Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Anne Gibson Boardroom, City Hospital **Date** 24 September 2009 at 1430h

Members

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

In Attendance

Mr G Seager	(GS)	
Miss K Dhami	(KD)	
Mr C Holden	(CH)	
Mrs J Kinghorn	(JK)	
Miss J Whalley	(JW)	
Mr J Cash	(JC)	

Guests

Mr J Riley	(JR)	[Item 7 only]
Mrs J Dunn	(JD)	[Item 8 only]

Secretariat

Mr S Grainger-Payne	(SGP)	[Secretariat]

Item	Title	Reference No.	Lead
1	**Apologies for absence**	**Verbal**	**SGP**
2	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting*	**Verbal**	**All**
3	**Chair's opening comments**	**Verbal**	**Chair**
4	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 27 August 2009 as true and accurate records of discussions*	**SWBTB (8/09) 166**	**Chair**
5	**Update on actions arising from previous meetings**	**SWBTB (8/09) 166 (a)**	**Chair**
6	**Questions from members of the public**	**Verbal**	**Public**
	MATTERS FOR APPROVAL		
7	**Initiation of a Compulsory Purchase Order for the New Hospital Project**	**SWBTB (9/09) 168** **SWBTB (9/09) 168 (a)** **SWBTB (9/09) 168 (b)** **SWBTB (9/09) 168 (c)**	**GS**
8	**Maternity Service Review**	**SWBTB (9/09) 174** **SWBTB (9/09) 174 (a)** **SWBTB (9/09) 174 (b)** **SWBTB (9/09) 174 (c)**	**JA/JD**
9	**Statement of readiness for 'Swine Flu pandemic**	**SWBTB (9/09) 178** **SWBTB (9/09) 178 (a)** **SWBTB (9/09) 178 (b)** **SWBTB (9/09) 178 (c)**	**RK**

10	**Payment of injury benefit to former employee**	**SWBTB (9/09) 179** **SWBTB (9/09) 179 (a)**	**CH**
MATTERS FOR INFORMATION/NOTING			
11	**Strategy and Development**		
11.1	'Right Care, Right Here' programme: progress update	SWBTB (9/09) 175 SWBTB (9/09) 175 (a) SWBTB (9/09) 175 (b)	RK
12	**Performance Management**		
12.1	Monthly performance monitoring report	SWBTB (9/09) 180 SWBTB (9/09) 180 (a)	RW
12.2	Monthly finance report	SWBTB (9/09) 171 SWBTB (9/09) 171 (a)	RW
12.3	NHS Performance Framework monitoring report	SWBTB (9/09) 172 SWBTB (9/09) 172 (a)	RW
13	**Governance and Operational Management**		
13.1	Progress with delivering single sex accommodation	SWBTB (9/09) 173 SWBTB (9/09) 173 (a) SWBTB (9/09) 173 (b)	RK
13.2	Mortality update	SWBTB (9/09) 183 SWBTB (9/09) 183 (a) SWBTB (9/09) 183 (b)	DOD
13.3	Annual report on complaints handling	SWBTB (9/09) 177 SWBTB (9/09) 177 (a)	KD
13.4	Annual report on risk	SWBTB (9/09) 176 SWBTB (9/09) 176 (a)	KD
13.5	Quarterly integrated risk, complaints and claims report	SWBTB (9/09) 181 SWBTB (9/09) 181 (a)	KD
14	**Update from the Board Committees**		
14.1	Finance and Performance Management Committee		
▶	Minutes from meeting held 20 August 2009	SWBFC (8/09) 079	RT
15	**Any other business**	**Verbal**	**All**
16	**Details of next meeting** *The next public Trust Board will be held on 29 October 2009 at 1430h in the Churchvale/Hollyoak Rooms, City Hospital*	**Verbal**	**Chair**
17	**Exclusion of the press and public** *To resolve that representatives of the Press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).*	**Verbal**	**Chair**

MINUTES

Sandwell and West Birmingham Hospitals NHS Trust

Trust Board (Public Session) – Version 0.4

Venue Churchvale/Hollyoak Rooms, Sandwell Hospital **Date** 27 August 2009 at 1430 hrs

Present:	Mrs Sue Davis	Professor Derek Alderson	Mr Richard Kirby
	Miss Isobel Bartram	Mr Robert White	
	Mrs Gianjeet Hunjan	Miss Rachel Overfield	
	Dr Sarindar Sahota	Mr Donal O'Donoghue	
In Attendance:	Mr Colin Holden [Part]	Miss Kam Dhami	Mr Graham Seager
	Mr Nick Howells	Mr John Cash [Sandwell LINK]	
Guests:	Dr Beryl Oppenheim		
Secretariat:	Ms Rosie Fuller		

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Mr John Adler, Ms Parveen Akhtar, Mr Roger Trotman, Mrs Jess Kinghorn, Ms Judith Whalley and Mr Simon Grainger-Payne.	
2 Declaration of interests	**Verbal**
No declarations of interest were made in connection with any agenda item.	
3 Chair's opening comments	**Verbal**
Mrs Davis reported that the Pathology department had won a tender to provide services to Birmingham & Solihull Mental Health Trust. Congratulations are to be sent to the department.	
4 Minutes of the previous meeting	**SWBTB (7/09) 149**
The minutes of the meeting held on 30 July 09 were approved.	
AGREEMENT: The minutes of the previous meeting on 30 July 09 were approved as true and accurate reflections of discussions held	
5 Update on actions from previous meetings	**SWBTB (7/09) 150 (a)**
The updated action list was reviewed. There were noted to be no outstanding actions.	

6 Questions from members of the public	**Verbal**
There were no members of the public in attendance at the meeting. Mr Cash informed the Board that Sandwell Link had visited the Trust to view the progress with implementing single sex wards. Mr Cash also asked if the Trust would be present at the Sandwell Show taking place over the Bank Holiday weekend. Mr Howells advised that the Communications Department was aware of the show, however he was not aware of any plans for the Trust to be represented. Mrs. Davis suggested that this be considered outside of the meeting.	
7 Response to the Heathcare Commission investigation into Mid Staffordshire NHS Trust	**SWBTB (8/09) 164** **SWBTB (8/09) 164 (a)** **SWBTB (8/09) 164 (b)**
Miss Dhami informed the Board that the Healthcare Commission investigation into Mid Staffordshire NHS Trust report had been considered in detail and recommendations had been reviewed since it was presented at the March Trust Board. The review established that Mid Staffordshire NHS Trust had an unacceptably high mortality rate. The recommendations have been used as a checklist and a lot of work is currently underway at our Trust to address any areas requiring attention. This work has included paying attention to the two subsequent reports on Mid Staffordshire. A number of actions have arisen from the recommendations of the Healthcare Commission report: firstly, in terms of mortality, a significant amount of work has been undertaken and reports have been presented to the Governance Board and Governance & Risk Management Committee. Mr O'Donoghue is leading on the development of a framework on mortality and a summary of the work to date will be presented to the Board in September. The Board was also informed that all alerts from Dr Foster are formally reported to the Governance Board, together with responses/follow up actions undertaken by Mr O'Donoghue. At the November Board 'Timeout' the type of quality, risk management and patient safety information currently received will be discussed in detailed to ascertain what the Board actually requires. Other recommendations relate to Accident and Emergency. Mr Kirby and team have undertaken work to prepare for the review of the Accident and Emergency processes and numerous recommendations have been made which will be reported to the October Board after the Accident and Emergency Action Team has met. In relation to the development of a Quality Management Framework, a presentation will be made to the meeting of the Trust Board in January 2010. Miss Dhami responded to a query on patient safety, informing the Board that since implementation of the patient safety development plan, the Governance Board receives reports every two months and the Board annually. Miss Bartram asked what the Trust's mortality rate was compared to that of Mid Staffordshire. Mr. O'Donoghue advised that it was around 80, which was average for an organisation of this size. In comparison, Mid Staffordshire NHS Trust was fluctuating between 127 and 103. Mr. Kirby informed the Board he had met with senior clinicians in A&E and discussed	

the Alberti report.. He stated that no immediate remedial action would need to take place, however a series of improvements and trust wide work on future developments is being lead by Mr. O'Donoghue. Mrs. Davis thanked Miss Dhami for the report and reminded the Board it was important that this Trust evaluates its own performance periodically.	
ACTION: **Mr O'Donoghue to present an update on mortality at the September meeting of the Trust Board** **ACTION:** **Miss Dhami to schedule a discussion around quality, risk management and patient safety information at the November Board 'Time Out'** **ACTION:** **Mr O'Donoghue to present the outcome of the work of the Accident and Emergency Action Team at the October meeting of the Trust Board** **ACTION:** **Mr O'Donoghue to present an update on the Quality Management Framework at the January 2010 meeting of the Trust Board**	
8 Policy on the development, approval and management of policies	**SWBTB (8/09) 158** **SWBTB (8/09) 158 (a)** **SWBTB (8/09) 158 (b)** **SWBTB (8/09) 158 (c)**
Miss Dhami reported that a number of changes to the format of policies are incorporated into the revised Policy on the development, approval and management of policies. Staff have been consulted widely on the revisions. Miss Bartram asked what defined those policies requiring Trust Board approval. Miss Dhami informed the Board that statutory and mandatory polices require approval at Board level. Other policies presented to the Board for Trust Board approval are suggested at the discretion of the lead executive director. Mrs. Davis suggested that it would be good to have a full list of all policies to see if there were any others that may be appropriate for Trust Board approval. The Long Service Award policy was queried, in terms of whether it was necessary to be presented to the Board. Miss Dhami informed the Board that Mr. Holden had identified that this policy as one requiring Trust Board approval. It was agreed that a full list of policies would be circulated to the Board and presented every four years. Mrs. Davis suggested a minor amendment to the wording on the initial equality checklist. Miss Dhami agreed to undertake this change. The Trust Board unanimously approved the policy.	
ACTION: **Miss Dhami to circulate the full list of policies to the Trust Board** **AGREEMENT:** **The Trust Board approved the Policy on the development, approval and management of policies**	
9 Whistleblowing policy	**SWBTB (8/09) XXX** **SWBTB (8/09) XXX (a)** **SWBTB (8/09) XXX (b)**

