Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Anne Gibson Boardroom, City Hospital **Date** 26 January 2012; 1530h - 1730h

Members			**In Attendance**	
Mr R Trotman	(RT)	[Chair]	Mr G Seager	(GS)
Dr S Sahota	(SS)		Miss K Dhami	(KD)
Mrs G Hunjan	(GH)		Mrs J Kinghorn	(JK)
Prof D Alderson	(DA)		Mrs C Rickards	(CR)
Mrs O Dutton	(OD)		Mrs C Powney	(CP) [Sandwell LINks]
Mr P Gayle	(PG)			
Mr J Adler	(JA)		**Secretariat**	
Mr D O'Donoghue	(DO'D)		Mr S Grainger-Payne	(SGP) [Secretariat]
Mr R White	(RW)			
Miss R Barlow	(RB)			
Miss R Overfield	(RO)			
Mr M Sharon	(MS)			

Item	Title	Reference Number	Lead
1	**Apologies**	**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	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 15 December 2011 as true and accurate records of discussions*	**SWBTB (12/11) 263**	**Chair**
4	**Update on actions arising from previous meetings**	**SWBTB (12/11) 263 (a)**	**Chair**
5	**Chair's opening comments**	**Verbal**	**Chair**
6	**Questions from members of the public**	**Verbal**	**Public**
	FOR APPROVAL		
7	**Updated Register of Interests**	**SWBTB (1/12) 265** **SWBTB (1/12) 265 (a)**	**SG-P**
8	**Single tender Action Rowley Regis Catering Refrigeration**	**SWBTB (1/12) 270** **SWBTB (1/12) 270 (a)**	**GS**

MATTERS FOR INFORMATION/NOTING			
9	**Safety, Quality and Governance**		
9.1	Care Quality Commission (CQC) report and update on action plans	SWBTB (1/12) 276 SWBTB (1/12) 276 (a)	RO
9.2	Nursing update	SWBTB (1/12) 275 SWBTB (1/12) 275 (a - c)	RO
9.3	Update on complaints handling	SWBTB (1/12) 284 SWBTB (1/12) 284 (a)	KD
10	**Performance Management**		
10.1	Monthly finance report	SWBTB (1/12) 267 SWBTB (1/12) 267 (a)	RW
10.2	Update from the Finance and Performance Management Committee meeting held on 19 January 2012	Verbal	RT
10.3	Monthly performance monitoring report	SWBTB (1/12) 273 SWBTB (1/12) 273 (a)	RW
10.4	NHS Performance Framework/FT Compliance monitoring report	SWBTB (1/12) 274 SWBTB (1/12) 274 (a)	RW
10.5	Corporate Objectives progress report – Quarter 3	SWBTB (1/12) 266 SWBTB (1/12) 266 (a)	MS
11	**Strategy and Development**		
11.1	Update on the delivery of the Transformation Plan	SWBTB (1/12) 289 SWBTB (1/12) 289 (a)	RB
11.2	Service Line Management strategy	SWBTB (1/12) 283 SWBTB (1/12) 283 (a)	DO'D
11.3	Organisational Development strategy	SWBTB (1/12) 268 SWBTB (1/12) 268 (a)	MS
11.4	Stroke reconfiguration plans	SWBTB (1/12) 286 SWBTB (1/12) 286 (a)	MS
11.5	Implications of the Innovation, Health and Wealth letter	SWBTB (1/12) 269 SWBTB (1/12) 269 (a)	MS
11.6	'Right Care, Right Here' programme: progress report including update on decommissioning – (4.30pm Jayne Dunn/Deva Situnayake/Kamel Sharobeem attending)	SWBTB (1/12) 282 SWBTB (1/12) 282 (a)	MS
11.7	Foundation Trust application programme		
▶	Programme Director's report	SWBTB (1/12) 278 SWBTB (1/12) 278 (a)	MS
▶	Minutes of the FT Programme Board held on 15 December 2011	SWBFT (11/11) 081	MS
11.8	Midland Metropolitan Hospital project: Programme Director's report	Verbal	GS

12	**Minutes from the meeting of the Audit Committee held on 1 December 2011**	**SWBAC (1/12) 068**	**GH**
13	**Update from the meeting of the Quality and Safety Committee held on 19 January 2011**	**Verbal**	**SS**
14	**Any other business**	**Verbal**	**All**
15	**Details of next meeting** *The next public Trust Board will be held on 23 February 2012 at 1530h in the Boardroom, Sandwell Hospital*		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.1

Venue Boardroom, Sandwell Hospital **Date** 15 December 2011

Present

Mr Roger Trotman (Chair)
Mrs Gianjeet Hunjan
Dr Sarindar Sahota OBE
Mr Phil Gayle
Mr John Adler
Mr Robert White
Miss Rachel Barlow
Miss Rachel Overfield
Mr Mike Sharon

In Attendance

Miss Kam Dhami
Mrs Jessamy Kinghorn
Mr Graham Seager
Mrs Carol Powney [Sandwell LINks]

Secretariat

Mr Simon Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Mrs Olwen Dutton, Professor Derek Alderson and Mr Donal O'Donoghue.	
2 Declaration of Interests	**Verbal**
There were no declarations of interest raised.	
3 Minutes of the previous meeting	**SWBTB (11/11) 242**
The minutes of the previous meeting were presented for approval and subject to minor amendment were accepted as a true and accurate reflection of discussions held on 24 November 2011.	
AGREEMENT: The Trust Board approved the minutes of the last meeting subject to minor amendment	

4 Update on actions arising from previous meetings	**SWBTB (11/11) 242 (a)**
The updated actions list was reviewed and it was noted that there were no outstanding actions requiring discussion or escalation.	
5 Chair's opening comments	**Verbal**
Mr Trotman did not wish to make any opening comments.	
6 Questions from members of the public	**Verbal**
There were no members of the public present.	
Items for Approval	
7 Estates strategy annual review	**SWBTB (12/11) 252** **SWBTB (12/11) 252 (a)**
Mr Seager presented a refreshed version of the estates strategy for approval, advising that overall progress with the plans was good. Mr Sharon asked what plans were being made for the transfer of the Leasowes facility that was currently owned by Sandwell PCT. Mr Seager explained that following the transfer of Community Services staff into the Trust, the facility was the only building out of which services were delivered, which met the criteria for buildings needing to transferred over to the Trust. The Board was advised that a risk workshop had been undertaken concerning the transfer and no particular risks to the plans had been identified.	
AGREEMENT: The Trust Board approved the annual update of the Estates Strategy	
8 Safety, Quality and Governance	
8.1 Care Quality Commission (CQC) reports and action plans	**SWBTB (12/11) 249** **SWBTB (12/11) 249 (a)** **SWBTB (12/11) 249 (b)**
Miss Overfield presented the updated action plans that had been developed to address the recommendations within the CQC reports into privacy, dignity and nutrition. The Board was advised that a number of mock inspections had been undertaken, which had identified that there had been improvements made in a number of areas, although further work was required to ensure consistent compliance with the standards. It was reported that managers from Heart of England Foundation Trust would also visit the Trust and undertake inspections as part of a reciprocal arrangement. Miss Overfield advised that the new configuration of ward Newton 4 was working	

well and would be assessed as part of the forthcoming Stroke Appreciative Enquiry.	
8.2 Fire safety annual report	**SWBTB (12/11) 244** **SWBTB (12/11) 244 (a)**
Mr Seager presented an annual update on Fire Safety matters within the Trust. He advised that discussions had been held within the year with West Midlands Fire Service concerning the revised response regime. The Board was advised that a pilot of the new response regime had been undertaken where a risk-based approach was taken, particularly to suspected fires. It was reported that full tenders would remain sent by the Fire Service in the case of confirmed fires. In terms of mandatory training in fire safety, the Board was informed that improved attendance had been seen in comparison to the previous year. Mr Trotman remarked that three false fire alarms per week appeared to be high. Mr Seager acknowledged that this was the case. It was reported that the meetings of the Fire Safety Committee would be held quarterly, with incidents remaining reviewed on a monthly basis by e-mail circulation. The Board was asked for and gave its approval to the proposal that the Chief Executive should sign the annual declaration of fire safety.	
AGREEMENT: The Board agreed that the Chief Executive should sign the annual declaration of Fire Safety	
8.3 Update on complaints handling	**Tabled report**
Miss Dhami advised that the plan to eliminate the backlog of complaints by the end of December 2011 remained on track. It was highlighted that it was likely that five complaints responses from the backlog would not be issued given that the complainants had requested meetings with the Trust to discuss their concerns and therefore the responses would be issued subsequently.	
9 Performance Management	
9.1 Monthly finance report	**SWBTB (12/11) 261** **SWBTB (12/11) 261 (a)**
Mr White reported that there continued to be concerns over the situation concerning income received by the Trust due to the lower than expected activity levels. The Board was advised that budget flexibilities had been used to offset the position during the month. It was reported that cost controls and vacancy management would be	

strengthened in the forthcoming months to ensure that the target surplus of £1.8m was achieved by the year end. On a separate point, Mr White advised that the Return on Assets value as part of the reported Financial Risk Rating calculation might be understated in the report.	
9.2 Update from the meeting of the Finance and Performance Management Committee held on 15 December 2011	**Verbal**
Mr Trotman advised that at its meeting earlier in the day, the Finance and Performance Management Committee had received a presentation from the Medicine & Emergency Care division, where concerns over activity levels being handled by the division had been highlighted. Mr Adler added that it had been agreed at the meeting that discussions were needed with the division to approve the proposed outturn position on its Cost Improvement Plan and the replacement schemes that would be necessary to address any shortfall. An update on the work to improve the Women and Child Health division's financial position was reported to have been received at the meeting. The Board was advised that a shortfall in the delivery of the Cost Improvement Programme by 9.2% had been reported, however the Committee had been given assurances that the target would be met by the end of the year. Mr Trotman reported that the Committee had been advised that following an exercise to recruit to the post of Associate Director for Transformation, an appointment had not been made.	
9.3 Monthly performance monitoring report	**SWBTB (12/11) 247** **SWBTB (12/11) 247 (a)**
Mr White advised that the reported breach of the 62 day cancer waiting time target had been determined to have been an error on further validation of the information, meaning that all cancer waiting time targets had been met for the month. Cancelled operations were reported to have increased slightly, with a third being attributable to the Oral Surgery area. Delayed Transfers of Care were noted to have deteriorated, particularly in Sandwell. Mr Gayle asked whether an agreement was in place around Delayed Transfers of Care. Miss Barlow advised that it was planned to adopt an integrated approach with the commissioners and the Local Authorities, which would implement robust escalation processes. Mr Adler asked what action was being taken in the meantime to address the position. He was advised that the Trust was working with Adult Social Care and was also reviewing the internal processes for discharge to ensure that escalation processes were as effective as possible. The Board was advised that this work was integral to the capacity and discharge project that was incorporated within the Transformation Plan.	

In terms of performance against stroke care targets, Mr White reported that there was a particular concern over the achievement of the high risk TIA target. It was reported however that the recruitment of an additional consultant into the area was expected to deliver an improved performance. The Board was informed that an Appreciative Enquiry into stroke care was planned for 16 December 2011. Performance against the Accident and Emergency waiting times was highlighted to be good and year to date remained above the 95% target. Twelve cases of *C difficile* were noted to have been reported during the month. There had been no breaches of the Single Sex Accommodation guidelines. Mrs Powney asked whether an analysis had been undertaken on ambulance turnaround times. Miss Barlow advised that work was underway to look at patient flow in this respect and to review the processes for handling ambulances on arrival.	
9.4 NHS Performance Framework/FT Compliance monitoring report	**SWBTB (12/11) 258** **SWBTB (12/11) 258 (a)**
Mr White presented the NHS Performance Framework/FT Compliance Framework update for receiving and noting. It was highlighted that the Trust remained classed as a 'performing organisation' against the NHS Performance Framework. The Trust was noted to be at amber/green status against the FT Compliance framework, which was reported to be reflective of the current level of *C difficile* infections being reported.	
9.5 Summary of the Operating Framework 2012/13	**SWBTB (12/11) 254** **SWBTB (12/11) 254 (a)** **SWBTB (12/11) 254 (b)**
Mr Sharon presented an overview of the Operating Framework for 2012/13, which he advised gave significant focus to quality, particularly given the increased amount of the tariff to be assigned to delivery of the CQUIN targets. The Board was advised that the Operating Framework stated that there would be tariff deflation and therefore this would be borne in mind as part of the forthcoming round of contracting negotiations. The negotiations were reported to have formally commenced and would be concluded by the end of February 2012. Mr Trotman observed that the Operating Framework referenced the increased number of Health Visitors due to be introduced and asked for how many the Trust would be responsible. Miss Overfield advised that the Trust would be responsible for recruiting 40 Health Visitors over four years. It was highlighted that the cost of the Health Visitors would be met from the Local Delivery Plan (LDP). Dr Sahota asked how inflation was taken into account as part of the plans and was	

advised that the tariff adjustment of around minus 1.9% was net of inflation and efficiency. There would be no cost of living salary uplift for staff during the year. A summary of the Any Qualified Provider approach was reviewed, which the Board was advised presented a risk to a proportion of the Trust's income. Mr Adler highlighted that the introduction of the Any Qualified Provider approach would also offer some opportunities for the Trust in addition to creating greater competition in the healthcare environment.	
10 Strategy and Development	
10.1 'Right Care, Right Here' programme: progress report including an update on decommissioning	**SWBTB (12/11) 246** **SWBTB (12/11) 246 (a)**
Mr Sharon advised the Board that there had been minor alterations to the decommissioning trajectories. The Board was informed that more care pathways were due to be published shortly and the approach to decommissioning for 2012/13 was being considered at present. It was highlighted that good progress had been made with identifying the annual total of savings required for the current year, however the process to pinpoint from where the savings needed to be realised had been challenging.	
10.2 Clinical services reconfiguration update	**SWBTB (12/11) 245** **SWBTB (12/11) 245 (a)**
Mr Sharon reported that the recent reconfiguration work had included the development of the Halcyon stand-alone birth centre. Mr Trotman asked whether the facility was being publicised and was advised that this was the case, including through an event for GPs. Dr Sahota suggested that posters should be displayed in community centres across the region. Miss Overfield confirmed that this was planned. Mrs Powney asked whether the facility was publicised in members' newsletters. Mrs Kinghorn confirmed that a feature was planned for inclusion in the next newsletter. Mr Sharon reported that the plans for vascular services and breast services reconfiguration had been discussed at a recent meeting of the Joint Overview and Scrutiny Committee, at which it had been agreed that no formal public consultation for these plans was necessary. Work was reported to be continuing on the reconfiguration of services in line with the Major Trauma Centre plans. It was reported that the clinical case for stroke services reconfiguration would be presented to the Joint Overview and Scrutiny Committee in January 2012; the plans for which were expected to require public consultation.	
10.3 Foundation Trust application: progress update	
Programme Director's report	**SWBTB (12/11) 250**

	SWBTB (12/11) 250 (a)
Mr Sharon presented the Foundation Trust Programme Director's report for receiving and noting. The Board was informed that the overall status of 'red' was reflective of the continued delay to receiving approval of the Outline Business Case for the new hospital. Satisfactory progress was reported to be being made in other areas of the programme however. The Historical Due Diligence work was noted to be nearly complete and the feedback from the Board to Board event in November 2011 was reported to be due. A further Board to Board event with NHS West Midlands was highlighted to be planned for May 2012. Mr Sharon advised that a new provider performance management regime was due to be introduced from 2012.	
Minutes of the FT Programme Board held on 24 November 2011	**SWBFT (11/11) 081**
The Trust Board received and noted the minutes of the FT Programme Board held on 24 November 2011.	
10.4 Update on the Communications and Engagement strategy	**SWBTB (12/11) 259** **SWBTB (12/11) 259 (a)**
Mrs Kinghorn reported that in terms of the actions within the Communications and Engagement strategy, the majority would be embedded by the end of the financial year. She thanked colleagues who had provided the support necessary to deliver the actions. The Board was advised that a strategy for 2012-15 was under development and would be presented at a future meeting for approval. In terms of internal communication, the Board was asked to note the list of subjects included in the discussion topics as part of the 'Hot Topics' briefings for managers. Mr Trotman highlighted that the number of applications for staff awards had increased year or year indicating the success of this work. The Board noted the high level of negative media coverage in September and October 2011, which was explained to be partly reflective of the messages within the Care Quality Commission's report into privacy, dignity and nutrition at the Trust. Mr Trotman asked whether the take up of press releases was monitored. Mrs Kinghorn confirmed that this was the case, however the correlation between the publicity received and the press releases was difficult to assess at times given that for any single press release more than one media entry may be generated. Mr Trotman asked whether the Trust used a 'cuttings' service. Mrs Kinghorn advised that a service was used, however it did not cover fully all press. Mrs Kinghorn advised that social media would be monitored in future, including	

routine review of feedback posted onto NHS Choices. Mrs Hunjan asked what guidelines were given to staff on the use of social media. Mrs Kinghorn advised that a social media policy was being prepared, however access was limited given that a block was in place at present to prevent staff accessing sites through the Trust's IT system. An update on membership was presented for information. Mrs Kinghorn highlighted that recruitment of members in Tipton and Rowley Regis continued to be difficult. Mr Trotman suggested that the local MP for this area be approached to assist. Mr Adler advised that he planned to discuss this matter with the MP as part of a forthcoming meeting. Mr Sharon observed that the Trust's website had received a high number of visits. An update on Owning the Future was presented for information.	
10.5 Midland Metropolitan Hospital project: progress report	**Verbal**
Mr Seager reported that a review of Private Finance Initiative (PFI) by the Treasury had commenced. The Board was informed that approval of the Outline Business Case remained awaited.	
11 Operational Matters	
11.1 Update on 'Listening into Action'	**SWBTB (12/11) 253** **SWBTB (12/11) 253 (a)**
Mr Adler reported that the 'Listening into Action' Sponsor Group continued to meet and that there had been a pleasing ongoing uptake of 'Listening into Action' to manage change and engage staff and patients across the Trust. It was highlighted that the Trust's divisions reported on a cyclical basis to the Sponsor Group. In terms of the wards' use of 'Listening into Action', the Board was advised that previously the Optimal Ward concept had been pursued which combined LiA with the NHS Institute's Product Ward programme. However it was felt that the time was right to undertake a round of "classic" LiA events for the wards. Mrs Hunjan asked how the 'Listening into Action' champions were split according to site. Mr Adler advised that all champions worked cross-site. Mrs Kinghorn added that the support given by the champions varied, with some focussed on supporting a division, while others provided corporate support.	
12 Update from the meeting of the Audit Committee held on 1 December 2011	**Verbal**
Mrs Hunjan advised that at the meeting of the Audit Committee on 1 December 2011 it had been reported that the progress with Internal Audit plan was ahead of schedule and that the majority of reviews had provided significant or full assurance. The Committee had been pleased to learn that there was a reducing number of open actions to address recommendations. A specific discussion of the	

Access to Medical Records review which had provided moderate assurance was reported to have been held, which had highlighted good progress was being made to address recommendations but more work was needed on risk assessments. The Board was informed that the draft Internal Audit plan for 2012/13 had been presented, with the final version due for consideration at the February 2012 meeting. The planned reduction in the Audit fees for 2012/13 had been welcomed by the Committee.

A review of the performance of Internal Audit against a number of Key Performance Indicators was reported to have been considered, which had highlighted 'hot spots' including communicating results and improving the speed of gaining management responses.

The Board was informed that a response to a letter concerning Data Quality Assurance from Chair of NHS West Midlands had been presented, where it was proposed that a scoring system be introduced into performance reports to indicate the quality of data being reviewed, with areas deemed to be of the highest risk being considered first.

Mrs Hunjan reported that the current performance against the Prompt Payment Target had been presented and that the Committee had been advised that a plan was in place to raise the profile of the requirement to to receipt good received. It had been pleasing to hear that the plan to achieve the 95% target set for year-end remained on track.

In terms of a progress report on the work of External Audit, the Committee had been advised that the post Annual Audit review had been completed and that a refreshed Audit Plan would be presented at the next meeting, which would include plans for audit of Quality Accounts.

The Board was advised that the Committee had considered a Counter Fraud Progress Report, including the detail of open cases currently under investigation. It had been reported that the Qualitative Assessment score for 2010/11 had been Level 2, the same as that of the previous year. Mrs Hunjan advised that a new assessment process was being piloted which would replace the Qualitative Assessment. It had been noted by the Committee that the reporting culture for counter fraud matters needed to be improved and it was suggested that further work was needed to raise profile among nursing staff in particular.

The Board was advised that a self-assessment of Audit Committee's effectiveness would be shared at the February 2012 meeting of the Committee.

In terms of other items received and noted by the Committee, the Board was informed that the Quality Account action plan and the updated Assurance Framework had been received and noted. The Committee was reported to have also received the minutes from the other Committees of the Board.

Mr White added that it had been agreed at the meeting that the timetable for the

preparation of the annual report should be aligned to that of the preparation for the annual accounts.	
13 Update from the meeting of the Charitable Funds Committee held on 1 December 2011	**Verbal**
Dr Sahota reported that at the meeting of the Charitable Funds Committee on 1 December 2011, a proposal had been received concerning the Management of Inactive Funds, whereby an escalation process would be implemented and funds transferred into general funds if not spent within a certain time. It was reported that the Committee had adopted the Charitable Funds annual accounts and had approved the annual report for submission to the Charities Commission in January 2012. In terms of the ISA260, the Board was pleased to learn that the Trust's auditors intended to issue an unqualified opinion. A recommendation to seek formal spending plans from fund managers had been proposed, therefore it had been agreed that managers holding funds in excess of £5000 would be asked for spending plans. The Board was advised that an update on investment markets had been provided from the Barclays Wealth adviser, who had highlighted the current volatility in markets and the recent plans to make better access to the US dollar. An agreement was reported to have been made to change the proportion of investment into different asset classes to include a greater number of bonds, thereby reducing the risk of the portfolio. Dr Sahota reported that the Committee had received the quarterly finance update, which presented the detail of income received via donations and charitable funds spent. It had been noted that expenditure was greater than income received at the present, therefore plans to progress with establishing the fundraising function were highlighted to be critical. The Committee had agreed that there was a need to take extra measures in terms of promoting the means by which the people may donate. A list of funds with a balance in excess of £50k was reviewed, as requested at the previous meeting of the Committee and an explanation given as to how the various funds were categorised historically into categories set by NHS Charities Commission. The total value of funds with a balance in excess of £50k was reported to be £2.4m.	
14 Any other business	**Verbal**
There was none.	
15 Schedule of meetings 2012	**SWBTB (12/11) 255**
The Board received and noted the schedule of meetings for 2012.	

16 Details of the next meeting	**Verbal**
The next public session of the Trust Board meeting was noted to be scheduled to start at 1530h on 26 January 2012 and would be held in the Anne Gibson Boardroom at City Hospital.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 26 January 2011, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

15 December 2011, Boardroom @ Sandwell Hospital

Members present: Mr R Trotman (RT), Dr S Sahota (SS), Mrs G Hunjan (GH), Mr P Gayle (PG), Mr J Adler (JA), Mr R White (RW), Miss R Barlow (RB), Mr M Sharon (MS), Miss R Overfield (RO)

In Attendance: Miss K Dhami (KD), Mrs J Kinghorn (JK), Mr G Seager (GS), Mrs C Powney (CP) [Sandwell LINks]

Apologies: Prof D Alderson (DA), Mrs O Dutton (OD), Mr D O'Donoghue (DO'D)

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 17 January 2012

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.195	Update on complaints handling	Hard copy papers	28-Apr-11	Consider the suggestion made to organise a 'walk through' a complainant's experience and the complaints process	KD	~~31/07/2011~~ ~~22/09/2011~~ 15/12/2011	Process flow of complaints process being developed at as part of the revised Complaints Handling strategy which will be shared the Trust Board in ~~December~~ February 2011	A
SWBACT.215	Update on complaints handling	Tabled report	27-Oct-11	Present the proposals to reduce the failsafe targets for complaints once the current backlog is cleared	KD	26/01/12	Failsafe target reduced as follows: Red complaints from 75 to 60 days; Amber from 90 to 70 days; Yellow & Green from 120 to 20 (fast track) or 60 days	G
SWBACT.216	Integrated risk report - Quarters 1 & 2	SWBTB (11/11) 237 SWBTB (11/11) 237 (a)	24-Nov-11	Build in the suggested changes to the integrated risk report into future versions	KD	~~26/01/2012~~ 23/02/2012	ACTION NOT YET DUE	G
SWBACT.218	Monthly performance monitoring report	SWBTB (11/11) 228 SWBTB (11/11) 228 (a)	24-Nov-11	Discuss the additional material needing to be included within the performance exceptions report with Mr White	JK	~~26/01/2012~~ 23/02/2012	Not yet discussed	G

KEY:

R	Outstanding action due for completion more than 6 months ago. Completion has been deferred more than once or there is no firm evidence that it is being progressed towards completion
A	Oustanding action due for completion more than 6 months ago. Completion has been deferred more than once but there is substantive evidence that work is progressing towards completion
Y	Outstanding action raised more than 3 months ago which has been deferred more than once
G	Action that is scheduled for completion in the future and there is evidence that work is progressing as planned towards the date set
B	Action that has been completed since the last meeting

Next Meeting: 26 January 2011, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

15 December 2011, Boardroom @ Sandwell Hospital

Members present: Mr R Trotman (RT), Dr S Sahota (SS), Mrs G Hunjan (GH), Mr P Gayle (PG), Mr J Adler (JA), Mr R White (RW), Miss R Barlow (RB), Mr M Sharon (MS), Miss R Overfield (RO)

In Attendance: Miss K Dhami (KD), Mrs J Kinghorn (JK), Mr G Seager (GS), Mrs C Powney (CP) [Sandwell LINks]

Apologies: Prof D Alderson (DA), Mrs O Dutton (OD), Mr D O'Donoghue (DO'D)

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 17 January 2012

Reference No	Item	Paper Ref	Date	Agreement
SWBTBAGR.252	Estates strategy annual review	SWBTB (12/11) 252 SWBTB (12/11) 252 (a)	15/12/2011	The Trust Board approved the annual update of the estates strategy
SWBTBAGR.253	Fire safety annual report	SWBTB (12/11) 244 SWBTB (12/11) 244 (a)	15/12/2011	The Board agreed that the Chief Executive should sign the annual declaration of fire safety

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Register of Interests
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	26 January 2012

SUMMARY OF KEY POINTS:

A refreshed version of the Register of Interests is presented for approval, which has been amended to take into account recent changes in the Board membership and revised interests.

Additions to the Register are highlighted in blue text and deletions are denoted by 'strikethrough' text.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to approve the revised Register of Interests.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	None specifically, although reflects good governance within the Trust
Annual priorities	
NHS LA standards	
CQC Essential Standards of Quality and Safety	
Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

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

PREVIOUS CONSIDERATION:

Included on the annual cycle of business for the Trust Board

Sandwell and West Birmingham Hospitals NHS
NHS Trust

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REGISTER OF INTERESTS AS AT JANUARY 2012

Name	Interests Declared
Acting Chairman	
~~Sue Davis CBE#~~ Roger Trotman	~~▪ Chair – Cruse Bereavement Care, Sandwell~~ ~~▪ Director – West Midlands Constitutional Convention~~ ~~▪ Non paid Board member – West Midlands Social Inclusion Forum~~ ▪ Non-Executive Director – Stephens Gaskets Ltd ~~▪ Non-Executive Director – Tufnol Industries Trustees Ltd~~ ▪ Non-Executive Director – Stephens Plastic Mouldings Ltd.
Non Executive Directors	
~~Roger Trotman~~	~~▪ Member – Business Voice West Midlands Ltd.~~ ~~▪ Member – Advantage West Midlands – Regional Finance Forum~~ ~~▪ Member – Regional Health Partnership~~
Gianjeet Hunjan	▪ Governor – Great Barr and Hamstead Children's Centre ▪ Governor – Ferndale Primary School ▪ ~~Local Authority~~ Community Governor – Oldbury College of Sport ▪ Member – GMB Trade Union ▪ Member – Managers in Partnership/UNISON ▪ Treasurer – Ferndale Primary School Parents Association
Sarindar Singh Sahota OBE	~~▪ Non Executive Director – Business Voice West Midlands Ltd~~ ▪ Trustee – Acorns Hospice ▪ Director – Sahota Enterprises Ltd ▪ Director – Sahota Properties Ltd ~~▪ Member – Ladywood Skills Academy~~ ▪ Member – Birmingham ~~& Solihull~~ Chamber of Commerce Council ▪ Member – Smethwick Delivery Board ▪ Governor – Nishkam Education Trust
Derek Alderson	Member – Council of Royal College of Surgeons of England
Phil Gayle	CEO New Servol
Olwen Dutton	~~▪ Director – West Midlands European Centre~~ ▪ Partner – Bevan Brittan LLP ▪ Fellow – Royal Society of Arts ▪ Member – Lunar Society ▪ Member – Midland Heart – Care and Support Committee

Name	Interests Declared
Executive Directors	
John Adler	Adviser – Guidepoint Global
Donal O'Donoghue	Director – Amo Amas Limited
Rachel Barlow	None
Rachel Overfield	None
Mike Sharon	None
Robert White	▪ Director – Midtech clg ▪ National Committee Member – HFMA Financial Management & Research Committee
Associate Members	
Graham Seager	None
Kam Dhami	None
Jessamy Kinghorn	None
Trust Secretary	
Simon Grainger-Payne	None

January 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Single Tender Action Rowley Regis Catering Refrigeration
SPONSORING DIRECTOR:	Director of Estates
AUTHOR:	Rob Banks / Kevin Reynolds
DATE OF MEETING:	26 January 2012

SUMMARY OF KEY POINTS:

The Trust Board are requested to approve "Single Tender Action" for replacement refrigeration equipment at Rowley Regis Hospital.

The proposal is covered by a Government Procurement Service (Buying Solutions) agreement contract reference RM673, with OJEU reference of 2009/s S57 82118.

The expected outturn cost including VAT is £225,588. This cost being met by the Statutory Standards allocation from the Capital Program

The project is required to improve resilience and comply with legislation regarding the use of ozone depleting refrigerants at the central food production unit based at Rowley Hospital.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
x		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

To approve the Single Tender Form in favour of Fosters Refrigeration as per Government Procurement Service agreement Ref RM 673 to the sum of £225,588 Inc VAT

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Supports the delivery of High Quality Clinical Care/Accessible & Responsive Care, Care Closer to Home, Good Use of Resources & 21st Century Facilities
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

Financial	**X**	Cost will be met by the Estates Related Capital Budget
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		*Non delivery of the scheme will increase business continuity risk as the plant is aging and utilises a refrigerant which is being phased out.*

PREVIOUS CONSIDERATION:

None.

Sandwell & West Birmingham Hospitals NHS Trust

Application to Waive Competitive Tendering

☐ **£50,000 - £135,668 (CEO & FD)** ■ **> £135,668 inc 20% VAT (Trust Board)**

Competitive tendering for goods and services is set out in Section 4 of the Scheme of Delegation and section 17.5 within the Standing Financial Instructions (see 'Guidelines and Policies' Trust intranet). This proforma meets Standing Orders as the report needed when approval is granted.

Dept/Division	Estates
Description of Goods/Service	Refrigeration Replacement Rowley Regis
Supplier (and # of waivers since 1st April)	Fosters Refrigeration / 0 waivers
Estimated Cost (**inc.** VAT)	£225,588
Value of Previous Order (if applicable)	N/A

Has supply been subjected to previous tendering exercise? Yes - Government Procurement Service (Buying Solutions)

If Yes, state date 2009

Select one basis for Application to waive tendering (see section 17.5.3 SFIs, (a) to (b) not applicable).

Continue free text narrative overleaf if needed.

- ☐ (d) CEO approval of exceptional circumstances, tendering not practicable
- ☐ (e) The supply is covered by an existing contract
- ■ (f) Board approved OGC/NHS Supply Change/PASA agreements are in place
- ☐ (g) Consortium arrangement in place, host body appointed to carry out tendering
- ☐ (h) Timescale genuinely precludes tendering (failure to plan work however is not regarded as justification for a single tender)
- ☐ (i) Specialist expertise required, available from only one source
- ☐ (j) Task essential to completion of project, inappropriate to engage new supplier
- ☐ (k) Continuity with earlier project outweighs benefits of competitive tendering
- ☐ (l) Specialist legal advice as regulated by the Law Society or Bar Council
- ☐ (m) As allowed and provided for in the Capital Investment Manual

"I declare that the information given on this form is correct. I understand that if I knowingly provide false information and/or do not declare any interests with the companies mentioned that it may result in disciplinary action and that I may also be liable to prosecution. Where necessary I consent to the disclosure of the information contained on this form to be used by the Trust for the purpose of verification, investigation, prevention, detection and prosecution of fraud".

The proposal is covered by a Government Procurement Service (Buying Solutions) agreement contract reference RM673, with OJEU reference of 2009/s S57 82118

DGM/DD R Banks	Date 17 / 01 / 2012
Sponsoring Board Director _____	Date____/_____/___
Chief Executive _____	Date____/_____/___
Finance Director_____	Date____/_____/___
Board Minute Reference _____	Date____/_____/___

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Report on recent CQC report and progress on action plans
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Rachel Overfield, Chief Nurse
DATE OF MEETING:	26 JANUARY 2012

SUMMARY OF KEY POINTS:

The Trust Board is asked to note the contents of this report; the CQC report following their third visit to Sandwell Hospital in December 2011.

The inspectors revisited wards Newton 4 and Newton 1.

Specifically, the Trust Board is asked to note the judgement of the CQC for Sandwell as being:

- **Compliant** with Outcome 5 (nutrition) – previously Minor concerns.
- **Compliant** with Outcome 1 (privacy and dignity) – previously Moderate concerns.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to note the contents of the attached report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	1.2 Continue to improve patient experience.
Annual priorities	1.2 Continue to improve patient experience.
NHS LA standards	
CQC Essential Standards Quality and Safety	Regulation 9, Outcome 4 – Care and welfare of people who use services. Regulation 10, Outcome 16 – Assessing and monitoring the quality of service provision. Regulation 17, Outcome 1 – Respecting and involving people who use services.
Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

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

PREVIOUS CONSIDERATION:

Governance Board 13th January 2012.

Review of compliance

Sandwell and West Birmingham Hospitals NHS Trust Sandwell General Hospital	
Region:	West Midlands
Location address:	Lyndon West Bromwich West Midlands B71 4HJ
Type of service:	Acute services with overnight beds
Date of Publication:	December 2011
Overview of the service:	Sandwell General Hospital is part of Sandwell and West Birmingham Hospitals NHS Trust. It is a busy acute hospital with 470 beds. The hospital serves a population of around 290,000. It provides many specialist services including accident and emergency provision.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Sandwell General Hospital was meeting all the essential standards of quality and safety.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review to check whether Sandwell General Hospital had made improvements in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 05 - Meeting nutritional needs

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 16 December 2011, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

Sandwell General Hospital is part of Sandwell and West Birmingham Hospitals NHS Trust (the trust). In March 2011 and August 2011 we carried out reviews of Sandwell General Hospital. These reviews were part of a targeted inspection programme in acute National Health Service (NHS) hospitals to assess how well older people are treated during their hospital stay. In particular we focused on whether people were treated with dignity and respect and whether people's nutritional needs were being met. Both our March 2011 and August 2011 reviews showed that Sandwell General Hospital was not compliant with the outcome areas we assessed which were:

Outcome 01- Respecting and involving people who use services (we assessed that there were moderate concerns in this area both in March and August 2011).

Outcome 05- Meeting nutritional needs (we assessed that there were major concerns in this area in March 2011 and minor concerns in August 2011).

Following our August 2011 review the trust closed a ward called Newton 4 as this is the ward where we identified shortfalls and concerns.The trust have kept us updated with their plans to make improvements.

We carried out this December 2011 review to check whether Sandwell General Hospital had made improvements. The wide range of evidence that we gathered during this review

confirmed compliance with both outcome areas.

A reconfiguration of wards and stroke provision has taken place. There are two dedicated wards to care for people who have suffered a stroke. Newton 1 is the acute assessment ward and Newton 4 is dedicated to stroke rehabilitation.

We assessed both of these wards as part of our review. Staff told us how the reconfiguration of wards had benefitted people in terms of there being clear stroke care pathways from the time they arrive at accident and emergency through to assessment, rehabilitation and discharge.

Staff wanted to speak with us. They wanted to tell us about the improvements that had been made. They told us how these improvements and changes were having a positive impact on the people that were being cared for on their wards.

All of the staff we spoke with highlighted the importance of "team working" and how everyone had an important role in making sure that people received a good standard of care. Staff were enthusiastic about the changes and improvements that they had made. Staff at all levels were aware of the need to continue with the work they had undertaken to make sure that improvements are furthered and sustained. Below are a few comments staff made;

"Things are where they should be now it was terrible before. It has taken a lot of hard work to get where we are now but things are a lot better".

"Staffing levels are better and leadership is better. There have been great improvements since March".

"There have been a lot of changes since August. Newton 4 was very busy and people were heavily dependant. Staff did not understand expectations. We have put a lot of processes into place to improve and improvements have been made".

"We have more time to spend with people to give them reassurance".

On both wards we spent time observing. We observed staff engaging with people. We listened to find out if staff gave people choices and spoke with them politely. We watched staff to see how they supported people to eat their meals. We looked at records to make sure that the care delivered was personalised and effective. Our findings from these observations demonstrated improvement and compliance.

We spoke with people to find out their views on the care provided. In total we spoke with twelve people across both wards.

People were complimentary about the care and service they had received. People made positive comments about their treatment and the staff. Below are a few comments people made;

"Everyone has been extremely kind to me".

"Have been treated well here, can't better it".

"Nothing could be improved".

"The staff are absolutely wonderful, I can't fault them at all. They do everything they can for me".

"Honestly, I can not complain about anything".

"The food is nice. We have choices every meal time".

"The food is not a problem".

What we found about the standards we reviewed and how well Sandwell General Hospital was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

The trust has implemented systems and processes to improve the way in which people are cared for to promote dignity, respect and involvement. This has had a positive outcome for people. People are shown respect and their care is provided in a polite, dignified way.

Outcome 05: Food and drink should meet people's individual dietary needs

Improvements in meal time processes, availability of food, drink and staff to give meal time support and greater diligence in recording keeping gives people assurance that their nutritional and hydration needs will be met.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We spoke with twelve people across both wards. People were positive about their care and treatment. People told us that they had been well looked after and used words such as "wonderful" to describe the staff. One person told us; "Staff are polite and kind". Another person told us; "I can not fault the staff they do everything they can for me".

People told us that they had been informed about their situations, treatments and care planning. One person told us; "I saw my consultant a day ago. They told me what tests I needed and why. I know what treatment I need and am happy with that".

Staff told us about the changes that had been made to improve care and treatment. They told us about the "dignity champion" campaign where numbers of staff have been trained to oversee and assess practices to make sure that the care that is delivered is done so in a respectful and dignified way.

Other evidence
When we reviewed Sandwell Hospital in March and August 2011 we had moderate concerns about this outcome area and we required that improvements were made. During both our March and August 2011 reviews evidence we gained by speaking with people and staff and looking at records was mixed. On some wards people spoke

highly about the treatment they had received and the way in which staff dealt with them and met their needs. However, during both reviews on Newton 4 we found shortfalls in care delivery and witnessed situations which confirmed that some people's needs were not being met and their dignity was not being promoted or respected.

Following our August 2011 review the trust have provided us with updated action plans and have told us about the changes they have made to improve care delivery.

We carried out our December 2011 review which included Newton 1 the acute stroke assessment ward and Newton 4 which is now dedicated to stroke rehabilitation and found that improvements have been made.

We made general observations on both wards. We saw that staff were available to supervise and support people at all times. We saw and heard staff asking people if they needed anything rather than people having to call for staff. Staff were responsive to people's needs. We did not hear call bells ringing for any length of time. We saw that call bells were within easy reach for people and this meant they were able to summon assistance if needed.

We saw that curtains were pulled around beds when personal care was being provided and that signs were available to alert staff not to enter bed spaces when the curtains were drawn.

We observed staff talking with people; they were friendly and polite to them. Records confirmed that the preferred form of address had been determined for each person and we heard staff addressing people by their preferred names.

We heard staff giving people choices about what they wanted to eat and wear.

We saw that hospital pyjamas and nightgowns were available for people who were unable to bring their own from home. We saw signs on walls and in individual care files encouraging relatives to bring people's own clothes in for them to wear. We saw that a number of people on the ward were wearing their own clothes and footwear. One person told us; "My daughter brings me some clean clothes everyday. I think it is much better. I like wearing my clothes". We saw that where people were sitting in chairs their legs were covered with a blanket to protect their dignity.

We spoke with people and asked them their views on the way they were treated. Everyone we spoke with confirmed that staff treated them well. People told us that they were informed about their situations and treatments and that they were satisfied with the care that they received. One person told us; "They are all very good. They are kind and polite. All staff treat me very well that's the doctor, ward staff and therapists. When they wash me or move me in the hoist they close the curtains and cover me up. They tell me what is happening all the time".

We spoke with one person who was being cared for in a side room. We asked this person if they minded being in the side room. The person told us that it had been their choice. They had told staff that they wanted a quiet room and they had been allocated that one.

We spoke with another person who was in another side room. They told us that they

had been in hospital for some time. They and their relatives had personalised their room. They had their own TV, family photos on display and Christmas decorations hanging on the walls.

We spoke with a number of staff who confirmed that there had been many changes and improvements made to benefit the people in their care. One staff member told us; "We have more staff. Things are more organised. Staff know what they should be doing and checks are made regularly. Things are much better".

Our judgement
The trust has implemented systems and processes to improve the way in which people are cared for to promote dignity, respect and involvement. This has had a positive outcome for people. People are shown respect and their care is provided in a polite, dignified way.

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
* Are supported to have adequate nutrition and hydration.

What we found

Our judgement

The provider is compliant with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
When we reviewed Sandwell Hospital in March 2011 we had major concerns about this outcome area. We found that there were insufficient staff available to help people who were at risk of malnutrition and dehydration to eat or drink. The recording of food and fluid intake was patchy to the extent it could not be used to determine if people had eaten and drunk enough to prevent ill health. Our August 2011 review indicated improvement but we still had minor concerns. People we spoke with were generally happy about the meals and support they received. However, we found that people who were at risk of weight loss were not always being supported appropriately to eat and there were significant gaps in food and fluid intake in records.

During our December 2011visit we asked people about their mealtime experiences and views on food. Overall, people confirmed that they were happy with the food provided and told us that they were given choices. Below are a few comments people made;

"The food they give me is plenty. They ask me if I want any supper but I never do. Once I have had my tea that's enough for me".

"Always food available and a choice of meals".

"The dinner was nice. They are always shoving food and drink down you"
(said positively and jokingly).

Other evidence
Following our March and August 2011 reviews the trust has kept us informed about

systems being put into place and action being taken to improve in this area. We carried out our December 2011 review to identify if improvements had been made and we found that they had.

During our December 2011 review we observed meals times, spoke with staff and people and looked at records.

Senior staff told us that people who were at risk from dehydration and malnutrition were placed on a "risk list". These people were put on a red tray and red beaker scheme which alerts and reminds staff and visitors that these people need help, support and regular encouragement to eat and drink. We tracked the care of eight people across both Newton 1 and Newton 4 to find out if this system was working. We found that it was.

We saw that there was a picture of a red tray and beaker above the beds of people who were at risk of malnutrition and dehydration. Information for relatives was available in people's care files and displayed on the ward telling them the purpose of the red tray/beaker scheme.

During the main meal time we observed people who were on the red tray/ beaker scheme to make sure that staff were available to give them support and encouragement with eating and drinking and saw that there were.

Staff giving the meals to people knew what individual people could and could not have to eat and drink and where thickener was needed to be added to drinks to prevent choking. One person told us; "I can only have drinks that are thickened and food that is mashed. I know why, it is to prevent me choking. Today I had cheese and potato pie which was nice".

We saw that staff were available to help people to eat as soon as their meal had been given to them. We saw that hand wipes were given to people to wipe their hands before they ate. Staff sat down next to people to help them to eat. We saw that people who were in bed were encouraged to sit up or helped to sit up to eat more comfortably and safely.

We heard staff giving people choices of what they wanted to drink and eat and what flavour yogurt they wanted. We heard people commenting that they had enjoyed their meals.

Senior staff told us that all staff made sure that meal times were "protected". During meal times only staff who needed to be there were allowed to remain on the ward. This is so that people can eat in a relaxed and peaceful environment without interruption. We saw this process in practice. At 11.40 a bell was rung. This was to alert all staff who were not needed at the mealtime that they need to finish what they were doing and leave the ward.

We saw the "meal coordinator" at work. This person told us about their role. They told us that at each mealtime one staff member is delegated as meal coordinator. It is that person's responsibility to ring the bell, ensure staff that don't need to be there leave the ward and that following the meal all food and fluid intake records are completed. After the meal had finished we saw the meal coordinator go around and check that the

records were completed properly. We saw that the meal coordinator asked questions of some staff who had supported people to eat for clarity and confirmation regarding the records.

Recent actions on the wards have improved mealtime experiences for people and have reduced the risk of ill health due to poor diet and fluid intake.

We looked at a number of care records. We saw that people were weighed regularly. We did not identify any significant weight loss. One person told us; "I did lose weight when I was first ill. I have been told now that I am the perfect weight they want me to be".

We spoke with staff who had worked on Newton 4 from March 2011 until present. They confirmed how much improvement there was in terms of meals and meal times. They said; "I bet you can see a difference to what you saw in March. There are staff available to help people eat. Everything is more peaceful. People even know that they can ask for food and snacks between meals. There have been big improvements".

Our judgement
Improvements in meal time processes, availability of food, drink and staff to give meal time support and greater diligence in recording keeping gives people assurance that their nutritional and hydration needs will be met.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
Copyright	

Care Quality Commission

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Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Nursing Update
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Rachel Overfield, Chief Nurse
DATE OF MEETING:	26th January 2012

SUMMARY OF KEY POINTS:

There has been significant progress made in achieving quality targets – most notably tissue damage, falls and nutrition.

Quality audits and ward reviews continue to show improvement across most wards. Exceptions are highlighted.

The number of 'concern' wards relating to flexible unfunded beds have decreased significantly. Staff : bed ratios (funded) remain fairly static and on the whole are acceptable. Attention now needs to be given to trained : untrained ratios when there are a number of areas not achieving the recommended ratio (nb in some cases this is a deliberate and justified decision).

Nursing related CQUiNs are all doing well and expected to meet targets by your end.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board are asked to note the contents of the attached report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	1.2, 2.2, 2.3, 2.8, 2.11, 6.2 High quality care
Annual priorities	1.2, 2.2 Improve care to vulnerable adults Improve quality and safety
NHS LA standards	2.3.3 Safeguarding Adults 2.3.5 Slips, Trips and Falls
CQC Essential Standards Quality and Safety	Regulation 10, Outcome 16, Regulation 11, Outcome 7, Regulation 14, Outcome 5, Regulation 17, Outcome 1
Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

Financial	**x**	Requirement to agree staffing model for flexible beds
Business and market share		
Clinical	**x**	
Workforce	**x**	Requirement to agree flexible staffing model
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience	**x**	
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

The Nursing Update report is submitted to the Trust Board bi-annually.

Report Title	*Nursing Update – October 2011 to January 2012*
Meeting	*Trust Board*
Author	*Rachel Overfield, Chief Nurse*
Date	*26th January 2012*

1) Introduction

The following report captures key nursing and quality safety issues and performance against standards and targets.

In future most of these will be reported as part of the Trust Quality report on a monthly basis with quarterly audits being included when appropriate.

It is proposed therefore that this report become an annual report against the nursing strategy and objectives which will be brought to the Trust Board in March.

