed that the scoring for the various assessment criteria should be agreed. Mr White suggested that the scoring be as follows: 4 – yes - fully agree; 3 – yes – agree; 2 – yes – sufficient; 1 – no – action required. Miss Bartram suggested that the terms should be more fully explained. 'Sufficient' should also be changed to 'adequate' to reflect that the minimal standard is being met.	

It was agreed that the assessment be undertaken in draft between Mr White, Mrs Moore and Mrs Hunjan, which should be presented for ratification at the May meeting.	
ACTION: **Robert White to add an indicator concerning communication between external and internal audit into the external audit assessment questionnaire** **ACTION:** **Sarah-Ann Moore to provide an example of a policy governing the use of external audit for non-audit related work, such as consultancy** **ACTION:** **Robert White to expand the definitions of the scores used as part of the external audit assessment** **ACTION:** **Robert White to change the 'sufficient' score to 'adequate' on the external audit assessment scoring criteria** **ACTION:** **Robert White to present the draft external audit assessment at the May meeting of the Audit Committee**	
4.3 Audit Committee Top 10 'To Dos'	**SWBAC (2/09) 003**
Mrs Moore presented the Top 10 'To Dos' for Audit Committees, guidance issued by the Audit Committee Institute, which sets out recommendations for Audit Committees when setting their 2009 agenda. It was suggested that the recommendation to assess the company's exposure to third parties in financial distress, was particularly pertinent to the Trust. Mr White agreed to raise this consideration at a future meeting of the Executive Team and present an update of then position at the next meeting of the Audit Committee. Mr Grainger-Payne was asked to circulate the Audit Committee Top 10 'To Dos' to all members of the Trust Board.	
ACTION: **Robert White to discuss the potential issue of the Trust's exposure to third parties in financial distress at a future Executive Team meeting and report back at the next Audit Committee** **ACTION:** **Simon Grainger-Payne to issue the 'Audit Committee Top 10 To Dos' to all Board members**	
5 Internal Audit matters	
5.1 Internal Audit progress report and recommendations tracking	**SWBAC (2/09) 004** **SWBAC (2/09) 004 (a)**
Ms Chaudary reported that 345 audit days had been delivered to date, broadly in line with plan. Work on financially-biased audits had been the major focus since the December meeting of the Committee. An audit on the Connecting for Health work had also been completed. Three draft reports had been issued: cash/treasury management, which provided significant assurance; activity/information monitoring, providing limited assurance; and performance management monitoring, providing significant assurance.	

A final report on KSF development/appraisal process had been issued during the period. Mr Trotman noted that previous reports showed a summary of the assurance levels, together with any movements from previous audits. He was advised that this is due to be incorporated within the Head of Internal Audit report. Dr Sahota remarked that every report provides a number of recommendations, yet the timescale for the completion of the actions is not clear. Ms Chaudary reported that this is due to be included in the recommendation tracking system. Miss Bartram noted that there appeared to be an error in the level of assurance associated with the KSF report, detailed in the progress report. Instead of limited assurance, the report stated that it provided significant assurance. Mr White observed that only provisional limited assurance can be provided by the Lorenzo system, however urged that any action that can be taken to rectify this situation should be undertaken as a priority. Ms Chaudary reported that a meeting had been arranged with key managers to discuss plans. Mrs Hunjan asked for further detail on the planned revised recommendation tracking system. She was advised that all managers are able to provide updates against actions directly, rather than needing to send updates to internal audit first. A summary of progress against agreed actions plans can then readily be obtained. Mrs Hunjan expressed her disappointment that a recommendation tracking report had not been produced for the Committee to consider. Ms Chaudary apologised and explained that due to a number of glitches in introducing the new electronic system the preparation of a report had not been possible. Mr White suggested that if the electronic system is not fully functioning by next meeting that a manual report be prepared for consideration instead. Ms Chaudary offered to provide a demonstration of the new recommendation tracking system at the next meeting. Mrs Hunjan asked that the dates the reports are issued as draft and final versions be added into future progress reports. She also highlighted that if the timing of an audit changes, such as movement into a subsequent quarter, then this should be highlighted in the report. Mr Wharram was asked what impact the external audit fieldwork and internal audit fieldwork was having on the routine functions of the finance department. He reported that there was no impact of significance.	
ACTION: **Rubina Chaudary to present a demonstration of the automated internal audit recommendation tracking system at the next meeting of the Audit Committee** **ACTION:** **Rubina Chaudary to present the updated internal audit recommendation tracking report at the next meeting** **ACTION:** **Rubina Chaudary to add dates internal audit reports issued in draft and in final into future internal audit progress reports**	
5.2 Key Skills Framework audit report	**SWBAC (2/09) 009** **SWBAC (2/09) 009 (a)**