	SWBTB (8/09) XXX (c)
Mr Holden presented the Whistleblowing policy for approval and informed the Board that although this policy was due for renewal, no significant changes had been made to the previous version. The minor changes made include the option to report concerns to the DGM. The policy also now includes safeguarding and fraud and corruption matters. Mr Holden reminded the Board that this policy has only been used once since it was published and advised that the policy has been through all relevant consultation sources. Mrs Davis enquired as to the role of the non-executive directors within this policy and asked for clarity as to why a non-executive had to report via the Director of Governance. Miss Dhami explained that the Director of Governance was a point of contact only and the wording in the policy would be revised to make this clear and also clarify that the point of contact is the Trust Secretary. Mr Kirby noted that the policy suggested a list of managers who could be approached with concerns but asked whether any manager be approached. Mr. Holden confirmed any manager could be approached and he would amend the policy to reflect this. The Trust Board unanimously approved the policy.	
AGREEMENT: Subject to minor amendment, The Trust Board approved the Whistleblowing policy	
10 Strategy and Development	
10.1 'Right Care Right Here' programme: progress report	**SWBTB (8/09) 151** **SWBTB (8/09) 151 (a)** **SWBTB (8/09) 151 (a)**
The Trust Board was asked to receive and note the latest version of the 'Right Care, Right Care' programme progress report. Mr Kirby highlighted the Programme Directors' report on the range of work to undertake in light of changes in the NHS and assumptions on financing in the future. It was also noted work to rethink the affordable and sustainable package was required.	
10.2 New acute hospital project: progress report	**SWBTB (8/09) 159** **SWBTB (8/09) 159 (a)**
Mr Seager reported that the formal approval regarding the Outline Business Case had been received from the Department of Health. The next step was to seek Secretary of State approval to obtain a Compulsory Purchase Order. Finalisation will take place in next few weeks, in readiness for a September Launch. The Trust Board noted the contents of the report.	
11 Performance Management	
11.1 Monthly performance report	**SWBTB (8/09) 163** **SWBTB (8/09) 163 (a)**

Mr. White presented a summary of the Trust's performance against a number of key targets and indicators for the period April - July 2009. The new national cancer waiting time thresholds have been published, with the Trust's performance against these currently being good. There continues to be an improvement against the Stroke Care targets and a further improvement during the next month is expected as new pathways become embedded. The performance against the waiting time targets for Accident and Emergency remains above the 98% threshold. On infection control, concern has been expressed about the slight increase in *C difficile* cases reported recently. A more robust method of recording smoking cessation referrals is now in place, with 85 referrals reported for the month of July. PDRs completed was noted to have increased for the second consecutive month. In relation to theatre utilisation, Professor Alderson noted that the term 'threshold' was misleading. Mr Kirby advised the threshold was a minimum not a maximum level. Mrs Davis recommended that this be incorporated into discussions around this topic at the Finance & Performance Committee.	
11.2 Monthly finance report	**SWBTB (8/09) 152** **SWBTB (8/09) 152 (a)**
Mr. White reported an in month surplus of £363k above target. This improvement against the slight deterioration in June was due to strong income performance. There was also a slowing down in pay spend. Plans have been received from Divisions reported as underperforming against targets at present. These plans will be worked through and actions agreed.	
11.3 NHS Performance Framework monitoring report	**SWBTB (8/09) 165** **SWBTB (8/09) 165 (a)**
Mr White presented the NHS Performance Framework monitoring report. The Board was pleased to note that the score for July was 2.94, classifying the Trust as a 'performing' organisation.	
12 Governance and Operational Management	
12.1 Corporate planning process and timetable	**SWBTB (8/09) 160** **SWBTB (8/09) 160 (a)**
Mr. Kirby sought Board approval of the proposed timetable and list of activities involved in the corporate planning process. Work is to be undertaken with divisions to ensure adequate engagement with the plans. The Trust Board is to be involved with the plans further at the October Trust Board meeting where the terms of Board engagement will be presented and	

approval of the process will be sought. At the November 'Time Out' a further progress report on the work will be presented. Mrs. Hunjan asked if a budget booklet would be produced this year. Mr. White advised that the booklet consisted a number of reports that have already been agreed by the Board, however he would review the timetable with a view to producing a draft budget book.	
AGREEMENT: The Trust Board approved the proposed corporate planning timetable and activities	
12.2 Staff engagement update	**SWBTB (8/09) 156** **SWBTB (8/09) 156 (a)**
Mr. Holden updated the Board on the Listening into Action programme and noted the Trust had been invited to take part in an academic study sponsored by the Strategic Health Authority. Mr. Holden was currently working on the specification and management of the study. Mrs. Davis asked if wards/teams volunteered for optimal wards work or whether they were chosen purposefully. Ms. Overfield responded that the first four wards were challenged wards but other wards have since been targeted. Mr. Seager asked for permission to delay the presentation of the sustainability work to the December meeting of the Trust Board, due to the timing of a sustainability event which is due to input to the work. This request was accepted.	
12.3 Infection control quarterly update	**SWBTB (8/09) 162** **SWBTB (8/09) 162 (a)**
Dr. Beryl Oppenheim reported that infection control organisational structures are working well, however working with community partners has been affected due to the preparation for the Swine 'Flu pandemic. MRSA bacteraemia infections remain low and under the national and local thresholds. The MRSA screening programme continues and remains challenging. The work to address the issues concerning antibiotics prescribing is progressing well. Dr. Oppenheim informed the Board that a relaunch of the ten key infection control rules occurred at the end of June and the key rules were now part of the junior doctors induction programme. Miss Bartram noted no 'flu cases were reported at Sandwell Hospital within the report. Dr Oppenheim advised the virus did not reach Sandwell for approximately three weeks after the outbreak around City Hospital. Mr. Kirby added that some Sandwell residents living in the south of the region may have attended City Hospital for treatment rather than Sandwell Hospital.	
12.4 Infection control assurance framework	**SWBTB (8/09) 155** **SWBTB (8/09) 155 (a)**
Miss Overfield presented the updated infection control assurance framework. The Board was asked to note that the amber maintenance issues would not improve until the Trust moved to the new site. It was noted there were more handwashing stations at Sandwell than at City. A	

tender is currently in progress to ensure that this is addressed at the City site. Mrs Davis asked once handwashing stations were in place whether visitors would be encouraged to hand wash or use alcohol rub. Miss Overfield confirmed gel would be used on wards and handwashing would be encouraged in public areas. Miss Overfield also informed the Board that floor transfers would be placed to draw staff and visitors attention to the sinks. Due to the ward dimensions at City Hospital handwashing stations would be located in corridors. Mr Cash asked if deep cleaning continued to be undertaken. Miss Overfield advised that last year the government released funds to support a deep clean programme, however it was difficult to undertake this efficiently while patients were *in situ*. The Trust has a programme of deep cleaning however, acknowledging this to be good practice. An overall cleaning schedule has been produced for all activities.	
12.5 Cleanliness report	**SWBTB (8/09) 154** **SWBTB (8/09) 154 (a)**
Miss Overfield presented the quarterly cleanliness report and advised that the external assessment of the Trust's PEAT scores had been validated. Some revised cleaning standards have been issued but this was deemed not to be a problem. Mr. Kirby updated the Board on the installation of the dignity and privacy screens: a final clean is currently being performed. Mr. Kirby expressed his thanks the Medicine B division who worked well in maintaining the work during an extremely busy period and with a closed ward. Mrs. Davis informed the Board that she had visited Priory 2 to view screens and was pleased with the impact they make on the environment.	
12.6 Safeguarding Steering Group report	**SWBTB (8/09) 157** **SWBTB (8/09) 157 (a)**
Miss Overfield informed the Board this was the first report from the Steering Group. The Steering Group oversees Safeguarding for adults and children as there is a degree of overlap and there are shared issues. It was also reported that level 1 Safeguarding training is complete and there is confidence in level 2 training being well underway to being completed. Miss Overfield reminded the Board of the Care Quality Commission's report on the Baby 'P' case and advised that the relevant actions for the Trust will be identified within the next few months. Training of surgeons and anaesthetists involved with operating on children was reported to be historically poor. Divisions have been asked to develop a training template of staff who have received training to monitor the situation. Mr. White highlighted that a recent press story reported that Claire Rayner had called for a review of nursing. Miss Overfield advised that these comments will be included in the wider review into nursing standards being undertaken by the Care Quality Commission. It was suggested that more work needs to be undertaken to inform all staff of the nominated safeguarding children leads. At present, the position of adult medical lead for this responsibility remains unfilled. Mr O'Donoghue remarked that this was a difficult role to fill and it would be best to have a doctor with relevant special	

interests.	
13 Update from the Committees	
13.1 Finance and Performance Management	**SWBFC (7/09) 071**
The Board noted the minutes of the Finance and Performance Management Committee meeting held on 23 July 2009.	
13.2 Governance and Risk Management Committee	**SWBGR (7/09) 044**
The Board noted the minutes of the Governance and Risk Management Committee meeting held on 23 July 2009.	
14 Any other business	**Verbal**
There was none.	
15 Details of the next meeting	**Verbal**
The next meeting is scheduled for Thursday 24 September 2009 at 14.30pm in the Anne Gibson Boardroom, City Hospital.	
16 Exclusion of the press and public	**Verbal**
The Board resolved that representatives of the Press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1 (2) Public Bodies (Admission to Meeting Act 1960).	