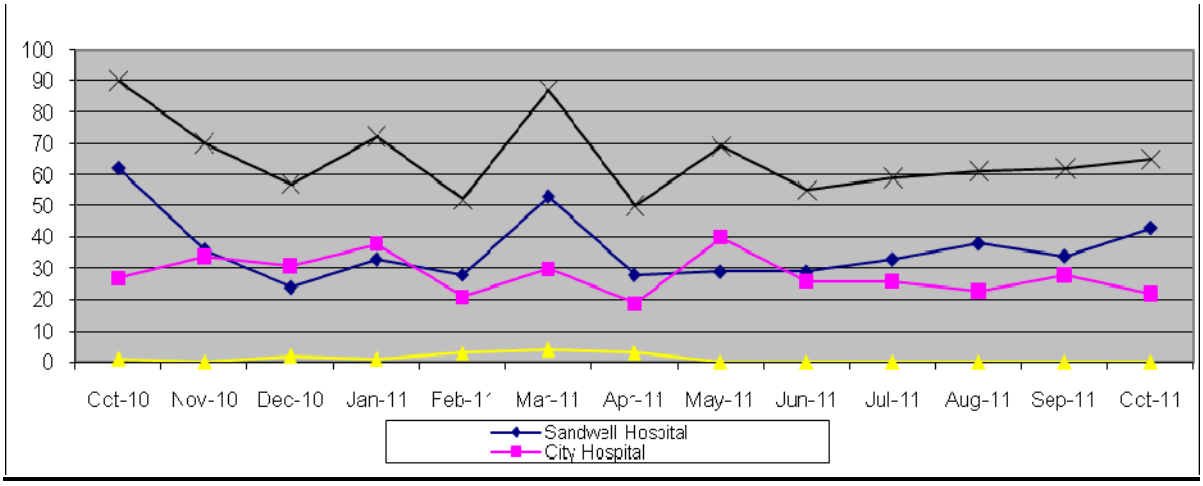
2) Patient Safety

2.1 Falls Prevention

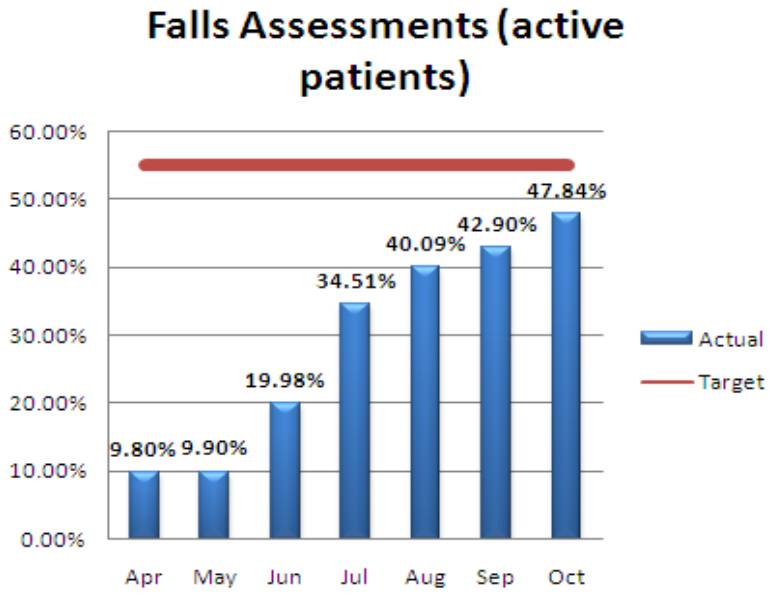
Target –	10% reduction of falls in 2011/12 (acute)	*Internal*
	95% falls risk assessment complete (acute)	*Internal*
	55% falls risk assessment complete (District Nursing)	*CQUiN*

YTD – 22% falls reduction (acute)
92.5% risk assessment (acute)
47.8% risk assessment (DN)
Incidence per 1000 bed days = 2.58 (3.35 same time 2010)

Trend of falls



Community Risk Assessment



Incidence per 1000 bed days

	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May - 11	June-11	July-11	Aug-11	Sept -11	Oct-11	Total
Sandwell Hospital	5.26	3.86	1.63	2.56	2.57	4.52	2.59	2.71	2.87	3.47	4.02	3.62	4.03	3.63
City Hospital	1.86	2.91	2.55	2.55	1.53	1.96	1.42	2.80	1.80	1.87	1.66	2.14	1.52	2.28
Rowley Regis Hospital	1.73	0.00	3.00	1.42	5.29	5.60	5.13	0.00	0.00	0.00	0.00	0.00	0.00	7.09
Trust Total	**3.35**	**2.64**	**2.07**	**1.42**	**2.07**	**3.14**	**2.02**	**2.74**	**2.24**	**2.52**	**2.62**	**2.78**	**2.58**	**2.97**

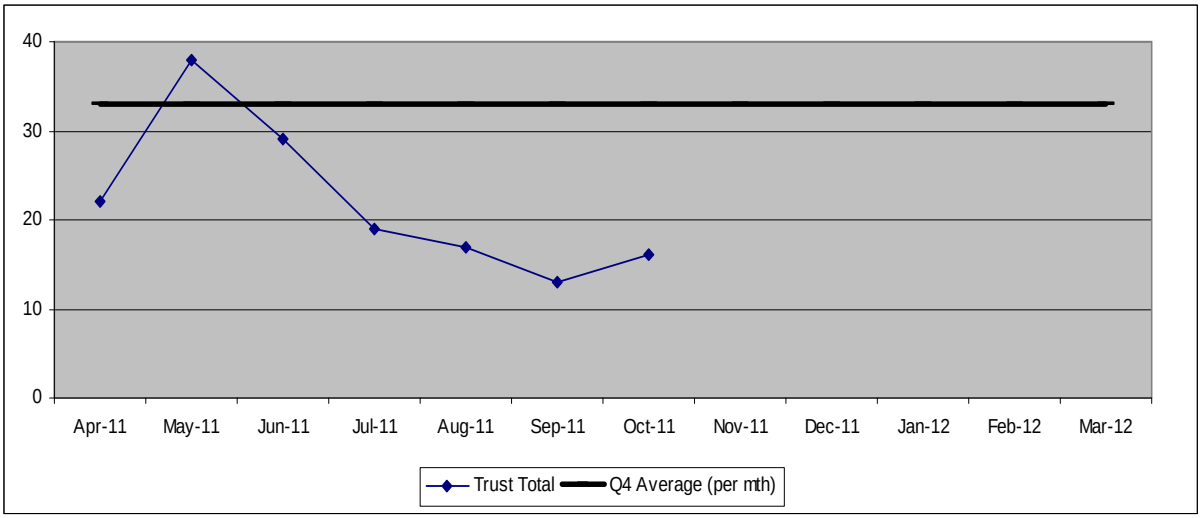
TTR's are completed on all injurious falls and are now sufficiently advanced to determine whether falls could have been avoided. Currently around 50% of falls with injury were unavoidable.

2.2 Pressure Damage

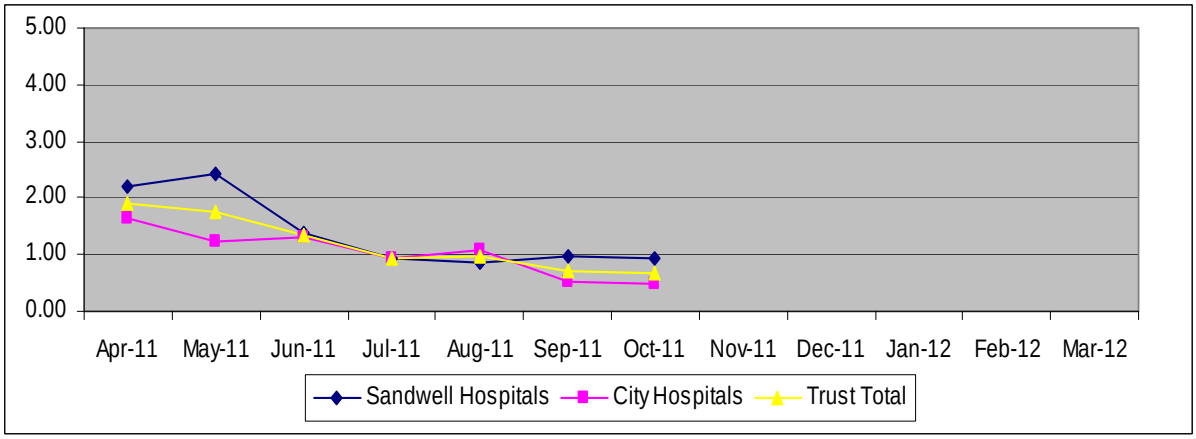
Target – 10% reduction in hospital acquired grade 2, 3 and 4 sores compared to Q4 2010/11
95% risk assessments completed
} acute only

YTD – Total 33.3% reduction
95% assessment target achieved
Sores per 1000 bed days – 0.8 (1.9 previous year)

Number of hospital acquired avoidable pressure damage Grade 2, 3 & 4, April - October 2011

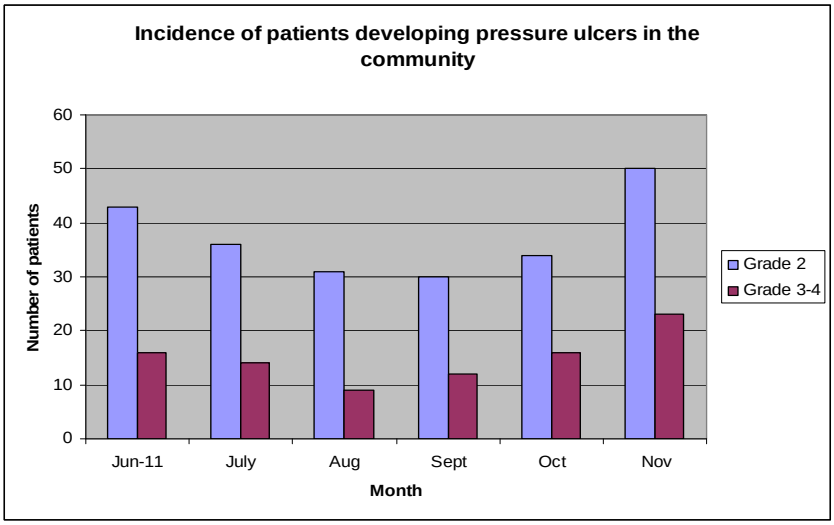


Hospital acquired data per 1000 bed days April - October 2011 Grade 1, 2, 3 + 4 Avoidable pressure ulcers only



There are currently no local targets for community services although national nurse high impact actions to reduce any health care acquired sores apply equally to the community.

The following table demonstrates current knowledge of community trends, however data is not yet fully reliable and only reflects sores known to either DN teams or community based tissue viability staff.



There is a very significant level of reported patient non compliance for which we need to agree management strategies.

2.3 Nutrition and Hydration

Target – 75% patients are MUST assessed within 12 hours of admission (CQUiN)
80% compliance protected meal times

YTD – Only 3 wards failed to achieve in excess of 85% MUST assessment (D16, D18, and L5)
All wards are achieving at least 80% compliance with protected meal times (based on snap shot audits)

- Our patients continue to be at the high end of the national average for malnourishment scores on admission at 29% (vs. national average 25-30%)
- Use of various risk mitigation actions, eg red trays is good at around 99% compliance vs. 69% in June 2010
- Food diaries are completed in 98% of patients who require them vs. 64% in June 2010
- Fluid balance charts are completed in 96% of patients requiring them vs. 74% in June 2010

2.4 Nurse Staffing Levels

The Trust aims to have staffing ratios at around 1 WTE:1 bed (unless guidance specifically states otherwise) and a qualified to unqualified ratio of 60:40.

	BUDGETED POSTS & FUNDED BEDS				BUDGETED POSTS& ACTUAL BEDS OPEN		ACTUAL IN POST & FUNDED BEDS				
Ward	TOTAL WTE	% of Trained Staff	No of funded beds	No of staff per Bed	Actual No of beds open	No of staff per Bed	TOTAL WTE	% Trained Staff	% Bank & Agency Staff	No of staff per Bed	Sickness Rate (%) (Nov)
Medicine & Emergency Care											
D5 (CCU/PCCU)	39.25	92.36%	17	2.31	17	2.31	38.74	79.89%	13.91%	2.28	6.59
CCU Sandwell	19.07	84.27%	10	1.91	10	1.91	18.46	83.97%	5.20%	1.85	7.39
D7 (includes 10 winter beds)	33.04	62.65%	26	1.27	26	1.27	34.03	52.98%	24.69%	1.31	3.4
D11	31.54	59.38%	21	1.50	21	1.50	32.70	52.05%	9.42%	1.56	4.35
D12	16.52	66.10%	10	1.65	10	1.65	20.34	65.00%	10.32%	2.03	17.72
D15	26.20	58.02%	24	1.09	24	1.09	26.59	49.46%	9.17%	1.11	2.19
D16	28.50	56.84%	23	1.24	23	1.24	26.79	46.21%	23.74%	1.16	11.65
D17	28.01	69.98%	26	1.08	26	1.08	27.88	59.00%	14.17%	1.07	8.12
D18	19.61	54.11%	16	1.23	16	1.23	24.27	46.27%	24.85%	1.52	11.56
D41	24.67	77.10%	17	1.45	17	1.45	25.44	66.38%	12.63%	1.50	3.43
D43	31.20	57.72%	28	1.11	28	1.11	30.20	41.75%	19.98%	1.08	2.73
D47 *Some ratios excl therapists*	30.17	49.96%	22	1.37	22	1.37	41.84	34.12%	41.80%	1.90	14.73
MAU	64.85	64.80%	28	2.32	28	2.32	63.45	59.62%	15.12%	2.27	10.54
Priory 3	30.30	51.55%	29	1.04	29	1.04	33.26	44.35%	10.71%	1.15	10.39
EAU (includes 4 winter beds)	48.64	64.58%	32	1.52	32	1.52	49.86	57.37%	20.19%	1.56	13.01
Newton 4	28.54	46.57%	22	1.30	22	1.30	36.20	36.74%	28.57%	1.65	4.75
Newton 1	20.63	83.57%	12	1.72	12	1.72	18.73	64.07%	18.05%	1.56	0
Priory 4	34.20	51.46%	35	**0.98**	35	**0.98**	35.37	42.40%	17.54%	1.01	7.59
Lyndon 4 (+7 winter beds)	33.30	56.19%	33	1.01	33	1.01	36.98	50.22%	17.41%	1.12	0.54
Lyndon 5 (closed)	0.00	#DIV/0!	30	**0.00**	30	**0.00**	0.69	0.00%	100.00%	**0.02**	n/a
Newton 5	23.70	76.37%	15	1.58	15	1.58	23.77	74.04%	11.65%	1.58	4.49
Winter Ward - Sandwell	24.00	50.00%	24	1.00	24	1.00	20.07	57.10%	13.00%	**0.84**	8.04
Winter Ward - City	24.00	60.00%	20	1.20	20	1.20	9.27	43.78%	31.20%	**0.46**	n/a
Priory 5	36.60	52.46%	34	1.08	34	1.08	34.18	57.64%	5.88%	1.01	8.94
McCarthy											

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	BUDGETED POSTS & FUNDED BEDS				BUDGETED POSTS& ACTUAL BEDS OPEN		ACTUAL IN POST & FUNDED BEDS				
Ward	TOTAL WTE	% of Trained Staff	No of funded beds	No of staff per Bed	Actual No of beds open	No of staff per Bed	TOTAL WTE	% Trained Staff	% Bank & Agency Staff	No of staff per Bed	Sickness Rate (%) (Nov)
Surgery											
Eye Ward/ Day Surgery Unit	27.54	83.77%	16	1.72	16	1.72	26.67	80.13%	4.35%	1.67	10.14
D6 (Pre Assessment Unit)	7.95	74.84%	0	#DIV/0!	0	#DIV/0!	8.08	73.64%	4.46%	#DIV/0!	3.63
ENT/Vascular (D21/24)	23.21	67.69%	15	1.55	15	1.55	22.67	63.52%	3.31%	1.51	3.59
D25	27.54	60.24%	23	1.2	23	1.2	27.42	60.36%	8.17%	1.19	6.84
Orthopaedics/Ortho Rehab (D26/28)	44.76	59.96%	36	1.24	36	1.24	40	60.80%	6.33%	1.11	2.44
D30	19.15	64.49%	19	1.01	19	1.01	19.84	58.01%	10.74%	1.04	14.34
D42 (SAU)	22.34	73.14%	30	**0.74**	30	**0.74**	23.33	68.97%	5.32%	**0.78**	10.86
ASU	26.2	74.05%	0	#DIV/0!	0	#DIV/0!	25.74	70.12%	3.26%	#DIV/0!	8.82
Newton 2 *(5 day ward, there shown beds as 24*5/7)*	17.85	61.79%	27	**0.66**	27	**0.66**	17.88	63.53%	2.85%	**0.66**	0.18
Lyndon 2	27.73	56.26%	32	**0.87**	32	**0.87**	29.18	45.58%	15.80%	**0.91**	15.31
Lyndon 3	30.17	50.58%	28	1.08	28	1.08	29.98	42.53%	14.44%	1.07	8.18
Priory 2	26.67	60.82%	26	1.03	26	1.03	29.11	47.30%	18.42%	1.12	1.26
Newton 3	37.9	40.26%	33	1.15	33	1.15	36.07	41.37%	18.48%	1.09	1.26

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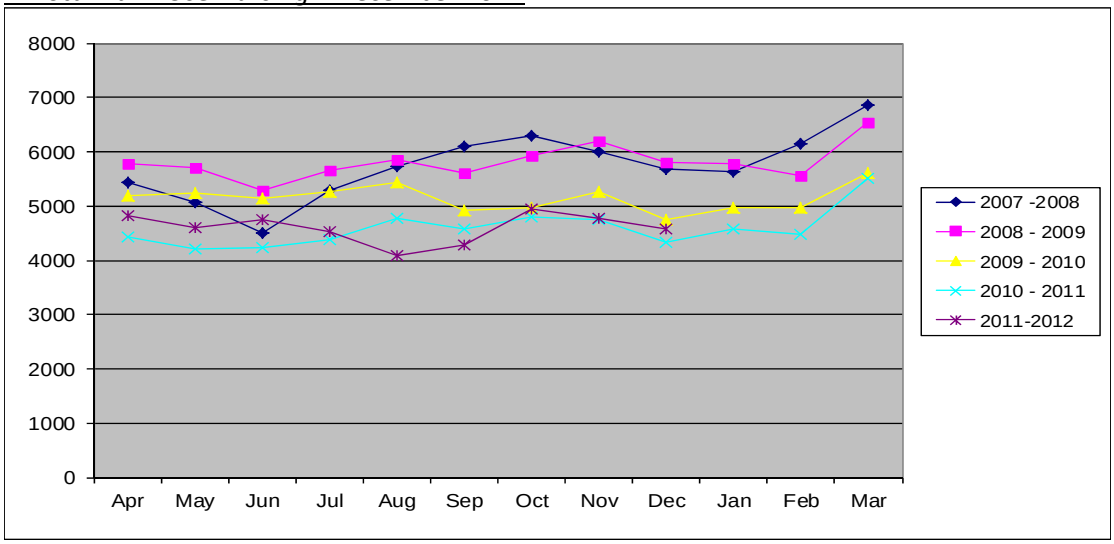
The above tables show the planned position vs. the actual position in month (November) using a fairly unsophisticated means of assessing beds open over the month and pulling in various pieces of information from several systems manually. E-rostering will enable much greater accuracy in the future. What the table suggests is that there are two wards who are still not established to the required staffing ratio.

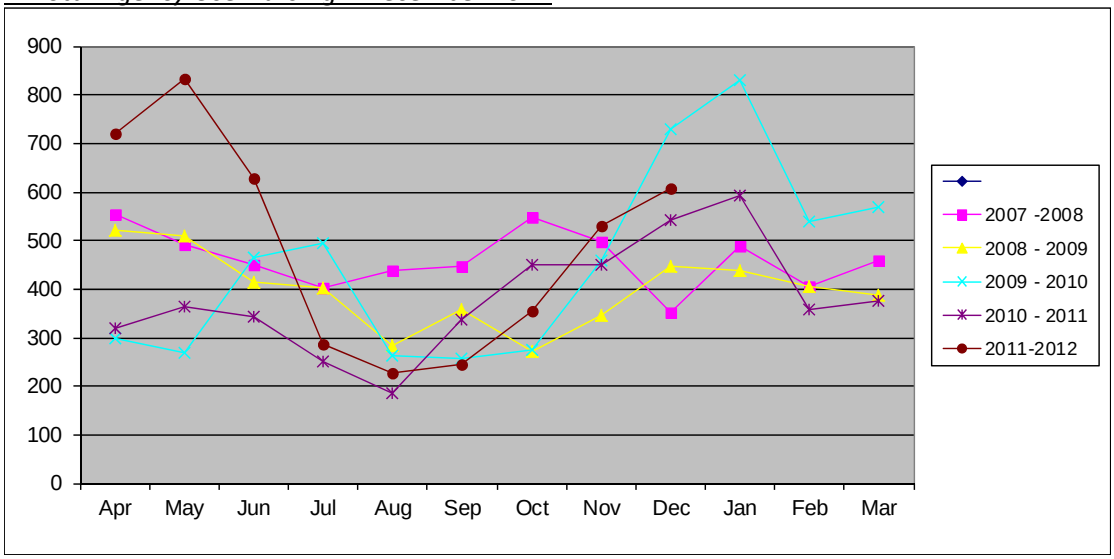
The Trust's nurse bank/agency rates are detailed below as tables 1, 2 and 3 and show year on year comparison from 2007/8 to date.

There remain several areas that do not have the 60:40 trained to untrained ratios – most of these are Elderly Care wards where this may be appropriate. More work is required. There remains a high reliance on bank staff in some areas.

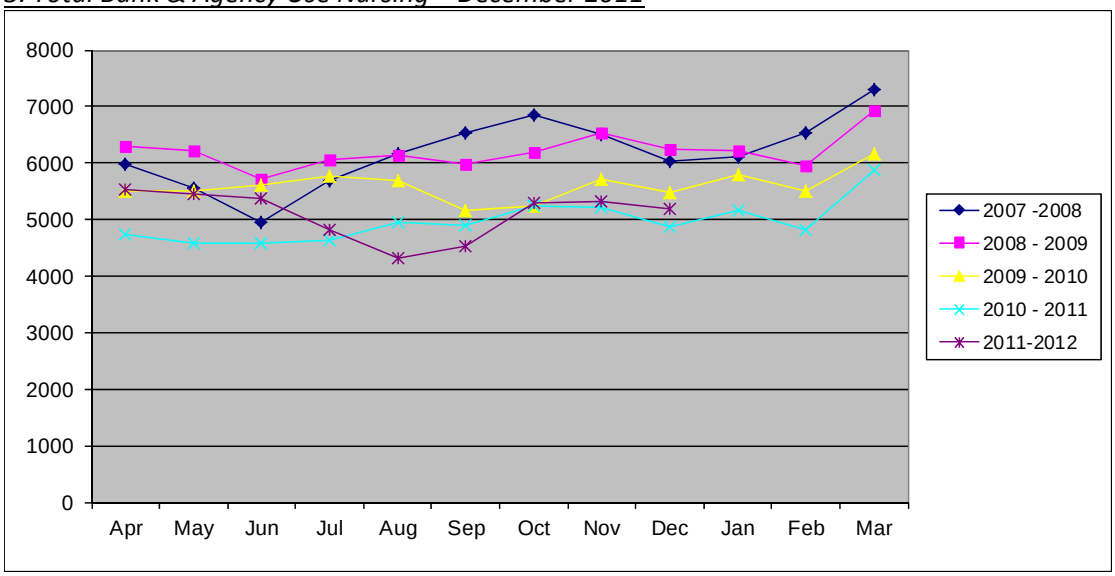
1. Total Bank Use Nursing – December 2011



2. Total Agency Use Nursing – December 2011



3. Total Bank & Agency Use Nursing – December 2011



The Board will see that over the years reliance on bank/agency staffing has reduced considerably with 2010/11 having the lowest recorded rates. However, there have been some months in 2011 that exceed 2010 rates, despite there being less activity and less open beds. It is thought that this is partly in response to quality concerns in light of CQC reports and better information regarding staffing ratios leading to an increase in mitigation action. Another explanation for the increase is the move of community services to the Trust. The community were fairly high users of agency staff which explains much of the increase in agency numbers. Work is ongoing to convert community agency workers to our bank.

2.5 Safer Nursing Care Tool

We are continuing to use this tool which is recommended nationally and regionally as a reasonable measure of patient acuity at a given point in time.

Used in conjunction with e-rostering we will be better abled eventually to match staff resources to patient need.

The tool has been used on all adult in patient areas twice now but there continues to be significant problems with nurses correctly rating patients acuity/dependency and until this is

consistently accurate we cannot use or share the results. There has been improvement in accuracy of recording between the first and second attempts and it is therefore hoped that next time results will be more reliable.

2.6 E-rostering

The system continues to be rolled out on a 3 ward per month basis with an ambition to have all wards including Maternity, Paediatrics and Critical Care using the system by March 2013.

Of the current wards using the system poor rostering practices have been identified with definite quality benefits to be had and also staff incentives and financial gains/savings.

2.7 Medicines Management

Target – 10% reduction on avoidable medicine omissions (CQUiN)

Q3 – Average reduction of 16%

3) Patient Experience

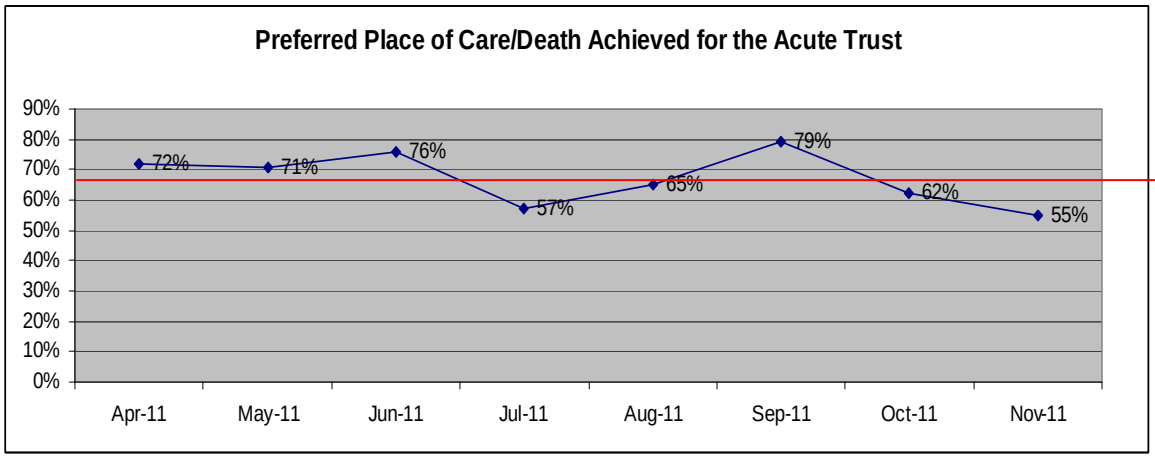
The Patient Satisfaction Survey report recently reported to TMB is attached as Appendix 1.

3.1 End of Life Care

Target – 10% increase in patients achieving preferred place of death (acute and community). Measured against Q4 baseline = 66% acute and 38% Sandwell Community (CQUiN).
10% reduction in emergency admissions.

YTD – 62% (acute) achieved preferred place of death.
56% (community) achieved preferred place of death.

Achieving preferred place of death for patients wishing to die at home who require discharge from the acute continues to be very challenging with only 46% achieving this ambition. Many of these patients achieve discharge but end up being readmitted for a variety of reasons, eg failed discharge packages; poor symptom control; anxiety.



3.2 Nursing Quality Audits

Audits are conducted on all adult in patient areas where the patient stay is usually longer than 12 hours (excludes Critical Care) by peer reviewers and quality assured by the nursing division. The audit is in 2 parts:

- Observation of care
- Record keeping of care

There has been improvement against most standards again in the quarter.

Observed care comparison December → September

Comparison of Trust Wide Data from the audits undertaken in September 2011 and December 2011 Part A: General and Observation of Care						
	September 2011 (Base: 48 wards/units)			December 2011 (Base: 49 wards/units)		
	Yes	No	Not observed removed	Yes	No	Not Observed removed
Generic	89%	11%	-	93%	7%	-
Observations of Care	91%	9%	-	97%	3%	-
Promoting health and well being	81%	19%	-	76%	34%	-
Bladder and Bowel care (HIA-8)	89%	11%	-	97%	3%	-
Environment and staff	89%	11%	-	94%	6%	-
Self care	91%	9%	-	94%	6%	-
Eating and drinking (HIA-3)	91%	9%	-	94%	6%	-
Safety (HIA-2)	88%	12%	-	95%	5%	-
DSSA compliance	67%	33%	-	84%	16%	-

Records of care comparison December → September

Comparison of Trust Wide Data from the audits undertaken in September 2011 and December 2011 Part B: Patients being risk assessed against prescribed benchmarks						
	September 2011 (Base: 524 patients)			December 2011 (Base: 571 patients)		
	Yes	No	Spoilt	Yes	No	Spoilt
Pressure Ulcers	92.4%	1.4%	6.2%	97.4%	1.6%	1.0%
Safety(falls)	92.4%	1.6%	6.0%	98.6%	0.7%	0.7%
Bladder & Bowel Care	91.2%	3.4%	5.4%	97.5%	1.6%	0.9%
Communications	90.8%	3.4%	5.8%	97.5%	1.9%	0.6%
Personal Hygiene/Self care	91.2%	3.1%	5.7%	96.8%	2.1%	1.1%
Manual Handling	90.8%	3.4%	5.8%	95.6%	3.3%	1.1%
Pain	90.1%	4.3%	5.6%	95.4%	3.7%	0.9%
Oral Hygiene	92.3%	2.0%	5.7%	98.2%	1.4%	0.4%
Record Keeping (mean value)	82.1%	11.7%	6.2%	87.8%	11.1%	1.1%
Mental Health	82.9%	11.3%	5.8%	87.4%	11.9%	0.7%
Nutrition	81.1%	12.9%	6.0%	89.3%	10.0%	0.7%

Benchmark compliance

Comparison of benchmark compliance from September 2011 audit to December 2011 (best to worst)					
September 2011			**DECEMBER 2011**		
1.	**Generic**	**95%**	**1.**	**Falls**	**98.6%**
2.	**Uniform compliance**	**93%**	**2.**	**Oral hygiene**	**98.2%**
3.	**Falls**	**92%**	**3.**	**Bladder and Bowel care**	**97.5%**
4.	**Pressure ulcers**	**92%**	**4.**	**Communication**	**97.5%**
5.	**Oral hygiene**	**92%**	**5.**	**Pressure ulcers**	**97.4%**
6.	**Bladder and Bowel care**	**91%**	**6.**	**Personal hygiene/self care**	**96.8%**
7.	**Personal hygiene/ self care**	**91%**	**7.**	**Manual Handling**	**95.6%**
8.	**Communication**	**90%**	**8.**	**Pain**	**95.4%**
9.	**Manual Handling**	**90%**	**9.**	**Environment**	**94%**
10.	**Pain**	**90%**	**10.**	**Generic**	**93%**
11.	**Patient ID compliance**	**89%**	**11.**	**Uniform compliance**	**90%**
12.	**Environment**	**89%**	**12.**	**Nutrition**	**89.3%**
13.	**Record keeping**	**82%**	**13.**	**Record keeping**	**87.8%**
14.	**Mental Health**	**81%**	**14.**	**Mental Health**	**87.4%**
15.	**Promoting health and wellbeing**	**81%**	**15.**	**Promoting health and wellbeing**	**76%**
16.	**Nutrition**	**81%**	**16.**	**Patient ID compliance**	**73%**

3.3 Ward Performance Reviews

The detail by ward is included as Appendix 2 and includes the results for reviews concluded in October 2011 with a comparison to June 2011.

3.4 Nurse Leadership

The national Care Quality Commission (CQC) report into dignity and nutrition, the Royal College of Nursing (RCN), and recent Department of Health (DH) and government announcements have all recommended Trusts consider releasing ward leaders from clinical and admin work to enable them to spend more time leading their areas, manage staff more effectively, drive standards and communicate more frequently with patients and relatives.

A paper has been produced for the Executive Team to consider how we might achieve this. The Trust Senior Nurses all believe this to now be the single most significant factor in achieving the standards we aspire to.

Ward Managers manage and lead the highest numbers of staff in the Trust. Currently, establishments allow 7 – 10 hours per week with very little administrative support to undertake this leadership role. The rest of the week is worked within the clinical numbers.

Increasing the hours available to Ward Managers to lead would:

- Improve standards
- Improve patient experience
- Improve knowledge of patient/relative views, complaints handling etc
- Improve risk processes
- Improve rostering and staff management
- Improve operational processes, eg discharge planning

The paper is due for further Executive Team discussion later this month.

3.5 Clinical Documentation

New bedside and nursing records have been developed in response to nurses advising us that they spend too much time on paperwork. This view has been reflected nationally via CQC reports, RCN, and DH releases on nursing in recent months.

The new documentation is anticipated to:

- Reduce the amount of charts at the bedside and reduce duplication of charting at the bedside
- Enables relatives/patients to contribute to bedside charts
- Streamlines all assessment processes into simple documentation that is led by a series of prompts
- Includes 'intentional round' – supports David Cameron announcement regarding hourly nursing visits to patients.
- Reduces the number and frequency of audits

So far the new documentation has been well received.

4) Workforce Developments in Nursing

HCA Young Apprentices

The first 10 have been appointed and have settled really well into their roles and into their ward. Ward Managers report high satisfaction rates with performance etc.

Advantages: Brings young people into the workforce.
Saves approximately £5k per head from ward establishments.
Ensures robust competency based training of HCA's.

Concerns: Young people in workplace.
Unable to work some shifts due to Young Worker regulations.
Attitude towards them from other staff.

Nursing MOT

Yearly requirement for all Band 5 nurses to undertake. Refresher on all basics of nursing care including numeracy and literacy testing. Seeking an e-delivery solution via NHS learning networks. So far approximately 1000 nurses have attended.

Significant training continues around

- Safety briefings
- SBAR
- MUST
- Safeguarding
- Dementia
- Diversity

5) Wards escalated via early warning systems

In the last report to the Trust Board I reported the following wards as being of some concern:

- N4
- L3 + N3
- D43
- D16

The following describes the status with these wards and also identifies any additional wards that are becoming a concern and our mitigation for this.

October 2011	
N4	Concerns resolved with de-merger of ward and considerable investment and work via nutrition, privacy and dignity and special measures plans. Students being re-introduced. CQC – fully compliant.
L3 + N3	Staffing levels now satisfactory and standards improving. Ward Manager recruitment for N3 in progress.
D43	Flexible beds now properly staffed. Standards are slowly improving.
D16	Change in leadership as part of ward management reconfiguration but continues to be a concern – see below.
January 2012	
D16/D18	Both wards are under new leadership since November 2011 and this has yet to impact. However, sickness is high and standards although being maintained, are at risk. Therefore, a condition report has been requested by the end of the month where a decision regarding increased support or special measures will be taken.
EAU, Sandwell	High sickness rates and activity are beginning to impact on some standards and have generated a request for a condition report by the end of January.
P4	Staffing levels and patient dependency make P4 a very challenging ward to work on. Staffing has been increased from November and the ward has new leadership. Currently keeping a watching brief with some additional targeted support from the nursing division.
L2	Targeted support and robust action plan are addressing the concerns on this ward which were starting to indicate a risk that standards would deteriorate – mainly around staff management issues as opposed to direct care.

6) Development of A Nursing Dashboard

A considerable amount of information (qualitative and quantitative) is collected for every in patient area within the Trust. Currently this data is shared piece meal with ward staff, Matrons, directorates and divisions as it is reported by the lead for the subject area – this will be on a monthly quarterly basis. Data is collected from:

- Patient Surveys – nursing division
- Audits – nursing division, infection control and facilities
- Observation of care – nursing division
- Collection of outcome data/incidents – tissue viability, falls, infection control, dietetics etc
- ESR – HR
- Bank system – nursing division

The quarterly ward performance review process pulls all of the various pieces of intelligence together into one place for a review meeting between the Ward Manager and Head of Nursing. The results of these are published via a RAG rated performance review dashboard.

Whilst the above processes serve a useful purpose a more simplistic and real time approach to ward performance indicators would allow for more immediate action if wards standards are slipping and would provide ward staff with meaningful information about how they are doing. It would also make sense of the plethora of information for the Trust Board and other assurance committees.

It is suggested that the KPI's that would form part of a ward quality dashboard would be:

- Falls rates (against reduction target)
- Tissue viability rates (against reduction target)
- MUST assessment
- Infection control rates
- Number of complaints
- Number of incidents
- Catheter rates
- VTE rates (?)
- Patient Survey (Net promoter)
- Sickness absence
- Bank/agency
- Vacancy rates

All of this information is currently collected but help is required from IT to create a dashboard.

This work has commenced.

7) Visits/Assessments

Since October 2011 the following have taken place:

November –	PCT unannounced visit to Sandwell Trauma & Orthopaedic wards
December –	The third CQC DaNi to N1/N4 (unannounced)
	Stroke appreciative enquiry – all Stroke wards City/Sandwell.
	Peer review (reciprocal) with HEFT of elderly care wards against CQC standards.
	52 mock CQC inspections (internal) unannounced – all wards

8) Conclusion

There is a continuing improvement trend across the majority of our wards and areas of concern are being identified and addressed.

9) Recommendations

The Trust Board is asked to consider the contents of this report, note the improvements made and assure itself that where concerns are highlighted sufficient action is being taken.

The Trust Board is also asked to approve proposal for future reporting.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST MANAGEMENT BOARD

DOCUMENT TITLE:	Patient Satisfaction Survey results for September – November 2011
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Rachel Overfield, Chief Nurse
DATE OF MEETING:	17 January 2012

SUMMARY OF KEY POINTS:

The attached report provides results of the Trust's Adult Inpatient Satisfaction Survey for September – November 2011.

Key Points To Note:

- Numbers of surveys returned in November were higher than the rest of the year and amounts to around 38% of total discharges in the month.
- Against 5 CQUiN questions very little change although divisions should be looking to improve scores against:
  - Involving patients in care decisions
  - Informing patients of medication side effects
  - Post discharge contact advice.
- Care as rated by patients – 87% patients rate care as excellent or good – an increase of around 2% from the previous month.
- 78.5% patients would recommend the Trust to friends/relatives – see appendix 1 regarding the definition of a net promoter score – a more sophisticated version will be incorporated when surveys next go to reprint.
- Access to interpreters has improved following a considerable drive at ward level.
- 8.3% patients claim that they shared sleeping accommodation with patients of the opposite sex. This is at odds with our breach reports and therefore needs urgent clarification at divisional level – every division has data down to ward level. (See Appendix 2 for information by ward).
- At least a quarter of patients consistently do not know the name of their consultant (see appendix 2 for information by ward).
- Perceptions of standards of cleanliness has deteriorated for the third month running.
- Noise at night, pain control and involvement in discharge planning continue to be a concern which we will bring to TMB next month by ward.
- Keeping patients informed during transfers is a deteriorating picture – possibly due to increased pressures during the winter.
- Discussing of dietary needs and choice remains a concern.
- Waiting for medications continues to be the most significant reason given by patients for delays in going home (250 patients) – (see appendix 2 for detail by ward.)

In the main report on page 8, 9 and 10 is a by ward performance monitoring table that identifies returns as a % of discharges; overall care ratings and hospital recommendation by ward. Within this N3 and D47 stand out as being of some concern (this correlates with other ward performance indicators).

TMB is asked to consider key points and especially to encourage greater detailed divisional reviews to improve patient perception and experience.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Management Board is asked to note the contents of the attached report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	1.2 Continue to improve patient experience. 2.3 Vulnerable children and adults – improve protection and care.
Annual priorities	1.2 Continue to improve patient experience. 2.3 Vulnerable children and adults – improve protection and care.
NHS LA standards	2.3.3 Safeguarding Adults
CQC Essential Standards Quality and Safety	Regulation 9, Outcome 4 – Care and welfare of people who use services. Regulation 10, Outcome 16 – Assessing and monitoring the quality of service provision. Regulation 11, Outcome 7 – Safeguarding people who use services from abuse. Regulation 17, Outcome 1 – Respecting and involving people who use services.
Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

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

Risks		

PREVIOUS CONSIDERATION:

Considered at December meeting of Trust Management Board.

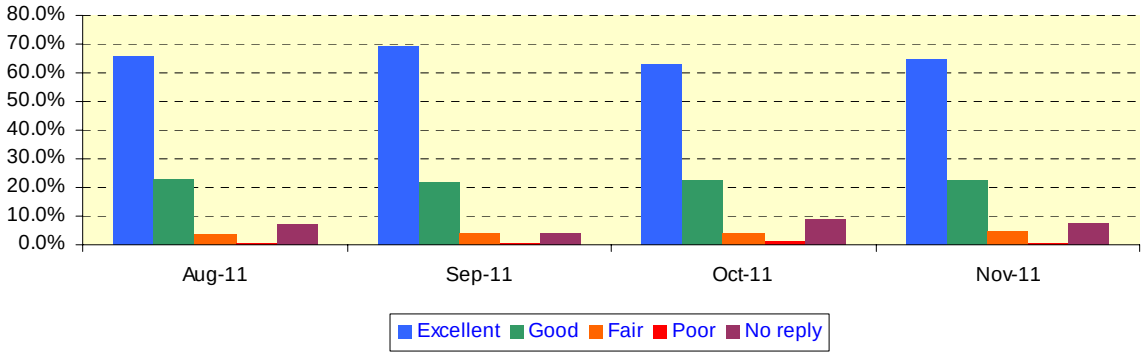
PATIENT SATISFACTION SURVEY- ADULT INPATIENTS

TRUST-WIDE MONTHLY RESULTS

SEPTEMBER – NOVEMBER 2011

- Results of surveys received back from the wards for the months September – November 2011
- 'No replies' are not displayed in the results figures below.