Ms Chaudary advised that the KSF report provided limited assurance. Recommendations made to address the limited assurance provided were reported to be high level. The database being used to monitor that all staff have a KSF was reported to not be working robustly, so a change to functionality of ESR to take over this monitoring is suggested. Ms Chaudary reported that the Trust's position regarding the implementation of the KSF is similar to that of a number of other Trusts. As many of the actions were noted to be due for delivery by December 2009, Mr Trotman suggested that a mechanism of tracking progress with the actions should be implemented.	
ACTION: **Internal Audit to provide an indication of interim progress with recommendations detailed in the KSF report, that are not due for completion until December 2009**	
5.3 Draft internal audit plan 2009/10	**SWBAC (2/09) 007** **SWBAC (2/09) 007 (a)**
Ms Chaudary reminded the Committee that the three-year strategic plan had been presented at a meeting of the Audit Committee in early 2008. The draft internal audit plan for 2009/10, was therefore highlighted to be an excerpt from the overall strategic plan. The final plan for 2009/10 will be considered by Mr White and Mr John Adler, as Accountable Officer, and then presented in final form at the May meeting of the Audit Committee. The draft version is to be adopted as the working plan until the Accountable Officer agrees the plan. It was suggested that audit activity around the new hospital should be added into the plan.	
ACTION: **Internal Audit to add audit activity around the new hospital into the audit plan for 2009/10**	
5.4 Internal Audit key performance indicators	**SWBAC (2/09) 005** **SWBAC (2/09) 005 (a)**
Ms Chaudary presented a number of key performance indicators which were proposed to assess the performance of Internal Audit. Mrs Hunjan observed that the proposed checklist did not seem to be tailored to an assessment of Internal Audit by the Audit Committee, but instead focussed on assessment of performance by those being audited. The proposed scoring system was discussed and agreed that a system identical to that for external audit assessment should be used. In terms of the scoring for those being audited, Miss Bartram suggested that the 'Don't Know' option should be removed. On a separate matter, Mr Trotman asked for an update at the next meeting on	

what plans were underway to achieve Internal Audit's CIP for the coming year. In the same way as the external audit assessment, it was agreed that a draft statement be prepared for ratification at the next Audit Committee	
ACTION: **Internal Audit to report back at the next meeting on what plans are being made to achieve a CIP in the internal audit function** **ACTION:** **Internal Audit to consider removing 'Don't Know' from the choices in the internal audit post-audit questionnaire** **ACTION:** **Robert White to present the draft internal audit assessment at the May meeting of the Audit Committee**	
5.5 Review of Counter Fraud progress report	**SWBAC (2/08) 009** **SWBAC (2/08) 009 (a)**
Mr Westwood presented the update against the Counter Fraud workplan update. He reported that delivery of counter fraud work continues to be incorporated within the corporate induction programme. A counter fraud newsletter has also been issued, which Mr Westwood agreed to circulate. The Trust is currently participating in a national fraud initiative, although there has been some delay to this due to external influences. Three new fraud case referrals have been made since the last meeting and there are several ongoing investigations. It was noted that only 88 days of counter fraud work has been undertaken against a year end forecast of 130, although Mr Westwood provided assurance that there was an expectation that the full plan would be completed as planned. Dr Sahota asked whether the Police were informed of cases such as case 2008-02, concerning spurious bank statements erroneously attributed to the Trust. He was advised that this situation had not been deemed to require escalation to the Police in this instance. Mrs Hunjan asked that appendix 2, the summary of 2008/09 investigations, be developed further to include dates of referral and closure.	
ACTION: **Paul Westwood to circulate the Counter Fraud newsletter to Audit Committee attendees** **ACTION:** **Paul Westwood to review the process for escalating fraud incidents, including involving Police Authorities if necessary** **ACTION:** **Paul Westwood to develop the counter fraud case summary to include dates for closure of the case and referral**	
5.6 CIPFA guidance – *Managing the Risk of Fraud*	**SWBAC (2/09) 008** **SWBAC (2/09) 008 (a)**
In connection with this item, the Chair asked that it be recorded that she is a member of CIPFA.	