Signed ……

Print……

Date ……

Next Meeting: 24 September 2009, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

27 August 2009 - Sandwell Hospital

Members present: Mrs S Davis (SD), Ms I Bartram (IB), Mrs G Hunjan (GH), Professor D Alderson (DA), Mr D O'Donoghue (DO), Mr R White (RW), Mr R Kirby (RK), Dr S Sahota (SS), Miss R Overfield (RO)

In Attendance: Mr C Holden (CH), Miss K Dhami (KD), Mr G Seager (GS), Mr N Howells (NH), Mr J Cash (JC)

Apologies: Miss P Akhtar (PA), Professor D Alderson (DA), Mr R Kirby (RK), Mr G Seager (GS), Miss K Dhami (KD)

Secretariat: Miss R Fuller (RF)

Last Updated: 18 September 2009

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status	Review Date
SWBTBACT. 085	New acute hospital: progress report	Verbal	30-Apr-09	Present the process for consultation on the name of the new hospital at the next Trust Board meeting	GS	28-May-09	Deferred to a future meeting. Suggest revisiting in October	Review next meeting	29-Oct-09
SWBTBACT. 099	Single Equality Scheme update	SWBTB (6/09) 126 SWBTB (6/09) 126 (a)	25-Jun-09	Include benchmarked data and contextual information into future versions of the Single Equality Scheme update	RO	24-Sep-09	Update to be provided within next SES update	Review next meeting	29-Oct-09
SWBTBACT. 105	Response to the HCC report into Mid Staffs NHS FT	SWBTB (8/09) 164 SWBTB (8/09) 164 (a) SWBTB (8/09) 164 (b)	27-Aug-09	Present the outcome of the work of the Accident and Emergency Action Team at the October meeting of the Trust Board	DOD	29-Oct-09		Review next meeting	
SWBTBACT. 107	Policy on the development, approval and management of policies	SWBTB (8/09) 158 SWBTB (8/09) 158 (a) SWBTB (8/09) 158 (b) SWBTB (8/09) 158 (c)	27-Aug-09	Circulate the full list of policies to the Trust Board	KD	29-Oct-09		Review next meeting	
SWBTBACT. 094	Patient Experience update	Hard copy papers	28-May-09	Present an update on progress against the Patient Experience Action Plan at a future meeting of the Trust Board	RO	24-Sep-09		Review next meeting	
SWBTBACT. 084	MRI business case	SWBTB (4/09) 093 SWBTB (4/09) 093 (a)	30-Apr-09	Present a post implementation review of the City Hospital MRI scanner	RK	29-Apr-10	**ACTION NOT YET DUE**	Future	
SWBTBACT. 096	Sustainability	Presentation	25-Jun-09	Present the sustainability strategy at the November meeting of the Trust Board	GS	26-Nov-09	**ACTION NOT YET DUE**	Future	
SWBTBACT. 106	Response to the HCC report into Mid Staffs NHS FT	SWBTB (8/09) 164 SWBTB (8/09) 164 (a) SWBTB (8/09) 164 (b)	27-Aug-09	Present an update on the Quality Management Framework at the January 2010 meeting of the Trust Board	DOD	01-Jan-10		Future	
SWBTBACT. 098	Delivering single sex accommodation	SWBTB (6/09) 123 SWBTB (6/09) 123 (a)	25-Jun-09	Present an update on delivery of single sex accommodation at the September meetings of the Trust Board and TMB	RK	24-Sep-09	Included on the agenda of the September Board meeting	Completed Since Last Meeting	

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status	Review Date
SWBTBACT. 104	Response to the HCC report into Mid Staffs NHS FT	SWBTB (8/09) 164 SWBTB (8/09) 164 (a) SWBTB (8/09) 164 (b)	27-Aug-09	Schedule a discussion around quality, risk management and patient safety information at the November Board 'Time Out'	KD	27-Nov-09	Scheduled as requested	Completed Since Last Meeting	
SWBTBACT. 103	Response to the HCC report into Mid Staffs NHS FT	SWBTB (8/09) 164 SWBTB (8/09) 164 (a) SWBTB (8/09) 164 (b)	27-Aug-09	Present an update on mortality at the September meeting of the Trust Board	DOD	24-Sep-09	Included on the agenda of the September Board meeting	Completed Since Last Meeting	

Next Meeting: 24 September 2009, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

27 August 2009 - Sandwell Hospital

Members: Mrs S Davis (SD), Ms I Bartram (IB), Mrs G Hunjan (GH), Professor D Alderson (DA), Mr D O'Donoghue (DO), Mr R White (RW), Mr R Kirby (RK), Dr S Sahota (SS), Miss R Overfield (RO)

In Attendance: Mr C Holden (CH), Miss K Dhami (KD), Mr G Seager (GS), Mr N Howells (NH), Mr J Cash (JC)

Apologies: Miss P Akhtar (PA), Professor D Alderson (DA), Mr R Kirby (RK), Mr G Seager (GS), Miss K Dhami (KD)

Secretariat: Mr S Grainger-Payne (SPGP)

Last Updated: 18 September 2009

Reference No	Item	Paper Ref	Date	Agreement
SWBBAGR.103	Minutes of the previous meeting	SWBTB (7/09) 149	27-Aug-09	The minutes of the previous meeting were accepted as a true and accurate reflection of discussions held
SWBBAGR.104	Policy on the development, approval and management of policies	SWBTB (8/09) 158 SWBTB (8/09) 158 (a) SWBTB (8/09) 158 (b) SWBTB (8/09) 158 (c)	27-Aug-09	The Trust Board approved the policy on the development, approval and management of policies
SWBBAGR.105	Whistleblowing policy	SWBTB (8/09) 161 SWBTB (8/09) 161 a) SWBTB (8/09) 161 (b) SWBTB (8/09) 161 (c)	27-Aug-09	Subject to minor amendment, the Trust Board approved the whistleblowing policy
SWBBAGR.106	Corporate planning process and timetable	SWBTB (8/09) 160 SWBTB (8/09) 160 (a)	27-Aug-09	The Trust Board approved the proposed corporate planning timetable and activities

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Acute Hospital Project Compulsory Purchase Order
SPONSORING DIRECTOR:	Graham Seager, New Hospital Project Director
AUTHOR:	Graham Seager, New Hospital Project Director
DATE OF MEETING:	24 September 2009

SUMMARY OF KEY POINTS:

The Board has received Department of Health approval of its Outline Business Case for the new hospital. Authority to use it's Compulsory Purchase Powers has been sought from the Secretary of State, with the authority being anticipated shortly.

The Board is asked to make the Order.

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:

- Subject to approval of the Secretary of State, to make the Compulsory Purchase Order which, if subsequently confirmed by the Secretary of State, will authorise the Trust to acquire the land for the new acute hospital
- To authorise the use of the Trust's seal for the making of the CPO
- To confirm that the Land Acquisition Group has authority to continue to manage all matters relating to the CPO and voluntary acquisitions of land for the new acute hospital on the Trust's behalf

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Continue to deliver the New Hospital Project as planned
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Not previously considered in any other corporate fora

Background

The Board will recall that the Outline Business Case (OBC) for the New Acute Hospital Project was approved by the Department of Health (DH) 28th July 2009 with formal confirmation letter being received 14th August 2009 (appendix 1). The OBC makes the case for the new acute hospital to be sited at Grove Lane. To deliver this project the site needs to be assembled from a number of land ownerships.

Since the approval of the Land Business Case by the Strategic Health Authority in November 2008 the Trust has been pursuing land acquisition on the basis of voluntary sales by owners. This has had limited success, with some owners resistant to sell or even to engage. Thus upon approval of the OBC the Board resolved to seek Secretary of State's approval to begin the Compulsory Purchase Order (CPO) process. The case for this was presented to the Secretary of State in the letter attached in appendix 2. (supporting appendices of the letter available to the Board)

Discussion

It is anticipated that the Secretary of State's approval for the Trust to use its CPO powers to assemble the land at Grove Lane for the new acute hospital will be granted shortly.

It remains the view of the Land Acquisition Group of the New Acute Hospital Project Board that a CPO is required to assemble the site; as set out in the letter in appendix 2.

To use its CPO powers the Trust now needs to make the Order (subject to receiving Secretary of State's approval), in doing so it needs to comply with all relevant legislation and good practice. To that end the Trust has retained the service of legal advisors -Pinsent Masons.

The Order needs to be sealed in accordance with the Trust's Standing Orders.

The NHS Act 2006 gives the Trust the power to use CPO "to purchase land compulsorily for the purposes of its functions". In making this Order the Board needs to consider the case made in letter to DH (appendix 2) and take account of the fundamental requirements for a successful CPO:

1. No planning obstacles: The Trust has outline planning permission for the new acute hospital:
2. A compelling case in the public interest:
3. Financial viability, both for land acquisition and the new acute hospital:

Detailed evidence on each of these items will be developed by the Trust and tested at public inquiry before the Secretary of State can confirm the Order.

Recommendation

The Board are recommended to:

- Subject to approval of the Secrtary of State make the Compulsory Purchase Order which, if subsequently confirmed by the Secretary of State, will authorise the Trust to acquire the land for the new acute hospital

- Authorise the use of the Trust's seal for the making of the CPO

- Confirm that the Land Acquisition Group has authority to continue to manage all matters relating to the CPO and voluntary acquisitions of land for the new acute hospital on the Trust's behalf,

Reports on progress of the CPO will be provided to the Board at Board meetings going forward.

APPENDIX 1

APPENDIX 2

Appendix 1 – SWBTB (9/09) 168 (b)

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 5461
Fax: 020 7210 5824

John Adler
Chief Executive
Sandwell & West Birmingham NHS Trust

14 August 2009

Dear John,

DH approval of Outline Business Case:

I am writing to you to confirm the Department of Health's approval of the Outline Business Case to redevelop the Trust's sites onto a single new site in the Grove Lane area of Smethwick. This approval clears the way for the Trust to begin the process of negotiating the acquisition of the land that is necessary for the new buildings, and the process of applying for a compulsory purchase order, should this prove necessary.

There are however a number of important matters that I need to draw to your attention.

Firstly, the Treasury has not yet considered the Outline Business Case. Their reason for not doing so was because they considered that the scheme parameters, particularly scheme cost, would be firmer once the trust has made progress with negotiating the acquisition of land and when it has worked up its procurement documentation. Treasury officials have advised that they intend to consider the case immediately prior to launch of the procurement.

This means that approval of the Outline Business Case is not complete and the Treasury will require an updated business case when the Trust has completed the arrangements to acquire the land. DH will liaise with both the Trust and the Treasury on the timing and arrangements for procuring the Treasury's approval in due course.