Care as rated by patients:



THE 5 CQUIN INDICATORS			
Was your privacy respected when discussing your condition and treatment?			
	Sept	**Oct**	**Nov**
Total number of surveys received:	864	1167	1406
Yes……..	91.8%	90.1%	89.8%
Sometimes……..	4.6%	3.9%	4.1%
No……	1.4%	1.4%	2.2%

Did the staff listen to your worries and fears?			
Yes	71.8%	69.8%	70.6%
No	1.9%	2.9%	2.8%
Not needed	20.4%	20.0%	19.9%

Were you involved as much as you wanted to be in decisions about your care and treatment?			
Yes	86.7%	84.7%	85.1%
No	5.9%	6.4%	6.8%

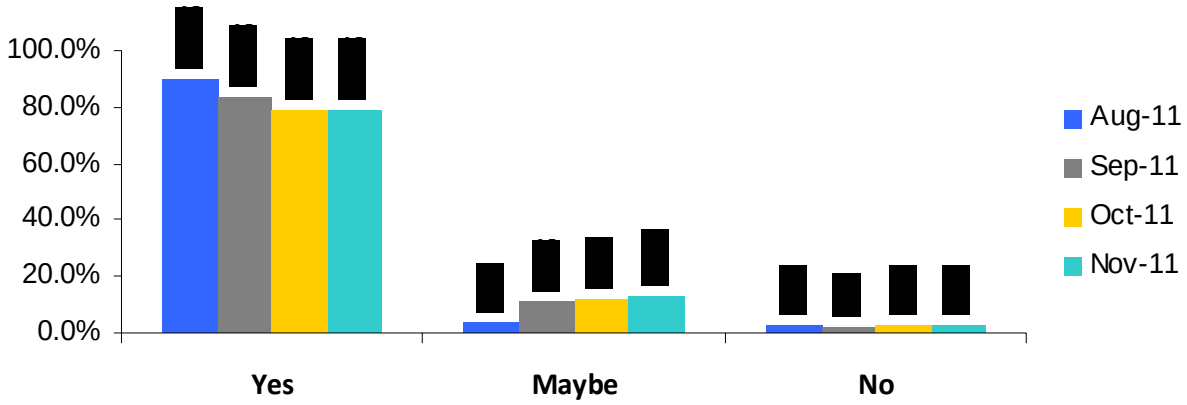
Did the staff tell you about medication side effects to watch out for when you went home?			
Yes	42.1%	36.3%	37.3%
No	10.6%	10.1%	10.2%
Not required	33.4%	35.4%	35.6%

Were you told whom to contact if you were worried about your condition or treatment after you left the hospital?			
Yes	71.5%	65.0%	67.8%
No	12.2%	12.9%	12.7%

NEW: Increasing the percentage of patients who would recommend the Trust to family and friends is one of the top three Quality and Safety related priorities for the Trust. To reflect this, the following question has now been included in the new version of the survey:

Number of patients who said they would recommend this hospital to family and friends

(Base: Aug - 172 pts, Sept - 429 pts, Oct - 715 pts and Nov - 1034 pts)



THE FULL SURVEY

PATIENT PROFILE			
Gender:	**Sept**	**Oct**	**Nov**
Total number of surveys received:	**864**	**1167**	**1406**
Male…….	37.5%	40.2%	41.6%
Female……	53.6%	49.2%	47.1%
Age groups:			
Under 18…...	0.6%	1.6%	1.4%
18 to 24……	7.9%	8.4%	7.6%
25 to 44……	27.3%	25.2%	23.6%
45 to 60……	22.9%	21.0%	24.2%
Over 60……	35.9%	37.2%	36.3%
Special needs:			
Learning disabilities	6.0%	5.0%	4.8%
Mental health needs	6.3%	5.8%	6.1%

Ethnic backgrounds:			
White - British ……	59.7%	57.1%	59.8%
White - Irish ……..	1.9%	2.5%	2.8%
White – European……..	1.9%	1.8%	2.0%
White – any other white b/g……..	0.3%	0.2%	0.6%
Mixed-White & Black Caribbean……	3.0%	1.5%	2.6%
Mixed-White & Black African……	0.9%	0.9%	0.6%
Mixed-White & Asian……	0.2%	0.8%	0.5%
Mixed- any other mixed b/g……	0.2%	0.1%	0.7%
Asian/Asian Brit – Indian……..	9.4%	8.9%	7.8%
Asian/Asian Brit – Pakistani……..	6.9%	7.1%	6.5%
Asian/Asian Brit – Bangladeshi……..	1.5%	1.3%	1.5%
Asian/Asian Brit-any oth Asian b/g…..	1.0%	0.8%	1.3%

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Black/Blk Brit-Caribbean……	6.5%	8.1%	5.5%
Black/Blk Brit-African……	1.6%	2.6%	1.4%
Black/Blk Brit – Any other Blk b/g	1.2%	0.6%	0.4%
Other Ethnic Group - Chinese	0.1%	0.3%	0.6%
Other Ethnic group	1.0%	1.0%	1.2%
Do not want to stated	0.5%	0.4%	0.9%
Were you provided with a language interpreter if you needed one?			
Yes……	4.4%	4.5%	3.8%
No……	11.7%	10.6%	9.2%
Not Applicable……	74.2%	74.1%	75.7%

PRIVACY & DIGNITY

Were you treated with respect and dignity while you were on this ward?			
Yes, always……..	92.6%	89.5%	90.5%
Yes, sometimes……	4.5%	5.3%	4.8%
No……	0.5%	0.9%	0.6%

During your stay on this ward, did you ever share a sleeping area (room or bay) with patients of the opposite sex?			
Yes……	4.5%	6.3%	8.3%
No……	92.1%	88.9%	87.1%
On this ward, did you ever have to use the same bathroom or shower area with patients of the opposite sex?			
Yes……	4.5%	4.5%	4.3%
No……	92.2%	90.2%	90.5%

Was your privacy respected when discussing your condition and treatment? (CQUIN)			
Yes……..	91.8%	90.1%	89.8%
Sometimes……..	4.6%	3.9%	4.1%
No……	1.4%	1.4%	2.2%
Were you given enough privacy when being examined or treated?			
Yes……..	95.3%	93.7%	93.6%
Sometimes……..	1.7%	2.1%	2.8%
No……	0.8%	0.3%	0.4%

ABOUT DOCTORS, NURSES & OTHER STAFF

When you arrived at this unit/ward, were you made to feel welcome by the staff?			
Yes……	93.9%	92.9%	94.5%
No……..	2.7%	2.2%	1.6%
Did you know the name of the consultant treating you?			
Yes……	67.1%	63.2%	66.3%
No……..	25.8%	27.5%	25.3%

Did the doctors talk in front of you as if you were not there?			
Yes……..	6.1%	5.6%	5.3%
Sometimes……	8.0%	9.0%	9.5%
No……	81.4%	78.2%	79.9%
Did the nurses talk in front of you as if you were not there?			
Yes, always ……..	4.5%	5.1%	4.3%
Yes, Sometimes……..	7.2%	6.8%	6.5%
No……	83.4%	80.8%	83.6%
Did you have confidence and trust in the doctors examining and treating you?			
Yes, always……	86.5%	84.1%	86.2%
Yes, sometimes……	8.2%	9.0%	7.9%
No	1.3%	1.3%	1.2%

Did you have confidence and trust in the nurses treating and caring for you?			
Yes, always……	88.1%	85.9%	86.6%
Yes, sometimes……	7.1%	7.6%	8.0%
No……	0.9%	0.9%	1.3%
Were the staff kind and caring while looking after you?			
Yes, always ……	88.4%	86.8%	89.0%
Yes, sometimes……	6.5%	6.9%	6.1%
No……	1.0%	0.4%	0.4%

THE WARD ENVIRONMENT

How clean was the ward/room that you were in?			
Very Clean……	83.7%	82.4%	81.6%
Fairly Clean……	11.6%	11.7%	13.6%
Not at all clean……	0.5%	0.5%	0.3%

Do you think the toilets and bathrooms in your ward were:			
Very Clean……..	70.0%	69.9%	71.1%
Fairly Clean…….	23.4%	22.2%	22.6%
Not at all clean……	1.2%	0.9%	0.8%
As a patient on this ward, were you satisfied with your hygiene arrangements (washing & toileting)?			
Yes, always……	85.8%	82.9%	84.6%
Sometimes……	7.2%	8.1%	8.3%
No……	2.0%	1.8%	1.6%

Were you bothered by noise from hospital staff at night?			
Yes……..	7.5%	8.1%	8.7%
Sometimes……..	19.3%	20.4%	19.9%
No……	63.4%	60.5%	58.7%
If it was needed to transfer you to another ward during your stay, was this well managed and were you kept informed?			
Yes……..	39.0%	37.4%	34.6%
No……..	2.9%	3.8%	5.0%
Not Applicable……	48.6%	48.9%	49.1%

FOOD & DRINK

Did a nurse discuss your dietary needs (food & drink) when you were admitted to this ward?			
Yes……	46.3%	44.0%	44.9%
No……..	13.3%	15.7%	14.5%
Not needed……..	34.4%	32.0%	33.0%
During your stay in hospital, did you have access to enough drinks?			
Yes……..	88.0%	86.1%	86.9%
No……	5.2%	5.8%	5.0%
Did you have enough choices for your meals?			
Yes……..	80.1%	75.7%	73.8%
No……..	10.3%	11.5%	11.4%
Did you get what you ordered?			
Yes……	76.2%	74.5%	71.8%
No……..	11.0%	8.4%	9.2%

Did you get help to eat your meals when required?			
Yes……..	14.6%	13.3%	14.9%
No……	2.7%	3.9%	2.8%
Not Needed……	74.1%	73.7%	71.2%

YOUR TREATMENT & CARE

Were you kept well informed about your treatment and care by the staff?			
Yes, always	80.8%	76.6%	78.8%
Yes, sometimes	12.4%	13.1%	12.7%
No	1.5%	3.2%	2.0%
Did you receive information (leaflets, etc) about your condition or treatment?			
Yes	49.5%	45.1%	47.9%
No	16.3%	19.1%	16.6%
Not required	28.5%	28.5%	28.8%
Was this information in a language/format you could easily understand?			
Yes	49.2%	47.6%	49.4%
No	1.6%	1.5%	2.3%
Not applicable	40.9%	40.8%	39.0%
Did you have chances to ask questions about your treatment or care?			
Yes	89.1%	88.0%	88.3%
No	5.3%	4.5%	4.3%
Did the staff listen to your worries and fears? (CQUIN)			
Yes	71.8%	69.8%	70.6%
No	1.9%	2.9%	2.8%
Not needed	20.4%	20.0%	19.9%

Did your family or someone close have the opportunity to talk to a doctor if they wanted to?			
Yes	55.4%	55.4%	51.9%
No	5.9%	6.8%	6.5%
Not needed	33.4%	31.2%	34.1%
Were you involved as much as you wanted to be in decisions about your care and treatment? (CQUIN)			
Yes	86.7%	84.7%	85.1%
No	5.9%	6.4%	6.8%
If you have a long-term condition that you manage at home, for example diabetes, were you supported and enabled to continue to manage this during your hospital stay?			
Yes	25.2%	24.1%	24.8%
No	1.6%	2.5%	3.1%
Not applicable	64.0%	62.7%	60.9%
Do you think that the hospital staff did everything they could to help control your pain?			
Yes, always	75.7%	72.0%	73.2%
Sometimes	8.0%	7.6%	7.6%
No	0.9%	1.8%	1.4%
Not required	9.8%	10.7%	10.6%

ABOUT YOUR DISCHARGE			
If there were delays in your going home after being discharged from the hospital, what were the reasons? (Tick all that apply)			
Waiting for transport	8.9%	9.0%	10.2%
Waiting for medicines to take home	21.4%	17.7%	18.1%
Delay in discharge planning from staff	5.6%	5.8%	5.8%
Other	5.3%	6.3%	6.8%
No delay	46.3%	44.7%	45.5%
Were you involved in decisions about your discharge from hospital?			
Yes	49.5%	48.2%	46.1%
No	10.9%	10.4%	9.2%
Not required	26.4%	25.2%	30.2%
When leaving the hospital were you given written or printed information about what you should or should not do?			
Yes	52.5%	50.0%	50.3%
No	8.6%	6.6%	6.9%
Not required	21.8%	22.7%	24.0%
Did the staff explain how to take and purpose of the medicines you were given to take at home in a way you could understand?			
Yes	64.7%	61.0%	59.2%
No	2.0%	2.2%	1.8%
Not required	19.0%	18.9%	22.5%
Were you given clear written or printed information about your medicines?			
Yes	59.4%	53.5%	53.1%
No	3.5%	4.0%	2.5%
Not required	24.9%	25.5%	28.4%

Did the staff tell you about medication side effects to watch out for when you went home? (CQUIN)			
Yes	42.1%	36.3%	37.3%
No	10.6%	10.1%	10.2%
Not required	33.4%	35.4%	35.6%

Were you told whom to contact if you were worried about your condition or treatment after you left the hospital? (CQUIN)			
Yes	71.5%	65.0%	67.8%
No	12.2%	12.9%	12.7%
Did the doctors or nurses give your family or someone close to you all the information they needed to help care for you?			
Yes	42.9%	39.2%	40.1%
No	5.1%	5.7%	6.5%
Not required	38.5%	37.8%	36.5%

ABOUT YOUR HOSPITAL EXPERIENCE			
Did you have access to spiritual care/chaplains during your stay?			
Yes	16.1%	13.5%	12.8%
No	9.8%	8.3%	10.6%
Not required	65.5%	66.7%	66.8%
When you were in this hospital, did you see posters or leaflets explaining how to complain about the care or treatment you received?			
Yes	52.3%	50.7%	52.8%

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No	36.2%	35.3%	33.6%

If you needed to raise concerns about your care or treatment, were these listened to and responded to appropriately?			
Yes	39.9%	38.8%	35.1%
No	3.2%	3.8%	4.7%
Not applicable	47.3%	44.1%	48.4%
Overall, how would you rate the care you received on this ward/unit:			
Excellent	69.2%	62.9%	65.0%
Good	21.8%	22.5%	22.3%
Fair	4.1%	4.4%	4.8%
Poor	0.6%	1.1%	0.5%

Performance Monitoring: Patient Satisfaction Surveys - November 2011

Adult Inpatient Survey returns November 2011												Overall care ratings				Hospital recommendation		
	Sep-11		Oct-11		Nov-11		Dec-11					Nov-11				Nov-11		
Wards	PSS	Carers	PSS	Carers	PSS	Carers	PSS	Carers	Total	D/C *	% Returns*	Excellent	Good	Fair	Poor	Yes	Maybe	No
D26	52	0	40	0	44	5			49	50	98.00	71%	23%	5%	0%	86.0%	6.0%	6.0%
D30	39	2	39	12	88	21			109	115	94.78	82%	12%	2%	1%	88.0%	8.0%	1.0%
Eye ward	18	0	36	0	62	3			65	70	92.86	70%	23%	2%	0%	88.0%	9.0%	0.0%
D21	29	0	27	1	38	3			41	47	87.23	79%	13%	0%	0%	84.0%	8.0%	0.0%
Lyndon 3	33	0	62	0	77	4			81	101	80.20	40%	18%	5%	0%	57.0%	11.0%	0.0%
Skin	3	0	5	1	7	0			7	9	77.78	71%	14%	0%	0%	71.0%	14.0%	0.0%
D28	24	0	46	0	41	0			41	56	73.21	73%	24%	0%	0%	92.0%	5.0%	0.0%
D7	12	18	26	21	58	1			59	81	72.84	36%	47%	5%	0%	53.0%	34.0%	0.0%
D5	54	6	34	15	73	2			75	108	69.44	73%	15%	8%	0%	84.0%	7.0%	4.0%
D25	123	2	86	5	72	0			72	114	63.16	56%	32%	6%	1%	82.0%	16.0%	3.0%
Lyndon 2	81	2	128	3	117	3			120	191	62.83	58%	27%	10%	1%	69.0%	21.0%	6.0%
CCU	28	0	27	8	35	0			35	63	55.56	90%	3%	3%	0%	91.0%	3.0%	0.0%
Newton 3	13	6	37	8	46	6			52	100	52.00	49%	20%	20%	2%	48.0%	29.0%	14.0%
D43	12	0	15	6	13	0			13	30	43.33	78%	22%	0%	0%	0.0%	0.0%	0.0%
D17	26	4	16	11	22	1			23	57	40.35	41%	32%	18%	0%	83.0%	6.0%	6.0%
Newton 2	48	1	71	1	56	2			58	149	38.93	77%	13%	2%	2%	82.0%	11.0%	2.0%
D27	52	4	39	4	44	1			45	122	36.89	59%	36%	2%	0%	82.0%	4.0%	4.0%
Newton 5	5	0	2	0	7	0			7	19	36.84	75%	0%	0%	0%	0.0%	0.0%	0.0%
Priory 2	10	0	30	0	33	0			33	92	35.87	52%	30%	6%	3%	72.0%	16.0%	6.0%
Priory 3	8	0	4	0	7	1			8	24	33.33	50%	50%	0%	0%	0.0%	0.0%	0.0%
Newton 4	3	0	3	13	6	5			11	34	32.35	83%	17%	0%	0%	100.0%	0.0%	0.0%
D47	7	4	9	11	8	1			9	32	28.13	75%	13%	0%	13%	71.0%	14.0%	14.0%
D18	0	2	1	4	6	3			9	33	27.27	33%	33%	17%	0%	0.0%	0.0%	0.0%
D41	11	0	31	0	18	3			21	93	22.58	61%	11%	6%	0%	61.0%	11.0%	0.0%
Lyndon 4	24	1	11	1	21	0			21	98	21.43	62%	33%	5%	0%	0.0%	0.0%	0.0%

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Performance Monitoring: Patient Satisfaction Surveys - November 2011

Adult Inpatient Survey returns November 2011												Overall care ratings				Hospital recommendation		
	Sep-11		Oct-11		Nov-11		Dec-11					Nov-11				Nov-11		
D16	8	1	3	8	4	3			7	40	17.50	25%	75%	0%	0%	0.0%	0.0%	0.0%
D15	19	3	14	11	4	6			10	98	10.20	75%	25%	0%	0%	0.0%	0.0%	0.0%
D24	8	1	27	2	4	0			4	40	10.00	67%	33%	0%	0%	100.0%	0.0%	0.0%
Priory 5	0	0	0	0	5	0			5	77	6.49	100%	0%	0%	0%	0.0%	0.0%	0.0%
D11	22	0	44	2	2	0			2	82	2.44	100%	0%	0%	0%	100.0%	0.0%	0.0%
Lyndon 5	16	2	6	2	0	1			1	81	1.23	No surveys recd						
D12	0	0	15	0	0	0			0	47	0.00	No surveys recd						
Newton 1			0	0	0	0			0	40	0.00	63%	38%	0%	0%	0.0%	0.0%	0.0%
Priory 4	3	0	0	1	0	0			0	79	0.00	No surveys recd						
TOTALS:					1018	75			1093	2472								

Key:			
PSS	Patient Satisfaction Survey	12345	Survey returns less than 40%
Total	Total (Patient + Carer) surveys	12345	Wards still using old version surveys
D/C*	Oct 2011discharges data used from CDA for over 24hrs stays.	12345	1 or 2 surveys of new version so not true representation
%Returns	% of returns* - Total D/Cs compared with total surveys returned.		
Ratings	Actual respondents data used and no replies not displayed		

SWBTM (1/12) 236 (a)

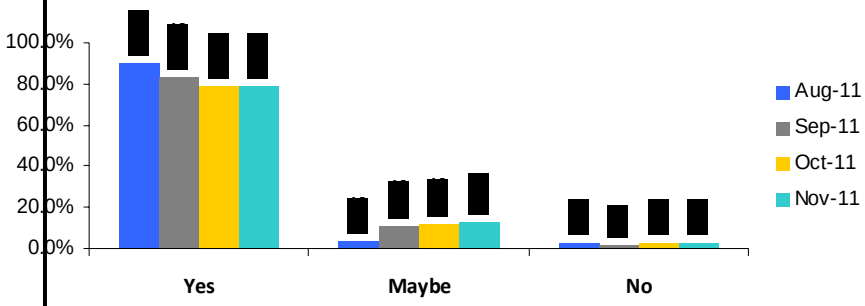
Short Stay Adult Inpatient Survey returns November 2011												Overall ratings					Hospital recommendation		
	Sep-11		Oct-11		Nov-11							Nov-11					Nov-11		
Wards	PSS	Carers	PSS	Carers	PSS	Carers	PSS	Carers	Total	D/C *	% Returns*	Excellent	Good	Fair	Poor		Yes	Maybe	No
ASU - BTC	72	0			37	0			37	N/A		75%	18%	3%	0%		0.0%	0.0%	0.0%
D6	5	0	3	0	3	0			3	246	**1.22**	100%	0%	0%	0%		100.0%	0.0%	0.0%
EAU	1	0	0	0	17	3			20	1196	**1.67**	50%	38%	0%	0%		75.0%	19.0%	0.0%
MAU	0	0	0	0	9	2			11	1190	**0.92**	50%	25%	25%	0%		75.0%	25.0%	0.0%
SAU	79	1	180	5	152	11			163	622	**26.21**	59%	28%	7%	0%		59.0%	36.0%	4.0%
SDU	20	0	33	0	158	0			158	1122	**14.08**	80%	14%	0%	0%		87.0%	6.0%	1.0%
Total:	177	1	216	5	376	16	0	0	392	4376									

Key:			
PSS	**PSS:** Patient Satisfaction Survey	12345	Survey returns less than 40%
Total	Total (Patient + Carer) surveys	12345	Wards still using old version surveys
D/C*	Oct 2011 discharge data used from CDA without 24hrs rule.	12345	1 or 2 surveys of new version so not true representation
%Returns	% Returns - Total D/Cs compared with total surveys returned.		
Ratings	Actual respondents data used and no replies not displayed		

Patient Surveys - Overall Summary Graphical Dashboard November 2011

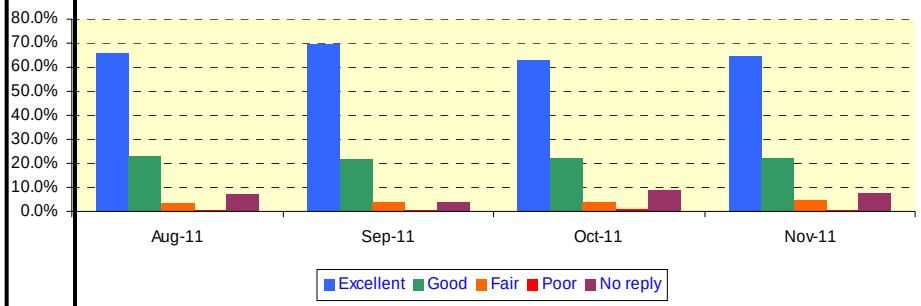
Number of patients who said they would recommend this hospital to family and friends

(Base: Aug - 172 pts, Sept - 429 pts, Oct - 715 pts and Nov - 1034 pts)



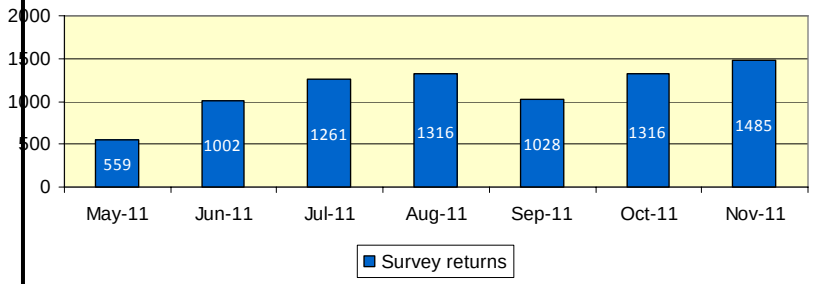
The decline in number of patients saying they would recommend this hospital to family and friends stopped in November and stayed at last month's figure of 78.5%.

Care as rated by patients



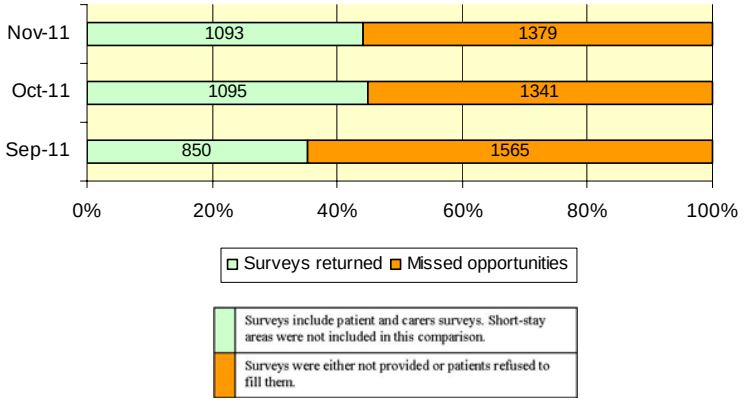
The 'Excellent' care rating improved to 65% from last month's 62% which was the lowest since August 2011.

Trust Patient and Carers Survey returns



The total number of surveys received continued to rise, reaching the highest figure of 1485 since the in-house surveys began.

Number of returned surveys compared with total discharges



The overall survey returns remained just over the minimum 40% of the total discharges from the wards.

SWBTM (1/12) 236 (b)

Net Promoter Score

Net promoter Score (NPS):
NPS is a concept from the marketing world which originated in the USA. It offers a simple way to capture what people will say in terms of 'word of mouth' locally, i.e., it is a measure to capture whether or not we are the hospital of choice for local people.

The net promoter score question can be framed as below:

How likely is it that you would recommend this hospital to a friend or family member if needed?
(Please indicate below by ticking a box indicating how likely you would recommend this hospital, with 0 being extremely unlikely to 10 meaning very likely.)

People who give a response between 0 and 6 are detractors
Those who give a response of 7 or 8 are passive or neutral
Those who give a response of 9 or 10 are promoters

The Net promoter score = % of promoters - % of detractors

This is a measure that can encourage staff to deliver 'something special'.

Usage among NHS Trusts:
Locally: Heartlands, UHB and New Cross are not using it. West Mids Ambulance Trust uses it in their reports.
Nationally: Quite a few Trusts East of England use it.

It is now gaining prominence due to its simplicity of use and understanding. It is normally backed up by a marketing strategy and linked to service improvement plans.

Our status:
We do ask the recommendation question but with only 3 answer options. If we need to calculate the Net score we would need to change our surveys. This can be done in the next round of reprint in approximately 2 – 3 months. SNAP survey system can do something similar to NPS if we incorporate the 0 – 10 rating question.

Performance Monitoring: Specific questions from Adult Inpatient Surveys

	March 2011 - August 2011 (Trust respondents - 5038 pts)											September 2011 - November 2011 (Trust respondents - 3437 pts)										
	Q10		Q11		Q15		Q40					Q10		Q11		Q15		Q40				
	Yes	No	Yes	No	Yes	No	Trans-port	Meds	D/c Planning	Other	No Delay	Yes	No	Yes	No	Yes	No	Trans-port	Meds	D/c Planning	Other	No Delay
Trust	**7%**	**89%**	**5%**	**91%**	**66%**	**26%**	**10%**	**19%**	**5%**	**6%**	**45%**	**7%**	**89%**	**4%**	**91%**	**65%**	**26%**	**10%**	**19%**	**6%**	**6%**	**45%**
Filter:																						
D5	46%	51%	7%	91%	72%	21%	9%	31%	4%	7%	40%	43%	54%	8%	90%	67%	26%	6%	19%	5%	7%	57%
CCU	43%	52%	20%	74%	78%	12%	9%	33%	2%	4%	47%	49%	49%	24%	70%	78%	18%	7%	24%	1%	3%	44%
EAU	27%	73%	33%	67%	47%	40%	20%	7%	0%	7%	67%	31%	69%	44%	56%	25%	63%	6%	19%	6%	6%	56%
MAU	15%	85%	15%	85%	39%	54%	23%	15%	7%	7%	39%	13%	88%	0%	100%	38%	38%	0%	13%	13%	0%	38%
D11	14%	79%	14%	83%	62%	29%	10%	7%	2%	9%	36%	16%	78%	21%	73%	72%	22%	8%	12%	5%	6%	40%
D18	13%	87%	13%	84%	52%	50%	13%	7%	7%	7%	32%	0%	86%	0%	86%	43%	57%	29%	0%	0%	0%	57%
Priory 5	8%	92%	13%	79%	46%	50%	13%	13%	0%	13%	25%	0%	100%	0%	100%	80%	20%	0%	60%	0%	0%	20%
D47	7%	86%	11%	82%	61%	25%	21%	11%	7%	11%	18%	8%	92%	13%	88%	67%	25%	29%	0%	17%	8%	42%
D6	6%	91%	3%	97%	77%	18%	6%	3%	0%	3%	71%	17%	67%	0%	100%	83%	0%	0%	0%	0%	0%	83%
D7	6%	92%	4%	94%	50%	42%	11%	27%	6%	3%	28%	3%	96%	0%	100%	52%	44%	28%	38%	9%	10%	31%
D26	5%	92%	2%	96%	97%	4%	9%	28%	5%	6%	47%	4%	93%	2%	96%	85%	13%	6%	26%	6%	9%	45%
SAU	5%	90%	5%	90%	43%	49%	9%	17%	5%	10%	39%	4%	93%	3%	92%	41%	48%	8%	12%	3%	10%	39%
Newton 5	5%	95%	5%	95%	80%	5%	10%	55%	0%	0%	20%	0%	87%	0%	93%	80%	7%	7%	13%	0%	0%	40%
Lyndon 4	5%	93%	10%	85%	33%	51%	25%	24%	6%	4%	21%	4%	95%	7%	91%	46%	42%	14%	21%	5%	2%	39%
Lyndon 3	5%	86%	6%	83%	37%	44%	10%	11%	7%	6%	46%	3%	70%	2%	71%	36%	30%	11%	12%	6%	6%	31%
D30	5%	93%	3%	95%	76%	21%	8%	18%	5%	7%	52%	2%	96%	2%	96%	78%	16%	8%	29%	6%	4%	48%
D43	4%	94%	6%	91%	77%	19%	37%	22%	4%	12%	25%	6%	94%	6%	92%	67%	31%	28%	19%	0%	8%	39%
ASU - BTC	4%	90%	6%	87%	87%	7%	9%	2%	2%	4%	65%	9%	87%	5%	92%	84%	13%	9%	8%	3%	6%	62%
Newton 4	4%	96%	9%	87%	30%	61%	0%	13%	0%	17%	13%	0%	100%	0%	100%	46%	55%	9%	0%	0%	0%	0%
D41	4%	94%	7%	91%	41%	49%	12%	12%	5%	6%	28%	5%	93%	5%	92%	38%	51%	10%	15%	7%	2%	34%
D15	4%	93%	1%	96%	69%	23%	14%	21%	3%	6%	48%	5%	93%	3%	95%	65%	30%	8%	28%	3%	8%	50%
SDU	4%	88%	3%	88%	87%	9%	12%	4%	3%	3%	62%	5%	90%	2%	92%	81%	12%	5%	4%	2%	4%	64%
D21	4%	95%	1%	98%	75%	20%	10%	29%	7%	9%	43%	2%	95%	0%	98%	78%	15%	12%	22%	4%	5%	46%
Priory 4	3%	94%	6%	91%	25%	66%	19%	19%	2%	6%	29%	0%	100%	0%	67%	100%	0%	66%	66%	0%	0%	33%
D24	3%	96%	1%	97%	73%	20%	9%	22%	5%	6%	47%											
D17	3%	97%	3%	96%	62%	35%	7%	30%	7%	6%	29%	5%	93%	7%	92%	67%	26%	26%	61%	7%	5%	16%
Eye ward	2%	95%	3%	92%	84%	12%	9%	37%	3%	3%	47%	2%	95%	0%	98%	85%	9%	12%	31%	2%	1%	49%
Lyndon 2	2%	97%	6%	93%	41%	50%	9%	19%	10%	7%	44%	3%	95%	4%	93%	45%	47%	5%	17%	8%	5%	47%
Priory 2	2%	95%	5%	92%	62%	28%	7%	27%	8%	1%	45%	3%	90%	0%	93%	75%	18%	1%	26%	7%	6%	49%
D25	2%	96%	2%	95%	79%	17%	8%	20%	5%	7%	57%	4%	95%	4%	94%	79%	16%	10%	17%	10%	7%	54%
D16	2%	95%	3%	95%	72%	20%	5%	8%	3%	5%	18%	0%	93%	0%	100%	80%	20%	7%	20%	7%	0%	20%
D28	2%	99%	2%	99%	97%	0%	15%	24%	2%	2%	53%	2%	96%	3%	96%	93%	4%	14%	21%	5%	2%	52%
Newton 2	1%	96%	0%	98%	82%	12%	6%	13%	6%	5%	54%	2%	94%	4%	90%	85%	10%	10%	10%	12%	10%	51%
Skin	0%	91%	5%	96%	96%	0%	5%	14%	0%	0%	46%	12%	88%	12%	88%	82%	18%	6%	24%	6%	0%	47%

	March 2011 - August 2011 (Trust respondents - 5038 pts)											September 2011 - November 2011 (Trust respondents - 3437 pts)										
	Q10		Q11		Q15		Q40					Q10		Q11		Q15		Q40				
	Yes	No	Yes	No	Yes	No	Trans-port	Meds	D/c Planning	Other	No Delay	Yes	No	Yes	No	Yes	No	Trans-port	Meds	D/c Planning	Other	No Delay
Newton 3	0%	96%	0%	96%	48%	43%	11%	20%	13%	9%	44%	5%	80%	10%	77%	41%	41%	7%	17%	12%	8%	31%
D27	0%	94%	0%	93%	73%	18%	4%	23%	4%	6%	35%	4%	94%	2%	95%	85%	11%	9%	28%	5%	10%	49%
D12	0%	97%	0%	97%	55%	97%	11%	8%	3%	5%	58%	0%	100%	0%	93%	67%	27%	13%	40%	0%	7%	40%
Newton 1												0%	100%	0%	100%	50%	38%	0%	25%	0%	0%	25%
Priory 3	0%	91%	18%	77%	53%	29%	6%	9%	9%	15%	38%	0%	100%	0%	100%	26%	47%	16%	0%	11%	0%	26%
Lyndon 5	0%	90%	25%	65%	35%	49%	16%	27%	4%	8%	29%	0%	91%	10%	81%	38%	38%	5%	29%	0%	5%	38%

Key:	
Q10	**During your stay on this ward, did you ever share a sleeping area with patients of the opposite sex?**
Q11	**Did you ever have to use the same bathroom or shower area with patients of the opposite sex?**
Q15	**Did you know the name of the Consultant treating you?**
Q40	**If there were delays in your going home after being discharged, what were the reasons? (tick all that apply)**

Notes:	
	The individual ward % are based on their individual total returns
	% are rounded off
	No reply' figures are not displayed.

Table shows comparison of the results which indicate movement in terms of increase or decrease against key performance areas.

Ward Review Objective Rag Rating- status change in target met

Qtr 1 June 2011				Qtr 2 October 2011		
R	A	G	N/A	R	A	G
0	3	5		0	0	7
0	0	8		0	1	6
0	3	5		0	2	5
0	0	8		not reviewed		
0	5	3		0	0	7
0	3	5		1	1	5
0	1	7		0	0	7
0	1	7		0	1	6
1	2	5		1	1	5
0	0	8		0	2	5
0	0	8		0	1	6
0	1	7		0	1	6
0	0	8		0	0	7
0	1	7		0	1	6
0	0	8		0	2	5
0	2	6		1	4	2
0	1	7		0	0	7
0	0	8		0	0	7
0	6	2		not reviewed		
0	2	6		2	2	3
0	0	8		0	0	7
0	1	6	1	0	3	4
0	2	6		0	1	6
0	2	6		0	0	7

Analysis

Medicine	Reds	Ambers	Greens	N/A	All
June 2011- Qtr1	1	36	154	1	192
Oct 2011- Qtr 2	5	23	126	0	154

0	0	8	
0	2	6	
2	5	1	
1	2	5	
0	0	8	
0	3	5	
0	3	5	
2	1	5	
0	2	6	
0	2	6	
0	2	6	
4	3	1	
0	1	7	

0	2	5	
0	4	3	
0	3	4	
0	3	4	
0	3	4	
0	3	4	
0	3	4	
0	7	0	
0	2	5	
0	5	2	
0	6	1	
0	3	4	
0	3	4	

Surgery	Reds	Ambers	Greens	All
June 2011- Qtr1	9	27	76	112
Oct 2011- Qtr 2	0	49	49	98

0	0	8	
0	0	5	

0	1	6	
0	2	5	

W&CH	Reds	Ambers	Greens	All

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Summary Profile of Complaints Figures
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Hillary Mottishaw, Head of PALS, Complaints and Litigation
DATE OF MEETING:	26 January 2012

SUMMARY OF KEY POINTS:

This is the Trust's report of its complaints activity as at 3 January 2012 for the eighth (of 8) and final reporting period (reporting period 8 (RP 8)) following implementation in April 2011 of a formal strategy for managing/eliminating and monitoring the complaints backlog which concluded on 30 December 2011.

Of note:

- RP 8 comprised 28 working days (WD) rather than the 21 WD utilised in RP 1-7 and the data across the RPs is therefore not comparable.
- For RP 8, 88 complaints were received; 105 complaints responses were sent.
- For RP 8, the complaints backlog of 23 cases was reduced and now comprises 5 cases where local resolution meetings are/have been held with the complainants and have/are being expedited.
- During implementation of the complaints backlog strategy, there has been an overall 24% reduction in the Total Active Workload for complaints.
- The parameters of the complaints failsafe system have been revised with full implementation by 1 April 2012.

The reduction in the complaints backlog is a notable achievement and the prevention of a recurrence will require ongoing, focussed and sustained effort by all Trust staff.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High quality of care
Annual priorities	Embed the Quality and Safety Strategy incorporating the FT Quality Governance Framework
NHS LA standards	Standard 5 'Learning from Experience'
CQC Essential Standards Quality and Safety	Regulation 19 (Outcome 17) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010
Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

Financial		
Business and market share		
Clinical	√	Achieving full compliance with the Essential Standards of Quality and Patient Safety and relevant regulations will contribute to improved patient care through lessons learnt from concerns and complaints
Workforce		
Environmental		
Legal & Policy	√	Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010
Equality and Diversity		
Patient Experience	√	Achieving full compliance with the Essential Standards of Quality and Patient Safety and relevant regulations will contribute to quality improvements for staff
Communications & Media		
Risks		Failure to meet the Trust's statutory duty of quality (Health Act 1999) and comply with the Health and Social Care Act 2008 (Registration Requirements) Regulations 2009 can result in organisation being registered with conditions or incurring a financial penalty.

PREVIOUS CONSIDERATION:

Routine monthly update.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

PALS, COMPLAINTS and LITIGATION DEPARTMENT

Summary Report for the Profile of Complaints Figures

1. Introduction

The attached is the report for the 8th of 8 and the final reporting period (RP) prescribed by the strategy the management of the complaints backlog[1] which concluded on 30 December 2011 such that RP 8 comprised 28 working days[2]. For RP 8, 88 complaints were received; 105 complaints responses were sent. The complaints backlog of 23 cases was reduced and now comprises 5 cases where local resolution meetings are/have been held with the complainants and have/are being expedited.

2. Data Comparison

The following comprises key data for 20 April 2011 (prior to commencement of RP1) and on conclusion of RP 1 and RP 8.

	21 April 2011	RP1	RP8	% Overall change in Active Complaints
Cases Outside the Failsafe System	86	85	5	-
Total Active Complaints	343	323	262	24%

3. Complaints backlog prevention strategy

A strategy for the prevention of the recurrence of the complaints backlog is being formulated and includes review of the parameters of the complaints failsafe system[3] as follows.

Grade	Red	Amber	Yellow Green
Current Target	75 days	90 days	120 days
Proposed Target (transitional)	60 days	70 days	20 days (fast track[4]) 60 days (standard)

The current failsafe target continues until 31 January 2012 with the proposed transitional target dates to be formally implemented from 1 February 2012 and full implementation from 1 April 2012.

4. Care Quality Commission (CQC)

The complaints backlog strategy has been implemented in the context of the Trust's Action Plan for compliance with the CQC's Essential Standards of Quality and Safety Outcome 17: Complaints (specifically Objective 17E). The CQC has been provided with details of 10 complainants who have agreed to participate in the its survey relating to the Trust's complaints handling during 2011.

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[1] 'Complaints backlog strategy: see section 7 of the report and section 6.1 of the report for RP 1 dated 25.5.11.
[2] In contrast to the 21 working days utilised for RP 1 to 7 such that data comparison is not appropriate.
[3] See sections 3 and 4 of the report.
[4] Complaints assessed as fast track comprise those with single straightforward issues and /or arising within a discrete/single area; these largely comprise those from the Community Services.

5. Conclusion

The reduction in the complaints backlog is a notable achievement and the prevention of a recurrence will require ongoing, focussed and sustained effort by all Trust staff.

January 2012

SUMMARY PROFILE OF COMPLAINTS FIGURES FOR REPORTING PERIOD 8
as at 3 January 2012

- **Overall Reporting Period: 31 March 2011 - 3 January 2012**
- **This Reporting Period[5]: 21 November 2011 to 3 January 2011 inclusive**

1. Number of Total Active Complaints:

'Total Active Complaints' = total of 'First contact'[6] complaints and 'Link'[7] complaints.

MONTHLY REPORT DATE		TOTAL ACTIVE COMPLAINTS NOS.	CHANGE IN NOS. IN TOTAL ACTIVE COMPLAINTS	% CHANGE IN TOTAL ACTIVE COMPLAINTS
2011	**3 January 2012**	**262**	**-30**	**-11%**
2011	**23 November 2011**	292	+6	+0.2%
2011	**25 October**	286	-30	-9.5%
2011	**22 September**	316	-29	-9%
2011	**23 August**	345	-1	<1%
2011	**25 July**	346	+30	+9.5%
2011	**24 June**	316	-7	-2.2%
2011	**25 May**	323	-20	-6%
2011	**21 April**	343	-8	-2.3%
2011	**31 March**	351	-23	-6.2%

2. Total Active Complaints grades using the Complaint Severity Matrix[8].

GRADE	TOTAL ACTIVE COMPLAINTS		TOTAL
	FIRST CONTACT	LINK	
Red	2	0	2
Amber	53	9	62
Yellow	119	19	138
Green	45	7	52
Ungraded	3	5	8
Total	**222**	**40**	**262**

[5] **Reporting Period:** see section 7 re: 21 working day (WD) reporting period introduced on 20 April 2011. This report is for reporting period (RP) 8 comprising 21 November – 19 December 2011 as extended to 30 December 2011 inclusive (28 WD) as it comprises the 8th and final reporting period in relation to the strategy for the management of the complaints backlog concluding December 2011 (see 6.1 of the report dated 25.5.11 for RP 1 for 20.4.11 -24.5.11).

[6] **First Contact complaint**: where the Trust's substantive (i.e. initial) response has not yet been made.

[7] **Link complaint**: the complainant has received the substantive response to their complaint but has returned as they remain dissatisfied/or require additional clarification

[8] Appendix 1 of the Policy on Handling Complaints.

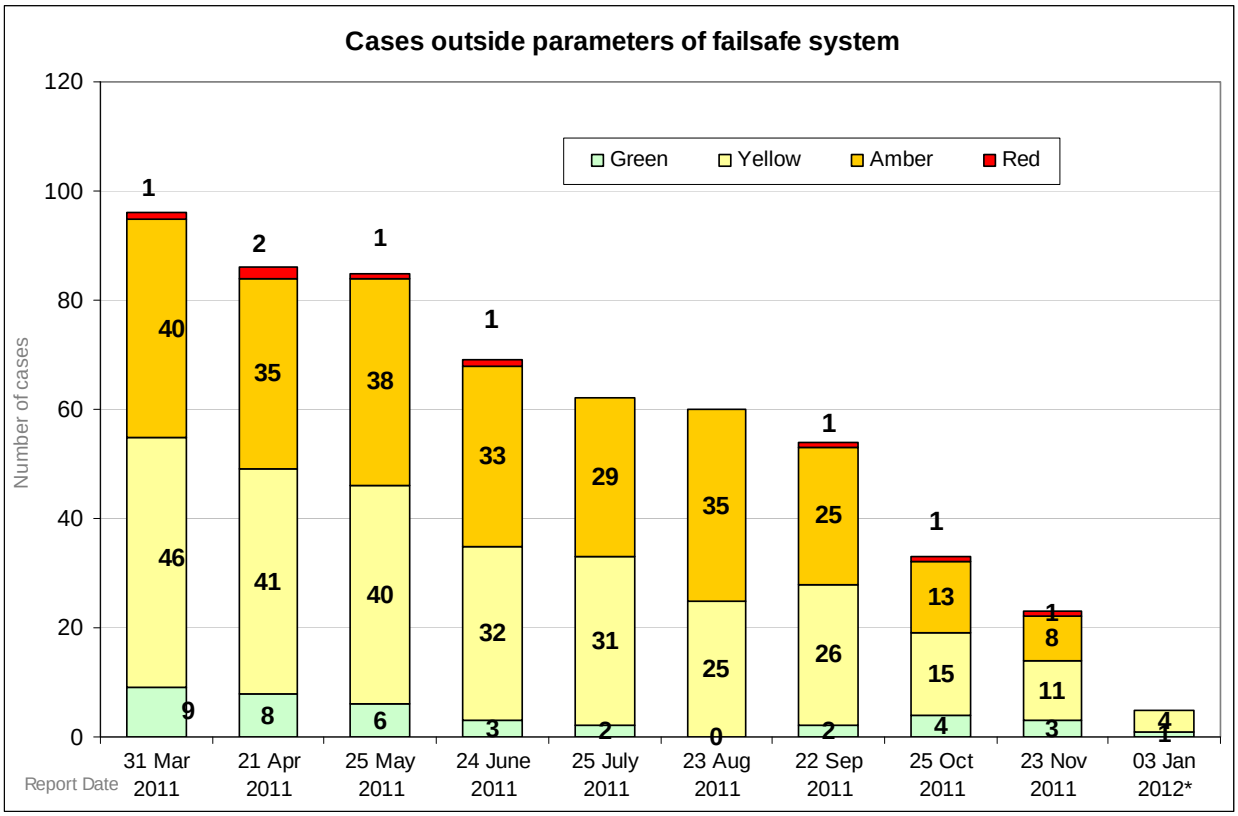
3. Parameters of failsafe system

Grade	Red	Amber	Yellow & Green
Target	75 days (all contacts)	90 days (all)	120 days (all)

The target timescales in the above table are designed to elicit the number of complaints where the Trust's substantive response is deemed to have breached an acceptable timescale. The target is adjusted according to the severity of the complaint, with more severe complaints taking priority. The grades indicated represent the initial classification of the severity of the complaint, in accordance with the Policy on Handling Complaints.

The failsafe system is an internal quality measure used by the Trust as there are presently no national timescale requirements for formal complaint responses (other than a general statutory requirement to respond as soon as practicable if the timescale exceeds 6 months).

4. Cases presently outside of parameters of failsafe system



The above graph represents the number of cases exceeding the target timescales highlighted in section 3 at the date of each report which essentially comprises the 'complaints backlog'.

* The 5 cases indicated as breaching the timescales on 3 January 2012 relate to local resolution meetings with the complainant to take place early in 2012 and which are being expedited. Of these 5, 1 meeting has taken place; 1 is arranged for 20 January 2012; 2 complainants are to confirm or provide provisional dates and 1 to confirm that they wish to proceed with the meeting.

5. Number of First Contact and Link complaints received in Reporting Period

MONTHLY REPORT PERIOD		NO. OF COMPLAINTS RECEIVED		
		FIRST CONTACT	LINK	TOTAL IN
2011	**30 December**	**73**	**15**	**88**
2011	**18 November**	74	6	82
2011	**21 October**	60	6	66
2011	**22 September**	62	6	68
2011	**23 August**	55	11	66
2011	**25 July**	92	14	106
2011	**24 June**	82	4	86
2011	**25 May**	63	4	67
2011	**21 April**	48	4	52
2011	**31 March**	33	7	40

6. Number of responses to Total Active Complaints sent in Reporting Period

MONTHLY REPORT PERIOD		NO. OF RESPONSES SENT		
		FIRST CONTACT	LINK	TOTAL SENT
2011	**30 December**	**89**	**16**	**105**
2011	**18 November**	68	18	86
2011	**21 October**	94	5	99
2011	**22 September**	92	9	101
2011	**23 August**	46	10	56
2011	**25 July**	75	21	96
2011	**24 June**	85	12	97
2011	**25 May**	87	13	100
2011	**21 April**	47	4	51
2011	**31 March**	46	7	53

7. Complaints backlog

7.1 Strategy

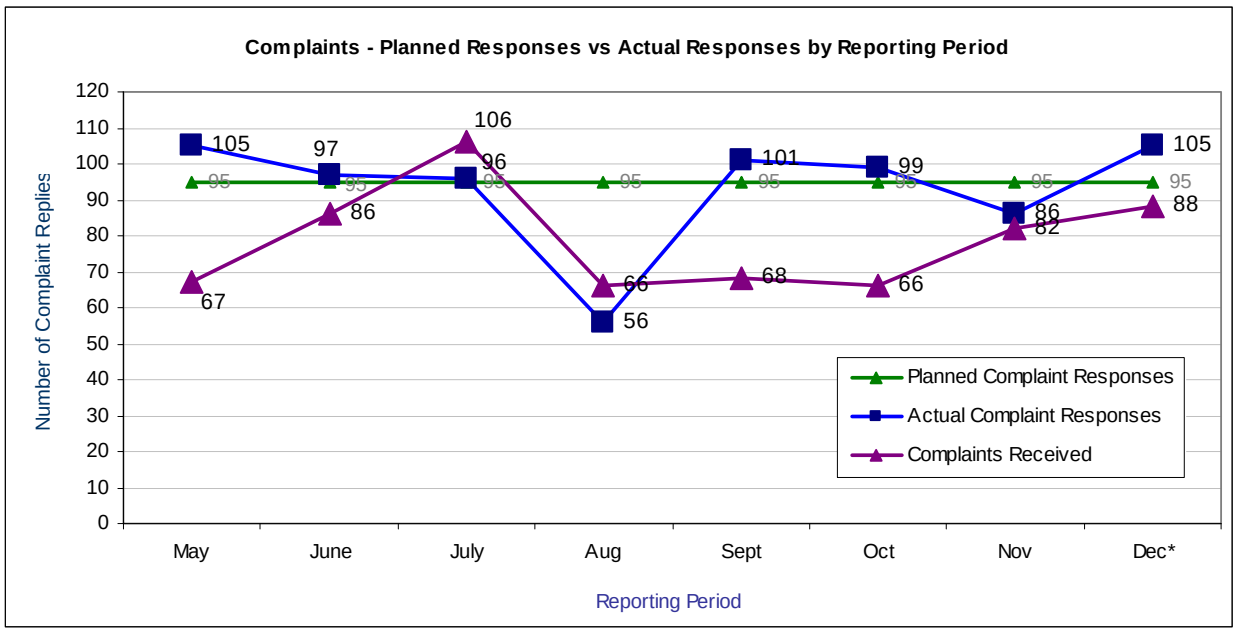
The strategy for the management of the complaints backlog has previously been shared with the Trust Board. On the basis that the average number of complaints received and sent in any one month is about 70, the target for the number of complaints responses to be sent within a 21 working day reporting period (being the average number of working days per calendar month across the year) commencing 20 April 2011[9] is **95** (i.e. 70 plus 25). This 21 day reporting period was applied to provide up-to-date information that allows direct comparison of equal time periods.

[9] Prior dates do not correspond as they are of varying periods.

7.2 Monitoring chart

The chart below sets out complaints reporting data for each 21 working day* reporting period for the periods 20 April 2011 to December 2011. The 3 lines comprise the planned trajectory (marked by green diamonds) as against the actual numbers of complaints responses sent (marked by blue squares) with the number of complaints received (marked by maroon triangles).

*As the final planned reporting period to clear the complaints backlog, the December figure reflects a 28 working day target schedule (i.e. until the end of the calendar year).



7.3 The table below states the reporting period for the chart at **7.2**.

Reporting Period		Calendar dates within period	Working Days
Current	December	21 November 2011 to 30 December 2011 inclusive	28

8. Conclusion

This is the 8th of 8 and the final reporting period prescribed by the strategy for the management of the complaints backlog and which period concluded on 30 December 2011. As reporting period 8 comprised 28 working days rather than 21 days utilised for reporting periods 1 to 7, direct comparison with data in previous reporting periods is not appropriate.

In summary for this reporting period, 88 complaints were received; 105 complaints responses were sent. The complaints backlog of 23 cases was reduced and now comprises 5 cases where local resolution meetings are/have been held with the complainants and have/are being expedited.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – December 2011
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Robert White/Tony Wharram
DATE OF MEETING:	26 January 2012

SUMMARY OF KEY POINTS:

The report provides an update on the financial performance of the Trust for December 2011.

For December, the Trust generated a "bottom line" surplus of £180,000 which is £13,000 higher than the planned position (as measured against the DoH performance target).

For the year to date, the Trust has a surplus of £771,000 which is £11,000 better than the planned position

Capital expenditure for the year to date is £4,260,000 and the cash balance at 31st December was £40.9m.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

APPROVE the amendments to the capital programme

NOTE the contents of the report and endorse any corrective actions required to ensure that the Trust achieves its financial targets.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	Compliance with financial management and governance standards.

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

Financial		Potential impact on trust financial performance targets.
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		Potential impact of higher than planned expenditure on trust financial performance.

PREVIOUS CONSIDERATION:

Performance Management Board and Trust Management Board on 17 January 2012 and Finance & Performance Management Committee on 19 January 2012

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – December 2011

EXECUTIVE SUMMARY

• For the month of December 2011, the Trust delivered a "bottom line" surplus of £180,000 compared to a planned surplus of £167,000 (as measured against the DoH performance target).

• For the year to date, the Trust has a surplus of £771,000 compared with a planned surplus of £760,000 so generating an positive variance from plan of £11,000.