Mr Westwood presented a self-assessment of the Trust's position against CIPFA's recognised best practice guidance 'Managing the Risk of Fraud'. Evidence of adherence with the guidance was reported to be needed as part of the ALE initiative. Although a number of areas of weakness were identified, Mr Westwood reported that the Trust's position relative to a number of other local Trusts is good. The inclusion of Fraud on the Trust's corporate risk register was noted to be needed. Mr Westwood reported that he was due to talk to the Head of Risk Management and the Director of Governance to ensure that this is arranged.	
ACTION: **Mr Westwood to discuss the inclusion of counter fraud on the corporate risk register with Miss Kam Dhami**	
6 Review of changes to the Standing Orders, Standing Financial Instructions (SFIs) and Scheme of Delegation	**SWBAC (2/09) 014** **SWBAC (2/09) 014 (a)**
Mr White presented a number of proposed changes to the Trust's standing orders, SFIs and scheme of delegation. The proposed changes were outlined to be: an amendment to the authorisation of quotations and tenders, specifically to contracts of £1m or below, which is currently within the authorisation of the Trust Chair to sign, to requiring both the Chair and Chief Executive; raising the value of single tenders requiring Board ratification from £50k to the EU procurement limit of c. £90k, although the need for formal tendering will remain unchanged at £50k; addition of an additional clause to section 17.5.3 of the SFIs, concerning exceptions and instances where formal tendering need not be applied, to read 'the provisions of this section apply equally to the requirements for competitive quotes for good and services below £90k (see scheme of delegation) in terms of the authorisation to waive competitive tender procurement processes'. The Audit Committee approved the changes.	
AGREEMENT: **The Audit Committee approved the proposed changes to the Trust's Standing Orders, Standing Financial Instructions (SFIs) and Scheme of Delegation**	
7 Draft cycle of business for 2009/10	**SWBAC (2/09) 002** **SWBAC (2/09) 002 (a)**
Mr Grainger-Payne presented the Audit Committee draft cycle of business for 2009/10. The Audit Committee approved the proposed cycle of business, although asked that the timing of the presentation of waived tenders and breaches to the Trust's standing orders be harmonised.	
ACTION: **Simon Grainger-Payne to schedule the presentation of waived tenders for the May meeting of the Audit Committee**	
8 Assurance framework update	**SWBAC (2/09) 011** **SWBAC (2/09) 011 (a)**

Mr Grainger-Payne presented the updated Assurance Framework. Progress with the actions to address the gaps in control and assurance was reported to be good, with the exception of actions against objectives to achieve national targets and improvement of productivity. The amber status of these targets was reported to be reflective of the recent operational pressures.	
9 Review of debtors report	**SWBAC (2/08) 010** **SWBAC (2/08) 010 (a)** **SWBAC (2/08) 010 (b)**
Mr Wharram presented the latest position regarding key debtors, outstanding payments due, action taken and plans to collect the debts. It was noted that the overall debtor balance had increased slightly, although the Committee was asked to note that a significant number of the debtors had been paid since the report had been produced. A specific area of concerns related to named patient ophthalmology, whereby individual patients are approved by PCTs for treatment, although payment for these cases has been delayed. Mr White agreed to discuss the matter with relevant PCT colleagues.	
ACTION: Mr White to discuss debts relating to named patient ophthalmology with the relevant PCT Finance Director	
10 IRFS project plan update	**Tabled paper**
Mr Wharram presented the progress and issues with the International Financial Reporting Standards (IFRS) implementation plan. He reported that the restatement of balances as at 1 April 2008 was submitted, in accordance with the Strategic Health Authority and Department of Health timetable, on 19 December 2008. The Audit Committee was advised that KPMG will be auditing the Trust's submission. The Committee was asked to endorse the exclusion of items from the exercise, having an annual value of less than £5,000 as not having a material impact. As a result of the implementation of the IFRS, Mr Wharram reported that some key procedural changes were needed, affecting in particular areas around leases, contractual arrangements, employee benefits, PFI and valuation of assets. The Committee was asked to endorse the proposed changes to the operational procedures outlined. Mr Wharram reported that there was also a need to introduce a revised accounting policy, which it was agreed would need to be presented to a future meeting of the Audit Committee. It was suggested that a special meeting be convened for this purpose as soon as possible. The recommendations from the recent historical due diligence exercise are also to be discussed at this meeting. Dr Sahota asked for clarity on the reported prepayments. He was advised that this related to prepaid tax and national insurance. Thanks were expressed to Mr Wharram and the team for their work in this area.	

ACTION: **Mr Grainger-Payne to convene a special meeting of the Audit Committee** **AGREEMENT:** **The Audit Committee approved the request to exclude items from the IFRS exercise, having an annual value of less than £5,000 as not having a material impact** **AGREEMENT:** **The Audit Committee approved the proposed operational changes outlined as a result of the introduction of IFRS**	
11 Minutes from Trust Board committees	
11.1 Finance and Performance Management Committee	**SWBFC (11/08) 066** **SWBFC (12/08) 073**
The Committee noted the minutes from the Finance and Performance Management Committee meetings held on 27 November 08 and 18 December 08.	
11.2 Charitable Funds Committee	**SWBCF (11/08) 023**
The Committee noted the minutes from the Charitable Funds Committee meeting held on 11 November 08.	
11.3 Governance and Risk Management Committee	**SWBGR (11/08) 045**
The Committee noted the minutes from the Governance and Risk Management Committee meeting held on 20 November 08.	
12 Any other business	**Verbal**
There was none	
13 Details of next meeting	**Verbal**
The next meeting is planned for 7 May 09 in the Executive Meeting Room, City Hospital at 1030h.	
Signed:	
Name:	
Date:	