Secondly, the Treasury may apply conditions to its approval over and above those applied by the Department of Health, which are summarised below:

1) The procurement documentation and any application for a compulsory purchase order will need to be approved by DH Capital Investment Branch/Private Finance Unit officials and DH Estates prior to procurement.

2) In developing the scheme further, the Trust should note that the capital cost should not vary, in real terms, from the current estimates of £432 million for construction and £22 million for land. Any increase of 10% or more would precipitate a requirement to have the Outline Business Case re-approved.

3) The plans must also remain affordable to the trust in revenue terms. The Trust should note in particular that the normalised revenue unitary charge of the scheme must not exceed 12.5% of the trust's turnover, and a real-terms increase of 5% or more in the revenue costs of the scheme would precipitate a requirement to have the Outline Business Case re-approved.

In the time between now and submission of the business case to the Treasury, the Trust should not just look carefully at scheme costs, but also continually update its income projections to ensure affordability. The trust should also ensure that the scheme is likely to remain within the financial parameters that Monitor may apply, should the Trust become an Foundation Trust.

Should, you or your team, require any further information concerning this approval, or on progressing the scheme in general, please refer to Ben Masterson on 0113 2545550 or ben.masterson@dh.gsi.gov.uk.

I would like to wish you and your team every success in the further development of this scheme.

Bob Alexander
Director of NHS Finance

cc David Flory
Peter Coates
Andrew Stubbings
Ben Masterson
Peter Spilsbury (West Midlands SHA)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Mr P Rimmer
Strategic Asset Manager
NHS Finance, Performance and Operations Directorate
Department of Health
Quarry House
Quarry Hill
LEEDS LS2 7UE

4th August 2009

Dear Peter

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
COMPULSORY PURCHASE OF LAND AT GROVE LANE, SMETHWICK

1. INTRODUCTION

As you are aware from our meetings over the past year, Sandwell and West Birmingham Hospitals NHS Trust (the "**Trust**") wishes to have the ability to purchase compulsorily land at Grove Lane in Smethwick, Sandwell (the "**Site**") for the construction of a new acute hospital and ancillary uses (the "**Scheme**").

The Trust is aware that before it may proceed to use its compulsory purchase powers, it needs prior approval from the Secretary of State for Health. The Trust appreciates that a detailed case should be submitted to the Department of Health ("**DH**") outlining the proper and sound justification for the use of the Trust's compulsory purchase powers to facilitate the Scheme. This will allow DH to seek the Secretary of State's prior approval in this instance.

2. THE SCHEME

The Trust is able to demonstrate its satisfaction that there is a compelling case in the public interest for the CPO. The Trust believes there is a very clear need in health terms for the Scheme.

2.1 Compelling case for the Scheme

For a compulsory purchase order to succeed, it must be demonstrated to the Secretary of State that there is a "compelling case in the public interest" for the compulsory acquisition of the land (paragraph 17 of Office of the Deputy Prime Minister Circular 06/2004). The compelling case for the compulsory acquisition of the Site will be built around the fact that Sandwell and West Birmingham suffer from some of the highest levels of deprivation in the country. The detrimental effect this has on the state of health of the community is indisputable. The statistical data[1] demonstrates a wholly unacceptable and untenable situation, which must be

[1] Please refer to the statistical data contained in the Outline Business Case for the Scheme

addressed as a matter of urgency and therefore the case for compulsory purchase is, in the Trust's view, compelling.

2.2 **Clear health need**

The areas of Sandwell and West Birmingham have some of the highest levels of deprivation in the country, which is a major cause of poor health in communities. The local health and social care services face desperately challenging health needs which are a major cause for concern and urgently need addressing by the provision of a new acute hospital facility. Some key statistics illustrate the critical state of health in the area and exemplify the need for a new hospital facility:

- Men and women live three to four years less than the national average;
- Infant mortality rates are high, and in some parts twice the national average;
- One in five people has a long-term illness which affects their daily life; and
- There is significant variation in health status within the area, and generally black and ethnic minority groups have poorer health than others.

2.3 **The Towards 2010 Programme**

2.3.1 The Scheme forms an integral element of the "Towards 2010 Programme – Investing in a Healthy Future" (the "**Towards 2010 Programme**"), which aims to implement new ways of delivering healthcare across the area covered by the Trust. The new hospital will be a major acute service provider and will contain around 700 beds, providing for approximately 98,800 in-patient and in the region of 178,000 out-patient appointments each year. It would be one of the Sandwell district's biggest ever capital projects with an approval value of approximately £480 million, replacing Sandwell General Hospital and City Hospital, Birmingham to provide a major new acute facility serving Sandwell and West Birmingham.

2.4 **Strategic Outline Case**

2.4.1 The need for major investment to develop and improve health and social care services to address the health needs identified above was formally recognised by the development of a Strategic Outline Case ("**SOC**") during 2003 and 2004. The SOC set out a clear direction to deliver a vision of improved physical, mental and social wellbeing for the population of Sandwell and West Birmingham and described the need to redesign the whole health and social care system by implementing a major change in service provision. Specifically, the SOC indicated a specific need for:

- a rebalanced capacity to reflect a substantial transfer of care into community and primary care settings; and
- a significant improvement in performance in acute hospital services.

2.4.2 Substantial reductions in the length of stay in hospitals are anticipated, with much of the consequent reduction in acute hospital capacity being re-provided in new services and facilities closer to people's homes. Investment in community health and social care services together with investment in acute hospital facilities is seen as the key to the vision's success. This

investment would also enable models of care to be put in place in advance of any changes to acute hospital facilities. All of these planned changes are consistent with "*Our NHS, Our Future*" and the NHS West Midlands Strategy "*Investing for Health*".

2.4.3 The Towards 2010 Programme fits squarely with the DH's aspirations for the future delivery of health care in England and the SOC was approved by DH in July 2004. Plans for the levels of investment required across the local health and social care system began to be formulated under the auspices of the Towards 2010 Programme Agency Board, now the Towards 2010 Partnership.

2.5 **Acute Hospital Services Development Project**

2.5.1 The Scheme forms an Acute Hospital Services Development Project which is designed to address the need for a significant improvement in performance in acute hospital services. The provision of a new hospital is crucial to both the Trust and the Towards 2010 Programme, due to the large amount of old and unsuitable buildings on the current sites at Birmingham City and Sandwell General Hospitals. It is imperative for acute services to be centralised in one location to enable services to be better located in the community and to provide overall improved care. There is considerable pressure for a new acute hospital to be created through the merger and replacement of the two largely outdated existing hospitals.

2.6 **Regeneration Benefits**

2.6.1 The Grove Lane area has a poor social and economic profile and evidence demonstrates that the local property market is also failing to some degree. If the area is to be regenerated comprehensively and in a timely manner then public sector intervention is needed to assemble, remediate and service the land to secure certainty of development. This is recognised by the number of high profile regeneration initiatives operating in the area.

2.6.2 The Site falls within the largest Regeneration Zone in the country, the South Black Country and West Birmingham Zone. Such locations should be the focus of regeneration initiatives - both physical and social - and where inward investment should be channelled. Accordingly, action in this part of the Zone incorporates initiatives associated with two delivery agencies – namely the Housing Market Renewal Area (HMRA – Urban Living) and RegenCo (Sandwell Urban Regeneration Company). Urban Living aim to bring about changes on a significant scale to make a 'real' impact, transforming areas, turning around low housing demand and providing lessons that can be applied elsewhere. Urban Living have proposals to deliver thousands of new houses and have developed an area framework for Smethwick and Soho which includes proposals for the renewal of the Windmill Eye estate located to the west of the Site. Regenco's key role is to drive forward the physical and economic transformation of the central part of the Regeneration Zone focussing on Smethwick, West Bromwich and Hill Top. Regenco's contribution to the transformation is being delivered via a number of large scale physical regeneration projects which will act as a catalyst to attract jobs and people to the area. Regenco aim to assemble sites for mixed use development including new economic development and housing. The Site falls within the RegenCo boundary recognising the need for public sector intervention to facilitate regeneration.

2.7 **Regenerative and health benefits**

2.7.1 The development of a new hospital at the Site would have substantial regenerative and health benefits which are mutually supportive. The

Scheme represents a significant step forward in terms of achieving Sandwell Metropolitan Borough Council's ("**SMBC**") policy objectives set out in the Smethwick Area Action Plan ("**AAP**") to regenerate the Grove Lane area of Smethwick. The redevelopment of the Site will remove low quality and piecemeal industrial development and replace it with a well-designed and comprehensive scheme to provide a new acute hospital facility. This will benefit the wider community specifically from a health services delivery perspective. The proposed development will also improve the visual appearance and commercial investment appeal of this area.

3. STATUTORY REQUIREMENTS FOR CPO

3.1 DH - Estatecode

3.1.1 Estatecode states at paragraph 5.70 that a preferred site must be identified and appropriate planning permission obtained before compulsory purchase may be considered. Planning permission was granted on 29 October 2008 (see paragraph 6.1.1 below) thus satisfying that requirement of Estatecode.

3.1.2 Estatecode also requires at paragraph 5.72 that in advance of an order for compulsory purchase being approved by the Trust, a robust business case giving full details of why compulsory purchase powers are required is submitted to the Strategic Health Authority ("**SHA**") and, with its support, to DH. The Land Business Case ("**LBC**") was submitted to the SHA and DH on 24 September 2008. It has been approved by the SHA Board. The LBC sets out the case for the voluntary acquisition of land, with valuations which take into account potential levels of compensation under a compulsory purchase order. This letter provides the business case for a compulsory purchase order.

3.1.3 We attach a copy of paragraphs 5.70 and 5.72 of Estatecode at Appendix 1 to this letter for your ease of reference.

3.2 National Health Service Act 2006

3.2.1 Similarly, section 25 of and paragraph 27 of Schedule 4 to the National Health Service Act 2006 (the "**2006 Act**") state that no compulsory purchase order may be made by an NHS Trust unless a proposal to seek the land compulsorily has been submitted to and approved by the Secretary of State. We would ask you to consider this letter as constituting the Trust's proposal.