•At month end, WTEs (whole time equivalents), excluding the impact of agency staff, were approximately 239 below plan. After taking into account the impact of agency staff, actual wte numbers are 160 below planned levels. This compares with a position last month of 80 below plan. Total pay expenditure for the month, inclusive of agency costs, is £698,000 below the planned level.

• The month-end cash balance was approximately £25.1m above the planned level.

Financial Performance Indicators - Variances

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	13	11	>= Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	(28)	(334)	>= Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	698	1,444	<=Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	(567)	(1,900)	<= Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	160	52	<= Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	25,099	25,099	>= Plan	> = 95% of plan	< 95% 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
Income and Expenditure	760	771
Capital Resource Limit	16,346	4,260
External Financing Limit	---	25,099
Return on Assets Employed	3.50%	3.50%

2011/2012 Summary Income & Expenditure Performance at December 2011	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	374,874	31,143	30,919	(224)	281,245	280,636	(609)	373,182
Other Income	40,352	3,248	3,313	65	29,054	29,785	731	40,651
Operating Expenses	(391,660)	(32,410)	(32,279)	131	(293,221)	(293,677)	(456)	(390,725)
EBITDA	23,566	1,981	1,953	(28)	17,078	16,744	(334)	23,108
Interest Receivable	25	2	11	9	19	82	63	104
Depreciation & Amortisation	(13,269)	(1,106)	(1,074)	32	(9,952)	(9,670)	282	(12,889)
PDC Dividend	(5,803)	(484)	(484)	0	(4,352)	(4,352)	0	(5,803)
Interest Payable	(2,156)	(180)	(180)	0	(1,617)	(1,617)	0	(2,156)
Net Surplus/(Deficit)	**2,363**	**213**	**226**	**13**	**1,176**	**1,187**	**11**	**2,364**
IFRS/Impairment Related Adjustments	(557)	(46)	(46)	0	(416)	(416)	0	(557)
SURPLUS/(DEFICIT) FOR DOH TARGET	**1,806**	**167**	**180**	**13**	**760**	**771**	**11**	**1,807**

The Trust's financial performance is monitored against the DoH target shown in the bottom line of the above table. IFRS and impairment adjustments are technical, non cash related items which are discounted when assessing performance against this target.

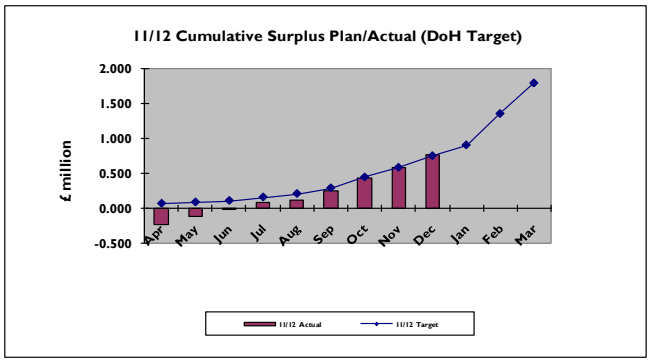
Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – December 2011

Overall Performance Against Plan

• The overall performance of the Trust against the DoH planned position is shown in the adjacent graph. Overall bottom-line performance delivered an actual surplus of £180,000 in December against a plan of £167,000. The resultant £13,000 positive variance moves the year to date position to £11,000 above targeted levels.

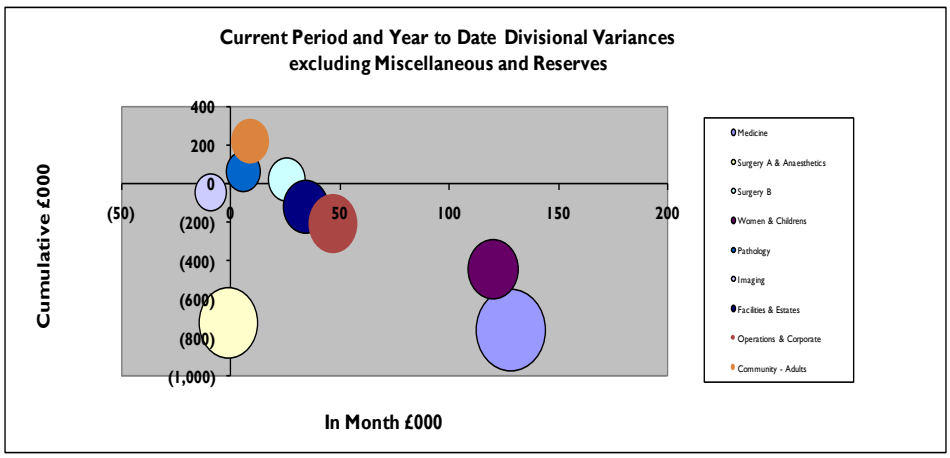


Divisional Performance

• For December, the only significant adverse variances is within Miscellaneous and Reserves and this is wholly the result of transfers between these and operational divisions to acknowledge changes in the SLA position with Sandwell PCT and the internal funding of recognised cost pressures.

• There has been a slight worsening in performance against SLA income targets in November (the latest month for which fully costed data is available) . For the month, actual performance is £164,000 lower than plan (taking into account all patient related income, contracted and non contracted).

•The Medicine Division has generated a significantly better than planned bottom line position in month and has reduced its year to date adverse performance, predominantly the result of higher than expected levels of vacancies.



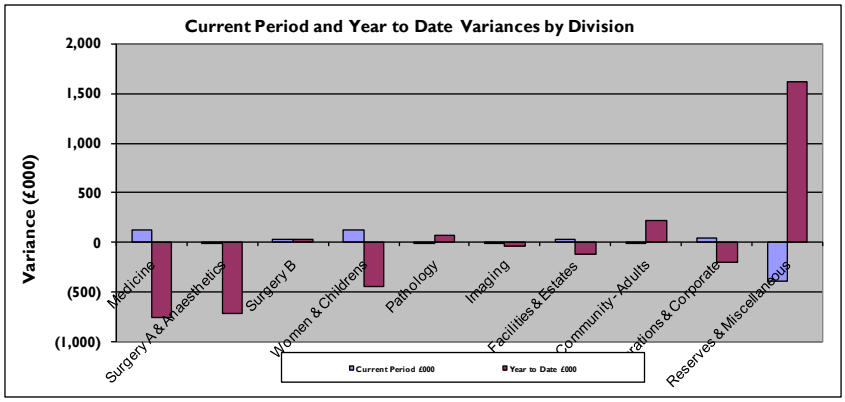
The tables adjacent and below show no significant in month variances from plan but ongoing year to date deficits for Surgery A, Womens & Child Health, Medicine, Facilities and Corporate Services.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

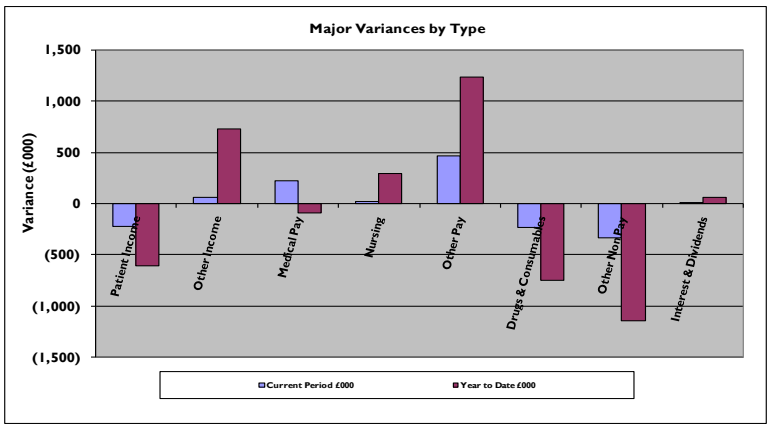
Financial Performance Report – December 2011

Divisional Variances from Plan	Current Period £000	Year to Date £000
Medicine	128	(758)
Surgery A & Anaesthetics	(1)	(720)
Surgery B	26	28
Women & Childrens	120	(441)
Pathology	6	66
Imaging	(9)	(40)
Facilities & Estates	34	(119)
Community - Adults	9	227
Operations & Corporate	47	(202)
Reserves & Miscellaneous	(386)	1,625



For December, patient income shows an adverse variance, although smaller than previous months, along with non pay but a positive position against plan for pay.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
Patient Income	(224)	(609)
Other Income	65	731
Medical Pay	219	(93)
Nursing	16	298
Other Pay	463	1,239
Drugs & Consumables	(235)	(755)
Other Non Pay	(332)	(1,145)
Interest & Dividends	9	63



Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – December 2011

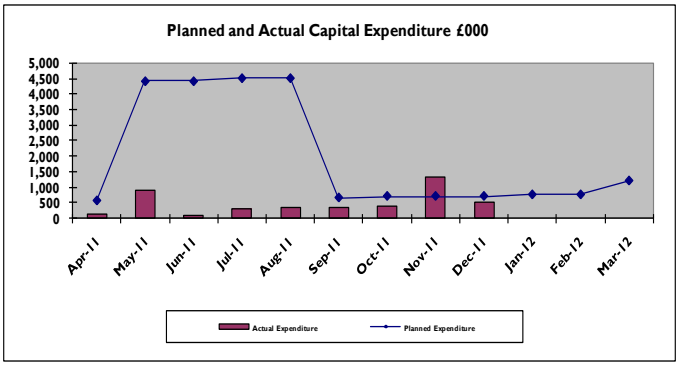
Capital Expenditure

• Planned and actual capital expenditure by month is summarised in the adjacent graph.

• Amendments to the programme have been approved by SIRG to reflect the fall in expected expenditure on land purchases to £3.75m:

- toxicology analysers £480k
- breast services ultrasound £250k
- fibroscan technology £47k
- IT data storage £700k
- IT review – systems enhancement £50k
- cleaning robots £66k
- medical equipment b/f from 12/13 £400k
- boiler replacement £240k
- initial estates rationalisation works £350k

• December expenditure was lower than planned for the month at £0.5m primarily related to statutory standards and paediatric ward refurbishment.

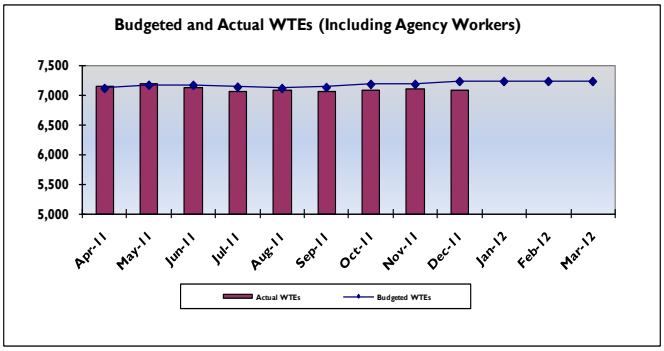


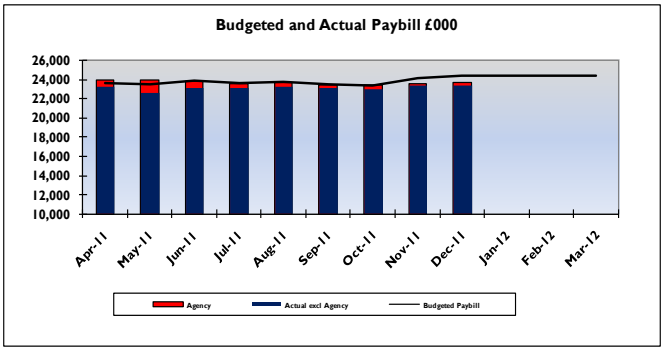
Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are approximately 160 below plan for December compared with 80 below plan in November. Excluding the impact of agency staff, wte numbers are around 239 below plan. Actual wtes have fallen by approximately 31 compared with November.

• Total pay costs (including agency workers) are £698,000 lower than budgeted levels for the month , particularly on medical, scientific & therapeutic and support staff groups.

• Expenditure for agency staff in December was £361,000 compared with £315,000 in November, an average of £540,000 for the year to date and a December 2010 spend of £563,000. The biggest single group accounting for agency expenditure remains medical staffing.





Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – December 2011

Pay Variance by Pay Group

• The table below provides an analysis of all pay costs by major staff category with actual expenditure analysed for substantive, bank and agency costs.

Analysis of Total Pay Costs by Staff Group

	Year to Date to December					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	57,058	54,516		2,635	57,151	(93)
Management	11,567	11,210		0	11,210	357
Administration & Estates	23,970	22,299	926	638	23,863	107
Healthcare Assistants & Support Staff	23,011	21,235	1,687	153	23,075	(64)
Nursing and Midwifery	65,747	62,071	2,526	852	65,449	298
Scientific, Therapeutic & Technical	33,276	31,867		584	32,451	825
Other Pay	30	16			16	14
Total Pay Costs	214,659	203,215	5,139	4,862	213,215	1,444

NOTE: Minor variations may occur as a result of roundings

Balance Sheet

• The opening Statement of Financial Position (balance sheet) for the year at 1st April reflects the statutory accounts for the year ended 31st March 2011.

• Cash balances at 31st December are approximately £40.9m which is around £0.9m higher than at 30th November.

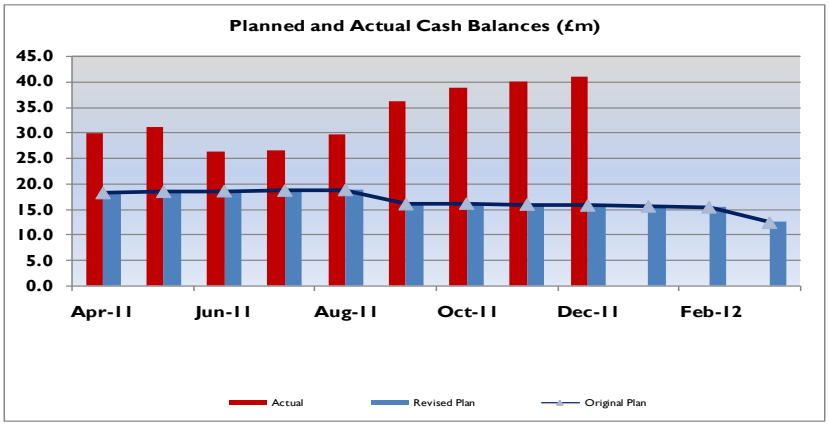
Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION

		Opening Balance as at 1st April 2011 £000	Balance as at December 2011 £000
Non Current Assets	Intangible Assets	1,077	1,002
	Tangible Assets	216,199	210,864
	Investments	0	0
	Receivables	649	680
Current Assets	Inventories	3,531	3,890
	Receivables and Accrued Income	12,652	15,030
	Investments	0	0
	Cash	20,666	40,882
Current Liabilities	Payables and Accrued Expenditure	(33,513)	(43,944)
	Loans	0	(2,000)
	Borrowings	(1,262)	(1,250)
	Provisions	(4,943)	(3,656)
Non Current Liabilities	Payables and Accrued Expenditure	0	0
	Loans	0	(6,000)
	Borrowings	(31,271)	(30,606)
	Provisions	(2,237)	(2,237)
		181,548	182,655
Financed By			
Taxpayers Equity	Public Dividend Capital	160,231	160,231
	Revaluation Reserve	36,573	37,073
	Donated Asset Reserve	2,099	0
	Government Grant Reserve	1,662	0
	Other Reserves	9,058	9,058
	Income and Expenditure Reserve	(28,075)	(23,707)
		181,548	182,655

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – December 2011



Cash Forecast

• A forecast of the expected cash position for the next 12 months is shown in the table below.

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW

12 MONTH ROLLING FORECAST AT December 2011

ACTUAL/FORECAST	Dec-11 £000s	Jan-12 £000s	Feb-12 £000s	Mar-12 £000s	Apr-12 £000s	May-12 £000s	Jun-12 £000s	Jul-12 £000s	Aug-12 £000s	Sep-12 £000s	Oct-12 £000s	Nov-12 £000s
Receipts												
SLAs: Sandwell PCT	**15,733**	15,399	15,399	15,399	15,091	15,091	15,091	15,091	15,091	15,091	15,091	15,091
HoB PCT	**7,477**	7,410	7,410	7,410	7,262	7,262	7,262	7,262	7,262	7,262	7,262	7,262
Associated PCTs	**5,499**	5,691	5,691	5,691	5,577	5,577	5,577	5,577	5,577	5,577	5,577	5,577
Pan Birmingham LSCG	**1,839**	1,839	1,839	1,839	1,802	1,802	1,802	1,802	1,802	1,802	1,802	1,802
Over Performance Payments					0	0	0	0	0	0	0	0
Education & Training	**1,365**	1,457	1,457	1,457	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255
Loans												
Other Receipts	**2,673**	2,976	2,976	2,976	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500
Total Receipts	**34,586**	34,773	34,773	34,773	33,488	33,488	33,488	33,488	33,488	33,488	33,488	33,488
Payments												
Payroll	**13,596**	13,911	14,911	16,411	13,215	13,215	13,215	13,215	13,215	13,215	13,215	13,215
Tax, NI and Pensions	**9,255**	9,463	9,963	10,963	8,990	8,990	8,990	8,990	8,990	8,990	8,990	8,990
Non Pay - NHS	**3,051**	2,500	2,500	2,500	2,450	2,450	2,450	2,450	2,450	2,450	2,450	2,450
Non Pay - Trade	**6,560**	8,328	7,496	8,763	8,325	7,325	7,325	7,575	7,575	7,575	7,575	7,575
Non Pay - Capital	**586**	4,331	2,166	5,414	500	500	500	500	500	500	500	500
PDC Dividend				2,928						2,900		
Repayment of Loans				1,000						1,000		
Interest				34						30	30	30
BTC Unitary Charge	**372**	396	396	396	415	415	415	415	415	415	415	415
Other Payments	**219**	250	250	250	200	200	200	200	200	200	200	200
Total Payments	**33,639**	39,179	37,681	48,659	34,095	33,095	33,095	33,345	33,345	37,275	33,375	33,375
Cash Brought Forward	**39,935**	40,882	36,475	33,567	19,681	19,074	19,467	19,860	20,003	20,146	16,359	16,472
Net Receipts/(Payments)	**947**	(4,407)	(2,908)	(13,886)	(607)	393	393	143	143	(3,787)	113	113
Cash Carried Forward	**40,882**	36,475	33,567	19,681	19,074	19,467	19,860	20,003	20,146	16,359	16,472	16,585

Actual numbers are in bold text, forecasts in light text.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – December 2011

Risk Ratings			
Measure	**Description**	**Value**	**Score**
EBITDA Margin	Excess of income over operational costs	5.7%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	97.6%	4
Return on Assets	Surplus before dividends over average assets employed	4.4%	3
I&E Surplus Margin	I&E Surplus as % of total income	0.4%	2
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	34.5	4
Overall Rating			**3.0**

Risk Ratings

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

• An adjustment has now been made to the liquidity ratio to reflect an uncommitted overdraft facility (which would be in place as an FT) as this more accurately reflects performance against the Monitor risk rating regime. The changes the Liquid Ratio score from 2 to 4.

•I&E Surplus Margin is lower than would normally be expected due to relatively low levels of surplus being delivered.

External Focus

•Birmingham and Solihull Cluster continues to report a difficult financial position although forecasting year end performance in line with a reduced control total. Expectations of potential difficulties in meeting winter pressures have been identified. The cluster continues to report pressures in some areas of acute activity although not generalised over all providers or all services.

• Financial performance at the Black Country Cluster remains strong, particularly for Wolverhampton PCT, although at the same time, over performance on acute contracts at Dudley Group, Royal Wolverhampton and Walsall Hospitals continues to be reported.

• Although the number of organisations concerned is still relatively small, there are increasing reports of deficits within the NHS trust sector in 2011/12 coupled with a general expectation of significant falls in forecast surpluses elsewhere. Actual and potential deficits have largely been associated with organisations finding increasing difficulty in delivering demanding savings targets, a problem which can only grow in 2012/13 with the roll out of another year of national efficiency savings requirements across providers.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – December 2011

Conclusions

• Measured against the DoH target, the Trust generated an actual surplus of £180,000 during December bringing its financial performance for the first six months of the year to an overall surplus of £771,000.

•The Trust's year to date performance against both its Department of Health control total (i.e. the bottom line budget position it must meet) and the statutory accounts target shows a positive variance of £11,000 against the planned position.

• The £180,000 surplus in December is £13,000 better than planned for the month.

• Year to date capital expenditure is £4,260,000 which remains significantly lower than plan. Expected expenditure on Grove Lane land is now expected to amount to only around £3.75m for the year although this represents a phasing issue rather than a real change with deferred expenditure expected to take place in 2012/13.

•At 31st December, cash balances are approximately £25.1m higher than the cash plan which is around £0.9m greater than the position at 30th November. This includes receipt of an £8m DoH capital expenditure loan planned to be used to fund land acquisition in Grove Lane.

• The only material adverse variance in month is within Reserves and Miscellaneous which is the result of transfers of resources to operational areas to reflect movements in the SLA position with Sandwell PCT and the recognition of trust cost pressures.

• Monitoring and review of the measures implemented in Medicine & Emergency Care, Surgery A, Anaesthetics & Critical Care and Women and Child Health Divisions continues on an ongoing basis. The current situation in these and all other divisions is being actively monitored and managed as any failure to deliver key financial targets will present a significant risk to the Trust's overall financial position including its agreed yearend surplus target. The finance committee continues to hold Divisions to account for financial & operational performance especially those in financial turnaround. As such it continues with its cycle of divisional attendance each month.

Recommendations

The Trust Board is asked to:

i. NOTE the contents of the report;

ii. APPROVE the amendments to the capital programme; and

iii. ENDORSE any actions taken to ensure that the Trust remains on target to achieve its planned financial position.

Robert White

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Monthly Performance Monitoring Report
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of planning & Performance Management
DATE OF MEETING:	26 January 2012

SUMMARY OF KEY POINTS:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April – December 2011.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Accessible and Responsive Care, High Quality Care and Good Use of Resources
Annual priorities	National targets and Infection Control
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	Internal Control and Value for Money

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

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

PREVIOUS CONSIDERATION:

Financial Management Board, Trust Management Board and Finance and Performance Management Committee.

SANDWELL AND WEST BIRMINGHAM HOSPITALS CORPORATE QUALITY AND PERFORMANCE MONITORING REPORT - DECEMBER 2011 - EXCEPTION REPORT

SWBTB (1/12) 273 (a)

AREA	PERFORMANCE				COMMENTS
	National Indicator(s)		Local Indicator(s)		
	Current	Year to date	Current	Year to date	
Cancer	●	●			The Trust has met, in month (September) and year to date performance thresholds for each of the 9 (national) headline, 2-week, 31-day and 62-day cancer indicators.
Cancelled Operations	●	●	●	●	The overall percentage of Cancelled Operations increased on both sites to 0.9% overall during the month of December. There was a breach of the 28-day standard reported following an initial cancellation, this is the first breach of this nature since May 2010.
Delayed Transfers of Care	●	●			During the month (December) Delayed Transfers of Care increased on both sites to 5.4% overall. On the census date 50% of delays were attributable to Sandwell Local Authority. Year to date Delayed Transfers of Care (5.7%) remain in excess of the 3.5% performance threshold.
Stroke Care	●	●	●	●	Stroke Care - provisional data for the month of December indicates that the percentage of patients who spent at least 90% of their hospital stay on a Stroke Unit has been maintained above the national target of 80%. TIA (High Risk) Treatment (within 24 hours of initial presentation) is reported as 28.5% for the month. In excess of 90% of patients presenting with Stroke during the month received a CT Scan within 24 hours of arrival and admission.
Accident & Emergency	●	●			A/E 4-hour waits - performance for the month of December fell to 94.00%. Performance for the year to date is 95.06%.
	●	●			Accident & Emergency Clinical Quality Indicators - for the purpose of performance monitoring the indicators are grouped into two groups, timeliness and patient impact. Organisations will be regarded as achieving the required minimum level of performance where robust data shows they have achieved the thresholds for at least one indicator in each of the two groups. During December 2 of the 5 indicators was met, one in each of the 2 groups. for the year to date 3 of the 5 indicaors are being met.
Infection Control	●	●			There were 2 cases of C Diff reported across the Trust during the month of December compared with a trajectory of 9. The number of C Diff cases reported for the year to date are also within the trajectory for the period. There was 1 case of MRSA Bacteraemia, during the month which is the first case reported during the year to date.
Referral to Treatment	●	●	●	●	All 5 National and 3 Local high level RTT Performance Indicators were met in month (November) and year to date. The only exception by specialty was Trauma & Orthopaedics, where 80.1% of admitted patients commened treatment within 18 weeks of referral (target 90%), similar to the previous month.
Cervical Cytology			●	●	The Turnaround Time of Cervical Cytology requests has been less than 9 days for each month for the year to date.
Same Sex Accommodation	●	●			There were 0 Breaches of Same Sex Accommodation reported during the month of October. No breaches have been reported since August.
Mortality			●	●	The Hospital Standardised Mortality Rate (HSMR) for the Trust for the most recent 12 month cumulative period (ending September 2011) is 101.9, compared with a Peer (SHA) rate of 104.5 and a Peer (National) rate of 95.7.
Sickness Absence			●	●	Sickness Absence for the month of December improved (reduced) to 4.28% (target for Q3 =<3.65%), influenced by a reduction in the rate for short term sickness.
Learning & Development			●	●	Approximately 4500 staff have received a PDR for the period to date (April - December), equivalent to a rate of 77%. Overall Mandatory Training compliance at the end of December is reported as 77%.
CQUIN	●	●			Acute Schemes - performance against several schemes for the most recent period is less than the respective trajectories for the period. Where early (provisional) data for more recent periods is available it suggests improvement to have occured in the majority of these schemes.
	●	●			Community Schemes - performance trajectories for all schemes except Health Visiting were met during November and for the year to date. Performance against the Health Visiting CQUIN target was 65.2%, marginally short of the 66% trajectory.
	●	●			Specialised Commissioners Schemes - all schemes are met for the year to date with the exception of Access to Chemotherapy Out of Hospital which is aimed at increasing the volume of chemotherapy / anti-cancer drug deliveries made either at the patient's home or in a community setting closer to the patient's home. To date 215 home deliveries have been made, compared with a trajectory for the period of 290. For Screening of Retinopathy of Prematurity performance was 91%, although the trajectory of 92% for the CQUIN performance assessment period (November - March inclusive) is met.
Referrals			●	●	For the period April - November inclusive overall referrals are approximately 8900 (7.0%) fewer and GP Referrals are approximately 5600 (6.5%) fewer than the corresponding period last year. Overall Referrals from Sandwell, HOB and Other (non-Sandwell / HOB) PCTs are approximately 4300(6.8%), 800 (2.4%) and 3700 (9.1%) less respectively for the 8 months year to date than for the same period last year.
Activity			●	●	Overall Elective activity for the month is 2.1% greater than plan, and in excess of plan for the year to date by 7.8%.
			●	●	Non Elective activity is 3.0% less than plan for the month and 9.5% less than plan for the first 9 months of the year.
			●	●	Outpatient New and Review activity continues to exceed the plan for the year to date by 6.3% and 8.7% respectively. During the month performance against plans for New and Review activity was -4.6% and +5.0% respectively. The Follow Up to New Outpatient Ratio for the year to date increased to 2.87, compared with a ratio derived from plan of 2.61.
			●	●	A/E Type I activity during the month of December was 5.8% less than plan, and is 2.4% less than plan for the year to date. Type II activity is 12.3% less than plan for the month, and remains in excess of plan for the year to date by 3.6%.
Ambulance Turnaround			●	●	The proportion of ambulances waiting greater than 30 minutes increased to 44.1% (West Midlands average 35.1%) during the month. There were 146 instances recorded of ambulances with a turnaround time in excess of 60 mins.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	The NHS Performance Framework Monitoring Report and summary performance assessed against the NHS FT Governance Risk Rating (FT Compliance Report)
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of Planning & Performance Management and Tony Wharram, Deputy Director of Finance
DATE OF MEETING:	26 January 2012

SUMMARY OF KEY POINTS:

The report provides an assessment of the Trust's performance mapped against the indicators which comprise the NHS Performance Framework.

Service Performance (December and Quarter 3):
There are 2 areas of underperformance during the month of December. These are A/E 4-hour waits and Delayed Transfers of Care. Actual performance is as indicated in the attached report. The overall score for the month is 2.57. There is 1 area of underperformance during Quarter 3, Delayed Transfers of Care. The overall score for the Quarter is 2.93.

A score in excess of 2.40 attracts a PERFORMING classification.

Financial Performance (December):
The weighted overall score remains 2.90 and is classified as PERFORMING. Underperformance is indicated in December in 3 areas; Better Payment Practice Code (Value), Better Payment Practice Code (Volume) and Creditor Days.

Foundation Trust Compliance Summary report:
There was 1 area of underperformance reported within the framework during the month of December. A/E 4-hour waits performance was 94.0%. As such the overall score for the month is 1.0, which attracts an AMBER / GREEN Governance Rating.

There were no areas of underperformance reported within the framework for the Quarter 3 period. As such the overall score for the Quarter is 0.0, which attracts a GREEN Governance Rating.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Accessible and Responsive Care, High Quality Care and Good Use of Resources
Annual priorities	National targets and Infection Control
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	Internal Control and Value for Money

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

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

PREVIOUS CONSIDERATION:

Finance and Performance Management Committee.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2011/12

Financial Indicators				SCORING			2011 / 2012			2011 / 2012			2011 / 2012			2011 / 2012		
Criteria	Metric	Weight (%)		3	2	1	September	Score	Weight x Score	October	Score	Weight x Score	November	Score	Weight x Score	December	Score	Weight x Score
Initial Planning	Planned Outturn as a proportion of turnover	5	5	Planned operating breakeven or surplus that is either equal to or at variance to SHA expectations by no more than 3% of income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to SHA expectations by more than 3% of planned income.	Operating deficit more than or equal to 2% of planned income	0.00%	3	0.15	0.00%	3	0.15	0.00%	3	0.15	0.00%	3	0.15
Year to Date	YTD Operating Performance	25	20	YTD operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of forecast income.	Operating deficit more than or equal to 2% of forecast income	0.06%	3	0.6	0.10%	3	0.6	0.14%	3	0.6	0.19%	3	0.6
	YTD EBITDA		5	Year to date EBITDA equal to or greater than 5% of actual year to date income	Year to date EBITDA equal to or greater than 1% but less than 5% of year to date income	Year to date EBITDA less than 1% of actual year to date income.	5.34%	3	0.15	5.31%	3	0.15	5.35%	3	0.15	5.39%	3	0.15
Forecast Outturn	Forecast Operating Performance	40	20	Forecast operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of income.	Operating deficit more than or equal to 2% of income	0.00	3	0.6	0.00	3	0.6	0.00	3	0.6	0.00	3	0.6
	Forecast EBITDA		5	Forecast EBITDA equal to or greater than 5% of forecast income.	Forecast EBITDA equal to or greater than 1% but less than 5% of forecast income.	Forecast EBITDA less than 1% of forecast income.	5.65%	3	0.15	5.59%	3	0.15	5.58%	3	0.15	5.58%	3	0.15
	Rate of Change in Forecast Surplus or Deficit		15	Still forecasting an operating surplus with a movement equal to or less than 3% of forecast income	Forecasting an operating deficit with a movement less than 2% of forecast income OR an operating surplus movement more than 3% of income.	Forecasting an operating deficit with a movement of greater than 2% of forecast income.	0.00%	3	0.45	0.00%	3	0.45	0.00%	3	0.45	0.00%	3	0.45
Underlying Financial Position	Underlying Position (%)	10	5	Underlying breakeven or Surplus	An underlying deficit that is less than 2% of underlying income.	An underlying deficit that is greater than 2% of underlying income	0.43%	3	0.15	0.44%	3	0.15	0.44%	3	0.15	0.44%	3	0.15
	EBITDA Margin (%)		5	Underlying EBITDA equal to or greater than 5% of underlying income	Underlying EBITDA equal to or greater than 5% but less than 1% of underlying income	Underlying EBITDA less than 1% of underlying income	5.65%	3	0.15	5.59%	3	0.15	5.58%	3	0.15	5.58%	3	0.15
Finance Processes & Balance Sheet Efficiency	Better Payment Practice Code Value (%)	20	2.5	95% or more of the value of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the value of NHS and Non NHS bills are paid within 30days	Less than 60% of the value of NHS and Non NHS bills are paid within 30 days	77.00%	2	0.05	89.00%	2	0.05	87.00%	2	0.05	85.00%	2	0.05
	Better Payment Practice Code Volume (%)		2.5	95% or more of the volume of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the volume of NHS and Non NHS bills are paid within 30days	Less than 60% of the volume of NHS and Non NHS bills are paid within 30 days	83.00%	2	0.05	85.00%	2	0.05	88.00%	2	0.05	88.00%	2	0.05
	Current Ratio		5	Current Ratio is equal to or greater than 1.	Current ratio is anything less than 1 and greater than or equal to 0.5	A current ratio of less than 0.5	1.22	3	0.15	1.18	3	0.15	1.16	3	0.15	1.18	3	0.15
	Debtor Days		5	Debtor days less than or equal to 30 days	Debtor days greater than 30 and less than or equal to 60 days	Debtor days greater than 60	12.97	3	0.15	11.79	3	0.15	14.53	3	0.15	13.86	3	0.15
	Creditor Days		5	Creditor days less than or equal to 30	Creditor days greater than 30 and less than or equal to 60 days	Creditor days greater than 60	34.25	2	0.1	37.29	2	0.1	41.48	2	0.1	40.98	2	0.1
						Weighted Overall Score			2.90			2.90			2.90			2.90

*Operating Position = Retained Surplus/Breakeven/deficit less impairments

Assessment Thresholds	
Performing	> 2.40
Performance Under Review	2.10 - 2.40
Underperforming	< 2.10

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Corporate Objectives 2011/12 – Progress Report (Quarter 3)
SPONSORING DIRECTOR:	Mike Sharon, Director of Strategy & Organisational Development
AUTHOR:	Ann Charlesworth, Head of Corporate Planning
DATE OF MEETING:	26 January 2012

SUMMARY OF KEY POINTS:

The report contains a summary of progress at the end of Quarter 3, towards the achievement of the Trust's Corporate Objectives set out in the Annual Plan 2011/12.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to receive and note the update.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Outlines progress towards those objectives
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

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

PREVIOUS CONSIDERATION:

Trust Management Board on 17 January 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ANNUAL PLAN 2011/12
CORPORATE OBJECTIVES PROGRESS REPORT (QUARTER THREE)

INTRODUCTION

The Trust's Annual Plan for 2011/12 set a series of corporate objectives for the year to ensure that we make progress towards our six strategic objectives. Progress on the majority of these objectives is reported to the Board at regular intervals either through routine monthly reports on finance and performance or through specific progress reports. Progress across all objectives is also reported quarterly to ensure the Board has a clear overview of our position.

QUARTER ONE PROGRESS

A summary of the position on each objective at the end of Quarter 3 is set out in the table that accompanies this report. An overview of the Q3 RAG assessment for each objective is set out in the table below. (Please note that from Q3 a revised standardised RAG rating is being applied see page 3).

Objective	R / A / G Assessment			
	Q1	Q2	Q3	Q4
1. Accessible and Responsive Care				
1.1 Identify & implement specific ways to improve health of popn.				
1.2 Close & effective relationship with GP consortia, PCT clusters & Local Authorities				
1.3 Deliver access performance measures				
1.4 Continue to improve outpatient booking systems				
1.5 Improve patient flow from admission through discharge to home				
2. High Quality Care				
2.1 Improve reported levels of patient satisfaction				
2.2 Continue to embed Customer Care promises				
2.3 Improve the care we provide to vulnerable adults				
2.4 Make improvements in A&E services				
2.5 Make improvements in Trauma & Orthopaedic services				
2.6 Make improvements in Stroke services				
2.7 Embed the Quality & Safety Strategy				
2.8 Reporting and learning from incidents				
2.9 Deliver the CQUIN targets				
3. Care Closer to Home				
3.1 Successful integration of adult & children's community services				
3.2 Deliver changes in activity as part of RCRH programme				
3.3 Actively promote healthy lifestyles and health education				
3.4 Develop local response to national plans for Health Visiting				
3.5 Make fuller use of Rowley Regis Community Hospital				

Objective	R / A / G Assessment			
	Q1	Q2	Q3	Q4
4. Good Use of Resources				
4.1 Deliver £21.1m CIP & plans for £20m CIP for further 3 years				
4.2 Achieve a £2m surplus				
4.3 Reduce premium rate working				
4.4 Develop plans to improve service line position of the Trust				
5. 21st Century Facilities				
5.1 Begin to procure a new hospital				
5.2 Continue to improve current facilities				
5.3 Develop detailed plans for development of community estate				
6. An Effective NHS Organisation				
6.1 Make significant progress towards becoming a Foundation Trust				
6.2 Organisational Development activities – stronger voice for staff				
6.3 Clinical systems & processes – safe, error free care				
6.4 Improve staff satisfaction, health and well being				
6.5 Agree IT strategy inc. route to procurement of EPR				
6.6 Continue approach to sustainability, transport and access				
6.7 Develop resourced Training Plan to support workforce plan				

At the end of quarter three, 15 of our 33 objectives are now assessed as green and 14 are assessed as amber.

The two objectives identified at the end of quarter two as red (3.2 Deliver Changes as part of RCRH Programme and 5.1 Begin to Procure a New Hospital), remain the same at the end of quarter three.
Two further objectives have been changed from amber to red:

- Objective 6.1 - timetable delay to Foundation Trust status as a result of the OBC delay.
- Objective 6.5 – IT strategy is delayed pending completion of an IM&T review.

CONCLUSION AND RECOMMENDATIONS

This report and the accompanying table present an overview of the position on our corporate objectives for 2011/12 at the end of Quarter 3. The Trust Board is recommended to:

- NOTE the progress made on the corporate objectives at Q3.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
TRUST OBJECTIVES 2011/12: QUARTER TWO PROGRESS REPORT

PROGRESS REPORTING

Progress with many of the corporate objectives will be reported to the Board monthly through for example the monthly performance and finance reports (e.g. progress with 2011/12 financial plan and progress with national access targets) or through specific monthly reports (e.g. 'Right Care Right Here' programme reports). In addition to this and in order to ensure that the Board has a clear view of progress across the corporate objectives as a whole it is intended to report progress quarterly, as we have in previous years, using a traffic-light based system at the following Board meetings:

- Q1 position reported to July Board meeting;
- Q2 position reported to October Board meeting;
- Q3 position reported to January Board meeting;
- Q4 position reported to April Board meeting.

CATEGORISATION

Progress with the actions in the plan has been assessed on the scale set out in the table below. (N.B. This is a revised standardised assessment rating).

Status	
5	Action complete
4	Progressing as planned
3	Some delay but expect to be completed as planned
2	Significant delay – unlikely to be completed as planned
1	Action not yet due to start

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Three (December 2011)**	**Red /Amber /Green Assessment**
1.	***Accessible and Responsive Care***				
1.1	**Identify and implement specific ways of improving the health of the population we serve.** **DO'D**	• Catalogue of relevant indicators drawn from primary care but mapped to each directorate • Discussions with Directors of Public Health to establish priorities • Identify data sources and create data flow for each indicator • Incorporate indicators into SWBH QMF dashboards for each directorate or specialty • Incorporate indicators into a Clinical Quality dashboard for RCRH		• Process agreed for defining and assuring data quality in QMF • January 2012 Discussions held with DPH. Indicator selection and deployment remains delayed due to resource limitations and competing priorities	**3**
1.2	**Ensure close and effective relationships with local GP consortia, PCT Clusters and Local Authorities.** **MS (with DO'D)**	• Deliver on medical engagement LIA action plan. • Identify leaders and opinion formers in each consortium and continue active engagement. • Promote and improve direct contacts between directorates and primary care clinicians. • Trust represented by Executive or senior Medical leads at all Cluster meetings for Birmingham and Solihull and the Black Country. • Integrate work of Business Development Team with representatives from each Division.	Consortia emerging, regular contact established but lack of systematic approach involving clinical divisions	• All SWBH facing CCGs have agreed to form a single federation covering the whole of Sandwell and part of HoB • Engagement event now scheduled for February • Excellent relationships maintained with clusters, though Birmingham and Solihull still does not have a clinical Senate	**3**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Three (December 2011)**	**Red /Amber /Green Assessment**
		• Improve flow of information and communication between hospital doctors and GPs.			
1.3	**Deliver Access performance measures including those set out in the Operating Framework for 2011/12.** **RB**	• New A&E standards.	Not available Not available Not available Not available Not available 96.99%	A/E Clinical Quality Indicators: - Total time (hrs:mins) in Dep't (95th centile) Actual 4:02 (Q3) (Target <4:00) RED - Time (mins) to Initial Assessment (95th centile). Actual 20 mins (Q3)(Target =<15) RED - Time (mins) to Treatment in Dep't (median) Actual 54 mins (Q3)(Target =<60) GREEN - Unplanned reattendance rate (%) Actual 7.97% (Q3)(Target =<5.0) RED - Left Dep't without being seen rate (%) Actual 4.93% (Q3)(Target =<5.0) GREEN A/E 4-hour waits - 95.06% (Q3)(Target =>95.00) Rapid Improvement Event work programme in train reporting to EDAT. Erratic performance indicates underlying issues. New DGM appointed and review of Directorate work plan to inform Quarter 4 improvements.	**3**
		• 18 weeks referral to treatment standard maintained (95th percentile).	20 weeks (March 2011) 16 weeks (March 2011)	18 weeks RTT Standards: - Admitted Care (weeks) (95th centile) Actual 16 weeks (Nov 2011)(Target =<23) - Non-Admitted (weeks)(95th centile) Actual 14 weeks (Nov 2011)(Target =<18.3)	

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Three (December 2011)**	**Red /Amber /Green Assessment**
		• Cancer waiting times (2 wks, 31 days & 62 days) standards maintained. • GUM 48 hr access standard maintained. • Rapid access chest pain standard (2 wk) maintained.	94.5% 94.7% 99.7% 88.0% 100% 100%	Cancer Waiting Times: - 2 weeks all cancers (%) Actual 93.8% (Sept/Nov 2011)(Target =>93) - 2 weeks Breast Symptomatic (%) Actual 95.1% (Sept/Nov 2011)(Target =>93) - 31 days diagnosis to treatment (%) Actual 99.8% (Sept/Nov 2011)(Target =>96) - 62 days urgent GP referral to treatment (%) Actual 85.3% (Sept/Nov 2011)(Target =>85) GUM 48 hour access: - Patients Offered App't within 48 hours (%) Actual 100% (Q3) (Target =>98%) Rapid Access Chest Pain: - Patients seen <14 days following urgent GP referral Actual 100% (Sept-Nov S/well) (Target =>98%) No City data	
1.4	**Continue to improve outpatient booking systems.** **RB**	• Hospital short notice cancellations reduced so that less than 20% of total are short notice. • DNA rate reduced to less than 10%. • Hospital initiated cancellations reduced to less than 15% of appts made in month.	(35% in Feb) (12% in Feb) (16% in Feb)	- Short notice cancellations actual 33.5% (Dec 2011) - DNA Rate New OP appointments actual 13.7% (Dec 2011) - DNA Rate Review OP appointments actual 11.5% (Dec 2011) - Hospital initiated cancellations actual 15.4% (Dec 2011) This work stream will now be coordinated under the Transformation Plan and has a visioning event and governance infrastructure managed by the TSO. A new clinical sponsor has been appointed for this work programme.	**3**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Three (December 2011)**	**Red /Amber /Green Assessment**
1.5	**Improve patient flow from admission through discharge to home care / after care.** **RB**	• Acute delayed discharges reduced to less than 4% of acute beds. • Average hospital length of stay maintained at less than 4.5 days. • Numbers of very long stay patients (>28 days) reduced to 150 or less. • Reduced readmissions within 30 days.	(5% in Feb) (4.4 in Feb) (187 in Feb) (8.0% following initial Elective or Non Elective Admission)	- Acute delayed discharges actual 4.9% (Q3) Multiagency work stream in train to improve performance. Additional capacity purchased as part of winter plan externally with PCT and social services. - Average length of stay actual 4.1 days (Sept/Oct 2011) - Long Stay Patients >28 days actual 141 (Dec 2011) - Readmission Rate actual 7.5% (Q3 2011) Rapid Improvement Event completed in Q3 to inform high impact change programme to support patient flow. Patient flow is now part of the Transformation Plan and has a visioning event and governance infrastructure managed by the TSO. A new clinical sponsor has been appointed for this work programme.	**3**
2.	***High Quality Care***				
2.1	**Improve reported levels of patient satisfaction.** **RO (with all Execs)**	• Establish systems to seek patient/carer/user views that ensure all groups are represented. • Establish reporting and feedback systems of patient views at the Trust, Division, Directorate and Department level. • To ensure action plans exist and are delivered against areas of dissatisfaction/requiring improvement. • To have a list of priority patient		• Numbers of patient survey responses have now increased significantly. • Quarterly reports to divisions, directorates and wards. • Priority actions identified and being progressed. • Reports requested based on: - ethnicity - age - gender Next print run to include Consultant name.	**4**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Three (December 2011)**	**Red /Amber /Green Assessment**
		experience improvement themes/topics and corporately plan and deliver the action. • Ensure external views are fed into internal feedback systems. • To deliver CQUIN target for patient experience improvement. • To measure behaviours against Trust Promises. • To develop an approach to 'customer care' training.		• Net promoter index included. • Reporting to TMB monthly.	
2.2	**Continue to embed Customer Care promises.** **JK**	• Refresh the customer care promise action plan in line with the feedback from Hot Topics. • Regular analysis of patient survey results and complaints by customer care promises. • Revised recruitment, induction and appraisal processes focusing on customer care.		In the last quarter a Customer Care Promise LiA event has been held for the Imaging Division with best practice being identified and ideas developed to further imbed the promises within the division and the potential to roll out new ideas across the Trust. Plans are also being made with the heads of nursing to raise the profile of the customer care promises in the clinical environment.	**4**
2.3	**Improve the care we provide to vulnerable adults.** **RO**	• Ensure systems and processes for vulnerable adults are embedded in all clinical areas – including Deprivation of Liberty, Safeguarding, and Mental Health. • Deliver level 1 and 2 training targets. • Relevant policies are in place. • Delivery of targets set within dementia action plan. • Establishment of domestic		WMQRS visit – positive feedback Task and Finish Group for Nutrition, Privacy and Dignity working well. Action plans shared with the Trust Board. Pressure damage/falls continue to reduce in number and severity. Nutrition audits improving.	**4**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Three (December 2011)**	**Red /Amber /Green Assessment**
		violence training. • Achievement of standards/rules of the Mental Health Act. • CQC and NHSLA standards met. • Nutrition CQUIN achieved. • Falls and pressure damage targets achieved.			
2.4	**Make improvements in A&E services.** **JA**	• Build on the work from 2010/11 in respect of integration. • Ensure that newly developed systems become embedded and continue to support safer and more responsive care. • Ensure that the agreed financial investments lead to the successful recruitment of high quality Clinical staff (Medical and Nursing). • Implement systems to monitor and manage performance in respect of the new ED quality standards.	Baseline to be established at EDAT from evaluation new national quality standards (not previously monitored)	EDAT meeting monthly. Middle grade recruitment improved. Revised Integrated Development Plan approved and in implementation. Erratic performance and red incident indicates continuing underlying issues.	**3**
2.5	**Make improvements in Trauma and Orthopaedic services.** **RB**	• 18 week waiting time standard achieved for orthopaedics (c. 70% in 18 weeks in Feb). • Workforce plan agreed and delivered for T&O wards. • Improved service line position for T&O. • Improved outpatient performance (reduced cancellations, short notice cancellations and review rates).	74.4% (March 2011)	- 18 week Admitted RTT 80.1% (Nov 2011) Discussions with Medical Director regarding plans for T&O have been held - specialty currently developing measures to improve efficiency and throughput as well as implementing decommissioning measures. Flood engagement for pathway redesign through RCRH.	**3**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Three (December 2011)**	**Red /Amber /Green Assessment**
2.6	**Make improvements in Stroke services.** **DO'D**	• Stroke dashboard fully populated and incorporated into the Quality Management Framework. • Ensure that performance remains in the top Quartile nationally. • Continued improvements in KPIs for Stroke and TIA pathways. • Ensure robust management structure for stroke services including clarity on reporting lines and accountability. • Develop an option appraisal in partnership with commissioners to ensure optimal configuration of Acute and rehabilitation components of stroke/TIA services and pathways.		• Stroke dashboard continues to evolve. • Trajectories agreed for delivery of performance to attract best practice tariff. • Business case approved by SIRG being implemented • Additional Stroke Consultant appointed 10/10/11, to start in January 2012. Post covered by locum in the interim. • Weekend ward rounds covering Stroke and TIA across sites commenced 8/10/11 with imaging slots for high risk TIA delivered. • Work on high risk TIA pathway continues. • January 2012 Targets still disappointing, but appreciative enquiry acknowledged progress has been made in improving stroke services • Option appraisal process on track	**3**
2.7	**Embed the Quality and Safety Strategy incorporating the FT Quality Governance Framework.** **KD**	• Achieve the plan developed to ensure effective implementation of the Quality and Safety Strategy. • Positive outcomes to support the Trust's top 3 quality related priorities.		• Directorate quality goals identified at the Consultant Conference; these are now being finalised. • Quality goals to be requested from the Trust-wide governance committees for inclusion in the Quality Improvement Plan.	**3**
2.8	**Improve and heighten awareness of the need to report and learn from incidents.** **KD (with all Execs)**	• Annual rate of incident reporting increased at least 10% on previous year. • Improved position with the NRLS report as benchmarked against similar size Trusts. • Reduced number of incidents that cause harm, of a similar nature and / or within the same environment / location.	Q1 – 2891 Q2 – 3286 Q3 – 3263 Q4 – 3322 Total - 12744	• Data to the end of Q3, including those incidents not yet merged onto the live safeguard system show 10652, an increase of 1230. This does not include figures from community division. • Electronic incident reporting rollout is almost complete and has not shown the expected dip in reporting. Training is being offered either in groups or in one to one sessions as required.	**4**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Three (December 2011)**	**Red /Amber /Green Assessment**
2.9	**Deliver the CQUIN targets** **RO/DO'D/RB**	• VTE prevention • Improve patient experience • Alcohol prevention • Smoking cessation • Nutrition assessment on admission • End of life care – choice of place to die • Mortality Reviews • Enhanced recovery Stroke discharge • Medicines management – missed doses • Health Visiting response times	92.3% (Q4) 2041 referrals to smoking cessation End of Life Care (Acute) 56% (Q4)	• VTE prevention remained on track through Q3 91.8% (Target =>90%) • January 2012 Performance remains generally satisfactory, though with a slight dip in December. • January 2012 Alcohol CQUIN now deployed and being performance managed Alcohol interventions 9.1% Dec 11 (Q4 target = 80%) • Smoking cessation interventions still being developed (693 referrals to smoking cessation service in Q3 (2065 Apr-Dec 11 Annual target = 2000) • 95% Dec 11 (target 75%) Consistently achieving in excess of 90% • 55% Nov 11 (66% end year target) On track to achieve target • Mortality review rates improving on trajectory • 13% (Dec 2011) (Target 90% throughout Q4) Initial benchmark data poor, but team have rapid improvement trajectory and plan for Q4. • Baseline complete. 8.4% less than base (end year target 10% less than base) • HV assessment 65.2% (Nov 11) (70% end year target)	**3**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Three (December 2011)**	**Red /Amber /Green Assessment**
		• Falls assessment	Falls assessment (Community) 25% (Q4)	• Falls assessment Community – 51.6% (Nov 2011) (55% end year target)	
3.	***Care Closer to Home***				
3.1	**Ensure a successful integration of adult and children's community services that has benefits for patients.** **RB (with RO)**	• Transfer successfully completed in April. • Agreed benefits realisation plan in place by end Q1. • Integration / benefits realisation delivered as planned.		Transfer of community services on plan and the Division are establishing more integrated approaches to supporting patient pathways across the organisation. The development of further integration opportunities as part of the Transformation programme is a cross cutting theme of work. Henderson beds opened and initially evaluated well.	**4**
3.2	**Deliver the agreed changes in activity required as part of the Right Care Right Here programme.** **RB**	• Decommissioning plan agreed with commissioners (value = £16m). • Plan successfully delivered by end of the year.		Decommissioning plan developed by SWBHT currently identifies 85% of the total value to be decommissioned (FYE). The part year effect for 2011/12 still needs to be identified and will be less.	**2**
3.3	**Play a key role in the local community, actively promoting healthy lifestyles and health education.** **JK**	• Development and approval of health promotion strategy. • Delivery of health promotion / education LiA and resulting action plan, involving all key stakeholders. • Launch of involvement website to promote healthy lifestyles.	No baseline for 2010/11	Work continues but progress is slower than planned, primarily due to lack of resource and capacity issues. Every effort is being made to ensure that this objective is reached by the year end.	**3**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Three (December 2011)**	**Red /Amber /Green Assessment**
		• Lead the development of a RCRH health promotion and education strategy. • Participate in joint venture tender for lifestyle services.			
3.4	**Develop a local response to national plans for Health Visiting.** **RO**	• Implementation plan supported by PCT/SHA. • Clear recruitment plans. • Increase University commissions. • Review of team skill mix. • Retention plan in place. • New models of care developed, including family partnerships.		Implementation plan produced. Briefing paper produced for Trust Committees. SIRG paper and workforce plan produced. Increase commissions done. Pending funding agreements from Commissioners.	**4**
3.5	**Make fuller use of the facilities at Rowley Regis Community Hospital to provide care closer to home.** **RB**	• Launch of new intermediate care unit in June. • Agree and deliver plan for services at Rowley in 2011/12. • Increased numbers of outpatient clinics scheduled at Rowley.		The new Henderson Reablement Unit opened as planned in September. Consideration of Rowley is part of strategic annual planning at service level and will be driven forward in the Transformation plan work.	**4**
4	***Good Use of Resources***				
4.1	**Deliver a £21.1m CIP and produce detailed plans to deliver a £20m annual CIP for a further three years.** **RW (with all Execs)**	• Presentation of the line by line CIP plan for the next financial year as assessed for quality and risk, deliverability and presented to the Finance and Performance Committee as part of the Trust Board's approval of the overall plan. Continuation of the robust monitoring and management of		At the end of Quarter 3, the previously reported slippage is approximately c. £1.2m and reflects the in-year slippage associated with the financial positions of the Surgery A and Medicine divisions with mitigating actions being pursued as part of the recovery plans. The shortfall is much less c.£300k as reported to the SHA via the monthly 'FIMs' reports as	**3**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Three (December 2011)**	**Red /Amber /Green Assessment**
		the plan via the Performance Management Board including tracking of replacement schemes, Full year/part year effects and any shifts from recurrent categories to non-recurrent. • Develop and agree the basis of allocating operational targets as part of 3 year CIP, ensuring capacity and expertise is developed so that plans are expressed in QUiPP and QuEP categories making use of all internal and external benchmarking data, e.g. SLR. Completion target to be consistent with commencement of strategic CIP work, end of Q1. • Integration of the plan within overall financial modelling including explicit cross-model audit trails of the impact of CIPs within the external and internal financial models (e.g. LTFM, LTSM, FIMS)		the Trust took the decision to increase the CIP plan above that agreed at the start of the financial year. The exceptions reporting and replacement scheme protocol is in place as part of recovering the position during 11/12 including the approval of replacement schemes where appropriate. Separate bi-weekly meetings and monitoring of weekly expenditure in some areas is in place as are regular reports to PMB, FPC and Trust Board. The Full Year Effect of the programme is separately monitoring and shows underlying delivery. Additional resources are being placed into the Divisions to bolster capacity in order to assist with getting back on track.	
4.2	**Achieve a £2m surplus.** **RW**	• Prepare a detailed financial plan with sufficient income based resources to meet anticipated expenditure in accordance with operating framework imperatives, capacity plans and risk reserves. • Ensure that Board reporting is clear between the DH target		Year to date surplus (M8) of £583k versus plan of £591k. This is slightly 'off plan' but is not altering the forecast to yearend owing to the measures being adopted to improve the position. Similar to the reporting of CIP performance, enhanced reporting is provided to the Finance	**4**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Three (December 2011)**	**Red /Amber /Green Assessment**
		surplus and IFRS based bottom line results that take account of on-balance sheet treatment of long term contracts • Ensure that variations in the plan are reported at the earliest opportunity together with corrective mitigating plans as developed and implemented through the Performance Management Board.		committee along with action plans aimed at improving CIP performance and in turn contributing to the forecast outturn as agreed at the start of the year.	
4.3	**Reduce premium rate working.** **RB**	• Premium rate working reduced by £1.8m compared with 2010/11 outturn. • Theatre utilisation improved: <20% late starts, <25% early finishes, average of >3.5 cases per list).	80% prompt starts (March 2011) 46% on time finishes (March 2011) 2.9 cases per list (March 2011)	• 74% prompt starts (<15 mins late) (Dec 2011) • 51% on time finishes (<15 mins early) (Dec 2011) • 2.9 average cases per list (Dec 2011)	**3**
4.4	**Develop plans to improve the service line position of the Trust.** **MS**	• Identify three services. • Evaluate baseline position. • Develop improvement plan for each service.	Three services identified – Orthopaedics, Obstetrics and Dermatology	• Specialties have agreed baseline position • Impact of CIP delivery being assessed • Benchmark services identified and other Trusts contacted to provide benchmark data • Agreement reached with Dudley to encourage more women to deliver at SWBH. Marketing materials prepared • Orthopaedics and Dermatology identifying which service elements are main	**3**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Three (December 2011)**	**Red /Amber /Green Assessment**
				contributors to deficits	
5	***21st Century Facilities***				
5.1	**Begin to Procure a new hospital.** **GS**	• OJEU notice placed. • GVD executed. • Clarity on Deed on Safeguard achieved.	Awaiting OBC approval.	Progress halted, awaiting approval from DH and HMT. DH resolving FTPBC/PFI issues.	**2**
5.2	**Continue to improve current facilities.** **GS**	• Updated Estates Strategy. • Capital programme on plan. • Satisfactory environmental assessments (CQC, Hygiene Code, PEAT etc).	2010/11 Capital Programme delivered to plan.	Capital programme for 2011/12 agreed, being implemented.	**4**
5.3	**Develop detailed plans for the development of the community estate.** **GS**	• RCRH Community Facilities Programme Team embedded. • Programme for development agreed. • Initial projects commenced.	Engagement with PCTs commenced.	RCRH Community Facilities Programme team established, feasibility work being undertaken.	**4**
6	***An Effective NHS Organisation***				
6.1	**Make significant progress towards becoming a Foundation Trust.** **MS**	• Develop a detailed project plan. • Ensure delivery of all milestones in the project plan. • Secure any additional support required for the application including stakeholder support.	Project structure set up	• IBP submitted on time • TFA agreed • Delayed by at least four months due to delay in OBC approval	**2**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Three (December 2011)**	**Red /Amber /Green Assessment**
6.2	**Deliver a set of Organisational Development activities including a stronger voice for front line staff.** **MS**	• Develop an OD framework and action plan to support FT application. • Deliver a model of staff engagement and incentive system.	Lack of coherent set of OD activities	• OD strategy developed • OD steering group set up • OtF staff ambassadors being piloted in community services and pathology • Ambassador elections and welcome event held	**4**
6.3	**Develop our clinical systems and processes to reduce variability and ensure safe, error free care.** **DO'D**	• Continue diagnostic project in respect of Clinical Back Office Systems. • Establish Project Board to deliver on Paperlite and Clinical Back Office Projects. • Relevant processes (including SBAR for reliable clinical handover, "kitemarking" clinical offices and departments for information standards & root cause analysis) developed and embedded in all clinical departments.		• Paperlite and Clinical Back Office projects on track and expected to deliver 1st phase implementation by September • Q2: Standards now adopted • Self assessment tool under development • Completion date renegotiated to Q4 • January 2012 Electronic requesting rates improved significantly and acknowledgement is becoming embedded • There are still challenges with robustness of the technology	**4**
6.4	**Improve staff satisfaction, health and wellbeing.** **MS/RO**	• System of gathering staff views throughout the year. • Identify actions arising from staff views. • Publish staff survey results. • Regular communications to staff. • Health and Wellbeing action plan – delivery against timescales. • Reduction in sickness absence. • Measurable improvements in survey results. • Links to OD/OTF plans around staff engagement and ownership.		• Reduced sickness rates being achieved. Trust and regional targets being met • Significant improvement in staff satisfaction score in 2011 • Health and wellbeing action plan being delivered to timescales, new focus on nutrition advice	**4**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Three (December 2011)**	**Red /Amber /Green Assessment**
6.5	**Agree an IT strategy including an affordable route to procurement of an Electronic Patient Record.** **DO'D**	• Programme board set up and running. • Option appraisal complete. • Decision-making process agreed and underway.		• 1st workshop held to develop a plan for the plan • Relatively little progress in developing the strategy • Project delayed until IM&T review complete • January 2012 IM&T review complete and have now entered stabilisation phase • Strategy document will now be deferred to 2012/13	**2**
6.6	**Continue to develop and implement the Trust's approach to sustainability and transport and access.** **GS**	• Carbon Management Plan agreed. • Sustainability action plan on target. • Review and update travel plan.	Sustainability Action Plan being implemented.	Sustainability action plan and carbon management plan on track.	**4**
6.7	**Develop a training plan that reflects service needs, is resourced and supports the workforce plan.** **RO**	• Trust Training Plan developed by May. • Funding to support plan agreed June/July. • LBR and JIF funding identified. • Commissions with higher education institutions agreed. • L&D Committee monitoring of plan. • Plan clearly linked to workforce plan due September. • Learning Hub/Health tech proposal written and presented to relevant parties.		Training plan developed and submitted to SHA. LBR funding agreed. Non-medical commissions agreed. No change.	**4**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Update on the delivery of the Transformation Plan
SPONSORING DIRECTOR:	Rachel Barlow, Chief Operating Officer
AUTHOR:	Paul Crabtree and Tom Bayston
DATE OF MEETING:	26TH January 2012

SUMMARY OF KEY POINTS:

- Initial activity started well, particularly in BTEC, with practical work happening with local stakeholders.
- Preparation for visioning events on schedule for following 3 weeks.
- Focus for next 2 weeks must be to push ownership with project leads to allow TSO to engage with all projects.
- Governance structure finalised ready for agreement
- Reporting and tracking systems under development for review by steering group on Thursday
- Central repository created to capture all plans submitted on 13th - to be further refined as plans develop
- Preparations made to present to Clinical Exec Team next week
- Meeting held with Mike Sharon & Jayne Dunn to review development of roadmap in relation to IBP

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

To receipt and not the contents of the report

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

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

PREVIOUS CONSIDERATION:

Report ID: SWBH 02b

Issued by Paul Crabtree / Tom Bayston

TSO weekly report

19/01/2012

Overview	Status		Resp: TBC / Tom B / Paul C	Status	

Initial activity started well, particularly in BTEC, with practical work happening with local stakeholders.
Preparation for visioning events on schedule for following 3 weeks.
Focus for next 2 weeks must be to push ownership with project leads to allow TSO to engage with all projects.
Governance structure finalised ready for agreement
Reporting and tracking systems under development for review by steering group on Thursday
Central repository created to capture all plans submitted on 13th - to be further refined as plans develop
Preparations made to present to Clinical Exec Team next week
Meeting held with Mike Sharon & Jayne Dunn to review development of roadmap in relation to IBP

Days Tracking (298 total)	
Target days	50
Used days	50
Balance	0

Outpatient Efficiency	Resp: Cath D / John Mc	Status	

This week-
Fully engaged with existing optho OP improvement team, changing meeting focus.
Created draft project plan in support of this team
Identified area for satellite TSO in OP staff area

Next week-
OP visioning event on 25th
Complete project plan and sign off, define performance metrics
Align TSPs with project plans

Concerns: Require focus on other divisions

Diagnostics	Resp: Leann C / John Mc	Status	

This week-
Centralised booking- 2 staff engagement events held
Histopathology- 'Achieving TSP' meeting
Biochemistry RIE planning meeting
Meeting held with Pathology and Imaging

Next week-
First imaging steering group meeting
Pathology –blood sampling- first steering group meeting
First workforce efficiency workshop

Concerns: none

Patient Flow & Bed Utilisation	Resp: Anne T / Valerie C	Status	

This week-
1st steering group held. Focus was to prepare for visioning event
Gathering of Voice of Patient and baseline information
Process observation of wards and use of eBMS

Next week-
Visioning event 27th
Early care pilot - understand barriers to implementation
Optimal ward programme - review methods used and align with TSO activity

Concerns: none

Community Service Efficiency	Resp: Julie H / John Mc	Status	

This week: -
Meeting held relating to mobile technology

Next week -
TSO manager - Julie - return to work following leave
Create high level project plan and review project charter
Establish current performance and metrics
Complete stakeholder analysis

Concerns: Need to better grasp project status with return of STO manager next week

Urgent Care	Resp: Kay P / Valerie C	Status	

This week: -
BMEC current state map started to understand current flow
Introduction meeting s held with MAU (city) and ED (SGH) unit lead - process flow reviewed
MAU opportunities identified and reviewed

MAU opportunities identified and reviewed
Next week: -
Finalise current state map for BMEC ED and draft project charter
Finalise detail for visioning event
Review current state map with CD for emergency BMEC ED

Concerns - None

Theatre Productivity	Resp: Cath D / Valerie C	Status	

This week: -
Catherine Dhanda agreed as interim TSO manager
Additional support from Bethan Doweling discussed to support progress - meeting to be set up asap to agree detail

Next week: -
Finalise visioning event for 31st
Process observation of theatres and establish workstreams

Concerns - Delayed start while establishing TSO support - Resourse agreed this week and plan to align roles next week

Workforce		Status	

This week:
Initial meeting held with workforce team to discuss schemes within project
TSO light touch support to be agreed for individual projects

Next Week:

Concerns:

Medical Workforce		Status	

This week:
Initial meeting held with Kam to discuss approach.
Meeting held with Donal to discuss approach to medical staffing committee and development of slides to support

Next week:
Follow up meeting set to understand roll out of PA guideline procedure and agree method to present data to CDs in order to fully grasp information
Support Medical Staffing Committee

Concerns: Clear approach defined, but need to grasp ability to deply in order to achieve financial targets

Procurement		Status	TBC

This week:
Not yet started

Next week:
Set up initial "grasp the situation" meeting

Concerns:

Corporate Services		Status	TBC

This week:
Not yet started

Next week:
Set up initial "grasp the situation" meeting

Concerns:

Estates		Status	
This week: Meeting held with Graham to discuss Estates rationalisation strategy	Next week:		
Concerns:			

Strategic IT Enablement		Status	
This week: Meeting held with Donal to review IT strategy. Briefly met with Fiona Sanders	Next week: Set up further meetings to progress		
Concerns: Need to review project in more detail to grasp status			

Capacity & Demand		Status	TBC
This week: Not yet started	Next week: Set up initial "grasp the situation" meeting with Mike Sharon & Fiona Sanders		
Concerns:			

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Draft Service Line Management Strategy Refresh 2011
SPONSORING DIRECTOR:	Donal O'Donoghue, Medical Director
AUTHOR:	Rosey Monaghan & Donal O'Donoghue
DATE OF MEETING:	26TH January 2012

SUMMARY OF KEY POINTS:

A revised SLM strategy is attached.

Outline the background to why SLM should be adopted and that a project approach needs to be adopted.

4 work streams are identified

- Organisation Structure
- Information Management
- Performance Management
- Strategy & Planning

The paper outline significant changes are proposed to the way the Trust does business. This will require patient level costing, clear service line reporting based on high quality information, a QMF and dashboard, and a range of tools upon which an empowered, engaged leadership team make their business decisions to deliver high quality patient care.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
x		**x**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

Agree that a nominated exec lead will be responsible for the success of each work stream

Agree that a project management approach should be adopted.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Safe High Quality Care, An Effective Organisation, Good Use of resources
Annual priorities	CQC standards, financial balance
NHS LA standards	Clear governance and accountability
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

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

PREVIOUS CONSIDERATION:

PMB November 2011

Sandwell and West Birmingham Hospitals NHS Trust

Service Line Management Strategy Refresh November 2011

1.0 Introduction

1.1 Service Line Management (SLM) is a method of organising how a trust works in order to run its business in an effective way. Organisational structures are based on business units with the capability and authority to make strategic and tactical decisions based on sound clinical, quality, safety, and financial information, informed by a good understanding of costs at the patient level. Monitor has recommended that foundation trusts (FT) and those working towards FT status adopt SLM to ensure that a business management focus is directed towards how they deliver high quality services to patients.

1.2 More importantly, it is considered that by organising the Trust workforce into distinct business units led by clinical and management teams, the clinicians will be more responsible and accountable for patient care by having control of the resources which they use on behalf of those in their care. Patient care and performance management is driven by quality outcomes as well as financial performance.

1.3 This Trust is aiming to become an FT in the near future. It is therefore considered that even more focus should be made on embedding SLM in the organisation.

2.0 Background

2.1 SLM has been gradually introduced over the past three years. There has been considerable work and progress developing an integrated governance system called the Quality Management Framework (QMF) which is being devolved to the Divisions. This is being used as a basis for the performance management of quality, finance, and activity.

2.2 A report was submitted to the Trust Board in January 2010 by the Medical Director, which outlined the progress of the implementation of SLM and the QMF. It also identified the governance arrangements around how the work would be progressed and what key tasks were pivotal in developing SLM. This was overseen by a high level SLM Steering Group.

2.3 A review of progress towards achievement of SLM was carried out in August 2011 using the Monitor self assessment toolkit. Whilst there has been significant progress in some areas, such as performance management and organisation structure, information management, service line reporting and planning were identified as having a greater distance to travel to contribute to significant implementation of SLM against the Monitor assessment toolkit.

2.4 In September 2011, the Trust launched the Organising for Excellence strategy. This strategy described and brought together in a single framework all of the existing systems, projects, service transformation, and Quality & Safety strategies currently being delivered, developed or proposed for the Trust. Organising for Excellence sets out the direction of travel for the next few years with the aid of a series of quality, organisational, and systems maps.

2.5 SLM has been identified in this document as a key programme of work and an enabler for achievement of the Trusts strategic objectives, specifically 'Safe, high quality care', 'good use of resources' and 'being an effective organisation'.

3.0 Vision

3.1 The Service Line Management Steering Group continues to adhere to a common understanding of the purpose of the SLM :

> *Service Line Management entails the empowerment of individual directorates or service lines and providing them with the instruments and information they need to run and manage their services and to respond rapidly to the changing needs of our patients and commissioners. SLM will also provide the organisation at large with a comprehensive understanding of its activities and evidence-based assurance about the quality and safety of the services we provide. The successful establishment of Service Line Management will enable us to use our resources wisely and to become a true learning organisation.*

3.2 The SLM Steering Group proposes, pending formal agreement with the whole executive team, that SLM should be progressed and that by the end of March 2013 the Trust should have achieved at least level 3 using Monitor's self assessment tool. With that in mind, additional investment of time and resources will need to be committed.

3.3 The area where most work will be required will be in the financial and information systems so that progress can be made in the following key areas:

- Aligning the data gathered in respect of quality, safety, activity and finance with the newly emerging SLM structures
- The development of systems that ensure that all of the data gathered is accurate and complete
- The introduction of patient level costing (PLICS)
- The deployment of analysis and reporting tools that inform decision making at every level
- The creation of budgets based on service lines that accurately reflect costs, income, and expenditure

3.4 The SLM work will take an integrated approach to organisation structure and will ensure careful synergy with the Organisational Development plan, the Transformation Plan, and the Trust outline business case for FT.

4.0 Progress to date

4.1 Since March 2010, it has become increasingly apparent that there is considerable amount of work to be carried out to ensure that the organisation knows what needs to be done to achieve SLM in a form that will be recognisable to those working in the Trust. The areas of work to be focused on have been themed using the 4 work streams identified in the Monitor toolkit. These are:

- Organisation structure
- Information Management
- Performance Management
- Strategy and planning

4.2 What has become evident is that the work streams need to be project managed in a very structured way to ensure that outputs are realised within agreed timescales. The SLM Steering Group agreed that, to ensure strong senior leadership, each of the above work streams should have an executive director to lead the work. The leaders are all from within the membership of the SLM Steering Group.

Organisation structure -	Rachel Barlow (Chief Operating Officer)
Information Management -	Robert White (Director of Finance)
Performance Management -	Donal O'Donoghue (Medical Director)
Strategy & Planning -	Mike Sharon (Director of Strategy & Organisational Development)

4.3 The main enabling projects are: continuing to develop division and directorate structures, financial information systems which include service line reporting, patient level costing, and cross charging and the development of aligned budgetary structures, continuing of development of the Quality Management Framework (QMF) and performance management practice, and a more granular approach to strategy and planning.

5.0 Organisation structures

5.1 The key enablers for organisation structure development are: a clear service-line structure; defined service line leadership roles, and capability linked, defined decision rights at each level of the organisation.

The operational divisions are currently defined as:
Surgery, Anaesthetics and Critical Care,
Surgery B,
Medicine & Emergency Care,
Women's and Child Health
Imaging
Pathology.

Sandwell Community Adult Health

5.2 Corporate functions such as finance, HR, estates, IM&T and governance are apportioned to divisions. The different divisions are at varying levels of maturity relating to capability and capacity to performance manage and have delegated autonomy and decision rights. The aim is to bring all management teams up to the same level through development and training. Clarity about what leaders are expected to do in their roles is a vital part of their leadership development and needs constant reinforcement through actions of the Trust executive team.

5.3 There is a level of understanding between divisions, clinical directorates, the people who work in them and the clinical areas such as wards and outpatients that are relevant to each directorate. A comprehensive knowledge will take quite some time to evolve, but provided staff are supported to develop skills and competencies, this can be achieved.

5.4 The Divisions do not all replicate the same management structure. The larger divisions, such as The Medicine Division have a triumvirate structure of Divisional Director, Divisional Manager and Head of Nursing. Other divisions have a version of this and recruitment of suitable people to these critical posts is essential to work towards effective cultural change.

5.5 All Directorates have Clinical Directors in post and allocated General Managers & Matrons although their time is not exclusive to single directorates. Clear definition and understanding of the level of support , both management and administrative, is required to be able to meet leadership teams' needs to be able to implement SLM fully. The SLM Steering Group needs to undertake work to establish agreed terms of reference, decision rights, and a process for "earned autonomy" for the divisions and directorates.

5.6 A change in structure alone will not get people to work differently. Cultural change is required to shift the culture from one of compliance to one of commitment and engagement. Inherent in this is also the need to develop service improvement, and leadership and management capability across the organisation.

5.7 For the division and directorate teams to be successful in leadership and management, many will need to increase their skills and capabilities. The Learning & Development Team are working on a framework, based on the national The Management and Leadership Development Framework to support staff to perform better in their roles. The role out of development programmes at all levels in the Trust will support SLM.

The NHS Leadership Qualities Framework (LQF)

6.0 Information Management

6.1 High quality information is vital for the Trust to be successful. Managers and leaders at all levels in the Trust need accurate, timely, appropriate information upon which to make clinical and business decisions.

6.2 Work is underway to address general issues with informatics. However, for the Trust to progress further with SLM, financial information needs to meet the needs of the directorate and divisional management teams. The Trust has acquired a service line reporting system, Ardentia, but this will not take the Trust to a position of understanding patient level costing without changes to the resources committed to delivery of a PLICs system. In addition, support services divisions (Imaging & Pathology) need to be in a position where cross changing can take place which would reinforce the responsibility and accountability of how user directorates append their funds and budgets are set using service lines.

6.3 A process of iterative dialogue with the directorates will inform the development of accurate financial statements and information displayed using the portfolio of tools proposed by Monitor based on high quality information. The tools present a different perspective of financial performance. However, understanding a new presentation of financial information will call for management teams to be educated about how to understand and interpret the outputs.

6.4 The SLM Steering Group will continue to review issues relating to service line reporting and PLICs, particularly the suitability of the current software solution.

6.5 The intention is that, in due course, monthly or potentially live information will be available both to the divisions, directorates and to the corporate teams at their desktops.

7.0 Performance Management

7.1 The Quality Management Framework, together with front end dashboard systems, will provide the information infrastructure for service line management. The QMF will integrate the Financial, Performance, and Quality information streams into a single system that provides relevant data and assurance at every level of the organisation. Work continues on the data flows to populate the outputs both from quality and quantitative measures.

8.0 Conclusions

8.1 The Trust has committed to fully implementing SLM. It does remain a highly ambitious strategy, not least because it involves substantial developments in the organisational culture, systems, information flows, and the "rules of engagement" throughout the organisation. However, given these constraints the Trust has been making steady process towards the goal of being able to delegate responsibility for decision making to the appropriate levels.

8.2 Between now and March 2013, for the 4 work streams to be successfully taken forward, an investment of time and resources will needed. The Trust will need to adopt a formal project management approach to this trust-wide work for it to be successful and to support other trust wide initiatives.

Donal O'Donoghue

Medical Director

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**ORGANISATIONAL DEVELOPMENT STRATEGY**
SPONSORING DIRECTOR:	**Mike Sharon, Director of Strategy & OD**
AUTHOR:	**Mike Sharon, Director of Strategy & OD**
DATE OF MEETING:	**26th January 2012**

SUMMARY OF KEY POINTS:

The purpose of this paper is to seek Trust Board approval for the Organisation Development (OD) Strategy and to agree the membership and terms of reference of the Organisation Development Steering Group (ODSG).

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
x		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Board is asked to approve the OD Strategy & Terms of Reference of the OD Steering Group

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Supports being an effective organisation
Annual priorities	Supports delivery of annual priorities
NHS LA standards	
CQC Essential Standards Quality and Safety	Supports delivery of high quality services
Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

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

PREVIOUS CONSIDERATION:

The Board considered a definition of OD and priorities for OD at a time Out in November 2010
The OD Strategy has been discussed at TMB and at the OD Steering Group.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report to the Public Trust Board
Thursday 26th January 2012

Organisation Development Strategy

Introduction

The purpose of this paper is to seek Trust Board approval for the Organisation Development (OD) Strategy and to discuss the membership and terms of reference of the Organisation Development Steering Group (ODSG)

The OD Strategy

This is attached at **Appendix 1**

The paper provides a working definition of OD, describes the approach used to developing the Strategy and sets out six priorities for the Trust.

OD Steering Group

The Group held its first meeting on 12 January 2012.

It discussed membership and terms of reference (attached to this paper at **Appendix 2**. The Group concluded that, given the strategic nature of likely future agenda items, two non Executive Directors should be invited to become members of the Group.

The Group reviewed the OD strategy and agreed that the actions under 6.4 – Achieving a cultural shift – needed to be reviewed and this would be discussed at the next ODSG meeting.

The Group reviewed the Organising for Excellence grid to ensure that each of the key strategies and programmes was being adequately monitored and reported. A number of proposals or changes were made – these are highlighted in bold italics in the table below

Strategy/Programme	**Reports to**
Right Care Right Here	Right Care Right here Implementation Board and Trust Board
Recommissioning Programme	***Right Care Right Here Implementation Board and Trust Board)will be part of Transformation Plan in the future***
Reconfiguration Programme	Reconfiguration Board and Trust Board

New Hospital Project	New Hospital Project Board and Trust Board
Community Facilities Project	Reconfiguration Board
Quality and Safety Strategy	Governance Board, Quality and Safety Committee and Trust Board
Research and Development Strategy	R&D Committee, Governance board and Trust Board
IM&T Strategy	***Set up an Information Strategy Board with some common membership to OD steering group***
Equality and Diversity Strategy	Trust Board – ***should have NED membership***
Transformation Plan	Steering Group and Trust Board
Service Line Management	**ODSG**
Sustainability and Environment Strategy	Sustainability Steering Group and Trust Board
Business development Strategy	***Performance Management Board, F&P Committee and Trust Board***
Listening into Action	LIA sponsor Group ***and ODSG***
Owning the Future	***ODSG***
Workforce strategy	***Strategic workforce planning group and Trust Board***
Nursing Strategy	PPAG and Trust Board
Medical Education Strategy	Medical Education Committee and Trust Board
Foundation Trust Project	FT Programme Board and Trust Board
Communications and Engagement Strategy	***ODSG*** and Trust Board
Leadership Development Strategy	***ODSG*** and Trust Board
Organisation Development strategy	***ODSG*** and Trust Board
Learning and Development Strategy	L&D Committee and Trust Board

Recommendations

The Trust Board is asked to:

Approve the OD strategy
Approve the terms of reference for the OD Steering Group
Discuss and agree the changes to the strategies and programmes accountability arrangements

Mike Sharon
Director of Strategy & Organisational Development

January 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Appendix 1

Organisational Development Strategy

1. Introduction

This document sets out the Trust's approach to the creation of an Organisational Development (OD) Strategy

The purpose of the Strategy is twofold:

- to identify the gaps in organisational capacity and capability that could impact adversely on the achievement of the organisation's vision/strategic objectives
- to deliver appropriate OD interventions to improve the effectiveness, efficiency and capability of the organisation over the long term

The Board has agreed the following working definition of OD:

A range of techniques and interventions used to move the organisation forward, developing its culture, people, systems and processes to deliver the organisation's objectives.

The overall purpose of these activities is to ensure all these organisational elements are congruent, that gaps are identified (and addressed) and that the organisation is responsive and adaptable in changing circumstances. Effective OD will ensure that the organisation develops its capacity for continuous critical self examination, reflection and learning.'

2. Organisational context

In developing the Strategy the Board has considered the main strategic challenges faced by the organisation. These can be summarised as:

A need to achieve unprecedented levels of financial savings year on year, whilst providing more effective and higher quality care to patients.

The Trust is also operating in an increasingly competitive environment in which published outcomes data will increasingly be used to inform the choices of patients and commissioners

The Right Care Right Here Programme and external service reviews require the Trust to change significantly the way in which services are delivered.

The planning for the new hospital presents an additional management capacity challenge for the Trust.

3. Defining the OD challenge

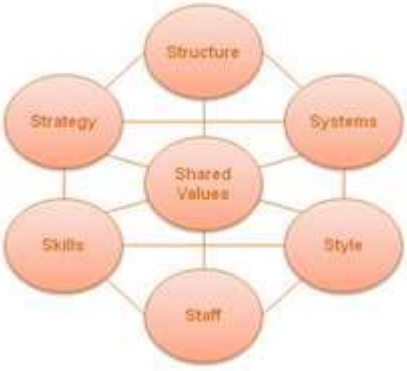
The Trust has loosely based its analysis of its current strengths and weaknesses on the McKinsey '7 s' model.

This model identifies the 'hard and soft levers' which impact on performance gaps. (Hard levers are identified in black type, soft levers in blue)

They are defined as:

- **Skills-**capabilities and knowledge possessed by the organisation as a whole as distinct from the individuals.
- **Strategy**-a coherent set of actions aimed at gaining sustainable advantage over competition
- **Shared values**-those ideas of what is right and desirable (in corporate and/or individual behaviour) which are typical of the organisation and common to most of its members
- **Structure**-the design and structure of the organisation, including who reports to whom and how tasks are both divided up and integrated
- **Staff**-the people in the organisation considered in terms of corporate demographics, not individual personalities
- **Systems**-the processes and procedures through which things get done from day to day
- **Style**-the way managers collectively behave with respect to use of time, attention and symbolic actions

The McKinsey 7 S model



It is widely recognised that organisations need to consider all these levers in order to make informed decisions about their performance and to identify the gaps in capacity and capability.
A paper identifying key questions for the organisation using the 7 s model was considered by the Executive team in May 2011, and was the basis for determining the diagnostic work undertaken.

This paper focused on the need to examine organisational governance, particularly in relation to the Board and Board development, organisational grip, agility, learning, structure, strategy, style, systems and processes, and

staff and skills. Diagnostic activities were then agreed for each key area, most of which have now been completed. There is still further work to do in some areas.

4. Diagnosing the specific issues

The Trust has engaged in a variety of specific diagnostic activities over recent months.

These have included:

- The identification of the key drivers facing the organisation by the Board
- A review of Board effectiveness and development activity by an external consultancy
- A review of the organisation's ability to deliver on its cost improvement programme (CIP) via its current structure and processes conducted by an external consultancy
- Review of the Trust's overall readiness as an organisation to achieve Foundation status, including a review of the Integrated Business Plan conducted by an external consultancy
- Identifying and articulating an 'organisational map' which plots the key strategies and programmes against the strategic objectives-'Organising for Excellence

The Trust is also conducting a review of its organisational agility, and plans to examine the way in which organisation learns and shares knowledge.

These diagnostic activities, the work undertaken to date in preparing for Trust Foundation status and some external reports, have identified the following key gaps in organisational capability:

- Evidence that the project management of key CIP/change management programmes is inadequate resulting in unexpected budget variances
- Lack of integration between CIP/QuEP programmes
- Evidence that Divisions do not use the concepts of Service Line Management to drive decision making
- Evidence that the current performance management arrangements encourage a focus on the Division, rather than specialities
- Evidence that the Board is not sufficiently visible to staff
- Failure to meet the CQC essential care standards consistently across the organisation
- A lack of a consistent approach to leadership development across the Trust
- A lack of a coherent framework which maps strategies/programme

The diagnostic process should not be seen as a discrete exercise and new evidence on capability will continue to emerge (for example, the outcome of CQC inspections). The organisation should, on at least an annual basis

undertake a review of capabilities and capacity and update the OD strategy to take account of those findings.

6. Our OD strategy

The Trust's OD strategy has therefore been developed to address the issues identified through the diagnostic work. It sets out six key objectives and associated actions:

6.1 Achieving congruence and integration in organisational development activity

- The development of a coherent and integrated approach to development activities to be achieved by the creation of an OD steering group with an oversight and co-ordination function, of a strategies and programmes identified in the Organising for Excellence model.

The Trust has a range of programmes and strategies in place to support the achievement of its strategic objectives, supported by performance management and reporting systems. For the first time these strategies, programmes, systems and structures have been mapped.

This mapping has been conducted as an organisational development exercise, to identify linkages, overlaps and gaps, and to assist in communication. It demonstrates, in a simple format, the complex range of activities the Trust is undertaking.

This 'organisational map' (Organising for Excellence) will be used on an ongoing basis to assess progress and will be at the heart of ongoing organisational development activity. It will be the key reference document for the OD Steering Group, which will ensure appropriate oversight and co-ordination of OD activity across the Trust.

6.2 Driving improved business performance and focus at a local level

- The implementation of the service line management model to improve business performance, supported by a revised planning process which will encourage a specialty led approach

The Trust has made some progress on introducing service line management (SLM) over the last 2 years. However, a recent baseline assessment of SLM using the Monitor self-assessment tool demonstrated that there is more to be done, particularly in relation to the provision of accurate integrated comprehensive line information for improved decision making and budget management. There are also a number of other issues around the delegation of responsibility to divisions and directorates, the performance of corporate business units, performance management and annual planning which will need to be addressed as part of the implementation of SLM.

The Trust will now establish the SLM programme as a free standing project in its own right. This reflects its importance to the effective functioning of the

organisation as a whole and its critical role as part of the Trust's FT application. Progress towards implementation of SLM will be monitored by the Performance Management Board and the Trust Board.

6.3 Achieving greater organisational efficiency through a more coherent approach to large scale change management

- The creation of a centralised 'Transformation Support Office' (TSO) to provide service redesign and improvement, LEAN expertise and direct project management where appropriate to Divisions/Directorates

The diagnostic work led by ATOS identified that the Trust does not have a standard approach to delivering projects, resulting in variable quality of project plans and successful delivery. The benefits of change are not always identified or quantified adequately. In addition, the Trust had not fully capitalised on the use of proven service improvement techniques.

The Trust has set out its approach to moving from its current position to readiness for the new hospital (and delivery of the financial plan outlined in the Integrated Business Plan) in a Transformation Plan. This work will be supported by a Transformation Support Office (TSO) which will provide enhanced project management capacity across the organisation.

The Transformation Plan encompasses a range of key projects and its aim is to take the Trust to a level of top decile performance in a range of efficiency benchmarks compared to peers.

Progress against the Transformation Plan will be monitored by a dedicated steering group, the Performance Management Board and the Trust Board.

6.4 Achieving a 'cultural shift' – where everyone feels responsible for the delivery of quality care

- Building on our existing approach to staff engagement and involvement, exploring new ways to achieve better levels of engagement and commitment

The Trust has been using the 'Listening into Action' approach since April 2008, and it has been been widely used to address service improvement, change management, wider corporate issues and as a methodology for engaging patients. This approach will continue as an effective way of putting staff at the centre of change and harnessing their ideas and enthusiasm.

However, the Trust is now piloting another complementary staff engagement mechanism, 'Owning the Future', which is based on the John Lewis forum model, and involves the use of 'staff ambassadors'. This pilot will be evaluated, during 2012.

The Trust continues to work on securing ever higher levels of staff engagement to achieve its ultimate aim-a culture where every employee feels

responsible for the delivery of excellent patient care and is willing to ‘go the extra mile’ to help patients and visitors.

The Trust is now working on how improved performance against the customer care promises might be measured, and the design of incentives which might encourage and support the delivery of excellent patient care..

LiA activity will continue to be monitored via the Executive Steering Group, and the OtF work will be monitored by the OD Steering Group.

6.5 Investing in Leadership

The development of a systematic approach to Leadership Development across the Trust based on action learning

The Trust developed a ‘leadership framework’ in 2009 which articulates its expectations of leaders. This identifies the kind of behaviours that good leaders adopt, and has a strong emphasis on leading in an engaging way. The Trust recognises that the development of good leadership and management capacity and capability is critical to the deliver of safe and effective patient care.

The Trust also identified key gaps in terms of leadership development, and the Learning and Development Committee was created in 2010 to oversee the development of appropriate leadership interventions to fill these gaps.

The Trust has now developed an approach based on the John Adair Action Centred Leadership Model, and this will form the basis of the Trust’s leadership and management development programmes.

6.6 Improving the quality of our services to patients

- The implementation of the Quality and Safety strategy

The Trust’s vision for’ High Quality Care’ is one where all clinical care provided is appropriately measured for its safety, effectiveness and patient experience, where we can increasingly measure the ultimate outcomes of care, and where information on safety and quality is acted upon rapidly an effectively to ensure continual improvement.

The Trust has a Quality and Safety Strategy, and its aim is place the Trust in the top quartile of comparable Trusts within all key measurable benchmarks.

The Board had identified patient safety, effectiveness of care and patient experience as its top three quality and safety priorities, and these will be addressed through an annual programme of quality improvement.

The overall implementation of the Quality and Safety Strategy will be monitored by the Quality and Safety Committee.

7. Conclusion

This strategy outlines the Trust's key OD priorities and the approaches it will use to enhance the capacity and capability of the organisation, and equip it to deliver better patient care, and improved organisational and business performance.

Each element of the strategy will have its own action plan and reporting structure to ensure that real progress is made and maintained.

The overall approach will be regularly reviewed and evaluated via the Organising for Excellence framework, and adapted as necessary to ensure that it continues to support the organisation in the delivery of its strategic objectives.

8. Recommendation

The Trust Management Board is asked to **discuss** the draft strategy

Sally Fox
LIA Facilitator

1 December 2011

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Appendix 2

Organisational Development Steering Group

TERMS OF REFERENCE

1. PURPOSE

The purpose of the OD Steering Group (ODSG) is to ensure the effective implementation of the Trust's Organisational Development Strategy and to ensure delivery of, keep under review and update the 'Organising for Excellence' framework.

2. SCOPE

To oversee and monitor progress of the key action plans developed to deliver the following six key objectives of the Trust's Organisational Development Strategy:

- Achieving congruence and integration in organisational development activity
- Driving improved business performance and focus at a local level
- Achieving greater organisational efficiency through a more coherent approach to large scale change management
- Achieving a 'cultural shift' – where everyone feels responsible for the delivery of quality care
- Investing in leadership
- Improving the quality of our services to patients

To ensure a coherent and integrated approach to organisational development activities through the use of the 'Organising for Excellence' framework.

The ODSG will ensure that the key programmes and strategies identified in Organising for excellence (including the Organisation Development Strategy) are delivered and reported. The ODSG will keep under review the arrangements for delivery of the key strategies and Programmes and will ensure that each programme either:

- has adequate existing delivery and reporting arrangements
- should be reported to the OD Steering Group
- should be reported to another body

The ODSG will initially take direct responsibility for the following strategies and programmes:

- Leadership Development – including talent management
- Listening into Action (LiA)
- Owning the Future (OtF) –including the use of incentives
- Workforce Strategy
- Communications and Engagement Strategy
- Service Line Management

3. MEMBERSHIP

- Non Executive Directors x2
- Chief Executive (Chair)
- Director of Strategy and Organisational Development
- Chief Nurse
- Medical Director
- Chief Operating Officer
- LiA Facilitator
- Head of Communications and Engagement

4. GOVERNANCE ARRANGEMENTS

The ODSG will, initially meet once very two months and provide a written report to the Trust Board three times per year.

The ODSG will receive regular written progress reports from each of the programmes for which it has responsibility.

The ODSG will be quorate when half of the members are present.

M. Sharon
Director of Strategy and OD

18 January 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Outline Business Case For Consultation On The Reconfiguration Of Acute Stroke, Tia And Neurology Services
SPONSORING DIRECTOR:	Mike Sharon, Director of Organisational Development and Strategy
AUTHOR:	Jayne Dunn, Redesign Director – RCRH
DATE OF MEETING:	26th January 2012

SUMMARY OF KEY POINTS:

This paper sets out for the Trust Board:

- the clinical case for reconfiguration of our acute stroke, Transient Ischemic Attack (TIA) and inpatient Neurology services,
- the short listed options
- the case for formal public consultation on the proposed reconfiguration of these services, including the draft consultation document,
- the initial activity, capacity and financial analysis of the short listed options.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is recommended to:

- AGREE the clinical case for change of our acute stroke and TIA services and in particular the need to consolidate acute services in order to deliver improved patient outcomes and experience.
- NOTE the engagement to date including the process for short listing options.
- NOTE the proposed short listed options and AGREE that the activity, capacity and financial analysis to date does not exclude any of the short listed options at this stage.
- AGREE that a formal public consultation of the short listed options is undertaken.
- AGREE the consultation document (Appendix 3).
- AGREE the decision making process to identify an approved option.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Corporate Objective 2: High Quality Care
Annual priorities	Review of Stroke Services
NHS LA standards	
CQC Essential Standards of Quality and Safety	
Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

Financial	**X**	High level analysis suggests: • Potential loss of income owing to catchment changes must be matched to funding strategy • Capital investment associated with options • Potential revenue investment in additional nursing staff The analysis at this stage does not suggest a significant variation between the short listed options.
Business and market share	**x**	Potential catchment loss, requires service and financial prioritisation
Clinical	**X**	Clinical case for change in order to improve clinical outcomes
Workforce	**X**	New ways of working to deliver new service model consolidate on one site for at leas the acute element of the stroke and TIA care
Environmental	**x**	Potential ward refurbishment Potential for a 2nd CT scanner at Sandwell Hospital
Legal & Policy		
Equality and Diversity	**X**	Equality Impact Assessment Screening undertaken
Patient Experience	**x**	Reconfiguration will result in improved patient outcomes and experience but will mean some patients and visitors will have to travel further.
Communications & Media	**X**	Request to proceed to formal public consultation on short listed options for service reconfiguration
Risks		Project risks identified as part of the project risk register

PREVIOUS CONSIDERATION:

Previous progress reports relating to Clinical Service Reconfiguration – last report December 2011.