3.3 Health and Social Care (Community Health and Standards) Act 2003

3.3.1 Section 34 of and paragraph 46 of Schedule 4 to the Health and Social Care (Community Health and Standards) Act 2003 (the "**2003 Act**") are the parallel compulsory purchase provisions for Foundation Trusts. The Trust is proposing to apply for Foundation Trust status. In the event that it is successful in that application, the Trust would nonetheless wish to proceed with the compulsory acquisition and understands that the Secretary of State's approval of this proposal would be sufficient to satisfy the purposes of section 34 and paragraph 46 of Schedule 4 to the 2003 Act.

3.4 Section 26 National Health Service Act 2006

3.4.1 An NHS Trust is required by section 26 of the 2006 Act to exercise its functions effectively, efficiently and economically. The process of furthering the Scheme has and will continue to be carried out fully in accordance with these statutory requirements.

3.5 **Planning powers**

3.5.1 The Trust considered the potential use of regeneration powers by SMBC under Section 226 of the Town and Country Planning Act 1990 as an alternative to the use of NHS Trust CPO powers. SMBC were only prepared to use regeneration powers in the context of the wider regeneration of the Grove Lane area, rather than just in relation to delivering the Scheme. Work with SMBC and its regeneration partners has shown that the timescale for developing such a broader regeneration initiative would delay the delivery of the new hospital by at least 18 months whilst appropriate funding is secured for the regeneration project. This would threaten the viability of the hospital project, and as importantly, delay the significant benefits which the new hospital will bring to the area.

3.5.2 Paragraph 15 of Circular 06/2004 requires acquiring authorities to seek to use the most specific power available for the purpose in mind, and only use a general power where unavoidable. The powers pursuant to the 2003 Act and the 2006 Act are clearly the most appropriate powers, which the Trust could use in pursuance of the Scheme.

4. **THE SITE AND ALTERNATIVE LOCATIONS**

The Trust believes that all the land and property within the Site is necessary for the Scheme. The Trust has carefully developed the plans for the new hospital to ensure that the land take of the development is the minimum that is required to meet the Trust's needs and to optimise the relationship between the Scheme and the wider area. The Trust is also confident that there are no satisfactory alternative locations and the site selection process which led to this conclusion is detailed below.

4.1 **Grove Lane Site Selection**

4.1.1 In 2005, once it was established that a new hospital was required the Trust initiated a site search across Sandwell and West Birmingham to identify a suitably located site to accommodate the new acute facility. The search involved extensive consultation with officers from SMBC, Birmingham City Council (the "**City Council**") and local regeneration agencies, including AWM and RegenCo.

4.1.2 A total of 18 sites were identified, the vast majority of which were located in the area between the existing City Hospital and Sandwell General Hospital. These were assessed against 4 core factors, including site size, location, deliverability and regeneration impact. Following this evaluation, 4 of the original 18 sites were identified as being preferred:

- City Hospital, Birmingham;
- Windmill Eye, Smethwick;
- Lyng Industrial Estate, West Bromwich; and
- South of Birmingham Road (A41) Junction 1 M5.

4.1.3 These sites were then assessed further by technical specialists against a number of detailed criteria, and then evaluated at workshops attended by representatives of the Towards 2010 Partnership in April 2005. Attendees including hospital, patient and community representatives, officers from the City Council, SMBC and representatives from local regeneration agencies. As a result, in August 2005, the Partnership Board selected the Smethwick area as an appropriate location for the new acute facility.

4.1.4 The Trust undertook extensive consultation between November 2006 and March 2007 on the entire Towards 2010 Programme. This included reference to the plans to build a new acute facility in the Grove Lane area. The consultation included around 200 meetings over 16 weeks, advertorial in the local papers, letters to 1,800 people, emails to staff, public meetings and exhibitions.

4.1.5 In Spring-Summer 2007, a series of meetings with transport, planning and development officers from SMBC were held to identify the most appropriate site for the hospital in the wider Smethwick area. After several meetings and further analysis, it was agreed that the Grove Lane industrial area of Smethwick, adjacent to the Windmill Eye residential area, was favoured.

4.1.6 The Grove Lane area originally featured in the list of 18 original sites. It was ranked fifth in the overall assessment and was only excluded from the initial short list given the proximity to the Windmill Eye site. To ensure a fair and transparent process the Grove Lane site was re-assessed against the three sites on the original short list and this demonstrated that the Grove Lane site compared favourably with the Windmill Eye site, and scored significantly higher than the other options. In September 2007, the preferred site for the new acute hospital was identified at Grove Lane, Smethwick by the Trust and officers at SMBC.

4.1.7 In January 2008, the Trust arranged five specific consultation events as part of the pre-application consultation. This included a meeting with the landowners of the Grove Lane site, meeting with local MPs and Councillors and three public exhibitions held at a community centre in the Windmill Eye estate, Birmingham City and Sandwell General Hospitals.

4.1.8 The preparation of the AAP coincided with the Trust's site selection process. The Trust submitted representations at all stages of the consultation, including the Issues and Options in August 2006, the preferred options in April 2007 and the submission document in December 2007. In its responses, the Trust identified the opportunity presented by the Grove Lane area to accommodate a new acute hospital. For further information on the AAP, please refer to paragraph 6.2 below.

5. LAND ACQUISITION

5.1 The Site

5.1.1 The Site extends across a site of approximately 6.76 hectares, bounded by the A457 (Grove Lane) and the A4092, a major arterial road between Birmingham and Sandwell. It is located in the centre of the wider Grove Lane site, which incorporates all land bordered by London Street, Heath Street, Grove Lane, Grove Street and the Cape Arm Canal. We attach a plan at Appendix 2 to this letter showing the extent of the Site.

5.1.2 The Site is intensively developed with predominantly industrial and storage uses, together with associated offices and car parking, but is also derelict in part with poor quality, or vacant units. Much of the Site is under-utilised and characterised by low-value uses, the exception being the Unifix landholding, which is a relatively new factory/warehouse. The Site contains two pubs. There are no known dwellings within the Site. The Trust is not aware of any consequential special requirements for owners.

5.2 Ownership

5.2.1 The Trust has appointed land advisors Bruton Knowles to conduct an exhaustive investigation of the identity of the owners and occupiers of the

Site. The initial part of this investigation is now complete and Bruton Knowles' Land Referencing Report is appended to this letter at Appendix 3. Bruton Knowles have not identified any significant changes since the date of that report, though an update showing what changes there have been to the Land Acquisition Plan is attached to this letter at Appendix 4.

5.2.2 The results of Bruton Knowles' initial investigation have confirmed that the Site is currently in multiple ownership, with 31 known owners at the date of this letter. Within the 68 plots there are some 116 known interests, all of which would need to be acquired to enable the Scheme to progress. None of the Site is owned by the NHS or any other public sector bodies (save for highway land which is in the ownership of SMBC).

5.3 **Voluntary acquisition**

5.3.1 Circular 06/2004 is clear that before embarking on compulsory purchase and throughout the preparation and procedural stages, acquiring authorities should seek to acquire land by negotiation wherever practicable. Paragraph 24 of the Circular states that before embarking on compulsory purchase and throughout the preparation and procedural stages, acquiring authorities should seek to acquire land by negotiation wherever practicable.

5.3.2 Until the Land Business Case ("**LBC**") was approved, the Trust was not able to start negotiations with owners and tenants of properties at the Site. However, the Trust was keen to pave the way for those negotiations to commence as soon as possible following approval of the LBC and ensured that the necessary land referencing procedure was completed and an initial dialogue with owners and tenants started well in advance of that approval being secured. Now the LBC is approved by the SHA and planning permission has been obtained, negotiations have commenced, with letters having been sent out to owners and tenants of properties within the Site. A sample copy of the letter to owners and tenants is attached to this letter at Appendix 5.

5.3.3 As discussed in paragraph 5.2 above, Bruton Knowles have conducted an initial investigation into the ownership of the Site. Appendix 1 of the Land Referencing Report (appended to this letter at Appendix 3) suggests that most owners appear to be prepared to enter into negotiations. However, the Land Referencing Report reveals some key concerns:

(a) It is evident from the Land Acquisition Plan at Appendix 2 of the Land Referencing Report that the majority in terms of area of those plots where discussions have commenced are categorised as being of medium complexity. Reasons for this complexity range from the owner being an off-shore investment company to expected difficulties in relocation and are detailed in Appendix 1 of the Land Referencing Report. This indicates that in fact successful negotiation within the requisite timeframes with all those owners who have so far shown a willingness to negotiate is far from guaranteed.

(b) Additionally, significant areas of strategically key land within the Site remain where no discussions have been commenced.

(c) Of even greater concern is the strategic position of those plots where, despite diligent efforts, it has not been possible to identify or to make contact with landowners at all and there is no indication that this will change.

(d) Finally, a number of sites are affected by restrictive covenants. Some restrictive covenants are likely to disappear when the titles within the Site merge on acquisition. However, it is likely that there will be some which benefit land outside the Site. Unless compulsory purchase powers are used, then the Trust would need to negotiate for their release or even acquire the benefiting land.

It is therefore clear to the Trust that the mere potential for compulsory purchase at some stage in the future is insufficient to bring forward the land required in the necessary timescale.

5.3.4 The Trust is proposing to pursue the route of compulsory purchase in tandem with negotiations with owners and tenants of properties affected. The Trust views this dual approach as essential to ensure that as little time as possible is lost and that the Scheme is brought forward as expeditiously as possible in line with the timeframes outlined in paragraph 5.5.3 below. This approach fully accords with government policy guidance contained in Circular 06/04. While acknowledging that the compulsory purchase of land is intended as a last resort in the event that attempts to acquire by agreement fail, paragraph 24 of Circular 06/2004 further states that:

"*Acquiring authorities should […] consider at what point the land they are seeking to acquire will be needed and, as a contingency measure, should plan a compulsory purchase timetable at the same time as conducting negotiations. Given the amount of time which needs to be allowed to complete the compulsory purchase process, it may often be sensible for the acquiring authority to initiate the formal procedures in parallel with such negotiations. This will also help to make the seriousness of the authority's intentions clear from the outset, which in turn might encourage those whose land is affected to enter more readily into meaningful negotiations.*"

5.3.5 This Government policy guidance makes clear that authorities may pursue the route of compulsory purchase in tandem with negotiations with owners and occupiers. This dual approach is essential to ensure that as little time as possible is lost and that the Scheme is brought forward as expeditiously as possible.