EXECUTIVE SUMMARY

Introduction

We provide acute and inpatient rehabilitation stroke and Transient Ischemic Attack (TIA) services at both City Hospital and Sandwell General Hospital. There are significant clinical drivers at a national, regional and local level to consolidate the acute element of these services in order to provide a critical mass of specialist experience and skills that can deliver improved health outcomes as measured by reduced mortality rates and increased numbers of patients returning to independent living following a stroke. In response to these drivers for change we have established, in partnership with our local commissioners, a project to identify and develop the options that will provide a configuration of services that delivers these improved outcomes for our local population.

The purpose of this report is to outline for the Trust Board:

- the clinical case for reconfiguration of our acute stroke, Transient Ischemic Attack (TIA) and inpatient Neurology services,
- the short listed options,
- the case for formal public consultation on the proposed reconfiguration of these services, including the draft consultation document,
- the initial activity, capacity and financial analysis of the short listed options.

Clinical Case for Change

In October 2010 a peer review visit by the West Midlands Quality Review Service (WMQRS) to look at our Stroke Services raised concerns about the long term sustainability of maintaining high quality acute Stroke Services on both City and Sandwell Hospital sites that are able to robustly meet the standards identified for Stroke Services. It stated:
"*The sustainability of the current configuration of services should be considered. Achieving the expected Quality Standards on two hospital sites will be difficult given current staffing levels. The health economy may wish to consider the improvement in quality, and expected outcomes, which could be achieved by providing acute stroke care on one hospital site. Improving the availability and speed of response of imaging services will be an important part of this consideration*."

We had also undertaken some work internally that identified similar concerns. In view of this the Trust Management Board agreed in January 2011 to initiate a project to develop options that would ensure a configuration of acute stroke and TIA services that meet quality standards in a sustained way and allow the service to continually improve. A Clinical Case for Change was developed and approved by our Clinical Services Reconfiguration Programme Board in June 2011.

This acknowledged that since the WMQRS findings, our Stoke Action Team has been working to introduce streamlined processes with a focus on developing and improving our Stroke and TIA service with the aim of ensuring the quality and safety of the service in response to national guidance and to local concerns. These efforts have produced some good results with clear improvements in meeting national, regional and local key performance indicators (KPIs) for the stroke and TIA service (target times). However, we struggle to consistently meet the required quality and performance standards for all patients at all times. To do this requires our acute stroke and TIA services to be consolidated on one site allowing the concentration of specialist staff and giving a critical mass of patients that allow these staff to further develop specialist skills. Evidence is emerging from service reconfigurations in other parts of the country (end especially London) that consolidation of acute stroke and TIA care in fewer but more specialist units delivers improved clinical outcomes, including reduced mortality rates and improved levels of independent living following an acute stroke.

The Department of Health guidelines require that proposals for significant reconfigurations are subject to initial clinical assurance by the National Clinical Advisory Team (NCAT). In line with this requirement a visit by NCAT took place in January 2012 and whilst we have yet to receive their written report, their verbal feedback endorsed the clinical case for change and the need to consolidate acute stroke and TIA services on one site. They strongly supported the direction of travel and if anything were surprised these changes had not already been made. NCAT felt both of the short listed service models were appropriate.

Options

The Project Board and Steering Group through several staff engagement events developed a long list of options along with a set of evaluation criteria and a short listing process. Using the agreed evaluation criteria and weighting the long list of 6 options were scored by 3 stakeholder groups: –

1. Local patients and carers who are stroke and TIA experts by experience
2. Stroke Reconfiguration Project Steering Group
3. Clinical staff from all relevant professions working in stroke and TIA services at SWBH at a 'Listening into Action' event.

GPs have subsequently been engaged by the project team on a one to one basis with representation across the relevant Sandwell and West Birmingham Clinical Commissioning Group (SWBCCG) to discuss the proposed short list and the process. All the individual GPs consulted were satisfied with the process that had been undertaken and stated preferences for the short listed options. The Project Board then identified the two options with the highest scores as the short list. These are:

Option 3: A single site model with all inpatient (acute and rehabilitation) stroke, Neurology and TIA facilities and services located at one Hospital.
Option 6: A two site model with one hyper-acute stroke unit, acut Neurology inpatients and high risk TIA services located at one Hospital. Rehabilitation services would be provided at both City and Sandwell Hospitals.

At this stage no clear clinical reasons had been identified to suggest which of the City and Sandwell Hospital sites the acute services should be located on. Subsequently a high level scoping analysis has been undertaken around the areas of activity, capacity, facilities, staffing and finance. Whilst the Trust is currently engaged in discussions with commissioners on the overall funding settlement for services in 12/13, the findings from this work confirm that the impact associated with the short listed options are within the boundaries of what would normally be affordable to the health economy taking account of capacity and feasibility and that the variations between placing the acute services on either City or Sandwell Hospital are not significant enough to discount either site at this stage. As a result it is proposed that each or the short listed options has two variant options with one locating acute services at the City site and the other at the Sandwell site giving four short listed options for consultation. It is important to recognise however, that further, more detailed work will need to be undertaken in each of these areas, for each of the short listed options with the findings being fed into the decision making process that will be undertaken at the end of consultation, to determine a preferred option. It should also be noted that at this stage all options appear likely to require some capital investment.

It was agreed that the options of Do Nothing and retain the current configuration but introduce new ways of working for medical teams in order to provide acceptable levels of cover at all times would not be scored as they did not meet the clinical drivers for change in terms of consolidating acute stroke and TIA services in order to provide the critical mass of expertise and skills that could meet the standards in a consistent was and deliver improved clinical outcomes. They will however need to be included in the next stage of detailed financial

analysis in order to provide a baseline comparator in the business case for the preferred option.

Engagement and Consultation

To date the project has engaged with a wide range of stakeholders in developing and short listing the options. These include:

- Clinical staff
- Patients
- GP commissioners
- The West Midlands Ambulance Service
- The Joint Health Scrutiny Committee.

This is in line with national guidance and as a result the project meets the Secretary of State's tests for service reconfiguration projects.

All of the short listed options for acute stroke and TIA reconfiguration involve consolidating acute services on one hospital site. The Joint Health Scrutiny Committee have advised that this is a significant service change and as such a formal public consultation is required. This needs to take place over a 12 week period and in line with the project timetable it is proposed that public consultation starts on 9th February 2012 and finishes on 25th April 2012. A consultation framework has been developed and includes identifying and planning to utilise a number of different methodologies involving a wide cohort of people across the local economy in order to gain views from a range of diverse ethnic and cultural groups.

The final decision to undertake a formal public consultation of the short listed options will be taken by the Black Country PCT Cluster Board at its meeting on 31st January 2012. This will be based upon the case for change presented in this report. In making this decision the Black Country PCT Cluster Board will seek agreement to the consultation from our Trust Board through the case for change outlined in this paper. Agreement to proceed to formal public consultation will also be sought from the SHA.

Recommendations

The Board is recommended to:

- AGREE the clinical case for change of our acute stroke and TIA services and in particular the need to consolidate acute services in order to deliver improved patient outcomes and experience.
- NOTE the engagement to date including the process for short listing options.
- NOTE the proposed short listed options and AGREE that the activity, capacity and financial analysis to date does not exclude any of the short listed options at this stage.
- AGREE that a formal public consultation of the short listed options is undertaken.
- AGREE the consultation document (Appendix 3).
- AGREE the decision making process to identify an approved preferred option.

OUTLINE BUSINESS CASE FOR CONSULTATION ON THE RECONFIGURATION OF ACUTE STROKE, TIA AND NEUROLOGY SERVICES

1. INTRODUCTION

Currently we provide acute and inpatient rehabilitation stroke and Transient Ischemic Attack (TIA) services at both City Hospital and Sandwell General Hospital. There are significant clinical drivers at a national, regional and local level to consolidate the acute element of these services in order to provide a critical mass of specialist experience and skills that can deliver improved health outcomes as measured by reduced mortality rates and increased numbers of patients returning to independent living following a stroke. In response to these drivers for change we have established, in partnership with our local commissioners, a project to identify and develop the options that will provide a configuration of services that delivers these improved outcomes for our local population.

The purpose of this report is to outline for the Trust Board:

- the clinical case for reconfiguration of our acute stroke, Transient Ischemic Attack (TIA) and inpatient Neurology services,
- the short listed options,
- the case for formal public consultation on the proposed reconfiguration of these services, including the draft consultation document,
- the initial activity, capacity and financial analysis of the short listed options.

2. STRATEGIC CONTEXT

2.1 What are Acute Stroke and TIA Services?

Hyper-acute stroke services enable patients to have rapid access to the right skills and equipment and be treated 24/7 on a dedicated stroke unit, staffed by specialist multi-disciplinary teams. Following a stroke, a patient is taken directly to a hyper-acute stroke unit where they will receive expert care, including immediate assessment, access to a CT scan and clot-busting drugs (if appropriate) within 30 minutes.

Following this acute care patients then receive inpatient based rehabilitation or are discharged to their usual place of residence with community rehabilitation as appropriate.

Patients who have suffered a suspected TIA, also known as a ‘mini stroke’, can use an outpatient assessment service within 24 hours for those deemed to be at high risk of further TIA or stroke and within seven days for patients at lower risk.

2.2 National and Regional Context

Stroke has a major impact on people’s lives. It is caused by a disturbance of blood supply to the brain and may be ischemic or haemorrhagic in nature. It starts as an acute medical emergency, presents complex care needs, may result in long-term disability and can lead to admission to long-term care.

Each year, 110,000 people in England and Wales have their first stroke, and 30,000 people go on to have further strokes. It is the single biggest cause of severe disability and the third most common cause of death in the UK. Over 5% of NHS resources and significant social care resources are devoted to the immediate and continuing care of people with stroke. In an average general hospital at any one time there are 25–35 patients with stroke as their primary diagnosis.

An initial structured assessment, for example, the Recognition of Stroke In the Emergency Room (ROSIER) scale, in a high-dependency area, such as, the emergency department or medical assessment unit, is needed to determine the diagnosis and whether urgent brain imaging is required.

In 2007 the National Stroke Strategy was published by the Government. It provides a national quality framework through which local services can, over a ten year period, secure improvements across the stroke pathway against quality markers. It recommends:

- Provision of Hyper-acute stroke services which enable patients to have rapid access to the right equipment and be treated 24/7 on a dedicated stroke unit, staffed by specialist teams.
- Once the patient is stabilised (within around 72 hours) they will be moved to a dedicated stroke unit where they receive further care and rehabilitation support.

Since then a number of key national documents have been developed around stroke care which include:

- National Stroke Strategy (DoH, 2007)
- National Clinical Guideline for Stroke 3rd edition-Prepared by the Intercollegiate Stroke Working Party (July 2008)
- Implementing the National Stroke Strategy- Imaging Guide. (DoH , 2008)
- NICE guidelines 'Diagnosis and initial management of acute stroke and transient ischemic attack' (2008) and the draft NICE Quality Standard for Stroke (2009).
- Royal College of Physicians *'National Clinical Guideline for Stroke' (3rd Edition)* (2008).

Stroke has been a health priority across the West Midlands resulting in several key regional documents including:

- West Midlands Service Specification for the Management of Stroke Thrombolysis and Acute Care (Hyper-Acute) (2009)
- West Midlands Specification of Services for Patients with Transient Ischemic Attack and Non-Disabling / Minor Stroke (2010).
- West Midlands Acute Stroke Steering Group accelerated standards
- West Midlands Quality Review Service Quality Standards

The NHS Midlands and East have recently notified Chief Executive Officers of PCT clusters and acute Trusts of plans to complete a review of acute stroke services, with an interest in potentially replicating the model being delivered in London. Between 2008 and 2011 a significant reconfiguration of acute stroke and TIA services took place across London. Emerging evidence from this reconfiguration is demonstrating compelling improved outcomes for stroke associated mortality rates, speed and access to appropriate treatments and specialist care. In addition it is also showing evidence of other improved patient outcomes in terms of increased levels of independence and reduced levels of disability.

Birmingham PCT Cluster have recently asked the Birmingham and Sandwell Cardiac and Stroke Network to facilitate a review of the configuration of acute stroke services across Birmingham which currently are delivered from University Hospitals of Birmingham Foundation Trust, Heart of England Foundation Trust and our Trust. There are performance concerns for each acute trust, which has led Birmingham PCT Cluster to consider configuration options. This process will have clear interdependencies with our proposed reconfiguration of acute stroke and TIA services. Conversations between the respective PCT

Cluster Directors of Commissioning Development and with the Strategic Health Authority (SHA) confirmed that although these processes are linked, our reconfiguration process should continue on the basis that:

- a significant momentum has already been achieved,
- the reconfiguration of our stroke services could form a helpful 'first piece in the jigsaw' which the Birmingham configuration could then build upon and
- there is an imperative to improve the quality of this stroke service for local patients to deliver better outcomes.

The Black Country Cluster Clinical Senate received a report in December 2011 from the Black Country Cardiovascular Network on stroke services across the Black Country. A key recommendation of that report was "the need for a formal review of the provision of hyper-acute stroke services across the Black Country Cluster…. And whether a review in the Black Country should form part of a wider West Midlands review, as patient flows impact on providers outside the Black Country Cluster." The relationship of our proposed reconfiguration will relate to any future Black Country review in a similar way as to the Birmingham Cluster review.

2.3 Local Context

In October 2010 a peer review visit by the West Midlands Quality Review Service (WMQRS) to look at our Stroke Services raised concerns about the long term sustainability of maintaining high quality acute Stroke Services on both City and Sandwell Hospital sites that are able to robustly meet the standards identified for Stroke Services. It stated:

"*The sustainability of the current configuration of services should be considered. Achieving the expected Quality Standards on two hospital sites will be difficult given current staffing levels. The health economy may wish to consider the improvement in quality, and expected outcomes, which could be achieved by providing acute stroke care on one hospital site. Improving the availability and speed of response of imaging services will be an important part of this consideration*."

We had also undertaken some work internally that identified similar concerns. Whilst acute stroke and TIA services are currently provided at Sandwell and City Hospital sites, the type of service provision and activity varies between the sites. For example:

- In-patient bed facilities and configurations differ
- Consultant cover differs on both sites
- Nursing configurations and competencies differ
- Delivery of Care pathways is not mirrored
- Imaging times and facilities and staffing differs
- Therapy input is managed differently
- Approach to rehabilitation and early supportive discharge differs.

Table 1 below summarises the total number of patients we admitted during 2010/11 with a main diagnosis of stroke or a main diagnosis of TIA and the number of patients seen as outpatients with a TIA.

Table 1 – Number of patients seen by SWBH for stroke and TIA in 2010/11

	Trust	**City Hospital**	**Sandwell Hospital**
Stroke – patients admitted	625	338	287
TIA – patients admitted	201	121	80

TIA – high risk outpatient appointments	188	71	117
TIA – low risk outpatient appointments	340	164	176

Since the WMQRS findings, our Stoke Action Team has been working to introduce streamlined processes using LEAN principles with a focus on developing and improving our Stroke and TIA service; with the aim of ensuring the quality and safety of the service in response to national guidance and to local concerns. These efforts have produced some good results with clear improvements in meeting national, regional and local key performance indicators (KPIs) for the stroke and TIA service (target times). However, we struggle to consistently meet the required Quality Standards as outlined by the West Midlands Cardiac and Stroke Network for all patients at all times. There remain continuing concerns about medium term sustainability, particularly in respect of the Consultant led component of the service and also the ability to provide timely imaging and diagnostic investigations. In view of this the Trust Management Board agreed in January 2011 to initiate a project to develop options that would ensure a configuration of acute stroke and TIA services that meet quality standards in a sustained way and allow the service to continually improve.

As with previous reconfigurations and in line with national guidance this project has been established with our local commissioners with Sandwell PCT (as our host commissioner) being the lead organisation for the planning phase of the project.

In the longer term and in line with our strategic objectives, our acute stroke and TIA services would transfer along with other acute in-patient care to the Midland Metropolitan Hospital when this opens. This is subject to the approval of the Outline Business Case for the new hospital which is currently being considered by the Department of Health.

3. THE CLINICAL CASE FOR CHANGE

Following the Trust Management Board decision to initiate a review of the configuration of stroke services a Project Steering Group was established to develop a Clinical Case for Change. This is a separate document that was agreed by the Trust's Clinical Service Reconfiguration Programme Board in June 2011. The key points are summarised below.

National Guidance has defined the key bundles of care that are necessary for optimum stroke care. Achieving the goals will ensure the best outcomes for our population and would likely lead to a reduction in mortality and morbidity of stroke. Delivering the care bundles represents a significant organisational and service challenge particularly when duplicated across two hospital settings. The clinical case for change review has identified the following key drivers for change.

3.1 New and increasing National standards particularly in relation to Specialist Consultant cover and wider staffing requirements.

The National Stroke Strategy (DoH, 2007) recommends that all front-line staff should be competent in identifying people with suspected stroke. It also recommends that commissioners ensure that care pathways and protocols are in place so that all people with suspected acute stroke are transferred immediately by ambulance to a hospital with access to a 24-hour, 7-day a week (24/7) hyper-acute stroke service that can provide a stroke triage system, expert clinical assessment, timely imaging and intravenous thrombolysis.

Currently our services fall short of the recommendations as, although there is a service being delivered across the Trust, this service is not consistent in its approach on both acute sites over the 24hour/seven day period. We currently have 8 specialist consultants (5 stroke

physicians and 3 Neurologists) and whilst they work as one team they are not able to provide 24/7 cover for the two acute sites. The service is therefore also reliant at both sites on non-specialist but trained Consultants in Acute Medicine, Emergency Medicine and General Physicians to deliver thrombolysis, assessment and treatment. Specialist registrars who are designated 'on call' for general medicine to support the service. Although safe this is unlikely to deliver the required commitment to achieve the accelerated access to thrombolysis that will be required in the longer term. In addition developing further specialist skills in stroke care will be difficult whilst this range of doctors deliver specialist stroke care and whilst there is not a sufficient critical mass of stroke patients on each site.

3.2 The need to ensure that the actions which have been taken to improve quality and safety are sustainable in the medium term.

Clinical leadership and supervision- A key aspect of the actions to be implemented by the Stroke Action Team is to strengthen the clinical leadership within the service. This is in line with national recommendations and review findings including, *'the overall root cause of poor performance is often weak managerial or clinical leadership which can leave problems unidentified or unresolved'* (Healthcare Commission, 2007). A Clinical lead for Stroke and TIA has been appointed and there is currently a dedicated Consultant Stroke Clinician working at City Hospital. However a key part of ensuring improvements are implemented and remain sustainable will be continuing and extending robust clinical leadership and supervision. This will be particularly challenging with acute services being delivered on two sites with the requirement for a stroke specialist to be present on both sites.

The two acute stroke wards and related TIA services are part of one Service within the Trust and there is a need to ensure access to services and quality of care is equitable across the Trust. Cross site clinical policies and monitoring arrangements have been introduced but it is challenging to integrate staff into one team whilst individuals primarily work on one site or another. Cross site working and rotation can be introduced but raises issues of continuity of care and services. Currently there are duplications of functions and there is insufficient critical mass at either site to deliver an excellent service.

The National Stroke Strategy (DoH,2007) proposes a model of hyper-acute stroke units Hyper-acute stroke services enable patients to have rapid access to the right equipment and be treated 24/7 on a dedicated stroke unit, staffed by specialist teams. This means following a stroke, a patient is taken directly to a hyper-acute stroke unit where they will receive expert care, including access to a CT scan and clot-busting drugs (if appropriate) within 30 minutes.

The consolidation of acute care on to one site would facilitate improvements more rapidly e.g. extended consultant cover for Stroke ward rather than trying to achieve this on two sites. It will also more robustly ensure the improvements will be sustained in the medium term particularly in relation to clinical leadership and presence. In addition such consolidation will ensure integration of staff from the two sites into one team working to the same clinical policies, competences and processes ahead of the opening of the new Acute Hospital.

Reconfiguration on to one site would allow 24/7 cover from our team of 8 specialist consultants (5 stroke physicians and 3 Neurologists) and ensure continuity of service and capacity for development of real time leadership. This would also facilitate data collection and audit of stroke metrics.

Consolidation of acute stroke and TIA services on one site would have a similar impact on nursing and other clinical staff in terms of developing and consolidating stroke specific competencies, skills and experience.

3.3 Meeting Key Performance Indicators

We have struggled to consistently meet the key performance indicators for stroke and TIA services in the national Vital Signs/Integrated Performance Measures.

One of the key measures (in the Stroke Vital Signs) is the percentage of stroke inpatients who receive over 90% of their acute care on a designated stroke ward with **the national threshold being 80%.** Table 2 below shows our performance against this measure for the financial year 2010/11 and the first 6 months of 2011/12. It can be seen that our performance was below the national threshold in two quarters of 2010/11.

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Table 2 – The % of stroke inpatients in who received over 90% of their acute care on a designated stroke ward

Performance 02010/11	Number of Patients who spent >= 90% of stay on a stroke ward	Total Stoke Patients	% Of Stoke Patients who spent >= 90% of stay on a Stroke Ward
Quarter 1	62	76	81.6
Quarter 2	71	92	77.2
Quarter 3	60	78	76.9
Quarter 4	65	77	84.4
2011/12 Q1	57	67	85.1
2011/12 Q2	55	67	82

Another key measure (in TIA Vital Signs) is the percentage of TIA patients with a predicted high risk of further stroke (ABCD score of 4 or more) who are seen at an Out Patient TIA clinic within 24hrs of first presentation to a medical professional (GP, A+E etc). **The national threshold is 60%.** Table 3 below shows our performance against this measure for the financial year 2010/11 and the first 6 months of 2011/12. It can be seen that whilst our performance has improved it remains below the national threshold.

Table 3 – The % of high risk TIA patients seen in a TIA clinic within 24 hours of first presentation to a doctor

Performance 2010/11	Total High Risk TIA Patients	Total High Risk TIA Treated within 24hrs	% of High Risk TIAs treated in 24 hours
Quarter 1	34	0	0 %
Quarter 2	50	4	8 %
Quarter 3	26	0	0 %
Quarter 4	18	10	55.6
2011/12 Q1	9	5	55.6
2011/12 Q2	20	11	55

A third key measure is the percentage of patients receiving thrombolysis (where clinically appropriate). The national standard is 20%. Our performance against this standard has improved but is currently around 7% with 82% of these patients receiving thrombolysis within 4.5 hours of the onset of symptoms. In addition to access to a hyper acute stroke service a key factor is the time patients present to hospital from the onset of symptoms. The consolidation of our acute services and specialist team will also facilitate time for our clinical team to work with primary care and public health clinicians to raise awareness in our local population of stoke symptoms and the importance of presenting early to hospital. .

This data does indicate an improving performance but would be improved further through the reconfiguration of services and related consolidation of specialist skills and expertise and the

availability of this on a 24/7 basis. The outcomes now being seen following the London reconfiguration support this approach to deliver a step change in performance improvements for stroke and TIA care.

3.4 Neurology

Patients admitted to hospital with acute Neurological conditions require many of the same specialist clinical skills as acute stroke and TIA patients. In addition timely assessment by a consultant Neurologist is a key part of the care of a patient with an acute stroke or TIA. As a result our consultant Neurologists feel that Neurology inpatients should be cared for on the same site and ideally in the same ward as acute stroke patients. Currently we only provide inpatient care for patients admitted under Neurology at City Hospital but these patients are cared for on the same acute ward as acute stroke patients and both groups of patients also share the same rehabilitation ward. Neurology inpatient care therefore needs to be considered as part of this reconfiguration project and if acute stroke and TIA services are consolidated at Sandwell Hospital the inpatient Neurology service will also need to transfer. This view has been endorsed by the National Clinical Advisory Team review (see later in the report) although they emphasised the focus of an acute stroke unit should be primarily stroke care but it is appropriate to care for patients with acute Neurological conditions in the same area if they require the same nursing skills.

4. PLANNED OUTCOMES AND BENEFITS

The Project Board and Project Steering Group have identified a number of benefits that a reconfiguration of acute stroke and TIA services should deliver. These will need to be developed into a full benefits realisation framework but the identified benefits are described in Appendix 1. In summary these are:

- Mortality rates for those affected by stroke and treated at our Trust will be reduced from current levels.
- Levels of long term disability related to stroke for those affected by stroke and treated at our Trust will be reduced, increasing independence and levels of functioning in the stroke population.
- We will provide Stroke services which comply with WMQRS standards
- We will deliver consistent high quality stroke & TIA diagnostic services
- We will have a recognised centre of excellence for Stroke
- The experience of patients using our stroke and TIA services will be improved
- We will have appropriately trained and competent staff available at all times for both acute care and rehabilitation
- All stroke patients in the area (Sandwell and West Birmingham) will have access to the same level of care.
- Specialist support services will be available in the community as part of the integrated service and early supportive discharge arrangements.
- We will deliver safe care with a reduction in long term complications.
- Our services will offer value for money.

5. PROJECT MANAGEMENT

The Acute Stroke and TIA Reconfiguration Project has been set up as a formal reconfiguration project in line with Department of Health guidance (2010). As such the project management structure has been established jointly with our PCTs, with Sandwell PCT confirmed as the lead organisation for the planning phase of the project.

A Project Board has been established and is chaired by Janine Brown (Project Director, Sandwell PCT) who is the Senior Responsible Officer (SRO) for the project. A Project Steering Group has also been set up and has clinical representatives from a range of specialities and disciplines. This is chaired by Dr Deva Situnayake, one of our Deputy Medical Directors.

The structured project methodology is set out in the Project Initiation Document (PID) with the main objectives of the project being to maximise the potential for acute stroke and TIA care to be delivered at optimal levels of quality and efficiency at SWBH. Through the project a preferred option will be identified and this should:

- Meet national, regional and local standards of care and deliver safe and effective stroke and TIA care for the people of Sandwell and West Birmingham.
- Improve the health outcomes of the stroke population in the short, medium and long term.
- Meet local commissioning intentions (including emerging CCGs) and meet the clinical needs of patients and carers as well as being delivered in an integrated way with relevant services in the acute sector and the community.
- Deliver stroke and TIA services that sustain performance that exceed expected thresholds in the national Vital Signs/Integrated Performance Measures and Cardiac and Stroke Network measures derived from the national stroke strategy.
- Deliver excellent levels of patient/carer satisfaction.

In line with national guidance the potential need for formal public consultation if the reconfiguration resulted in the removal of a range of clinical services from one hospital, was tested with the Joint Health Scrutiny Committee at an early stage who confirmed that formal public consultation would be a likely requirement. On this basis and again in line with national guidance the project requires external reviews including:

- An assessment from the National Clinical Advisory Team (described in section 7 below) and
- Office of Government Commerce Gateway Reviews.

5.1 Gateway Review

A series of Gateway reviews will be required at key points in the project. The Gateway review process examines a project at key decision points in order to provide assurance that the project can progress successfully to the next stage and is designed to provide independent guidance to the Senior Responsible Officer of the project on how best to ensure that the project is successful.

An initial Gateway Review of this project was undertaken 10th-12th January 2012 with the purpose of assessing the project's readiness to go to formal public consultation.

The outcome of this review was that the delivery confidence assessment status for the project is:

- Amber i.e. Successful delivery appears feasible but issues require management attention. The issues appear resolvable at this stage of the programme/project if addressed promptly.

The Gateway Review Team commented that:
'*The team's stakeholder engagement and management, including clinical involvement within the Acute Trust, Local Authority HOSC relationship and a willingness from Primary Care to participate fully in implementation, is also to be commended.'*

The Gateway Review made the following 6 recommendations:

Table 4 – Recommendations from the Gateway Review

Ref. No.	**Recommendation**	**Timing**
1.	Clearly identify the capital and revenue implications of each option to be consulted on and ensure explicit agreement from all partners as to how these will be managed prior to moving to public consultation.	Do Now
2.	Clarify the process and timetable for sign-off of the consultation document.	Do Now
3.	Establish the proposed benefits to inform the consultation process.	Do Now
4.	Develop the benefits realisation plan for the project, with owners and clear metrics for measurement.	Do by June 2012
5.	Review the timings of the final phase of work prior to consultation.	Do Now
6.	Establish a detailed plan for implementation of the service model.	Do by June 2012

The Project Board have reviewed these recommendations and responded through the following actions:

1. SWBH finance dept have now put together headline cost implications for each option which will be presented to Trust Board on 26th January
2. Process timeline of sign off for the consultation document have now been included in the PID
3. The benefits realisation has been amended to reflect the key outcomes to patients of reduced rates of mortality and long term disability. Additions to the consultation document have been agreed to include explanation of these benefits.
4. The benefits realisation plan has been added to the agenda of the next project Steering Group meeting in February to develop further
5. The timeline and process of approval for the short list options ('final phase of work') has been included in the PID
6. The project plan has been updated to include the development of a clear implementation plan over the next 5 months.

6. OPTIONS

6.1 Long List of Options

We identified an initial long list of 7 options for future service models through several Listening into Action (LiA) events with clinical staff. These took place through 2011 in January, April and July. The service models were then refined through the Project Steering Group with key multi-disciplinary clinical leaders. This long list of 7 options was then reduced to 6 options at the request of the Project Board in October 2011 as option 3 and option 6 of that list were almost identical. This proposal to reduce to 6 options was then agreed by the Project Steering Group and the new options were re-numbered.

6.2 Short Listing Process

In the initial scoping of the long list of options neither City Hospital nor Sandwell Hospital offered any fundamental reason for locating the acute stroke and TIA services at one site over the other site. As such the priority of the Project Board was to agree the models of service rather than on which site these models would be located. It was therefore agreed that the long list of options would not be site specific and the short listing process would focus on

the service model and the benefits of each and would not at this stage take into account which site the acute services would be placed on.

In addition it was agreed that Options 1a (Do Nothing) and 1 b (Retain the current configuration but introduce new ways of working for medical teams in order to provide acceptable levels of cover at all times) would not be scored as they did not meet the clinical drivers for change in terms of consolidating acute stroke and TIA services in order to provide the critical mass of expertise and skills that could meet the standards in a consistent was and deliver improved clinical outcomes.

The short listing process, including the long list of options to be scored and the evaluation criteria, was discussed with the local Joint Health Scrutiny Committee in September 2011.

6.2.1 Short-listing Scoring Criteria

The criteria for evaluating the long list of options in order to identify a short list, were initially developed by staff through a Listening into Action style event. These were then refined by the Project Steering Group and Project Board, allocated weightings and tested with the Joint Health Scrutiny Committee.

The evaluation criteria are:

1. Access (2)
2. Improved Clinical Quality of Services (3)
3. Improved Environmental Quality of Services (2)
4. Meeting National, Regional and Local Policy Imperatives (3)
5. Improved Strategic Fit (2)
6. Developing New and Existing Services (3)
7. Finance and Value for Money (2)
8. Sustainability (3)

The numbers in brackets indicate the weighting applied to each criteria with 3 being the highest weighting.

6.2.3 Short-listing Stakeholders

Using the agreed evaluation criteria and weighting (above) the long list of 6 options were scored by 3 stakeholder groups –

4. Local patients and carers who are stroke and TIA experts by experience (28/11/11)
5. Stroke Reconfiguration Project Steering Group (8/12/11)
6. Clinical staff from all relevant professions working in stroke and TIA services at SWBH at a 'Listening into Action' event (9/12/11).

GPs have subsequently been engaged by the project team on a one to one basis with representation across the relevant Sandwell and West Birmingham Clinical Commissioning Group (SWBCCG) between 14th December 2011 and 6th January 2012 to discuss the proposed short list and the process. The individual GPs consulted were -

- Dr Mitchell and Dr Solomon (SWBCCG – Black Country Locality)
- Dr Baig and Dr Harding (SWBHCCG – HealthWorks Locality)
- Dr Hassouna and Dr Chawla (SWBCCG – SHAC Locality)

All the individual GPs consulted were satisfied with the process that had been undertaken and stated preferences for the short listed options. This input has been taken into account by the Project Board in arriving at the proposed short list. The Sandwell and West Birmingham CCG Board were presented with these short listed options for approval on 18th January 2012.

The Joint Health Scrutiny Committee have also been engaged in this process with progress reports being tabled at their July and September 2011 Committee meetings. A report requesting support and comment for the short-listed options was presented to the Committee on 17th January 2011.

7. NON FINANCIAL OPTION APPRAISAL

7.1 Non Financial Evaluation Criteria and Scores

Following the scoring sessions of each stakeholder group (as described above), the scores were calculated according to the weighting criteria. The scores from the 3 stakeholder groups were combined to provide an overall score for each option. The weighting attached to each stakeholder group is as follows:

- Patients/carers group – 22% of overall score
- Project Steering Group – 43% of overall score
- SWBH Clinical Staff – 35% of overall score.

The Project Board agreed to short list the 2 highest scoring options.

The options appraisal indicated that options 3 and 6 are the two highest scoring options**. Therefore options 3 and 6 will be presented for the formal consultation process.** These options will be subdivided into options 3a and 3b, and 6a and 6b to include the possibility of configuring acute services in each option at either hospital (City or Sandwell).

7.2 Short Listed Options

Option 3a

This is a single site model with all stroke and TIA facilities and services located at City Hospital.

This includes all hyper-acute emergency care and acute care, rehabilitation wards, Imaging and Out -patient services, TIA services. Patients who arrive in the Accident and Emergency Department (A&E) at Sandwell Hospital, who are suspected as having a stroke or TIA would be transferred to City Hospital for in-patient treatment and/or specialist out-patient care.

This option provides at City Hospital:

- A single Hyper-Acute Stroke Unit with a 24/7 service and incorporating neurology beds within the hyper-acute area.
- Initially patients would access the Hyper- Acute Stroke Unit from ED but the plan would be for the Unit to take direct admissions within 12- 24 months (allowing a two stage approach for the implementation of this model).
- Short and long stay rehabilitation would be provided in a dedicated stroke rehabilitation ward located at the same site near to the hyper-acute unit.
- There would be a telemedicine link from the Emergency Department (ED) to the hyper-acute facility.
- In addition there would be early supportive discharge (ESD) assessment and intervention available on site from the earliest opportunity.
- All TIA patients would be managed on an outpatient basis. TIA services would be enhanced via inclusion of a telemedicine approach from the Hyper-Acute Unit to ED.

Option 3b (As above but at Sandwell Hospital)

This is a single site model with all stroke and TIA facilities and services located at Sandwell Hospital.

Option 6a

Provides a two site model with one hyper-acute stroke unit and high risk TIA services located at City Hospital. Rehabilitation services would be provided at both City and Sandwell Hospitals.

This option provides:

- A single Hyper-Acute Stroke Unit at City Hospital with a 24/7 service and incorporating neurology beds within the hyper-acute area.
- Initially patients would access the Hyper- Acute Stroke Unit from ED but the plan would be for the Unit to take direct admissions within 12- 24 months (allowing a two stage approach for the implementation of this model).
- Rehabilitation units which provide both short and long stay rehabilitation and include dedicated stroke palliative care services as part of continuing care would be provided on both City and Sandwell Hospitals as would early supportive discharge services.
- High risk TIA service would be provided 7 days per week at City Hospital alongside the Hyper-Acute Stroke Unit. This service would see all high risk patients and some low risks patients depending on daily capacity. In addition there would be dedicated low risk TIA slots within general OPD to ensure capacity at all times to enable the

appropriate timeframes within the care pathway to be met. There would be telemedicine links between the hyper-acute unit, ED and OPD.

Option 6b (As above but with Hyper-acute unit at Sandwell Hospital)
Provides a two site model with one hyper-acute stroke unit and high risk TIA services located at Sandwell Hospital. Rehabilitation services would be provided at both City and Sandwell Hospitals.

7.3 National Clinical Advisory Team (NCAT)

The National Clinical Advisory Team (NCAT) undertook a review of the project, on January 10th 2012, with regard to the project's clinical aspects. Whilst we have yet to receive their written report, their verbal feedback endorsed the clinical case for change and the need to consolidate acute stroke and TIA services on one site. They strongly supported the direction of travel and if anything were surprised these changes had not already been made.

NCAT felt both of the short listed service models were appropriate and whilst they feel all inpatient service on one site leads to better outcomes they recognise (especially after their session with patients/carers) the importance of local access for rehabilitation and so felt the service model with rehabilitation on both sites is also valid.

The written report from the review will be submitted to the SHA with the expectation that this will published on their website.

7.4 Equality Impact Assessment

The Public Sector Equality Duty of the Equality Act 2010 requires public sector organisations to undertake an Equality Analysis of the impact of their decisions on groups with characteristics protected by legislation.

Sandwell PCT has an Equality Impact Assessment methodology and process in place that enables it to assess the impact of its current or intended policies, programmes and service delivery for any disadvantageous experiences or outcomes for protected groups; and to take appropriate and proportionate action to address issues identified. As Sandwell PCT is the lead organisation for the project this methodology will be used.

The Project Board has identified the requirement to conduct equality impact assessments (EqIA) at each stage of this service reconfiguration project. This will support the process and provide evidence that consideration of equality has been embedded into each stage of the project. The phases within the EqIA process are:

- Phase 1 – EqIA of Stroke and TIA Service Options
- Phase 2 – EqIA Implementation of selected Stroke and TIA Service option
- Phase 3 – EqIA Delivery of Stroke and TIA Services

An initial EqIA screening workshop to support phase 1 was held on Friday 2nd December 2011. Participants included patients, carers, clinical staff, Public Health Consultant and commissioners. The workshop identified a number of issues and communities for example, people from Indian, Black Caribbean and Irish communities who may potentially be disadvantaged by the outcome given the prevalence of stroke and TIA in these communities. The results of the EqIA workshop have been taken into account as part of the consultation plan i.e. the plan will ensure consultation with these specific communities within our local population.

8. FINANCIAL CONSIDERATIONS

As part of the short listing process a high level scoping analysis has been undertaken around the areas of activity, capacity, facilities, staffing and finance. Whilst the Trust is currently engaged in discussions with commissioners on the overall funding settlement for services in 12/13, the findings from this work confirm that the impact associated with the short listed options are within the boundaries of what would normally be affordable to the health economy taking account of capacity and feasibility. The variations between the short listed options are not significant enough to discount any of the options at this stage. It is important to recognise however, that further, more detailed work is needed for each of the short listed options. The resultant findings will be fed into the decision making process that will be undertaken at the end of consultation, to determine a preferred option.

8.1 Activity

It should be noted that the activity modelling to date does not include Neurology inpatients because the clinical view that Neurology inpatient beds should be collocated with stroke acute beds regardless of which option in terms of hospital site has only just been confirmed.

An important factor in looking at activity is the potential catchment loss from removing services from one hospital and consolidating them at the other. The majority of patients experiencing a stroke present to hospital via an ambulance (in 2011 this was circa 82% of the patients admitted to our hospitals and diagnosed as having had a stroke). Initial discussions have been held with the West Midlands Ambulance Service (WMAS) who have identified the number of ambulances with patients with suspected strokes (FAST positive) taken to each of City and Sandwell Hospitals in the first six months of 2011/12 (Table 5). WMAS have advised that they will be able to model different ambulance flows depending upon which site the Hyper-Acute Stroke Unit is based upon but have been unable to provide this to date. They have explained that there is evidence that especially in an urban area it is more important to ensure the patient reaches a Hyper-Acute Stroke Unit offering a full 24/7 specialist service than taking the patient to the nearest hospital if this does not offer such a service. They have implied that direct admission to the Hyper-Acute Stroke Unit will influence ambulance flows and potentially reduce catchment loss if this is not offered by other Trusts.

Further work is being undertaken around modelling ambulance flows and as the majority of stroke patients arrive at hospital by ambulance this should allow a more accurate view of catchment loss prior to identifying the preferred option.

Table 5: Ambulance Flows for first 6 months of 2011/12

	Ambulance Numbers
City	366
Sandwell	348
Trust	714

In the absence of the ambulance flow modelling described above the following assumptions and scenarios have been used to identify a range for potential catchment loss:

- Neurology inpatients and TIA outpatients not included
- TIA inpatients assumed to primarily self present via OPD or ED rather than via ambulance and therefore no catchment loss assumed.
- Catchment loss is associated with the location of acute services rather than location of rehabilitation and as the service models in all the shortlisted options include one Hyper-Acute Stroke Unit the catchment loss modelling is based on Hospital site rather than service model.
- The catchment loss scenarios are:
  - No catchment loss
  - 25% loss from City catchment assuming the Hyper- Acute Stroke Unit is at Sandwell Hospital
  - 50% loss from City catchment assuming the Hyper- Acute Stroke Unit is at Sandwell Hospital
  - 25% loss from Sandwell catchment assuming the Hyper- Acute Stroke Unit is at City Hospital
  - 50% loss from Sandwell catchment assuming the Hyper- Acute Stroke Unit is at City Hospital.
- These catchment loss values are estimates based on the modelling work for the New Acute Hospital which suggested a 22% catchment loss for emergency admissions and experience from Maternity reconfiguration has shown a circa 33% loss from Sandwell Hospital catchment post reconfiguration.

Table 6 below shows the inpatient Stroke and TIA activity for 2010/11 and the forecast activity for 2011/12. It then uses 6 months from 2010/11 and 6 months from 2011/12 as a baseline figure from which to calculate a range of potential catchment loss. This suggests that the catchment and income loss is greater if the Hyper-Acute Stroke Unit is located at Sandwell Hospital.

Table 6: Catchment Loss Modelling

Activity Type	**10-11 Outturn**	**11-12 Forecast Outturn**	No catchment loss	25% catchment loss if Acute Stroke Services based at Sandwell Hospital	50 % catchment loss if Acute Stroke Services based at Sandwell Hospital	25% catchment loss if Acute Stroke Services based at City Hospital	50 % catchment loss if Acute Stroke Services based at City Hospital
Stroke – patients admitted	628	560	583	505	426	516	449
TIA – patients admitted	201	213	213	213	213	213	213
Income Change			0	(579)	(1,159)	(486)	(973)

NB: Assumptions for Income Change include:

The reduction in A&E att income has been based on data from WMAS

The reduction in NEL income has been calculated using 80% achievement of the Best Practice Tariff

The reduction in excess bed day income has been calculated using an average trimpoint of 51 days

This catchment loss modelling and underlying assumptions will need to be further tested and modified prior to identifying a preferred option and using the ambulance flow modelling work when this is available. For example, the 'income change' indicated is a gross change and has not been adjusted for cost changes or mitigating transitional funding arrangements.

8.2 Capacity

In terms of implications for capacity the following assumptions have been used in order to identify the 'worst case scenario' in terms of potential capacity required: These include:

- No catchment loss and so continuing with current activity levels.
- Continue with current length of stay i.e. an average of 29 days for patients who have had a stroke.
- In addition diagnostic capacity was considered and specifically the need for the Hyper-Acute stroke service to be located on a site with 2 CT scanners in order to ensure continuity of service if a CT scanner is unavailable. This is considered essential as a CT scan is one of the key diagnostic tools that has to be provided at a very early stage in the patient pathway in order to identify if thrombolysis is appropriate and allow this to be delivered within the required timescale to maximise the patient outcome.

A high level design brief based on the short listed options and the above capacity requirements was provided by clinical and operational leads for consideration of potential capital refurbishment requirements and an initial scoping study.

The capacity required in summary is:

- The site with the Hyper-Acute Stroke Unit requires 2 CT scanners.
- The functional content of all options includes 33 acute beds on one site (which is comprises 17 acute short stay beds; 7 acute neuro beds; 8 monitored beds and 1 Transient Ischaemic Attack (TIA) assessment bed/trolley) and 50 Rehabilitation beds. This is considered 'a worst case scenario' in terms of beds numbers and would need to be refined for the next stage of work including a clearer view on targeted lower length of stay and probable catchment loss.

The Capital Projects Team used the high level design brief to identify the potential capital investment required under each option. The initial outcome of this high level work suggests:

- a capital investment of up to £2.5 million may be required for the options with acute services consolidated at City Hospital. This is based on identifying the space required for the number of beds identified and assumes some form of refurbishment to this space is needed e.g. to meet enhanced bed head requirements for the monitored beds and also to improve the ward environment e.g. additional en suite bathrooms. City Hospital currently has 2 CT scanners and so an additional scanner would not be required.
- a capital investment of up to £5 million may be required for the options with acute services consolidated at Sandwell Hospital. This is based on identifying the space required for the number of beds identified and assumes some form of refurbishment to this space is needed e.g. to meet enhanced bed head requirements for the monitored beds and also to improve the ward environment e.g. additional en suite bathrooms. In addition Sandwell Hospital currently only has 1 CT scanner and so an additional scanner would be required.

These costs are high level estimates made by applying actual refurbishment costs by m2 from a recent refurbishment of similar areas. The capital investments proposed to support the reconfiguration need to be considered in conjunction with the Trust's strategy to centralise acute inpatient services at the Midland Metropolitan Hospital (MMH). Therefore, the estimated capital costs allow for appropriate refurbishment of areas of current estate to support service delivery for the time between now and planned move to the MMH. Issues such as BREEAM and backlog maintenance are being addressed through the agreed strategy.

This analysis suggests there is a greater capital cost for the options with the acute stroke services based at Sandwell Hospital in the order of an additional £2.5 m. This is due to the need for an additional CT scanner at Sandwell Hospital. It should be noted that one of the CT scanners based at City Hospital is due to be replaced in the next 12-18 months and the view has been expressed that this could be located at Sandwell rather than City Hospital. The cost of replacing the CT scanner at City would be in the order of £2.2m (based on the outturn cost for the last replacement) and so if this is taken into account the difference between Sandwell and City options reduces to £0.3m.

The initial study also suggests that it is not possible to meet the identified bed numbers for the options with acute stroke services based at Sandwell Hospital -for option 3b and 6b there would be a short fall of 1 rehabilitation and 9 acute beds. However, the bed numbers as previously explained assume the current length of stay which would reduce under a new service model to an average of circa 21 days and therefore 13 less beds would be required. Emerging evidence from similar reconfigurations would support this reduction in length of stay and in some cases even greater reductions are being seen.

The next stage of more detailed work would be an assessment of the reduction in length of stay, including how this will be achieved and linking to the Trust's Transformation Programme, which will then generate a more robust estimate of required bed numbers. In addition more detailed surveys of the current condition of estate being considered as part of the reconfiguration need to take place in order to identify the actual refurbishment required to meet the design brief. It is likely that together these will reduce the refurbishment costs. Also the timescale for any refurbishment work will be reviewed as part of the next stage of planning and consideration will be given to phasing of the work to ensure it first with the Trust's overall capital programme.

It should be noted that if a capital investment of £3million or more is required it will be necessary to submit a case to the SHA for approval of this investment.

In summary the work to date suggests all options require a capital investment although the level identified is likely to be reduced as a result of work to reduce length of stay and therefore bed numbers and the more detailed surveys into the actual condition of the current estate. Also the variation between the options is due to the need for a 2nd CT scanner at Sandwell Hospital. Given this could be installed on the basis of one due to be replaced at City Hospital (this would leave 1 CT scanner at City and 2 at Sandwell) the difference between the options can be argued to be £300 000 which is due to additional refurbishment work that would be required to convert an existing area within the Imaging Department at Sandwell to accommodate the 2nd CT scanner. Therefore given the high level nature of the work to date and the potential difference between options of only £300 000k it is questionable whether there is sufficient evidence to exclude any of the short listed options at this stage on the grounds of the capital investment required.

8.3 Revenue Costs

The initial high level analysis of the medical staffing implications associated with the proposed reconfiguration suggests there will be no additional medical staff revenue costs associated

with any of the short listed options however the work to describe medical staff rotas in detail is ongoing and further analysis is required in relation to the potential impact on the General Medical/Acute Medicine rotas.

In terms of nurse staffing levels it has not yet been possible to identify nationally recommended ratios for stroke service and based on some internal benchmarks associated with recent changes to Newton 1 and Newton 4 there may be a need for an additional £280k or 6.63 wte (based on 83 beds - 33 acute and 50 rehabilitation) The required bed numbers will reduce either as a result of catchment loss or through reduced length of stay (see previous section) and if less beds are required these nursing staff costs will reduce. This can be seen in the catchment loss modelling where at a high level it is estimated that 6 less beds will be required with a 25% catchment loss and 12 less beds with a 50% catchment loss. These are summarised in table 7.