5.3.6 The Trust is committed to discussing compensation issues and to acquire land by agreement wherever possible, rather than compulsorily. Owners and tenants of affected properties who wish to discuss this option have been advised to contact the Trust's appointed land advisors, Bruton Knowles.

5.3.7 The Trust has appointed experienced solicitors to act on its behalf in progressing the making of a compulsory purchase order. Owners and tenants of properties affected by the Order will be advised to contact them directly on any legal issues arising in respect of the process, but will also be warned to seek their own professional advice concerning their specific rights, including potential rights to compensation.

5.4 The need for an NHS-related CPO

5.4.1 The Site is both eminently suitable for, and indeed necessary to secure, the provision of a new acute hospital facility. However, it is currently in multiple ownership. Single ownership is essential to enable development to proceed. Negotiations will inevitably be protracted and are far from certain to guarantee purchase of the entirety of the Site. Contact has been made with owners and occupiers of the Site and it is already apparent that there is very limited proactive willingness to negotiate for voluntary acquisition of land. Compulsory purchase is therefore crucial to enable the Trust to bring the Scheme forward with the urgency it warrants.

5.4.2 Due to the nature of construction works for a scheme of this scale, it will be necessary not only to acquire land within the Site, but also to obtain new rights over land without which development cannot be achieved within a strip up to 20m wide around the circumference of the Site, as shown shaded blue on the plan at Appendix 2 to this letter. At the present time, it is envisaged that necessary rights over this strip will include oversailing rights for the purposes of construction cranes and rights of access to remove third party owned bridges and block up accesses to the Site over the canal. The Trust will seek to acquire these rights by agreement, but if that cannot be achieved then the Trust will need to rely on its compulsory purchase powers.

5.4.3 Please refer to paragraph 3.5.1 for details of the justification for the decision to seek to use NHS Trust compulsory purchase powers.

5.5 The urgency for a CPO

5.5.1 As illustrated above, Sandwell and West Birmingham suffer from some of the highest levels of deprivation in the country. The detrimental effect this has on the state of health of the community is indisputable. The statistics quoted demonstrate a wholly unacceptable and untenable situation, which must be addressed as a matter of urgency.

5.5.2 The Trust is able to demonstrate why it needs to buy the Site now, given the future timescale for the procurement of the proposed new hospital. The Scheme is to be delivered through the Government's private finance initiative ("**PFI**"). The Trust cannot proceed to the market to commence the PFI process until the Trust has achieved certainty on land acquisition.

5.5.3 Completion of construction of the Scheme is scheduled for 2015. This means that financial close must be achieved by 2012. Working backwards, the Trust must therefore be in a position to go to market for PFI during 2010. The only means of achieving certainty on site acquisitions is through the use of an NHS-related CPO. This is supported by the recommendation of our land advisors. This course of action is made more imperative given the above mentioned delays if the regeneration CPO powers were to be used.

6. PLANNING

Paragraph 22 of Circular 06/2004 states that authorities need to be able to show that a scheme is unlikely to be blocked by any impediments to implementation. This includes planning impediments and the Trust is confident that it has satisfied this requirement.

6.1 Planning permission

6.1.1 Outline planning permission for the Scheme was granted on 29 October 2008 (the "**Permission**") under reference DC/08/49418. A copy of the Permission is attached as Appendix 6 to this letter.

6.1.2 The Permission enables the redevelopment of the Site to provide a new 90,000m^2 acute hospital within Class C2 of the Town and Country Planning Use Classes Order 1987 (as amended) and a 8,200m^2 supporting education, research and administration centre (Class B1 (a) and (b)), together with a multi-storey car park, gym (Class D2), crèche (Class D1), car parking and means of access.

6.2 Planning policy

6.2.1 The Committee Report leading to the grant of the Permission states as follows:

"The proposal accords with the allocation Local Policy Sme4 – Grove Lane within the emerging Smethwick Area Action Plan, but does not accord with the current Policy E2 'Business Zones'. Whilst the proposal remains a departure against the current Unitary Development Plan, it is considered that firstly the site would be an employment generator and therefore a complementary use to the B1, B2 and B8 uses. Furthermore the emerging Smethwick Area Action Plan should be given as much weight if not more than the Unitary Development Plan due to the processes that the AAP has already undertaken with the preferred options being endorsed by Full Council on 30th October 2007 and the examination hearing on the AAP taking place in June of this year. Furthermore the Inspectors Report on the Panel was received by the Council during August 2008. The Inspector concluded that the wording of Policy Sme4 (the hospital site) should remain as is. Therefore he has suggested no changes are necessary and the Plan is sound as it is. The AAP will be taken to the December Planning Committee and should be adopted shortly afterwards. It is therefore considered that the proposal is not a departure from emerging policy which is now of more substance than the extant UDP."

6.2.2 The AAP was adopted on 2 December 2008.

6.3 **Judicial Review**

6.3.1 The period during which a judicial review of the grant of planning permission can be brought expired at the end of January 2009 without any challenge or claim being brought. In light of this and the contents of the Committee Report, the Trust is confident that the Scheme is unlikely to be blocked by any impediments to implementation in planning terms.

7. PROJECT VIABILITY AND FEASIBILITY

7.1 We understand that DH needs to be assured that the Trust is satisfied that the Scheme is realistic, affordable and achievable in the timescales envisaged. Paragraphs 20 and 21 of Circular 06/2004 state that in preparing its justification for a scheme, an authority should provide as much information as possible about the resource implications of both acquiring the land and implementing the Scheme for which the land is required.

7.2 The Outline Business Case for the Scheme ("**OBC**") prepared by the Trust sets out in detail the justification for the Scheme and provides the detailed evidence in support of this statement. OBC was submitted for approval on 4 December 2008 and showed that the project is affordable within the forecast resources likely to be available to the Trust. Approval of the OBC was confirmed by the SHA on 27 January 2009 and by DH on 28 July 2009. A copy of the e-mail confirming approval of the OBC by DH is attached to this letter at Appendix 7.

7.3 The test of financial viability involves demonstrating that sufficient resources are likely to be available to acquire the land and pay compensation, for example for business relocations. The test also involves some examination of whether there are sufficient resources likely to be available to develop the Scheme. The finance to support the acquisition of the land by the Trust is in place following approval to the Land Business Case ("**LBC**") and the associated borrowing facility negotiated with the Department of Health. The LBC demonstrates that sufficient resources are available to acquire the land.

7.4 The Trust is satisfied that the Scheme is realistic, affordable and achievable.

7.5 The Trust is proposing to procure the Scheme through the Government's Private Finance Initiative. It will be appreciated that current financial market conditions make such funding more difficult to predict than previously.

7.6 Please note that there is case law to the effect that viability should not have to be definitively proven for a CPO to be confirmed by the Secretary of State. It follows that viability does not need to be definitively proven to secure DH approval to initiate a compulsory purchase order. Having said this, the detailed financial and affordability analysis undertaken within the OBC has shown that the project is likely to be affordable and offer best value under PFI.

7.7 Copies of all paragraphs of Circular 06/2004 referred to above are attached to this letter at Appendix 8.

8. RELOCATION

The Trust is anxious to assist those with interests within the Site seeking relocation. Owners and tenants of properties affected by the Scheme who require further information will be advised to contact Bruton Knowles during all normal office hours.

9. SPECIAL LAND AND RELATED PERMISSIONS

None of the buildings within the Site are listed and the Site is not designated as a Conservation Area. The Cape Arm Canal (linked to the Birmingham Canal) forms the north eastern boundary to the Site. Part of the Cape Arm Canal does fall within the Smethwick Summit Conservation Area and the end of the Cape Arm canal does fall within the Site. However, this part is excluded from the Conservation Area designation.

10. ARCHAEOLOGICAL INVESTIGATIONS

The Permission notes that the Site is of potential archaeological significance. Consequently, condition 56 of the Permission requires the implementation of a programme of archaeological works and recording of existing buildings prior to commencement of development. This is standard condition for the majority of brownfield redevelopments in urban areas.

11. ENVIRONMENTAL ASSESSMENT

The application for outline planning permission addressed the need for an environmental assessment and its scope. Planning permission has now been granted and the environmental assessment will be dealt with through that planning process.

12. PROJECT MANAGEMENT

The Trust has in place comprehensive plans for the delivery of the Scheme and clear governance arrangements to ensure that the acquisition of land is effectively managed. Given the importance of the land acquisition to the overall project, a dedicated Land Acquisition Group has been established within the overall project structure, with clear terms of reference and reporting arrangements.

13. CONCLUSION

We refer to Part 4 Section A of the Compulsory Purchase Procedure Manual dated September 2006 entitled "*Management of the Compulsory Purchase Process*". This states that by the Initial Period of the Project Management Programme, which the Trust has now reached, an authority should have been satisfied that there is a proper and sound justification for the use of compulsory purchase powers to achieve the project. It states that at this stage there should be in place those items detailed on Check List A.1. A copy of that Check List is appended to this letter at Appendix 9. Some of the items in that list may not be relevant to the Scheme. However, the Trust is confident that all relevant items have been demonstrated as having been satisfied in the paragraphs above. Specifically:

- As demonstrated in paragraph 3, all statutory requirements, including the requirements of Estatecode have been met or will be met upon receipt of the Secretary of State's approval to this proposal.

- The Trust is confident that this letter illustrates that the Scheme fulfils the necessary criteria set out in Circular 06/2004. There is a clear compelling case for compulsory purchase, with no planning impediments and the viability of the Scheme is proven.

- Finally, the SHA have confirmed their support for the Scheme and its viability in the context of the whole health economy. A copy of that letter is attached at Appendix 10 to this letter. Further support for the viability of the Scheme can be gleaned from approval of the OBC by both the SHA and DH.

- In addition the Trust is satisfied that it has addressed all those queries and criteria which you have identified on behalf of DH as necessary to address.

I hope that this is of assistance and should be grateful if you would kindly confirm in writing that the Secretary of State for Health has given his prior approval to the use of CPO powers by the Trust.

Should you have any queries, please do not hesitate to contact me on the details provided.

Yours sincerely

Graham Seager
Director of Estates/New Hospital Project Director

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Maternity Service- Medium Term Review : Board Report Outlining The Case For Change
SPONSORING DIRECTOR:	John Adler, Chief Executive
AUTHOR:	Jayne Dunn, Redesign Director – Right Care Right Here
DATE OF MEETING:	24 September 2009

SUMMARY OF KEY POINTS:

The report is designed to:

- Outline progress to date with the medium term review into the Trust's Maternity Services
- Set out the case for change and
- Seek Board approval to undertake a formal public consultation 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:

- NOTE the progress that has been made with the medium term review to date.
- AGREE the case for change to the configuration of maternity services in the medium term.
- AGREE that a formal public consultation of the short listed options is undertaken.
- AGREE the consultation framework.
- AGREE the consultation document.
- AGREE the decision making process to identify an approved option.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	2.4 Review of Review of Maternity Services for Medium Term Sustainability.
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

Financial	**X**	Potentially significant financial implications. Significant investments already agreed
Business and market share		
Clinical	**X**	Changes to clinical practice Compliance with national guidance
Workforce	**X**	Investment in additional posts and implications from potential reconfiguration
Environmental		
Legal & Policy		
Equality and Diversity	**X**	Medium term review requires full impact assessment.
Patient Experience	**X**	Extensive internal and external requirements Public consultation proposed.
Communications & Media	**X**	Extensive engagement with mothers required
Risks		As set out in the report

PREVIOUS CONSIDERATION:

Plans have been considered in various corporate maternity fora

MATERNITY SERVICE- MEDIUM TERM REVIEW
BOARD REPORT OUTLINING THE CASE FOR CHANGE
16/09/2009

1. Executive Summary

Following a report summarising recent developments in the Sandwell and West Birmingham Hospitals NHS Trust's maternity service, the Trust Board at its meeting in April approved a review of intra-partum care (labour and birth) Midwifery and Consultant led care (ante-natal, birth and post natal care) to ensure their medium term sustainability, up to the opening of the new Acute Hospital. A joint Maternity Services Review Project Steering Group, chaired by Sandwell PCT, has been established to lead the review.

This report is designed to:

- Outline progress with the medium term review to date
- Set out the case for change and
- Seek Board approval to undertake a formal public consultation of the short listed options.

Over the past 2-3 years there has been an intense focus on developing and improving the Trust's maternity 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 good results with clear improvements in the Trust's maternity services but there remain continuing concerns about medium term sustainability, particularly in respect of the Consultant led component of the service. It is these concerns along with the need to plan a transition to the new service model outlined for the new Acute Hospital under the Right Care Right Here Programme that led to the medium term review.

The Project Steering Group therefore identified the development of a report setting out the clinical case for change as a first step in the review. This clinical case for change concluded that from a clinical perspective a further change in the configuration of services is required in order to enable the continued promotion of normality for women with low risk factors and also the strengthening and further development of acute services for high risk women in line with the drivers for change. The consolidation of obstetric-led, high risk deliveries and associated acute care on one site would facilitate further improvements more rapidly (e.g. extended consultant cover for labour ward) than trying to achieve this on two sites and would also more robustly ensure that improvements would be sustained in the medium term particularly in relation to clinical leadership and presence. In addition such consolidation would ensure integration of staff from the two sites into one team working to the same clinical policies and processes ahead of the opening of the new Acute Hospital. This clinical case for change was approved by the Chief Executives of the Trust, Sandwell PCT and Heart of Birmingham teaching PCT.

The Department of Health requires that all new reconfiguration proposals are subject to initial clinical assurance provided by the National Clinical Advisory Team (NCAT). The purpose of the National Clinical Advisory Team (NCAT) is to provide a pool of clinical experts to support, advise and guide the local NHS on local service reconfiguration proposals to ensure safe, effective and accessible services for patients. In line with this requirement a visit by NCAT took place in July to review the

clinical case for change for the medium term service review of maternity services. The conclusion from this visit was support for the clinical case for change and a number of related recommendations were made.

The Project Steering Group agreed a long list of options for the configuration of acute maternity services in the medium term along with a set of evaluation criteria. These took account of feedback from some early workshops with front line staff working within the Trust's maternity services. The long list of options was scored by the Project Steering Group and through a User event, using the agreed evaluation criteria and reviewed by a wider reference group. Consideration was also given to feedback from pre-consultation engagement with the public. As a result the short list of options was identified and recommended for public consultation. These options are:

Option 1
Transfer all births and consultant activity to City Hospital and retain low risk Midwifery led antenatal services at Sandwell and City Hospitals including routine screening (scans). There would be no births at Sandwell Hospital and all Consultant antenatal clinics would transfer to City Hospital concentrating all high risk care to one site. All Neonatal care would be provided at City Hospital.

Option 2
All births and in-patient maternity care would be located at City Hospital. There would also be a full range of antenatal services at City Hospital. A small number of Consultant antenatal clinics would remain at Sandwell Hospital along with a full range of Midwifery antenatal services including routine screening. There would be no births or inpatient maternity care at Sandwell Hospital. High risk in-patient care will be provided at City Hospital. All Neonatal care would be provided at City Hospital.

Option 3
All consultant led care and, all in-patient services and, temporarily all births would transfer to City Hospital. A Stand Alone Midwifery Led Birth Centre would be developed within Sandwell and, once operational, some midwifery led low risk births would relocate to the new centre in Sandwell. Low risk midwifery led antenatal care and routine screening will be available in Sandwell and at City Hospital. Consultant led antenatal care would be relocated to City Hospital. All Neonatal care would be provided at City Hospital.

In addition a statement of what would need to happen if there was no change to the configuration of services but an improvement to facilities and further improvement to clinical leadership, operational management and workforce capacity at Sandwell Hospital, will be included but it will be clear that this is not supported by the local health economy partners especially from a clinical perspective.

The review has involved pre-consultation engagement with frontline staff, the public, women and the Joint Health Scrutiny Working Group. This has provided useful dialogue and feedback with many of the issues raised influencing the option appraisal process, consultation framework and consultation document.

In developing the options a level of detailed analysis around activity, capacity, facilities, finance, staffing and risk has been undertaken. The findings from this work have confirmed that the short listed options are viable in terms of affordability, capacity and feasibility. Work will continue in these areas in preparation for the

business case that will be developed and considered as part of the final decision making process to agree a preferred option.

All of the short listed options for the medium term review involve service change and in particular changes in location for the provision of services. Therefore a formal public consultation is required. The requirement is for this to take place over a 12 week period and in line with the medium term review project timetable it is proposed that public consultation starts on 12th October 2009 and finishes on 18th January 2010 (extended by two weeks to take account of the Christmas holiday period). A proposed consultation framework is presented in Appendix 5 along with the proposed consultation document in Appendix 6.

The final decision to undertake a formal public consultation will be taken by Sandwell PCT Board at its meeting in September 2009. This will be based upon the case for change presented in this report. In making this decision Sandwell PCT will seek agreement to the consultation from Sandwell and West Birmingham NHS Trust Board and will also require agreement to the consultation from Heart of Birmingham teaching PCT Board.

The Trust Board is recommended to:

- NOTE the progress that has been made with the medium term review to date.
- AGREE the case for change to the configuration of maternity services in the medium term.
- AGREE that a formal public consultation of the short listed options is undertaken.
- AGREE the consultation framework.
- AGREE the consultation document.
- AGREE the decision making process to identify an approved option.

- **Introduction**

A report was presented to the Trust Board in April that summarised recent developments in the Trust's maternity service, set out the progress that had been made and thus the current position and sought the Board's approval for a further review of the service to ensure its medium term sustainability and acknowledge that this may require a change to the configuration of some of the maternity services including the location from which they are provided. The Trust Board approved this further review and following a subsequent meeting with the Trust's Commissioning PCTs a joint Maternity Services Review Project Steering Group, chaired by Sandwell PCT, has been established to lead the review.

The medium term review of maternity services has focused on the intra-partum (labour & birth) Midwifery and Consultant led care (ante-natal care, and care during and immediately after birth) provided at Sandwell and West Birmingham Hospitals NHS Trust. It has considered the time period up to the opening of the new Acute Hospitals in 2015/16.

This report is designed to:

- Outline progress with the medium term review to date
- Set out the case for change and
- Seek Board approval to undertake a formal public consultation of the short listed options.

- **Long Term Vision for Maternity Care**

The expected standards for maternity care within in England have been defined by the Department of Health (DoH) in the Maternity Standard within the *National Service Framework for Children, Young People and Maternity Services* (DoH, 2004). The Maternity Standard identifies safety, normality, women's choice and involvement, and a focus on wide accessibility as key elements of a high-quality service which for low risk pregnancies should be community and midwifery based. The Department of Health publication *Maternity Matters: Choice, access and continuity of care in a safe service* (DoH, 2007) confirms the importance of these factors and sets out, from a national perspective, expectations relating to the delivery of these.

The service provided and the models of care delivered should encompass the central role of midwives as autonomous practitioners of normal labour and birth, together with their role as partners with obstetricians, anaesthetists and paediatricians, in the care of women with complex and complicated labours.

The long term plan for the Trust's maternity service is clearly articulated within the Right Care Right Here Programme. This envisages a model of community-based ante- and post-natal care, with a centralised delivery and specialist care facility in the new Acute Hospital in Smethwick which is due to open in 2015. The delivery facility will be clearly split between a higher risk obstetric-led unit and a low risk midwifery-led unit.

The Right Care Right Here Programme is currently developing more detailed service models through Strategic Model of Care groups (SMOCs) and in relation to maternity services the proposed service model will include one or more stand alone midwifery led birth centres in addition to the main Delivery Suite and midwifery led birth centre located on the new Acute Hospital site. In this context the review into the medium

term sustainability of maternity services focuses on intra-partum and acute Consultant led elements of the service.