Table 7: Impact on Staffing

	Existing Bed Numbers	Reduction of 6 beds	Reduction of 12 beds
	WTEs	**WTEs**	**WTEs**
Medical staffing	0	0	0
Nursing	6.63	-1.82	-10.28
Total	**6.63**	**-1.82**	**-10.28**
Additional Cost/Saving	(280)	(17)	246

To date no detailed work has been undertaken in relation to revenue costs for Imaging. Given recent investment it is assumed there is no additional Imaging revenue costs associated with any of the short listed options. However the exception to this might be those revenue costs associated with a second CT scanner at Sandwell if the Hyper-Acute Stroke Unit is located at Sandwell Hospital especially if this is in addition to the two at City Hospital rather than a replacement.

It should be noted that to date no detailed work has been undertaken for other staff groups e.g. therapists.

8.4 Income and Expenditure Impact

Table 8 below summarises the results of the high level activity and financial analysis so far in terms of the potential impact on income and expenditure. In summary given the higher number of admissions at City if a % catchment loss is applied there is potentially a greater loss of activity if the Hyper-Acute Stroke Unit is based at Sandwell Hospital, the difference in income being a £93k greater loss if there is a 25% catchment loss and £186k if a 50% catchment loss. However given most stroke patients are likely to present to hospital via an ambulance the catchment loss assumptions need to be informed by the results of the ambulance flow modelling currently underway.

When the impact on nurse staffing levels is considered the net financial impact is that all options result in a cost/loss of income to the Trust with the differential between scenarios remaining the same i.e. impact is greater if the Hyper-Acute Stroke Unit is based at Sandwell. These changes require a funding solution and this is being addressed as part of internal financial planning and the negotiations with commissioners regarding the implementation of BPT (best practice tariffs) and other mechanisms necessary to secure affordability.

It could be argued given the potential for more accurate catchment loss modelling, the need for further detailed work on the impact on staffing levels and the size of the differential between scenarios that the analysis of potential impact on income and expenditure at this stage does not give grounds for excluding any of the short listed options from consultation.

Table 8: Summary of Impact on Income and Expenditure

	No catchment loss	25% catchment loss if Acute Stroke Services based at Sandwell Hospital	50 % catchment loss if Acute Stroke Services based at Sandwell Hospital	25% catchment loss if Acute Stroke Services based at City Hospital	50 % catchment loss if Acute Stroke Services based at City Hospital
Income/Expenditure Item	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Income:					
Patient Related SLAs	0	(579)	(1,159)	(486)	(973)
Total Income	**0**	**(579)**	**(1,159)**	**(486)**	**(973)**
Expenditure					
Pay – Nursing	(280)	(17)		(17)	
Pay - Medical staffing					
Total Expenditure	**(280)**	**(17)**	**0**	**(17)**	**0**
Costs Saved:					
Pay - Nursing			246		246
Pay - Medical Staffing					
Total Costs Saved	**0**	**0**	**246**	**0**	**246**
Net Income/(Cost) of Proposal	**(280)**	**(596)**	**(913)**	**(503)**	**(727)**

Assumptions:

The reduction in A&E att income has been based on data from WMAS

The reduction in NEL income has been calculated using 80% achievement of the Best Practice Tariff

The reduction in excess bed day income has been calculated using an average trimpoint of 51 days

9. RISK ASSESSMENT AND MANAGEMENT

The following risks have been identified and mitigated in the project risk log.

9.1 Strategic Risks

The reforms of the NHS and the change in organisations does present a significant challenge particularly in terms of approval process through PCTs and SHA.

Other strategic risks relate to Birmingham PCT Cluster starting to undertake a reconfiguration review of stroke services across UHBfT, HEFT and SWBHT half way through the SWBH reconfiguration process being underway. If the Birmingham review seeks a conflicting solution for SWBH to the internal SWBH reconfiguration project this could limit implementation. However, close working is anticipated with the Birmingham review and early indications are that translating the model to Birmingham and the Black Country would lead to 3 hyper-acute units, one of which could be at SWBH. Both Birmingham and Black Country commissioning directors have agreed for the project to proceed despite these other review processes taking place.

9.2 GP Engagement

As reforms to the NHS develop GPs are involved in large scale upheaval and changes in roles. As such their focus is rightly on these emerging roles and organisations. It has proved challenging to sufficiently engage GPs in this stroke reconfiguration project at present, beyond presenting the project to them in their CCG meetings. GP engagement has improved significantly over the last 2 months of the project and with the newly formed Sandwell and West Birmingham CCG this is anticipated to become more straight forward.

9.3 Personnel/Staffing Risks

The reforms have a potentially destabilising effect on the project team (particularly from the PCT side). There are significant risks for the formal consultation process if the PPI lead is no longer in post, given her experience and reduced PPI personnel locally. However, as a priority of the local health economy, it is anticipated to be supported through the reforms by senior managers.

9.4 Finance/Activity Risks

With the location of the hyper-acute stroke unit on one site, this will geographically disadvantage a section of SWBH's catchment population leading to increased ambulance journey times. This could have a detrimental effect on the number of stroke and TIA patients attending SWBH with corresponding impact on PbR income, with potential operational and capacity issues at other local acute NHS provider trusts. However the mitigating planning being undertaken with WMAS should offset this risk significantly.

9.5 Unexpected Risks

As stroke and TIA services are so complex and the web of inter-dependencies so intricate it is possible for the project to deliver a new model of service provision which leads to unintended consequences elsewhere in the system. Strong clinical engagement throughout the project should ensure that all reasonable eventualities have been addressed within the project. The strategic commissioning role within the project team also ensures that this reconfiguration project is embedded in the whole pathway work for stroke and TIA.

10. EVIDENCE OF NATIONAL RECONFIGURATION TESTS

10.1 The Four National Tests of Reconfiguration

In December 2010, Ian Cumming (Chief Executive, WMSHA) wrote to PCT Cluster Chief Executives outlining the four national tests of reconfiguration that must be demonstrated in any significant service change (such as stroke reconfiguration). The four tests are -

- there has been real engagement of **patients and public**,
- **GPs** particularly in their commissioning role, have been actively involved in shaping the options, they support the overall approach and increasingly "own the process".
- there has been full use of the **evidence base** for service change by clinical leaders across the continuum of care and

- commissioners have properly considered how the proposals affect **choice** of provider, setting and intervention, making a strong case for the quality of the proposed service and improvements in patient experience.

The evidence for demonstrating how this project meets these four tests to date is summarised below.

10.2 Patients and Public Engagement

A consultation plan has been developed by the Patient and Public Involvement (PPI) team at Sandwell PCT which describes the various approaches to engage patients and the public at different stages of the project. A key outcome of the plan is "*An informed and aware patient and public body that understand the reasons for change and the solutions proposed*".

To date, during the pre-consultation phase, the project has included the following engagement:

- A presentation to patients and carers in the Birmingham, Sandwell and Solihull Cardiac and Stroke Network Shadow Board (this Shadow Board was established by the network to engage with patients and carers on key developments in stroke and cardiac care) on 29th September 2011 to inform them of this proposed reconfiguration work and seek their engagement.
- An event was held on 28th November 2011 to facilitate 12 local patients and carers to score the long list of options and seek their detailed views on the long list of options identified through the project steering group. Their scores make up a significant proportion of the final scoring in reaching a short list of options.
- Engagement with the Joint Health Scrutiny Committee of Sandwell and Birmingham Councils. As described in previous sections presentations have been made to this committee on 5th July 2011, 22nd September 2011 and 17th January 2012. Feedback from these discussions has been used to refine the evaluation criteria, consultation document and consultation plan in addition to seeking the committee's agreement that formal public consultation is required and the dates that this can take place.

10.3 GP Engagement

This is a time of great change for the NHS and particularly for GPs who are establishing Clinical Commissioning Groups (CCGs) to take on responsibility for the commissioning of local health services. As a result local CCGs have been changing their configuration across Sandwell and West Birmingham and the engagement for this stroke reconfiguration project in terms of GP representation on the project management structure has proved difficult. In recognition of this the project team has attempted to engage GPs meaningfully through:

- Presentation to all 3 Sandwell CCGs regarding stroke reconfiguration
- Engagement with the chair of the new, large Sandwell and West Birmingham CCG and co-chair of Birmingham stroke services reconfiguration process
- Engagement with GP representatives as part of the short listing process (see above).

Another round of presentations are also planned to each CCG, informing them of the proposed short list of options. This approach will continue to happen at every key milestone of the project.

In addition the consultation plan includes key engagement with GPs in the formal consultation process. This will take various forms but will build on the engagement work already achieved.

10.4 Evidence Base of Service Changes

The Clinical Case for Change provides a clear and extensive description of both the challenges of the current service model and opportunities for improvement from the proposed

service reconfiguration. This Clinical Case for Change draws evidence from a range of evidence based sources including the stroke strategy, NICE guidelines, WM Quality Review Service, Right Care Right Here Strategic Model of Care, Birmingham, Sandwell and Solihull Cardiac and Stroke Network Service Specifications, National Intercollegiate Stroke Working Party Clinical Guidelines and the West Midlands Acute Stroke Steering Group. This has been enhanced by the use of local evidence including performance data from our Stroke Dashboard. This evidence has also been used by the project to identify the future model of acute stroke and TIA services.

The Project Steering Group has multi-disciplinary and multi-speciality representation including from medicine, nursing, therapy services, imaging, dietetics and community rehabilitation. There has also been significant engagement with the West Midlands Ambulance Service who have been represented at the Project Steering Group and are providing ambulance data to the project.

In addition and as described previously a number of Listening into Action style events have been held to engage a wider group of clinical staff in identifying, clinical drivers for change, the long list of options, evaluation criteria and short listing the options.

11. CONSULTATION

All of the short listed options for acute stroke and TIA reconfiguration involve consolidating acute services on one hospital site. The Joint Health Scrutiny Committee have advised that this is a significant service change and as such a formal public consultation is required. This needs to take place over a 12 week period and in line with the project timetable it is proposed that public consultation starts on 9th February 2012 and finishes on 25th April 2012.

The Communication and Engagement Sub Group within the project management structure have developed a consultation framework. This includes identifying and planning to utilise a number of different methodologies involving a wide cohort of people across the local economy in order to gain views from a range of diverse ethnic and cultural groups including those identified in the EqIA screening. This has been shared with the Joint Health Scrutiny Committee.

Sandwell PCT have commissioned an external consultancy to develop the consultation document, support implementation of the consultation framework, receive and analyse the responses to the consultation. A draft consultation document has been developed in liaison with the project Steering Group and has included comments from the Joint Health Scrutiny Committee. The final draft of the consultation document can be found in Appendix 3 .

In addition ongoing engagement work with the public and users (in line with the Health Act 2006, Section 242) and front line clinical staff will be essential for the development of more detailed plans throughout the life of the project.

12. DECISION MAKING PROCESS

The purpose of this section is to set out and clarify the decision making process associated with different phases of the project.

12.1 Consultation

The final decision to undertake a formal public consultation of the short listed options will be taken by the Black Country PCT Cluster Board at its meeting on 31st January 2012. This will be based upon the case for change presented in this report.

In making this decision the Black Country PCT Cluster Board will seek agreement to the consultation from Sandwell and West Birmingham NHS Trust Board through the case for change being presented at its meeting on 26th January 2012.

Agreement to proceed to formal public consultation will be sought from the SHA.

12.2 Preferred Option

The Project Board plans to seek final approval of a preferred option to be undertaken by the Black Country PCT Cluster Board at its meeting in June 2012. In making this decision the Black Country PCT Cluster Board will require agreement from Sandwell and West Birmingham Hospitals NHS Trust Board through its meeting in June 2012 and also from SWBCCG Board and the Birmingham and Solihull PCT Cluster Board.

In approving a preferred option the Boards will consider the outcome of the consultation and a detailed business case which will be presented in June 2012 and will include a full analysis of activity, capacity, finance, staffing, risks, feasibility, timescale for implementation and stage 1 equality impact assessment. This business case will be developed by the Project Steering Group. In addition consideration will be given to progress with any wider review of stroke service within the PCT Clusters and wider SHA.

Agreement to the preferred option will then be sought from the SHA.

12.3 Implementation

Once a preferred option has been approved a detailed implementation plan will be developed and will include user and staff engagement. Given all the short listed options include a single site for acute services work can start on developing the implementation plan during the consultation period. A further Gateway Review will be required once a preferred option has been agreed along with an implementation plan but ahead of starting the implementation phase.

The aim will be to present the implementation plan and seek approval to implement from the Board meetings of Sandwell and West Birmingham Hospitals Trust, SWBCCG Board, Black Country PCT Cluster and the Birmingham and Solihull PCT Cluster in July or August 2012.

13. CONCLUSION

The clinical case for change makes a strong argument for the need to reconfigure stroke and TIA services in order to deliver improved patient outcomes in terms of reduced mortality and improved return to independent living as well as to improve the quality of care for patients and carers. This clinical case for change was reviewed and supported by the NCAT visit.

A robust project management methodology and structure has been followed to develop options and narrow these down to a meaningful short list. This has included a range of high level analysis and significant engagement with users and frontline staff as well as engagement with GP commissioners. This along with the clinical case for change meets the Department of Health four tests for service reconfiguration.

The project management methodology has been reviewed by a Gateway visit which concluded by making a number of recommendations but giving assurance that with these the project is in a sufficiently robust state for their to be confidence in it moving into the consultation process.

14. RECOMMENDATIONS

The Board is recommended to:

- AGREE the clinical case for change of our acute stroke and TIA services and in particular the need to consolidate acute services in order to deliver improved patient outcomes and experience.
- NOTE the engagement to date including the process for short listing options.
- NOTE the proposed short listed options and AGREE that the activity, capacity and financial analysis to date does not exclude any of the short listed options at this stage.
- AGREE that a formal public consultation of the short listed options is undertaken.
- AGREE the consultation document (Appendix 3).
- AGREE the decision making process to identify an approved preferred option.

Appendix 1

ACUTE STROKE AND TIA RECONFIGURATION PROJECT BENEFITS

Benefit to be Realised	Operational Definition	Target performance	Performance measurement
Stroke associated mortality rates at SWBH will be reduced	Mortality rates for those affected by stroke and treated at SWBH will be reduced from current levels	Mortality rates will reflect good practice and deliver on a par with national best practice standardised rates	Using Dr Foster Intelligence to monitor stroke related mortality rates
Levels of long term disability related to stroke will be reduced, increasing independence and levels of functioning in the stroke population	Measuring rates of Activities of Daily Living (ADLs) on discharge and follow up	Levels of disability to reflect national good practice and benchmarked against standardised national rates	Using approved tool such as Bartel Index
The Trust will provide Stroke services which comply with WMQRS	All stroke patients will be admitted directly to a stroke bed, with imaging on route to the ward, within 4hrs of arrival at hospital	Consistently deliver expected quality standards in relation to stroke services for multidisciplinary care as defined by WMQRS. 24/7 Stroke service including thrombolysis. Optimal use of beds with reduced length of stay	Clear patient pathways with consistent and timely stroke assessment and admission criteria. Number of stroke patients who are admitted to hospital but not to a specilist stroke bed within 4hrs.
The Trust will deliver consistent high quality care specific to Stroke	All stroke patients will be assessed daily by a specialist consultant clinician for stroke	All stroke patients will receive up to 0-72hrs of continuous monitoring in hyperacute environment according to clinical need.	Consistent delivery of acute care bundles for stroke which are monitored through implementation of a Daily ward round

The Trust will deliver services for TIA according to national and WMQRS standards	There will be better definition of high and low risk pathways. High risk patients will be seen as out-patients within 24hrs of onset symptoms. All low risk patients will be seen within 7 days of onset of symptoms. Specialist neurovascular clinic for rapid assessment of TIA for all phigh risk patients and surgery within 2/52 weeks of onset of symptoms for those at risk.	60% of high risk patients will be seen as out-patients and undergo carotid imaging if their ABCD score is greater than or equal to 4 within 24hrs	The Trust will admit fewer TIA patients to hospital in-patient beds
The Trust will deliver consistent high quality stroke & TIA diagnostic services	50% of stroke patients to undergo CT within 1hr. 90% of other stroke patients will have CT within 24hrs.	There will be continuous improvement in care outcomes with reduction in morbidity and mortality. 90% of all stroke patients will undergo imaging within 24hrs	admission to imaging times
The Trust will have a recognised centre of excellence for Stroke	Acute Stroke Specialist Care delivered in one place achieving critical mass and concentration of clinical expertise, enabling high quality traning , teaching, and research.	All of stroke patients assessed by a stroke specialist in a hyperacute stroke unit	Recruitment and retention figures for staff. Service can be maintained and developed to a high standard maximising opportunity for research and development
Improved patient experience	In addition to high quality timely care all patients will have a positive experience with timely appropriate nursing and medical interventions. Efficient use of clinical expertise.	Continuous improvement in care outcomes with reduced mortality and morbidity. All stroke patients will spend 90% of their hospital stay on a stroke ward.	mortality and morbidity data

Appropriately trained and competent staff available at all times for both acute care and rehabilitation	Patients will always be admitted under the specialist stroke team for acute care and rehabilitation, who has demonstrated achievement of WMQRS core standards.	High performing stroke team capable of delivering consistent quality care to expected standards with staff competencies achieved and signed off.	Trust will attract and retain high calibre staff, who attain all required competences. Patients will be consistently referred to the unit and where applicable will be enrolled in clinical trials. The trust will deliver medical and nursing training for stroke and TIA interventions.
All stroke patients in the area (Sandwell and West Birmingham) will have access to the same level of care	Equitable and sustainable patient pathways	Innovative early supportive discharge teams will be in place for all patients residing in both sandwell and HoB continuity care providers	Referral rates and geographical uptake of service by patients. EQIA assessment.
Specialist support services will be available in the community as part of the integrated service and early supportive discharge arrangements	Early supportive discharge teams in place for all patients residing in both Sandwell and HoB	Innovative early supportive discharge for all patients provided by both Sandwell and HOB PCT continuing care providers.	Reduced length of stay. Number of patients seen
Safe care reduction in long term complications	All patients will receive timely assessment and treatment for symptoms of stroke and/or TIA	reduction in incidents and long term complications mortality and morbidity	falls incidents data.Clinical case studies deviations from pathway
Value for Money	Introduce cost effective practices that attract best practice tariff and consistently achieve the expected quality care indicators.	financial savings	services will be both efficient and effective

Appendix 2

LONG LIST OF OPTIONS

The long list of 6 service model options is described below. It should be noted that these are service models and as such are not specific about hospital site.

Option 1a

Continue with the current service model 'Do Nothing'- not considered viable due to inability to meet WMQRS standards to provide 24/7 service, and then clinical risks associated with this. The risks and issues of this option are fully articulated in the project's Clinical Case for Change report and summarised in the section 2.3 above.

Option 1b

Retain the current configuration but introduce new ways of working for medical teams in order to provide acceptable level of cover at all times- not considered viable within a suitable timeframe, or sustainable due to medical staffing numbers, their clinical commitments and the ability to retain and recruit high calibre staff. This model would not achieve critical mass and would require extra support from nurses, who would require specialist training, which can only be achieved through a full training programme and clinical mentorship. This would take considerable time to implement and therefore there would be a delay in the ability to provide full 24/7 services. The issues raised are explained in the Clinical Case for Change report for Stroke and TIA services (SWBHT March 2011).

Option 2

Configure a two site model with all emergency hyper-acute care delivered from one site including the ability to review high risk TIA 24/7. There would also be short stay stroke beds at this site as part of continuing care within the stroke unit.
Long stay rehabilitation would be delivered at the second site along with OPD clinics including all follow up and also specific dedicated clinic slots for low risk TIA.

The centralisation of Hyper-acute stroke services will enable patients to have rapid access to the right skills and equipment and be treated 24/7 on a dedicated stroke unit, staffed by specialist teams. Hyper-acute units have a number of dedicated assessment beds available with full cardiac monitoring facilities and appropriate staffing for level 2 monitoring and also a number of dedicated stroke in-patient beds for short stay. **(All alternative Options, that is, options 2-6 include the development of a Hyper-acute Unit on one site only as this was a non-negotiable within the project).**

Option 3

This is a single site model with all facilities and services located at one site. All hyper-acute, rehab, imaging and OP services would be provided on the one site, with nothing provided on the other site. It provides a 24/7 service and incorporates neurology beds within the hyper-acute area. Short and long stay rehabilitation would be provided in a dedicated stroke rehab ward located at the same site near to the hyper-acute unit.
There would be a telemedicine link from the ED department to the Hyper-acute facility. In addition there would be early supportive discharge assessment and intervention available on site from the earliest opportunity.
All TIA patients would be managed on an outpatient basis. TIA services would be enhanced via inclusion of a telemedicine approach from the Hyper-acute Unit to ED.

Option 4

Provide a two site model with Hyper-acute services and early supportive discharge at one site and OPD at both sites. Provide long stay rehabilitation at both sites and identify dedicated stroke step down beds in both Sandwell and West Birmingham community locations potentially as part of an ESD service. All high risk TIA patients would be seen and treated at the first site with hyper acute unit or between Mon and Fri 9-5 at second site. All Low risk TIA patients would be seen and treated at the second site.
For some patients cross site travel may occur more than once.

Option 5

Provide a two site model with hyper-acute services, which takes direct admissions and has direct GP rapid access at one site only. Develop a centralised booking system for all TIA to include next available appointment and 'one stop' clinic at the same site as the hyper-acute unit. Provide rehabilitation at both sites run by therapists only and provide all follow up OPD at the second site. In addition Nurse Outreach teams based within the hyper-acute unit would visit assess patients transferred to rehab wards to undertake on-going nursing assessment and advice/support.

Option 6

Provide a two site model with one hyper-acute unit located at one site. Initially patient would access the unit from ED but the plan would be for the unit to take direct admissions within 12-24 months (allowing a two stage approach for the implementation of this model). Neurology would remain a separate service incorporated within the general medical bed configuration at City Hospital. Rehabilitation units which provide both short and long stay to include dedicated stroke palliative care as part of continuing care would be provided on both sites as would early supportive discharge services. TIA 9-5 service would be provided 7 days per week at the site with the hyper acute unit. This service would see both high and low risks patients depending on daily capacity. In addition there would be dedicated low risks TIA slots within general OPD to ensure capacity at all times to enable the appropriate timeframes within the care pathway to be met. There would be telemedicine links between the hyper-acute unit, ED and OPD.

Appendix 3

Draft Consultation Document

Separate document to follow

Appendix 4
References

- Department of Health (2007) *National Stroke Strategy*
- Department of Health (2008*) Implementing the National Stroke Strategy- Imaging Guide*
- Department of Health (29/07/2010) *Letter on Service Reconfiguration* (Gateway reference number: 14543)
- Intercollegiate Stroke Working Party (July 2008) *National Clinical Guideline for Stroke* 3rd edition
- NICE (2008) *'Diagnosis and initial management of acute stroke and transient ischaemic attack'* (NICE guideline)
- NICE (2009) *Quality Standard for Stroke- draft*
- Royal College of Physicians (2008) *'National Clinical Guideline for Stroke'* (3rd Edition)
- NHS West Midlands (2009) *West Midlands Service Specification for the Management of Stroke Thrombolysis and Acute Care (Hyper-Acute)*
- NHS West Midlands (2010) *West Midlands Specification of Services for Patients with Transient Ischaemic Attack and Non-Disabling / Minor Stroke*
- West Midlands Acute Stroke Steering Group accelerated standards
- West Midlands Quality Review Service (April 2010) *Quality Standards for Services for People with Stroke (Acute Phase) and Transient Ischaemic Attack, Version 1*
- West Midlands Quality Review Service (January 2011) *Review of Urgent Care, Critical Care, Stroke (Acute Phase) & TIA and Vascular Services for the Heart of Birmingham and Sandwell Health Economies*

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Innovation, Health and Wealth Report
SPONSORING DIRECTOR:	Mike Sharon, Director of Strategy & Organisational Development
AUTHOR:	Mike Sharon, Director of Strategy & Organisational Development
DATE OF MEETING:	26 January 2012

SUMMARY OF KEY POINTS:

This paper provides the Board with a review of the implications of the recently published Innovation, Health and Wealth report by the Department of Health.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
	X	**X**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The FT Programme Board is asked to **receive**, **note** and **discuss** the report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

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

PREVIOUS CONSIDERATION:

None

Trust Board Public Session January 2012

Implications of the Innovation, Health and Wealth Report

1.0 Introduction

Published by the Department of Health in December 2011, the Innovation, Health and Wealth Report outlines the NHS Chief Executive's review of how adoption and diffusion of innovation could be accelerated across the NHS. This review forms part of the wider UK strategy for Health Innovation and Life Sciences led by the Prime Minister's delivery unit.

As part of the proposed approach, the report outlines a number of key actions that are planned to come into effect that will be expected to be delivered by NHS Trusts and Commissioning Bodies, performance against which will be monitored by the NHS Commissioning Board.

This report outlines a summary of those actions required for consideration by the Board.

2.0 Summary of Key Actions

2.1 Reducing Variation and Strengthening Compliance

The report proposes that further work needs to take place in order to ensure adherence to the recommendations proposed by NICE both in its current and future role. This will include:

A. Introduction of a NICE compliance regime to reduce variation and drive up compliance with NICE technology appraisals. This will effectively mean that there should be no local barriers to accessing technologies recommended in NICE appraisals, beyond a clinical decision relating to an individual patient.
B. It will be required that all NICE technology appraisal recommendations are automatically incorporated into relevant local NHS formularies.

2.2 Metrics and Information

The report outlines a need to identify and measure individual organisational performance in adopting innovation. To support this, key actions include:

A. The NHS Commissioning Board will develop and publish a straightforward innovation scorecard designed to track adoption of NICE technology appraisals, which will be required by all Trusts at a local level.

2.3 Creating a System for Delivery of Innovation

It is proposed that in order to deliver some of the recommendations outlined in this report that key actions will include:

A. Establishment of a number of Academic Health Science Networks (AHSNs) across the country, the first going live during 2012/13. Working with stakeholders from across the NHS and scientific community, academia, the third sector and local authorities, the AHSNs will link up the system and drive up diffusion of innovation.
B. The report proposes that every local NHS organization should aspire to be affiliated to its local AHSN, which would act as a high quality, high value gateway for any NHS organization needing support with innovation and provide industry focused points of access to the NHS.

2.4 Incentives and Investment

The report indicates that financial, operational and performance incentives will be aligned to support the adoption and diffusion innovation, each of which will have direct impact upon the Trust. Namely, this will include the following:

A. Developing and introducing a shared savings formula to break down silo budgeting and encourage cross boundary working.
B. Developing a tariff for assistive technologies that would incentivise their spread.
C. Continue work on payment for outcomes in order to incentive cost effective means of delivering care directly through the tariff.
D. The DH will commission the NHS improvement body to work with organisations locally to help make best use of existing local tariff flexibilities, including best practice tariffs.
E. Explore options for an unbundled tariff for diagnostics and other scientific services.
F. The ‘never events’ regime will be extended to drive out clinically unsafe and outdated practice.
G. NICE will produce clearer guidance on activity and tariff which should be de-commissioned as a result of improved practice, and the NHS Commissioning Board will encourage disinvestment in activities that no longer add value.
H. A Specialised Services Commissioning innovation fund will be established

2.5 Procurement

In order to support the recommendations of the Innovation, Health and Wealth report it is proposed that:

A. A procurement strategy will be published in March 2012 by the DH.
B. This is likely to enable ‘open dialogue’ with suppliers in product surgeries outside of a procurement tendering process

C. It will also look to include opportunities to consult the market before tendering to encourage the market to propose creative solutions before specifications are finalised

2.6 Leadership for Innovation and Developing our People

A. The NHS Operating Framework 2012/13 asks the NHS to prioritise the adoption and spread of innovation. It sets out that commissioners and providers should have due regard to this report when developing local CQUIN schemes
B. CCGs will be under a duty to seek out and adopt best practice and promote innovation
C. The NHS Commissioning board will ensure innovation is 'hard-wired' into educational curricula, training and competency frameworks at every level
D. A joint industry and NHS training and education programme will developed for senior managers
E. A NHS innovation fellowship scheme will be established.

3.0 Implementation and High Impact Innovations

As part of the implementation of the reforms outlined in the DH report, it is proposed that a number of 'High Impact Innovations' are established in order to ensure commitment and adherence to the proposals are embedded by local NHS organisations. These will include:

A. The intention to rapidly accelerate the use of assistive technologies in the NHS, aiming to improve at least 3 million lives over the next five years
B. A national drive will be launched to achieve full implementation of Osophageal Doppler Monitoring (ODM) or similar fluid management monitoring technology into practice across the NHS
C. The 'child in a chair in a day' programme will launched to transform the delivery of wheelchair services throughout the NHS
D. NHS organisations will be required to explore opportunities to increase national and international healthcare activity and a summit will be hosted with UK trade and investment in 2012
E. NHS organisations will required to work towards reducing inappropriate face-to-face contacts and to switch to higher quality, more convenient, lower cost alternatives
F. Services commissioned and delivered for supporting people with dementia will need to be in line with NICE guidance
G. From April 2013, compliance with the high impact innovations will become a pre-qualification requirement for CQUIN

4.0 Timeline

LAUNCH-3 MONTHS

NICE to take responsibility for the iTAPP programme

International healthcare summit with UK Trade and Investment

NHS Operating Framework published

Whole Systems Demonstrator and Three Million Lives launched

First meeting of Showcase Hospital group

Uptake programme for use of ODM or similar fluid management monitoring technology launched

Sunset Review commissioned

Round two of the Innovation Challenge Prizes announced

Innovation Pipeline Project launched

Department of Health Procurement Strategy launched

NICE Compliance introduced

Advice on decommissioning in NICE Guidance strengthened

Details of AHSN designation process published

3-9 MONTHS

Specialised Services Commissioning Innovation Fund launched

Child in a Chair in a Day programme launched

NICE Implementation Collaborative established

Guidance on best use of existing local tariff flexibilities published by NHS Institute

Intellectual Property guidance published

NHS Innovation Fellowship Scheme launched

Joint NHS /Industry training and education programme established

Which consumer campaigns launched

Innovation Scorecard published

Web Portal for NHS Innovations launched

Extension of Never Events

Guidance on Digital by Default published

Academic Health Science Networks operational

9 MONTHS AND OVER

New managerial and clinical curricula launched

CQUIN prequalification introduced

Competency frameworks published

Guidance on tariff for diagnostics published

Guidance for job descriptions and performance appraisals published

Tariff for Assistive Technologies introduced

Shared Savings formula guidance published

5.0 Next Steps

The Innovation, Health and Wealth report outlines a number of key recommendations and actions that will need to be put in place by Trusts over the coming months. As noted, from April 2013, compliance with the high impact innovations will become a pre-qualification requirement for CQUIN and therefore readiness ahead of this deadline is imperative.

Key deliverables include the following:

- Ensuring adherence to the newly created NICE compliance regime
- Ensure NICE technology appraisal recommendations are automatically incorporated into local formularies
- Once published, contribute and monitor performance against the NHS Commissioning Board Innovation Scorecard
- Once the Academic Health Science Networks (AHSNs) have been launched to investigate the requirements and process for affiliation to the local AHSN
- To review and understand the implications of the extended 'never events' regime once published
- To monitor the changes to tariff proposed by the DH particularly in relation to payment for outcomes, diagnostic unbundling and assistive technologies
- To monitor the implications of NICE guidance which will look to recommend specific activity and tariff which should be de-commissioned as a result of improved practice
- To review the implications of the procurement strategy once published in March 2012
- To develop a process which looks to deliver the High Impact Innovations

6.0 Conclusion and recommendations

The Innovation health and Wealth report could have quite significant implications for this Trust.

An action plan will need to be developed once further details emerge to ensure that the Trust is able to respond appropriately to the challenges set out in the document.

The Board is asked to consider and discuss the report and to receive an update on progress in May 2012.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Right Care Right Here Progress Report
SPONSORING DIRECTOR:	Mike Sharon, Director of Organisational Development and Strategy
AUTHOR:	Jayne Dunn, Redesign Director – RCRH
DATE OF MEETING:	26th January, 2012

SUMMARY OF KEY POINTS:

The paper provides a progress report on the work of the *Right Care Right Here* Programme as at the end of December 2011.

It covers:

- Progress of the RCRH Programme including activity monitoring for the period April-October 2011.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is recommended to:

1. NOTE the progress made with the Right Care Right Here Programme.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Care Closer to Home: • Deliver the agreed changes in activity required as part of the Right Care Right Here programme. • Make fuller use of the facilities at Rowley Regis Community Hospital to provide care closer to home.
Annual priorities	
NHS LA standards	
CQC Essential Standards of Quality and Safety	

Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

Financial	**X**	The Right Care Right Here Programme sets out the future activity model for the local health economy including the transfer of activity into the community and to new PBC provider services.
Business and market share		
Clinical	**X**	The Right Care Right Here Programme sets the context for future clinical service models.
Workforce	**X**	The service redesign within the Right Care Right Here Programme will require development of the workforce to deliver redesigned services in a new way and in alternative locations. This will be overseen by the Workforce workstream within the Right Care Right Here programme.
Environmental		
Legal & Policy		
Equality and Diversity	**X**	The service redesign elements of the Right Care Right Here Programme will require equality impact assessments.
Patient Experience		
Communications & Media	**X**	Within the Right Care Right Here Programme there is a Communications and Engagement workstream.
Risks		

PREVIOUS CONSIDERATION:

Monthly progress reports to Trust Board

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

RIGHT CARE RIGHT HERE PROGRAMME: PROGRESS REPORT JANUARY 2012

INTRODUCTION

The Right Care Right Here Programme is the partnership of SWBH, HoB tPCT, Sandwell PCT and Birmingham and Sandwell local authorities leading the development of health services within Sandwell and Western Birmingham. This brief paper provides a progress report for the Trust Board on the work of the Programme as at the end of December 2012. It summarises the Right Care Right Here Programme Director's report and the RCRH Service Redesign Report that were presented to the Right Care Right Here Partnership Board in January.

The work of the Right Care Right Here Programme and involvement of the Trust in this is also discussed on a monthly basis at the Trust's Right Care Right Here Implementation Board meetings.

PROJECT PERFORMANCE

The RCRH Programme activity performance reports related to service redesign are included in Appendix 1 for information. They attempt to summarise overall progress with the Programme in key areas by providing data for the first seven months of 2011/12 and comparing it with actual performance in 2010/11, the trajectory in the RCRH Activity and Capacity (A&C) for 2011/12 and the targets in the A&C model for 2016/17.

In summary activity trends for April-October 2011 show:

- Inpatient Activity: Our Acute Occupied Bed Days (OBDs; in Summary A, figure 1) continue to show a downward trend and are 7.9% below 2010/11 levels but 14% above the 2011/12 trajectory. This includes our emergency inpatient OBDs being 7.2% lower than last year but 17% above the 2011/12 trajectory and our elective inpatient OBDs being 8.3% below last year and 5% below the 2011/12 trajectory (Summary A, figures 4 and 5).

- Community OBDs (in Summary B, figure 3) are 10% below 2010/11 levels and 17% below the 2011/12 trajectory.

- The intermediate care/re-ablement beds opened at Rowley Regis Hospital in October but the activity from these beds is not yet included in the monitoring report. It is envisaged that this activity will increase the Community OBDs and assist in reducing our Acute OBDs.

- Emergency Department Attendances: Our Emergency Department (ED) attendances (in Summary A, figure 2) are 0.1% above the 2010/11 end of year level, and 8% above the 2011/12 trajectory.

- The Urgent Care Centre attendances (in Summary B, figure 2) continue to show a downward trend but are still 14% above 2010/11 end of year level and 91% above the 2011/12 trajectory.

- Outpatient Attendances: Our acute Outpatient Activity (in Summary A, figure 3) is 4.1% below the 2010/11 end of year level and 0.5% above the 2011/12 trajectory.

- Community Outpatient Activity (including our community and new Community Provider activity, in Summary B, figure 1) remains below the 2010/11 end of year level by 4.5% but is still 222% above the 2011/12 trajectory although still some way (46%) from the 2016/17 trajectory.

- Referrals to acute services have shown a further reduction and are now 12% below the 2010/11 level (in Summary B, figure 4).

At this stage it therefore appears that across all three categories, our acute activity is showing a downward trend but with further work required to ensure maintenance of this trend, achievement of

2011/12 trajectories and ongoing progress towards the 2016/17 position. It is anticipated that the re-commissioning work (see below) will help to achieve this.

In terms of previous projects established through specific exemplars and individual re-design initiatives performance in terms of activity is now captured within the above summaries.

CARE PATHWAY AND SPECIALITY REVIEWS
The programme of Care Pathway Reviews is currently on hold, awaiting a wider review with the new GP Clinical Commissioning Groups (GP CCGs).

The RCRH Programme have undertaken further discussions with GP CCGs in order to develop an implementation mechanism to move reviewed pathways forward to full adoption from a commissioning perspective. In addition, meetings continue with GP CCG lead Managers in order to agree a process to activate and commission the service redesign requirements identified within the Care Pathway Reviews.

Many of the published care pathways will have the impact of reducing activity to our acute services but are likely to increase activity in our diagnostic and community services. The financial impact on our acute services, for this year, of the revised care pathways with associated loss of activity and income is captured within the re-commissioning work.

TRANSFER OF ACTIVITY (RE-COMMISSIONING)
There have been ongoing discussions across the local health economy regarding implementation of the LDP agreement to transfer a range of services, activity and related income from secondary care to community and primary care during 2011/12 in line with the RCRH Programme. The Trust and GP commissioners have identified a number of specific schemes which have now been agreed and for which implementation plans are now being developed. These schemes are collectively known as the Re-commissioning Programme.

The LDP agreement set a target of re-commissioning activity worth £16.2million and to date the Trust and PCTs have identified schemes that will result in the transfer of activity worth £13.8million over a full year. Work continues within the Trust and GP Clinical Commissioning Groups to identify the impact of a range of additional schemes although most of these will have an impact in 2012/13. For the period April – November 2011 there has been a transfer of activity worth £1.7 million which is a slight improvement since the last report but remains below the year to date target. A number of the schemes commenced in the Autumn and so a further improvement in performance is expected over the next few months.

The RCRH Programme recognises the need to develop a coherent programme of communications about this programme with clinical staff within the individual organisations and engagement with patients and the public in relation to many of these planned changes.

ENGAGEMENT WITH JOINT HEALTH SCRUTINY COMMITTEE
Representatives from the RCRH Programme attended a Joint Birmingham/Sandwell Health Scrutiny Committee meeting on the 13th December 2011, to provide an update on Clinical Service redesign, community-based developments and progress with the new hospital. All of which was very well received.

Committee members expressed concern at the level of engagement of the respective Local Authorities in the RCRH Programme Governance structure, and senior officers from the respective organisations gave a commitment to address.

RECOMMENDATIONS
The Trust Board is recommended to:

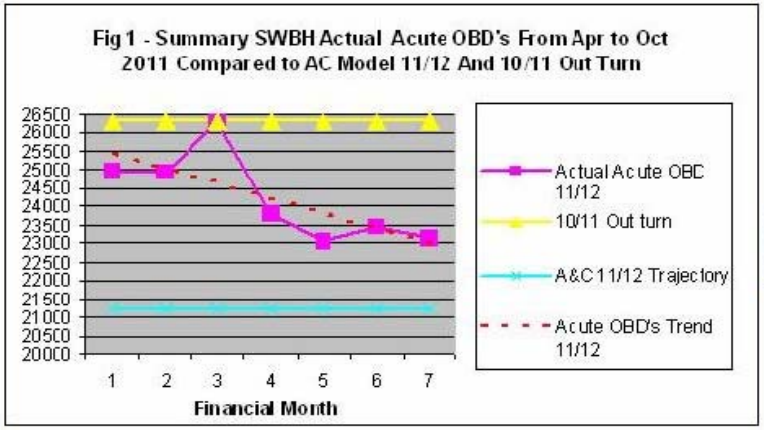
1. NOTE the progress made with the Right Care Right Here Programme.

Jayne Dunn
Redesign Director – Right Care Right Here
19th January 2012

APPENDIX 1 - RCRH Activity Summaries

Personal :: Summary PBR reports

Summary A - RCRH Programme Board Reports For the Acute Sector From Apr-Oct 2011/12



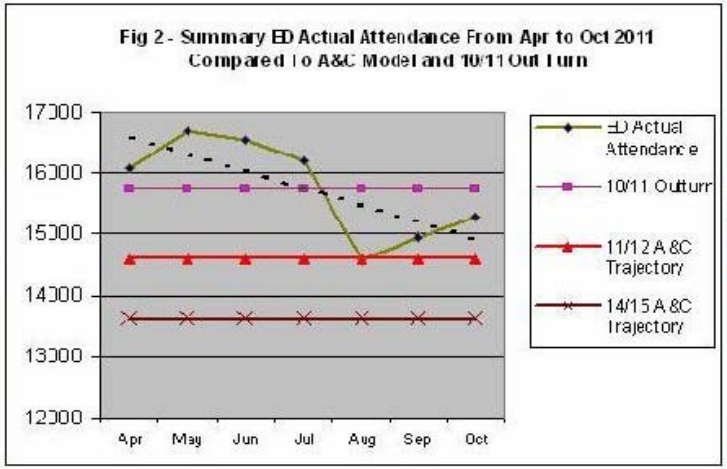


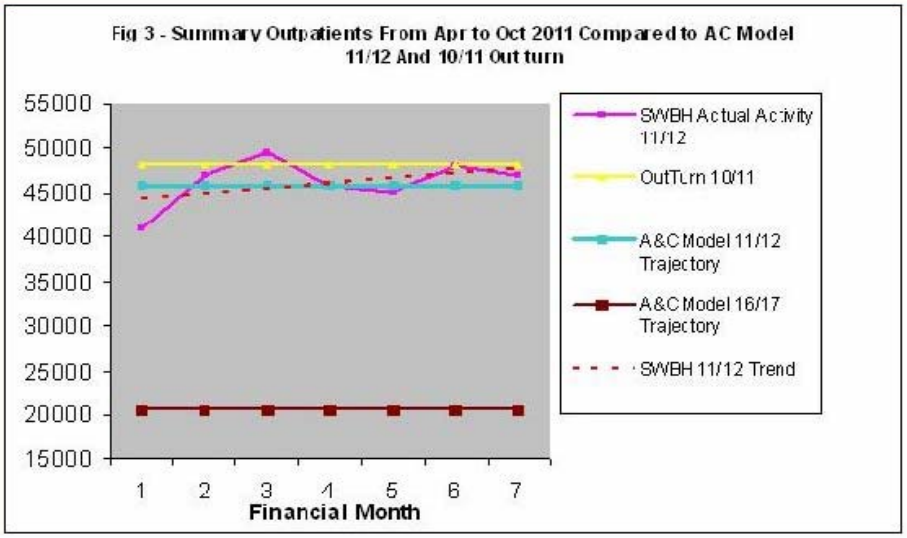
Fig 1 – At Month 7 all inpatients OBD's are 7.9% below 10/11 out turn and 14% above modelled A&C 11/12 trajectory. We are 48% above modelled 16/17 trajectory. The trend appears to be declining and has

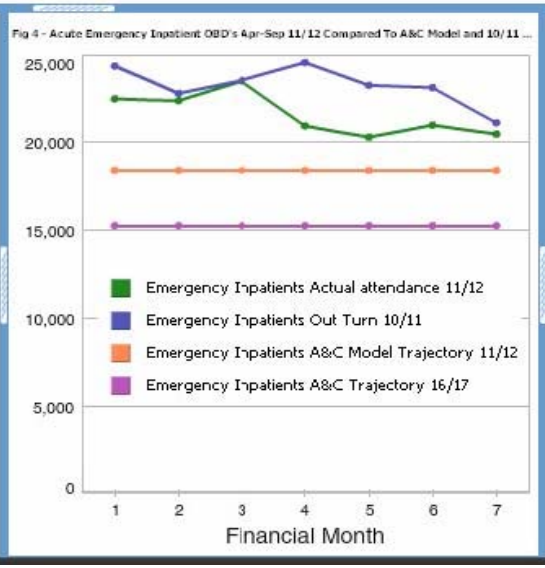
Fig 2 – ED Attendances are 0.1%(123) above 10/11 outturn and 8% (8215) above modelled 11/12 trajectory. The overall trend for actual ED attendance 11/12 appears to be declining.

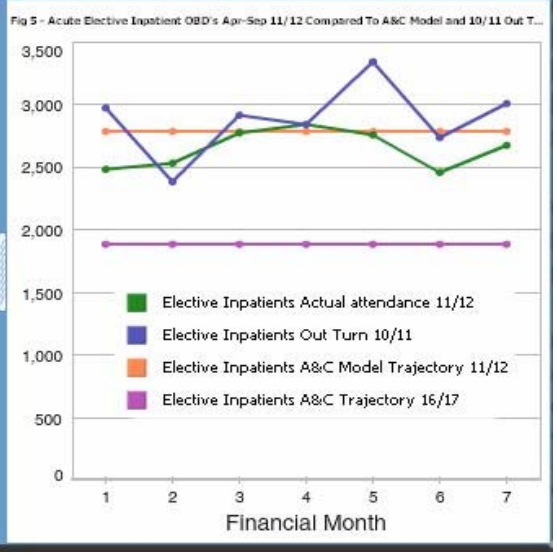
Fig 3 – At Month 7 outpatient activity is 4.1% less than 10/11 outturn and 0.5% below modelled 11/12 Trajectory. We are 125% above

Fig 4 – At Month 7 Non Elective (emergency) OBD's are 7.2% (11,700) lower than 10/11 Outturn and 17% (22,000) above modelled 11/12 A&C trajectory. We are 41% (44,000)

Fig 5 – Elective Inpatient OBD's are 8.3% (1679) below 10/11 outturn and 5% (974) below 11/12 A&C trajectory. We are 40% above







Summary PBR Community reports

Summary B - RCRH Programme Board Reports For Community Sector From Apr-Mar 2011/2012

Fig 1 Summary Community Outpatients From Apr-Oct 2011 Compared to A&C Model and 10/11 Out Turn

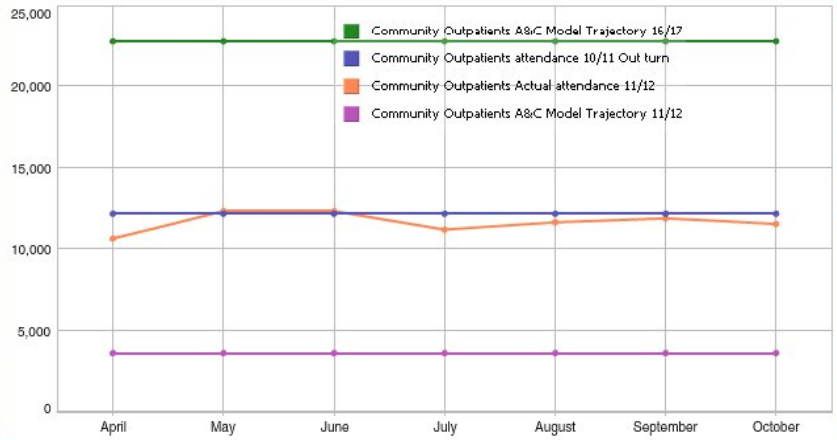


Fig 1 – At Month 7 community outpatient attendance is 4.5% less than 10/11 outturn. In comparison to the A&C model it is 222% above 2011/12 Trajectory and 46% less than 2016/17 trajectory.

Fig 2 – Urgent Care Centre attendance is 14% above 10/11 outturn. Urgent care activity appears to be trending up and we are 33% above 16/17 Trajectory and 91% above 11/12.

Fig 3 – Community OBD's are 10% below 10/11 outturn and 17% below modelled trajectory for 11/12. Please note that McCarthy ward at Rowley Regis closed in May 2011 and a new enablement ward (Henderson ward) opened in October 2011. Henderson OBD's data is missing and will be included in subsequent reports.

To meet 11/12 trajectory we need to introduce 16,154 new OBD's . The trajectory for 11/12 will be phased in from the point at which new beds are introduced into the system i.e. October 2011. Community OBDS includes:

Leasowes IC Centre,Barthalomew Lodge Nursing Home,Waterside Nursing Home,Greenhaven Care Home,Moseley Hall,Riverside Lodge,RCRH Exemplar projects

Fig 4 – Show referral activity which includes GP as well as other types. At month 7 referrals are 12% (12,125) below last years out turn.

Fig 2 Summary UCC Attendance From Apr-Sep 2011 Compared to A&C Model and 10/11 Out Turn

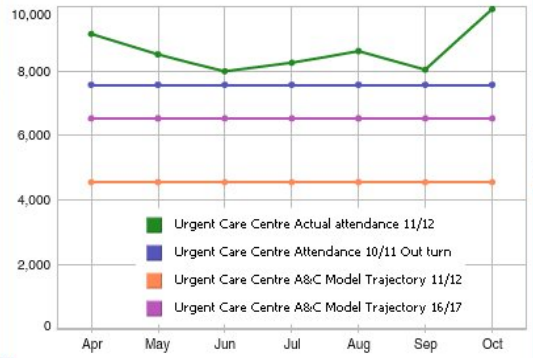


Fig 3 Summary Community OBD's From Apr-Oct 2011 Compared to A&C Model and 10/11 Out Turn

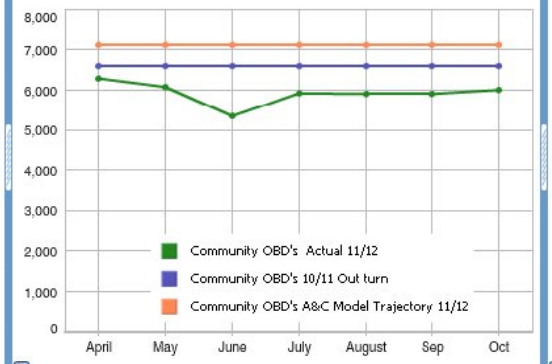
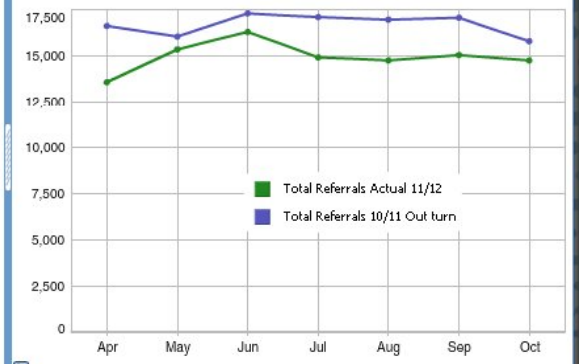


Fig 4 Summary Referrals From Apr-Sep 2011 Compared to 10/11 Out Turn



SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

RIGHT CARE RIGHT HERE PROGRAMME: PROGRESS REPORT JANUARY 2012

INTRODUCTION

The Right Care Right Here Programme is the partnership of SWBH, HoB tPCT, Sandwell PCT and Birmingham and Sandwell local authorities leading the development of health services within Sandwell and Western Birmingham. This brief paper provides a progress report for the Trust Board on the work of the Programme as at the end of December 2012. It summarises the Right Care Right Here Programme Director's report and the RCRH Service Redesign Report that were presented to the Right Care Right Here Partnership Board in January.

The work of the Right Care Right Here Programme and involvement of the Trust in this is also discussed on a monthly basis at the Trust's Right Care Right Here Implementation Board meetings.

PROJECT PERFORMANCE

The RCRH Programme activity performance reports related to service redesign are included in Appendix 1 for information. They attempt to summarise overall progress with the Programme in key areas by providing data for the first seven months of 2011/12 and comparing it with actual performance in 2010/11, the trajectory in the RCRH Activity and Capacity (A&C) for 2011/12 and the targets in the A&C model for 2016/17.

In summary activity trends for April-October 2011 show:

- Inpatient Activity: Our Acute Occupied Bed Days (OBDs; in Summary A, figure 1) continue to show a downward trend and are 7.9% below 2010/11 levels but 14% above the 2011/12 trajectory. This includes our emergency inpatient OBDs being 7.2% lower than last year but 17% above the 2011/12 trajectory and our elective inpatient OBDs being 8.3% below last year and 5% below the 2011/12 trajectory (Summary A, figures 4 and 5).

- Community OBDs (in Summary B, figure 3) are 10% below 2010/11 levels and 17% below the 2011/12 trajectory.

- The intermediate care/re-ablement beds opened at Rowley Regis Hospital in October but the activity from these beds is not yet included in the monitoring report. It is envisaged that this activity will increase the Community OBDs and assist in reducing our Acute OBDs.

- Emergency Department Attendances: Our Emergency Department (ED) attendances (in Summary A, figure 2) are 0.1% above the 2010/11 end of year level, and 8% above the 2011/12 trajectory.

- The Urgent Care Centre attendances (in Summary B, figure 2) continue to show a downward trend but are still 14% above 2010/11 end of year level and 91% above the 2011/12 trajectory.

- Outpatient Attendances: Our acute Outpatient Activity (in Summary A, figure 3) is 4.1% below the 2010/11 end of year level and 0.5% above the 2011/12 trajectory.

- Community Outpatient Activity (including our community and new Community Provider activity, in Summary B, figure 1) remains below the 2010/11 end of year level by 4.5% but is still 222% above the 2011/12 trajectory although still some way (46%) from the 2016/17 trajectory.

- Referrals to acute services have shown a further reduction and are now 12% below the 2010/11 level (in Summary B, figure 4).

At this stage it therefore appears that across all three categories, our acute activity is showing a downward trend but with further work required to ensure maintenance of this trend, achievement of

2011/12 trajectories and ongoing progress towards the 2016/17 position. It is anticipated that the re-commissioning work (see below) will help to achieve this.

In terms of previous projects established through specific exemplars and individual re-design initiatives performance in terms of activity is now captured within the above summaries.

CARE PATHWAY AND SPECIALITY REVIEWS
The programme of Care Pathway Reviews is currently on hold, awaiting a wider review with the new GP Clinical Commissioning Groups (GP CCGs).

The RCRH Programme have undertaken further discussions with GP CCGs in order to develop an implementation mechanism to move reviewed pathways forward to full adoption from a commissioning perspective. In addition, meetings continue with GP CCG lead Managers in order to agree a process to activate and commission the service redesign requirements identified within the Care Pathway Reviews.

Many of the published care pathways will have the impact of reducing activity to our acute services but are likely to increase activity in our diagnostic and community services. The financial impact on our acute services, for this year, of the revised care pathways with associated loss of activity and income is captured within the re-commissioning work.

TRANSFER OF ACTIVITY (RE-COMMISSIONING)
There have been ongoing discussions across the local health economy regarding implementation of the LDP agreement to transfer a range of services, activity and related income from secondary care to community and primary care during 2011/12 in line with the RCRH Programme. The Trust and GP commissioners have identified a number of specific schemes which have now been agreed and for which implementation plans are now being developed. These schemes are collectively known as the Re-commissioning Programme.

The LDP agreement set a target of re-commissioning activity worth £16.2million and to date the Trust and PCTs have identified schemes that will result in the transfer of activity worth £13.8million over a full year. Work continues within the Trust and GP Clinical Commissioning Groups to identify the impact of a range of additional schemes although most of these will have an impact in 2012/13. For the period April – November 2011 there has been a transfer of activity worth £1.7 million which is a slight improvement since the last report but remains below the year to date target. A number of the schemes commenced in the Autumn and so a further improvement in performance is expected over the next few months.

The RCRH Programme recognises the need to develop a coherent programme of communications about this programme with clinical staff within the individual organisations and engagement with patients and the public in relation to many of these planned changes.

ENGAGEMENT WITH JOINT HEALTH SCRUTINY COMMITTEE
Representatives from the RCRH Programme attended a Joint Birmingham/Sandwell Health Scrutiny Committee meeting on the 13th December 2011, to provide an update on Clinical Service redesign, community-based developments and progress with the new hospital. All of which was very well received.

Committee members expressed concern at the level of engagement of the respective Local Authorities in the RCRH Programme Governance structure, and senior officers from the respective organisations gave a commitment to address.

RECOMMENDATIONS
The Trust Board is recommended to:

1. NOTE the progress made with the Right Care Right Here Programme.

Jayne Dunn
Redesign Director – Right Care Right Here
19th January 2012

APPENDIX 1 - RCRH Activity Summaries

Personal :: Summary PBR reports

Summary A - RCRH Programme Board Reports For the Acute Sector From Apr-Oct 2011/12

Fig 1 - Summary SWBH Actual Acute OBD's From Apr to Oct 2011 Compared to AC Model 11/12 And 10/11 Out Turn

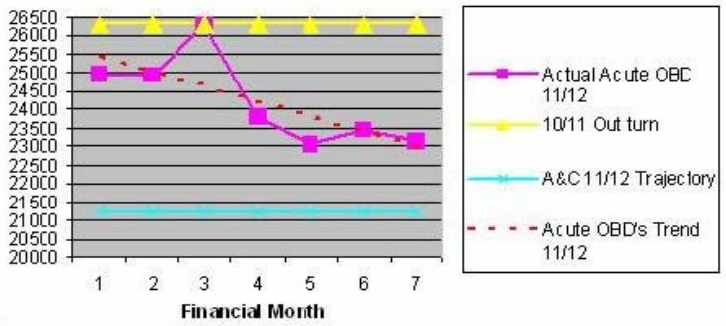


Fig 2 - Summary ED Actual Attendance From Apr to Oct 2011 Compared To A&C Model and 10/11 Out Turn

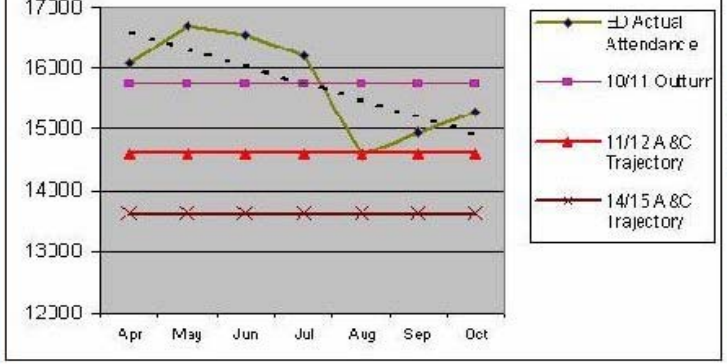


Fig 1 – At Month 7 all inpatients OBD's are 7.9% below 10/11 out turn and 14% above modelled A&C 11/12 trajectory. We are 48% above modelled 16/17 trajectory. The trend appears to be declining and has

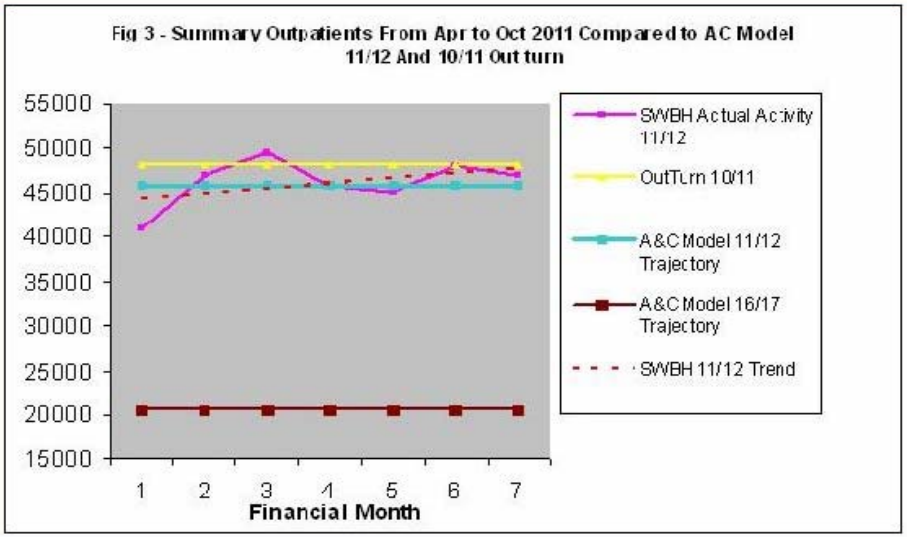
Fig 2 – ED Attendances are 0.1%(123) above 10/11 outturn and 8% (8215) above modelled 11/12 trajectory. The overall trend for actual ED attendance 11/12 appears to be declining.

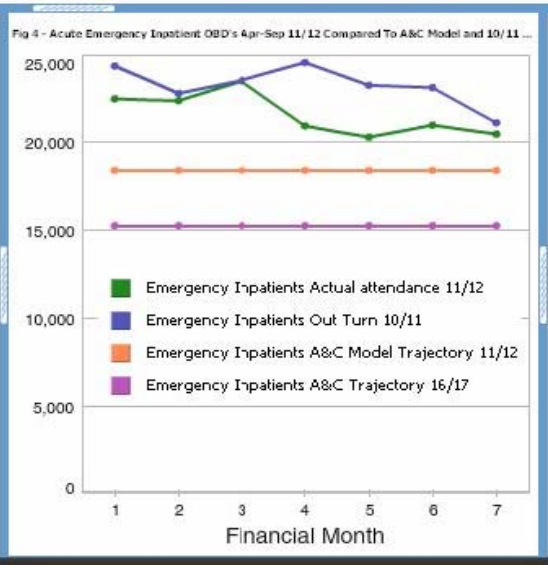
Fig 3 – At Month 7 outpatient activity is 4.1% less than 10/11 outturn and 0.5% below modelled 11/12 Trajectory. We are 125% above

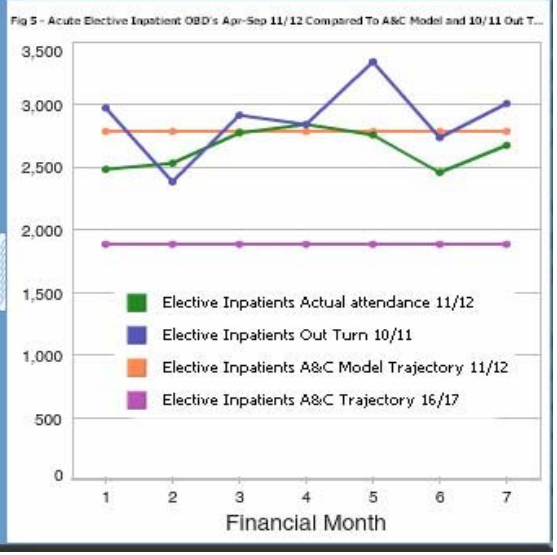
Fig 4 – At Month 7 Non Elective (emergency) OBD's are 7.2% (11,700) lower than 10/11 Outturn and 17% (22,000) above modelled 11/12 A&C trajectory. We are 41% (44,000)

Fig 5 – Elective Inpatient OBD's are 8.3% (1679) below 10/11 outturn and 5% (974) below 11/12 A&C trajectory. We are 40% above

Fig 3 - Summary Outpatients From Apr to Oct 2011 Compared to AC Model 11/12 And 10/11 Out turn







Summary PBR Community reports

Summary B - RCRH Programme Board Reports For Community Sector From Apr-Mar 2011/2012

Fig 1 Summary Community Outpatients From Apr-Oct 2011 Compared to A&C Model and 10/11 Out Turn

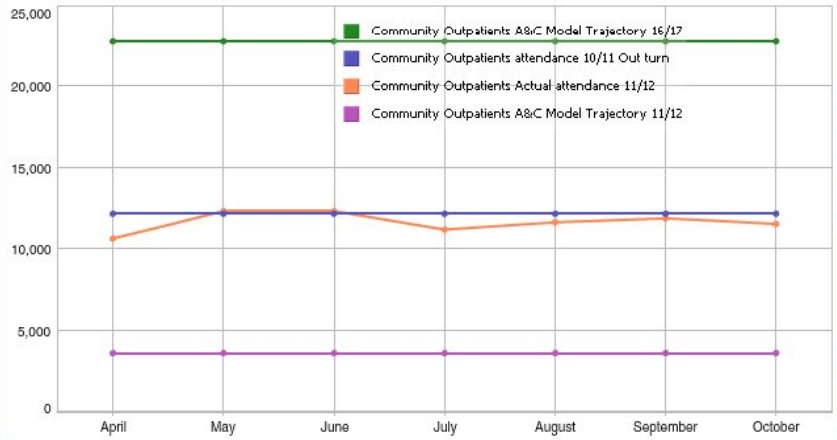


Fig 1 – At Month 7 community outpatient attendance is 4.5% less than 10/11 outturn. In comparison to the A&C model it is 222% above 2011/12 Trajectory and 46% less than 2016/17 trajectory.

Fig 2 – Urgent Care Centre attendance is 14% above 10/11 outturn. Urgent care activity appears to be trending up and we are 33% above 16/17 Trajectory and 91% above 11/12.

Fig 3 – Community OBD's are 10% below 10/11 outturn and 17% below modelled trajectory for 11/12. Please note that McCarthy ward at Rowley Regis closed in May 2011 and a new enablement ward (Henderson ward) opened in October 2011. Henderson OBD's data is missing and will be included in subsequent reports.

To meet 11/12 trajectory we need to introduce 16,154 new OBD's . The trajectory for 11/12 will be phased in from the point at which new beds are introduced into the system i.e. October 2011. Community OBDS includes:

Leasowes IC Centre,Barthalomew Lodge Nursing Home,Waterside Nursing Home,Greenhaven Care Home,Moseley Hall,Riverside Lodge,RCRH Exemplar projects

Fig 4 – Show referral activity which includes GP as well as other types. At month 7 referrals are 12% (12,125) below last years out turn.

Fig 2 Summary UCC Attendance From Apr-Sep 2011 Compared to A&C Model and 10/11 Out Turn

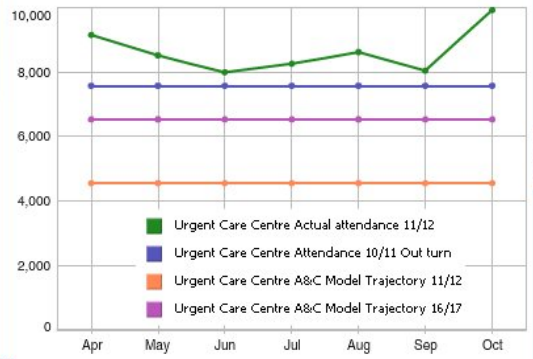


Fig 3 Summary Community OBD's From Apr-Oct 2011 Compared to A&C Model and 10/11 Out Turn

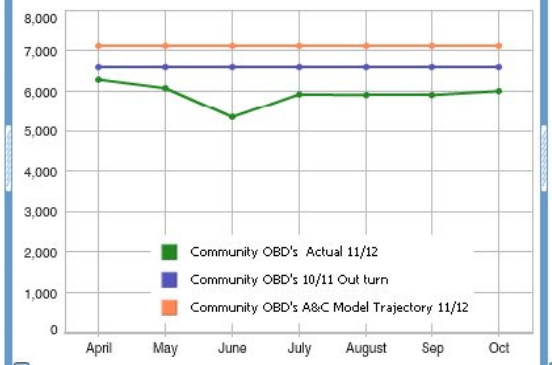
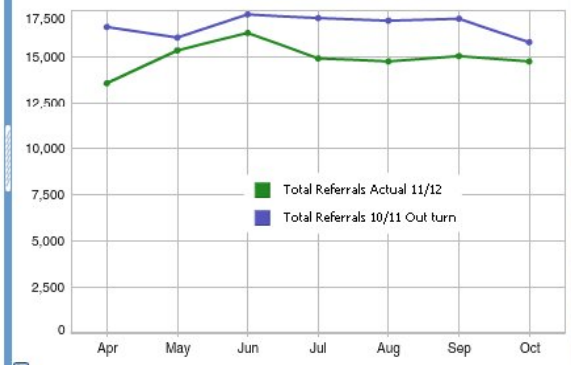


Fig 4 Summary Referrals From Apr-Sep 2011 Compared to 10/11 Out Turn



Sandwell and West Birmingham Hospitals NHS
NHS Trust

FT PROGRAMME BOARD

DOCUMENT TITLE:	Foundation Trust Programme: Project Director's Report
SPONSORING DIRECTOR:	Mike Sharon, Director of Strategy & Organisational Development
AUTHOR:	Mike Sharon, Director of Strategy & Organisational Development
DATE OF MEETING:	26 January 2012

SUMMARY OF KEY POINTS:

The Project Director's report gives an update on:

- Activities this period
- Activities next period
- Issues for resolution and risks in next period

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The FT Programme Board is asked to **receive** and **note** the update.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	An Effective Organisation
Annual priorities	Make Significant progress towards becoming a Foundation Trust
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

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

PREVIOUS CONSIDERATION:

Routine monthly update.

FT Programme Director Report January 2011 – Overall status - Red

Activities this period

- Draft HDD1 report received
- Planning for Deloitte Quality Governance assessment process commenced
- External stakeholders contacted as part of 8 week engagement process
- Engagement invitation letters sent to stakeholders
- Board Time Out held to review current position
- High level review of options and timelines for FT application undertaken
- New SHA performance framework comes into effect this month, with the first submission due on 31 January 2012

Activities next period

- Receive HDD1 final report
- Commence engagement
- Redevelop overall FT timetable and TFA taking into account delay to OBC approval
- Refine existing downside scenario
- Commence refresh to Activity and Capacity Model

Issues for resolution and risks in next period

- Gain stakeholder approval/support for revised TFA and IBP approach

MINUTES

Sandwell and West Birmingham Hospitals NHS
NHS Trust

FT Programme Board – Version 0.1

Venue Boardroom, Sandwell Hospital **Date** 15 December 2011

Present:	Mr Roger Trotman	Mr Mike Sharon	Miss Neetu Sharma
	Dr Sarindar Sahota	Miss Rachel Barlow	
	Mrs Gianjeet Hunjan	Miss Rachel Overfield	
	Mr Phil Gayle	Miss Kam Dhami	
	Mr John Adler	Mr Graham Seager	
	Mr Robert White	Mrs Jessamy Kinghorn	

Secretariat: Mr Simon Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Professor Derek Alderson, Mrs Olwen Dutton and Mr Donal O'Donoghue.	
2 Minutes of the previous meeting	**SWBFT (11/11) 081**
The minutes of the previous meeting were accepted as a true and accurate record of the discussions held on 24 November 2011.	
AGREEMENT: The minutes of the previous meeting were approved.	
3 Update on actions arising from previous meetings	**Verbal**
It was noted that there were no overdue actions or actions that required escalating for attention.	
4 FT Programme Critical Path	**SWBFT (12/11) 084** **SWBFT (12/11) 084 (a)**
The FT Programme Board received and noted the updated FT Programme Critical Path. Mr Sharon advised that the Historical Due Diligence audit was underway and would be completed shortly. It was reported that interviews had been set up with Non Executive Directors and that at present the Critical Path suggested that there would be a Board to Board meeting with the Strategic Health Authority early in	

the New Year. In terms of the estates strategy, the Board was advised that it was proving challenging to reconcile the retained estate position to that required in the Long Term Financial Model (LTFM). It was reported that the estates strategy had been updated to articulate the retained estates solution, including the services that would be provided from the various locations. The strategy was reported to encompass the estates rationalisation plans and some elements of the forthcoming stroke reconfiguration plans. It was highlighted that the retained estates plan looked to be valued at c. £60m rather than the original value of £30m therefore there was a need for further analysis and review. It was suggested that the most appropriate solution within the original financial envelope of £31m might need to be considered. Mr White advised that within the financial model, care was taken to ensure that a Financial Risk Rating of 3 was maintained, although it was recognised now that the retained estates position might impact. Mr Sharon asked whether the situation would result in the Trust needing to deliver additional savings through its Cost Improvement Programme. Mr White confirmed that this was possible if the liquidity ratio deteriorated. Mr Adler advised however, that there was no further scope to increase the magnitude of savings to be delivered through the Transformation Plan. In summary, it was agreed that Mr White would review the LTFM to identify what scope existed within the model for additional capital expenditure above the £31m originally assumed. The Estates strategy would then need to be reviewed to take into account the findings of the LTFM review.	
5 FT workstream high level milestone plan	**SWBFT (12/11) 085** **SWBFT (12/11) 085 (a)**
The FT Programme Board received and noted the updated FT workstream high level milestone plan. Mr Sharon reported that at present, the milestone plan showed that engagement would not commence until the Outline Business Case (OBC) had been approved. It was reported that there were advantages to commencing engagement in that it demonstrated a willingness to progress the FT application, however there seemed little benefit to doing so at present given the current level of uncertainty and delay. It was noted that the Aspirant Foundation Trust Assurance Framework (AFTAF) work now needed to be incorporated into the project timeline, which would extend the timescale to some degree. Mr Sharon advised that the Strategic Health Authority had postponed the Board to Board exercise until May 2012. Mr Adler advised that little further progress was expected on the consideration of the OBC until the 'bottom up' costing plans for the Transformation Plan had been developed. He suggested that this work could be completed by the end of the current financial year. In parallel, the Board was advised that a review of PFI schemes by the Treasury had commenced, during which time approval of the OBC	

was unlikely. It was suggested and agreed that in the light of the current situation, that a variation to the original engagement plan should be pursued, particularly as Mrs Kinghorn pointed out, if full engagement was completed during the current pause in the process, it was likely that the exercise would need to be repeated at a later date. Mr Seager asked what timetable was being followed for authorisation. Mr Sharon advised that it was the intention to reach the Department of Health review stage by March 2013, in readiness for authorisation to the current deadline of April 2014. Miss Sharma advised that the validation of the AFTAF work would need to be incorporated into the overall process. It was reported that the draft report following the conclusion of the Historical Due Diligence work would be issued by the end of December 2011. It was agreed that the assumption should be made that the approval of the OBC would not be gained until the Spring or Summer of 2012 and therefore while engagement should commence in January 2012, this should be confined to the FT process and not included the wider plans for the development of the new hospital at present. Miss Sharma highlighted that at present, there was no means of renegotiating the Tripartite Formal Agreement.	
6 Programme Director's report	**SWBFT (12/11) 086** **SWBFT (12/11) 086 (a)**
The FT Programme Board received and noted the FT Programme Director's report. Mr Sharon advised that a date for the interview between Professor Alderson and Deloitte was to be finalised. It was reported that the final report on Board Development also remained outstanding. Miss Sharma reported that following a meeting with the Strategic Health Authority recently, she had been advised that a new provider management regime would be implemented, which would follow that used by Monitor and would commence in shadow format from January 2012. The dashboard to be used was reported to require monthly submission to the Strategic Health Authority and would therefore require consideration by the Trust Board as part of its standard business. It was noted that the responsibility for completion the submission would fall mainly to Mike Harding, Head of Planning and Performance Management, who would be required to present a copy of the proposed return to the meetings of the Performance Management Board and Finance & Performance Management Committee monthly.	
ACTION: Mr. White to discuss with Mike Harding to ensure template completed by 31st January 2012. This then needs to be submitted to the Performance Management Board [PMB] and Public Trust Board	

respectively.	
7 Programme risk register	**SWBFT (12/11) 088** **SWBFT (12/11) 088 (a)**
The FT Programme Board received and noted the FT Programme Risk Register.	
8 Integrated Business Plan version 0.4	**SWBFT (12/11) 089** **SWBFT (12/11) 089 (a)**
Mr Sharon presented the refreshed version of the Integrated Business Plan, highlighting that the main changes were confined to Chapters 5, 6, 7 and 8. In respect of Chapter 5, the Board was advised that an amplified level of detail had been included around the strategic drivers to the Trust and that the reconfiguration section of the chapter had also been updated. Regarding Chapter 6, it was highlighted that the section concerning Cost Improvement needed to be developed further. In Chapter 7, the Board was informed that escalation process for risks had been strengthened and the involvement of the Board in handling risks had been given greater clarity. It was highlighted that the profile of the Assurance Framework needed to be raised as part of this process. The Board was asked to note that the downside scenario had been added, in line with the discussions held at the previous meeting of the FT Programme Board, with the mitigations having arisen from a specific workshop held recently. In Chapter 8, the draft Organisation Development strategy was reported to be due for presentation to the Trust Board at its meeting in January 2012. The Board noted the work that had been undertaken to provide further detail on the drivers of the workforce reduction, accepting that the most significant driver of future workforce reduction was national efficiency requirements, with additional drivers being the need to create financial headroom for the unitary payment and the reduction of activity as a result of implementing the Trust's strategy. Mr Seager asked whether the effect of the workforce changes on the wider health economy needed to be built into the narrative. It was pointed out that the proposed workforce transfers were identified in the chapter	
9 Governance Rationale update	**SWBFT (11/11) 078** **SWBFT (11/11) 078 (a)**
Mrs Kinghorn presented an update on the Governance Rationale, which she advised had incorporated the points of clarity requested at the meeting in October 2011. The Board was advised that it had been determined that temporary employees would have the same rights as permanent members of staff after 12 months continuous employment with the Trust and therefore would need to be	

considered within the staff membership. Mrs Kinghorn advised that the impact of the transfer of Community Services staff into the Trust had been reviewed and had been built into the proposed allocation of staff governors from the various areas. The Board was asked to comment on the proposed allocation of: Medical & Dental staff – 1; Nursing and Midwifery 3; Other clinical staff – 3; Administration and Management – 2; and Facilities and Ancillary – 2. It was suggested that the allocations should be amended slightly to increase the allocation to the Medical & Dental staff to 2 and to reduce the allocation from Other clinical staff to 2.	
10 Progress with the Quality Governance Framework assessment	**Verbal**
Miss Dhami reported that a meeting had been held with Deloitte LLP and one-to-one interviews with Board members would commence shortly. It was also reported that ward walkabouts would be undertaken in due course.	
11 Organising for Excellence action plan update	**SWBFT (12/11) 083** **SWBFT (12/11) 083 (a)**
Mr Adler reported that some of the timescales within the plan had been reset, including the establishment of the Organisational Development Steering Group in January 2012 and the presentation of the Service Line Management strategy at the meeting of the Trust Board on 26 January 2012. Miss Barlow provided an update on the proposed support for the delivery of the Transformation Plan.	
12 Annual Priorities for 2012/13	**Hard copy paper**
Mr Sharon presented the latest iteration of the Trust's Annual Priorities for 2012/13. It was suggested that a standard around dementia care may need to be included with the list, given the national focus on this aspect of care at present. Palliative care within the Care Closer to Home was further suggested. Mr Seager proposed that a priority be added around sustainability, which was approved. Mr Sharon noted that this would then provide 17 annual priorities for delivery in 2012/13.	
13 Matters for information	
13.1 Monitor FT bulletin	**SWBFT (12/11) 087**
The FT Programme Board received and noted the latest Monitor FT bulletin.	
14 Any other business	**Verbal**
Miss Sharma reported that the Aspirant Foundation Trust Assurance Framework (AFTAF) would be launched from 1 January 2012 and that Deloitte had been involved in the development of the concept.	

It was reported that a self-assessment of the Trust's position would need to be verified externally and was likely to cost £30k, and that it was unlikely that the Strategic Health Authority would meet this cost. Depending on the outcome of the assessment, the Board was advised that a number of additional modules may need to be completed. It was highlighted that the AFTAF would apply to all aspirant Foundation Trusts.	
15 Details of next meeting	**Verbal**
The next FT Programme Board meeting will be held on 26 January 2011 at 1300h in the Anne Gibson Boardroom at City Hospital.	

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Audit Committee – Version 0.1

Venue Executive Meeting Room, City Hospital **Date** 1 December 2011

Members	In Attendance		Secretariat	
Mrs G Hunjan [Chair]	Mr R White		Mr S Grainger-Payne	
Dr S Sahota	Mr P Capener	(CW Audit) [Part]		
Mr P Gayle	Mr P Westwood	(CW Audit)	**Observers**	
Prof D Alderson	Mr M Wright	(CW Audit)	Mr C Dickens	[PWC]
	Mr B Stone	(KPMG LLP)		

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
Apologies were received from Mrs Sarah-Ann Moore, Mr Andy Bostock, Mrs Rubina Chaudary and Mr Tony Wharram. Mrs Hunjan explained that as Mr Roger Trotman had taken on the role of Acting Chair, following the departure of Mrs Sue Davis, he would attend the Committee meetings by invitation.	
2 Minutes of the previous meeting	**SWBAC (9/11) 053**
The minutes of the meeting held on 8 September 2011 were approved as a true and accurate reflection of discussions held.	
AGREEMENT: The minutes of the meeting held on 8 September 2011 were approved	
3 Matters arising	**SWBAC (9/11) 053 (a)**
The Committee received and noted the updated actions log.	
3.1 Update on progress with improving performance against the Prompt Payment target	**SWBAC (12/11) 063** **SWBAC (12/11) 063 (a)**

Mr White reported that the need to improve the performance against the Prompt Payment target had been given a higher profile by including a summary of performance within the divisional review process. Mrs Hunjan asked whether the plans to improve further the position would be included within 'Hot Topics' briefings. Mr White advised that this was an option, however he suggested that a more targeted approach would be more useful. It was highlighted that an improvement by the Finance Department was needed particularly. The Committee was assured that it remained the intention of achieving the target of paying 95% of invoices within the required timeframe by the year end. Dr Sahota asked whether in some cases an invoice is requested for payment in respect of goods not received. Mr White advised that this situation occurred rarely.	
3.2 Process for auditor CRB checks	**Verbal**
Mr Stone advised that a process was in place within KPMG LLP to make annual declarations and that the screening process for new staff was routine. The Committee was advised that the team supporting the Trust had advanced CRB clearance which was updated on a routine basis. It was agreed that the position regarding CRB clearance for CW Audit members should be determined at the next meeting.	
ACTION: Mr Grainger-Payne to include CW Audit CRB clearance status on the agenda of the next meeting	
4 External Audit Matters	
4.1 External Audit progress report	**SWBAC (12/11) 064**
Mr Stone reported that the process for the 2010/11 audit had been completed, including the necessary debriefing sessions. Meetings for the 2011/12 audit were reported to be being arranged at present. The Committee was advised that meetings had been held with the Internal Audit function to agree a revised structure for the review of financial systems. Mr Stone advised that the refreshed audit plan would be presented at the next meeting, including the scope and timing of the audit of the Quality Account. A number of technical updates were presented, including the planned updated and revised compliance framework for Foundation Trusts.	
5 Internal Audit Matters	

5.1 Internal Audit progress report, including recommendation tracking update	**SWBAC (12/11) 057** **SWBAC (12/11) 057 (a)**
Mr Capener advised that progress of the Internal Audit work was ahead of the agreed profile. The Committee was informed that during the quarter, a number of pieces of work had been completed, including an occupation study of the Birmingham Treatment Centre. It was highlighted that the majority of the reviews had provided full or significant assurance. Moderate assurance was pointed out to have been gained from the review into Access to Medical Records, which the Committee was advised required further follow up work. It was explained that the key issue with respect to this review was ensuring that the appropriate workstreams were risk assessed, which would be undertaken routinely when a Sharepoint solution was introduced and as such a revised implementation date of 31 March 2012 had been set for the action. The Committee was informed that much work remained in progress, particularly with respect to reviewing the Trust's financial systems. In terms of recommendation tracking, Mr Capener reported that there was a diminishing number of outstanding recommendations and that a cleansing exercise would be undertaken before the end of the year to assess whether recommendations remained current and appropriate. Dr Sahota asked whether sufficient progress was being made to deliver the high priority actions and was informed that these were in hand. Mrs Hunjan noted that there had been changes to the implementation dates for a number of actions, such as those derived from the reviews into Outpatient Utilisation and Medical Staff Job Planning. She emphasised the need for these actions to be delivered by the end of the financial year and suggested that there needed to be clear evidence of progress presented at the next meeting of the Audit Committee. Regarding the Medical Staffing Job Planning, Mrs Hunjan noted that inconsistency with paying Clinical Directors' responsibility allowances had been identified. Incorrect payments to medical staff were also noted to have been identified and Mrs Hunjan asked how many of these instances there had been and whether they had been corrected. It was further suggested that confirmation that payments for job planning responsibilities had ceased was needed. Professor Alderson remarked that the job planning actions were especially complex to deliver and highlighted that the current timescales for completion may not be realistic. It was agreed that Kam Dhami, Director of Governance, should be invited to provide an update on both the progress with delivery of the actions from the Internal Audit review and the job planning work in the wider sense.	
ACTION: **Mr Grainger-Payne to arrange for Kam Dhami to attend the next Audit Committee meeting to present an update on the progress with medical staffing job planning**	

Implementation action dates – to be completed by the end of the Financial Year, to be updated by Mr Capener.	
5.2 Access to Medical Records review – Moderate Assurance	**SWBAC (12/11) 060**
Mr Capener presented the Access to Medical Records review for receiving and noting. He reiterated that moderate assurance had been gained from the review due to the issue with risk assessing the workstreams. It was highlighted that seven out of nine recommendations had been implemented, but was noted that given the number of staff required to undertake training in Information Governance to meet the needs of the Information Governance toolkit, the completion of the training had been included within the mandatory training suite.	
5.3 Draft Internal Audit Plan 2012-15	**SWBAC (12/11) 058** **SWBAC (12/11) 058 (a)**
The draft Internal Audit plan covering the period 2012-15 was presented for receipt and noting. Mr Capener advised that the final plan would be presented at the February 2012 meeting of the Audit Committee. The Committee was advised that preparation of the plan had included input from a number of the Executive Team and minor feedback from these discussions needed to be built into the next version. One of the principal changes which had been suggested by the Chief Executive was reported to be the alignment of the Cost Improvement Plan review with the Transformation Plan, which by so doing would release a number of days to support other areas. Mr Capener highlighted that the number of days within the plan had reduced from 360 to 385 and drew the Board's attention to the detail of the plan. It was noted that it was intended to reduce the coverage of the review of core financial systems, given the stability of the processes. It was reported that this measure had been discussed with and agreed by the External Auditors. Mrs Hunjan asked whether the proposed allocation to the review of the Transformation Plan was excessive. Mr Capener advised that since the Plan was only in its formative stages, it was difficult to judge whether the allocation was appropriate at present. Dr Sahota noted that there had been a reduction in the number of days allocated to following up actions. Mr Capener explained that this was reflective of the improved use of the tracking software that had been introduced to follow progress. Mrs Hunjan asked whether the financial management element of the plan would review the zero-based budgeting and flexible beds. Mr Capener advised that this was not planned unless it formed part of the budget processes directly. Mrs Hunjan asked whether performance against the prompt payment target was included within the plan and was advised that	

this would form part of the creditor payment review, however this may be considered as a specific piece of work as part of the next year's programme.	
5.4 Internal Audit self-assessment against Key Performance Indicators	**SWBAC (12/11) 059** **SWBAC (12/11) 059 (a)**
Mr Capener presented a self-assessment of performance against a number of key performance indicators for Internal Audit. He highlighted a 'hot spot' in terms of management response times. The Committee was informed that currently, 76% of draft reports were issued within 10 days of the exit meeting, which needed to be improved to achieve the target of 90%. Mr Capener advised that this was a challenging target to meet and that current performance was of a level similar to that in other organisations. Dr Sahota noted that on occasion, issuing the final reports had also taken longer than the desired time. Mr Capener advised that this was reflective of the cases where a more complex management response was required and the need for Executive Directors to sign off the reports. Mr Capener was asked to detail the cases that had taken the longest to issue in the next update. Professor Alderson asked for an explanation as to how the post audit questionnaires were used. Mr Capener explained that a set of questions would be presented to the responsible manager which covered the key processes undertaken as part of the audit. The Committee was informed that any negative responses received as part of the questionnaire were followed up. Mrs Hunjan asked what the current response rate was and whether it represented an improvement on the position in previous years. Mr Capener offered to determine the position.	
ACTION: Mr Capener to include a list of final review responses that had taken the longest time to issue in the next Internal Audit progress update **ACTION: Mr Capener to determine the response rates to post-audit questionnaires and to assess whether this represented an improvement on the position from previous years**	
5.5 Counter Fraud progress report, including an update on open cases	**SWBAC (12/11) 065** **SWBAC (12/11) 065 (a)**
Mr Westwood reported that training in counter fraud continued to be delivered to staff on induction and during the year 415 individuals had been trained in this way. Eight counter fraud cases were highlighted to have been carried forward from the previous year, with 13 new investigations having been referred. Reasonable progress against the Counter Fraud plan was reported and it was noted to be on track for delivery by the year end.	

Mrs Hunjan asked that the Counter Fraud newsletter be circulated to the Non Executive Directors via Mr Grainger-Payne. The detail of the live cases was discussed. In terms of the case involving safeguarding issues, Dr Sahota asked whether the matter should have been referred to the Police. Mr Westwood advised that the case had been handled internally but agreed to check whether Police involvement would have been appropriate.	
ACTION: **Mr Westwood to send Mr Grainger-Payne a copy of the Counter Fraud newsletter for circulation to Non Executive Directors** **ACTION:** **Mr Westwood to determine whether Police intervention was appropriate for similar cases to that of 2011-02 in future**	
5.6 2010/11 CFSMS qualitative assessment results	**SWBAC (12/11) 066** **SWBAC (12/11) 066 (a)**
Mr Westwood advised that the outcome of the CFSMS assessment was an award of Level 2, an identical result to that of the previous year. It was noted however that the report presented a more positive picture of the Counter Fraud work in the Trust. The results of the staff survey were observed to be particularly encouraging. It was highlighted that the correct reporting mechanisms for suspected fraud cases needed to be reinforced. Mrs Hunjan asked whether the assessment being undertaken in future years by NHS Protect would be changing. Mr Westwood advised that the proposals to roll out a new form of assessment would be piloted in the forthcoming year, meaning that a formal evaluation was not planned for 2011/12. An update on the delivery of the CFSMS qualitative assessment action plan was promised for the next meeting. Dr Sahota noted that the reporting culture for suspected Counter Fraud cases was important and asked whether work had been undertaken with the Chief Nurse to access means by which nursing staff could be made aware of the appropriate reporting mechanisms. Mr Westwood advised that the opportunity was taken to promote Counter Fraud work through existing fora at present. Mrs Hunjan suggested that Counter Fraud could be included within the ward assessment tool. Mr White agreed that this was a possibility, however advised that given the current priorities around privacy, dignity and nutrition, the timing of this needed to be considered. He agreed to discuss the matter with Rachel Overfield.	
ACTION: **Mr White to discuss the possibility of including Counter Fraud matters within the ward assessment tool with Miss Overfield**	

6 Governance matters	
6.1 Self-assessment of the Audit Committee's effectiveness	**SWBAC (12/11) 055** **SWBAC (12/11) 055 (a)**
Mr White presented the list of questions from the Audit Committee Handbook that would be used to undertake an assessment of the effectiveness of the Audit Committee. The Committee's attention was drawn to the changes to the questions given the recent revisions to the Handbook. The Committee was advised that the self-assessment would be completed by a subset of the Audit Committee prior to the next meeting and would be presented for comments at the meeting scheduled for 9 February 2012.	
ACTION: Mr Grainger-Payne to convene a subset of the Audit Committee to prepare an initial self-assessment of the Audit Committee's effectiveness	
6.2 Response to the letter from the Chair of NHS West Midlands: Data Quality Assurance	**SWBAC (12/11) 067** **SWBAC (12/11) 067 (a)** **SWBAC (12/11) 067 (b)**
Mr White reminded the Committee that a letter had been received from the Chair of NHS West Midlands seeking assurances that the Trust was considering its responsibilities in respect of data quality. He advised that the key consideration concerned the integrity of the information that was used to inform the performance against the NHS Performance Framework and the associated governance rating. As such, the Committee was informed that work had been undertaken to develop criteria that enable the various pieces of information to be ranked according to risk and to provide an indication as to whether the data was of good quality. Mrs Hunjan reported that Mr Trotman had questioned how the integrity of the data was maintained at all points in a system. Mr White advised that the matter concerned not only assurances on the quality of the data itself but also on the process by which it is generated. Mr Gayle agreed that a sound process was critical to guaranteeing the integrity of data. Mrs Hunjan encouraged greater attention to be given to reviewing the data quality of those pieces of information seen to be highest risk. Mr Capener remarked that he was encouraged by the work and in particular the plan to assess the risks around the various data workstreams. Professor Alderson noted that the data sources were all internal, apart from Dr Foster and highlighted that there was little control that the Trust could be expected to have over the integrity of data from external sources. It was agreed that a further update on the plans to review data quality should be considered at the next meeting.	

ACTION: Mr White to present an update on the data quality plans at the February 2012 meeting of the Audit Committee	
6.3 Quality Accounts action plan	**SWBAC (12/11) 062** **SWBAC (12/11) 062 (a)**
Mr Grainger-Payne presented the updated version of the Quality Accounts action plan and advised that the plan had been previously presented to and was monitored by the Governance Board. The action plan was highlighted to address observations raised as part of the External Audit review of the Quality Account 2010/11 that had been undertaken in the summer. The status assigned to each action was reported to represent the position as at 1 November 2011 and it was noted that the majority were at green status. An amber status was highlighted to be assigned to a number of the information-related actions, however the Committee was assured that plans were in place to address these delays. It was agreed that a further update on the action plan should be presented at the February 2012 meeting of the Audit Committee. Mr White remarked that overall the process for preparing the 2011/12 Quality Account was more robust.	
ACTION: Mr Grainger-Payne to arrange for a further update on the Quality Account to be presented at the February 2012 meeting of the Audit Committee	
6.4 Assurance Framework – Quarters 1 and 2	**SWBAC (12/11) 061** **SWBAC (12/11) 061 (a)**
Mr Grainger-Payne presented the Board Assurance Framework (BAF) which he advised had been updated to cover work in Quarters 1 and 2. The Committee was advised that presentation of the BAF had been deferred from the September 2011 meeting, to allow additional time for Executive Directors to populate the revised template. The BAF was highlighted to incorporate comments and recommendations made as part of the Internal Audit review of the 2010/11 version. The template was also noted to have been simplified and was accompanied by more comprehensive guidance on the purpose of the document and the information required to populate the BAF. The work to populate the BAF by Executive Directors was reported to have been more closely linked to an exercise to assess the risks to the delivery of the annual priorities, which the Committee was advised had been an effective measure. The Committee's attention was drawn to the examples provided of where gaps in control and assurance had been identified and the measures that	

had been agreed should be taken to rectify them. Dr Sahota asked whether there was a process by which severe incidents with rare probability could be flagged. He was advised that this detail would be included on the Trust Risk Register using the appropriate scoring from the risk severity matrix.	
7 Minutes from Trust Board Committees	
7.1 Finance and Performance Management Committee	**SWBFC (9/11) 103** **SWBFC (10/11) 112** **SWBFC (11/11) 125**
The Committee noted the minutes of the Finance and Performance Management Committee meetings held on the 22 September 2011, 20 October 2011 and the draft minutes of the meeting on 17 November 2011. Mr White highlighted that two Divisions were currently in formal financial recovery and that the Finance and Performance Management Committee was monitoring the recovery plans robustly. Since the last meeting, the Committee was advised that the financial position of the divisions had improved. In terms of the performance against the 2011/12 Cost Improvement Programme (CIP), it was highlighted that a shortfall of 10% was currently reported and that the Programme was comprised at present of 90% recurrent schemes. The number of non-recurrent schemes was noted to have increased, with substitute schemes having been identified for areas of shortfall or delay.	
7.2 Charitable Funds Committee	**SWBCF (5/10) 012**
The Committee noted the minutes of the Charitable Funds Committee meeting held on 8 September 2011. Dr Sahota advised that the minutes had been approved at the meeting of the Charitable Funds Committee earlier in the day.	
7.3 Quality and Safety Committee	**SWBQS (9/11) 043**
The Committee noted the minutes of the Quality and Safety Committee meetings held on 22 September 2011.	
8 Any Other Business	**Verbal**
There was none.	
9 Schedule of meetings for 2012	**SWBAC (12/11) 056**
The Committee received and noted the schedule of meetings for 2012.	
10 Date and time of next meeting	**Verbal**

The date and time of the next meeting will be 9 February 2012 at 1100h in the Executive Meeting Room, City Hospital.	

Signed:……..

Name:……

Date:…….