- **Current Maternity Service Provision**

In relation to intra-partum and acute Consultant led elements of the Trust's maternity services the current configuration, in summary has:

- Two obstetric (consultant) led Delivery Suites with associated inpatient beds and Antenatal Day Assessment Units, one at Sandwell Hospital and one at City Hospital, that primarily provide a medical model of care.
- Consultant led antenatal clinics are also held on both sites.
- The Trust delivers around 6100 babies a year with 3500 deliveries at City Hospital and 2600 deliveries at Sandwell Hospital. During 2007/08 the Trust supported 27 home births.
- There is a Level 2 Neonatal Unit at City Hospital that admits babies delivered from 26 weeks gestation requiring intensive or special care.
- There is a Level 1 Neonatal Unit at Sandwell Hospital that admits babies from 34 weeks gestation requiring special care. As a result women presenting at Sandwell Hospital in labour between 26 and 34 weeks gestation are transferred to City Hospital for delivery (or if there is no capacity at City another Hospital with an onsite Level 2 Neonatal Unit). It is estimated that up to about 200 women a year presenting at Sandwell will require this type of transfer.
- Women presenting at Sandwell or City Hospital in labour under 26 weeks gestation are transferred to a Hospital with an onsite Level 3 Neonatal Unit (locally these are the Birmingham Women's Hospital and Heartlands Hospital).
- In order to offer women with low risk pregnancies the advantages of more choice, a less technical and clinical environment and a midwifery led model of care with less likelihood of medical interventions, the Trust Board has recently approved the development of a Midwifery Led Birth Centre at City Hospital, co-located to the main Delivery Suite. It is anticipated that 30% of women delivering at City Hospital will be eligible to deliver in the Centre. The Centre is expected to open in April 2010.

- **The Clinical Case for Change**

Over the past 2-3 years there has been an intense focus on developing and improving the Trust's maternity service with the aim of ensuring the quality and safety of the service, in response to national guidance and to local concerns. The Trust has in place a Maternity Taskforce chaired by the Trust Chair, and with Executive Director, Non-Executive Director and senior clinical membership to provide assurance to the Trust Board that appropriate action is being taken to maintain and improve the quality of the Trust's maternity services, in particular by:

1. Monitoring progress against action plans
2. Reviewing the Trust's position against national maternity standards
3. Monitoring the rate, pattern of and follow up to clinical incidents
4. Ensuring proper assessment of the risk implications of planned service reconfigurations (e.g. neonatal services).

In order to bring together the various strands of existing work and give a framework for further development, an Integrated Maternity Development Plan was produced which was approved by the Trust Board (and the two local Primary Care Trust Boards) in the second half of 2008.

In addition to addressing National Policy imperatives, much of the Trust's activity has been aimed at addressing specific local issues so as to ensure the maintenance of a safe and effective service. Some of this work has been undertaken in conjunction with external bodies, notably the Healthcare Commission, West Midlands Strategic Health Authority, Sandwell and Heart of Birmingham Primary Care Trusts, the Royal College of Obstetricians and Gynaecologists (RCOG), and the Local Supervisor of Midwives (who has carried out regular independent supervisory reviews). The input of these external bodies has been invaluable, particularly in providing an independent perspective, in benchmarking the Trust's performance against its peers and in making clear recommendations for areas of further action.

These efforts have produced good results with clear improvements in the Trust's maternity services but there remain continuing concerns about medium term sustainability, particularly in respect of the Consultant led component of the service. It is these concerns along with the need to plan a transition to the new service model outlined for the new Acute Hospital under the Right Care Right Here Programme that led to the medium term review.

The medium term review is being carried out in accordance with national guidance as set out in *Changing for the Better* (DoH 2008). A key element of this guidance is that the focus should be on improving the quality of services and should be clinically led. Thus the guidance states that:

"Change will always be to the benefit of patients and, where appropriate, their carers. This means that they will improve the quality of care that patients receive – whether in terms of clinical outcomes, experiences, or safety.

Change will be clinically driven. We will ensure that change is to the benefit of patients by making sure that it is always led by clinicians and based on the best available clinical evidence."

- **Local Clinical Case for Change**

The Project Steering Group (see below) therefore identified the development of a report setting out the clinical case for change as a first step in the review. The clinical case for change identified a number of drivers for change to the intra-partum and acute consultant led elements of the Trust's maternity services to ensure medium term sustainability. In summary these included:

- New and increasingly challenging national standards.
- The need to ensure that the actions which have been taken to improve quality and safety are sustainable in the medium term.
- Given national staffing shortages, the need to attract and retain high calibre staff (obstetric and midwifery).
- The increasing complexity of the population the Trust serves, with a rising birth rate.
- The need to move towards the long term plan for the Trust's maternity services.

The clinical case for change concluded that from a clinical perspective a further change in the configuration of services is required in order to enable the continued promotion of normality for women with low risk factors and also the strengthening and further development of acute services for high risk women in line with the drivers for change. The consolidation of obstetric-led, high risk deliveries and associated acute care on one site would facilitate further improvements more rapidly (e.g. extended consultant cover for labour ward) than trying to achieve this on two sites and would also more robustly ensure the improvements would be sustained in the medium term particularly in relation to clinical leadership and presence. In addition such consolidation would ensure integration of staff from the two sites into one team working to the same clinical policies and processes ahead of the opening of the new Acute Hospital. This clinical case for change was approved by the Chief Executives of the Trust, Sandwell PCT and Heart of Birmingham teaching PCT.

- **National Clinical Advisory Team Assessment**

The Department of Health requires that all new reconfiguration proposals (since 1st April 2008) are subject to initial clinical assurance provided by the National Clinical Advisory Team (NCAT). The purpose of the National Clinical Advisory Team (NCAT) is to provide a pool of clinical experts to support, advise and guide the local NHS on local service reconfiguration proposals to ensure safe, effective and accessible services for patients.

In line with this requirement a visit by NCAT took place in July to review the clinical case for change for the medium term service review of maternity services. The conclusion from this visit was support for the clinical case for change with the following recommendations:

- Plan to transfer all high risk maternity services to one consultant unit at the City Hospital.
- Set up job swaps to break down barriers and encourage consistency of approach.
- Develop MLU at City Hospital.
- Consider developing MLU within Sandwell if and when sufficient midwifery staff have been trained and/or recruited.
- In the interim introduce a community midwifery team in Sandwell to test acceptability with users and build up midwifery capacity.
- Consider retaining some consultant ante natal care in Sandwell to minimise the need for women to travel.
- Consider re alignment and reconfiguration of gynaecological services between Sandwell and City to maximise on efficient delivery of care being cognisant of on call requirements and training issues.
- Develop strategic plan centred on Community communication for proposed plans to enable community and political support for these moves.
- Develop a strategic workforce plan for Women's Services across the Trust, highlighting midwifery recruitment and retention, specialist training and on call commitments and the future working practices of consultants.
- Consider an academic presence in midwifery and/or obstetrics and gynaecology, (separate from oncology), which might generate a more challenging atmosphere at the work place.

- **Review Project Methodology**

The medium term review of maternity services has been established as a project and as such has followed a structured project methodology which is set out in the Project Initiation Document (PID) for the initial stage of the review i.e. up to and including consultation. The main objectives of the project for this initial stage are to:

- Identify recommended options for medium term configuration of intra-partum and acute aspects of maternity care delivered by SWBHT.
- Take into account the views of staff, service users.
- Build on local public and service user engagement and consultation work that has previously taken place around maternity services.

The project is led by Sandwell PCT with Andy Williams, Director of Commissioning, being the Senior Responsible Officer (SRO). A Project Team and Steering Group have been established; membership and terms of reference for these are included in appendix 1.

In addition to the Project Steering Group, members of the Strategic Model of Care Group for Maternity Services are used as a reference group to provide advice and feedback on the work being undertaken through the project. Members of the reference group are included in appendix 2.

- **Gateway Review**

The review is being carried out in accordance with national guidance as set out in the *Changing for the Better* (DoH, 2008). This will involve a series of Gateway reviews undertaken by the Office of Government Commerce (OCG). This Gateway 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 Owner (SRO) of the project on how best to ensure that the project is successful.

A Gateway Review of the project was undertaken in early September. The assessment from this review was that the delivery confidence assessment status for the project is:

- Amber Green i.e. successful delivery appears likely. However attention will be needed to ensure risks do not materialise into major issues threatening delivery.

The Gateway Review highlighted the pre-consultation exercise (see below) as an example of good practice stating: ‘The diligence shown in the sphere of PPI is exemplar and should hold the Project in good stead for the consultation which is due to commence shortly.’

The Gateway Review made the following 5 recommendations:

Ref. No.	Recommendation	Timing
•	The SRO should complete a comprehensive communications plan to cover the logistics of the consultation process.	Do Now
•	The SRO should ensure that a step by step plan is produced to cover who needs to do what by when to enable the various approvals necessary to commence Consultation.	Do Now
•	The SRO should clarify the risk and issues management strategy for the project and undertakes a review and update of the risk register.	By Nov
•	The SRO should ensure that the final consultation document addresses the issue of maternity activity and capacity.	Do Now
•	The SRO may wish to liaise with partner organisations and the SHA to consider the advantages of a coordinated regional plan for MLUs and home births.	By Jan

NB: The suggested timing for implementation of recommendations is as follows:-

Do Now – To increase the likelihood of a successful outcome it is of the greatest importance that the programme/project should take action immediately.

Do By – To increase the likelihood of a successful outcome the programme/project should take action by the date defined.

The SRO has accepted these recommendations and the Project Steering Group are incorporating them into a revised project plan.

- **Development of Options**

a. Long List of Options

The Project Steering Group and Project Team developed a number of options for the configuration of acute maternity services in the medium term. From these a long list of seven options was agreed and a summary of these can be found in appendix 3.

o **Evaluation Criteria**

In order to identify which of the long list of options should be short listed to go forward for a more detailed option appraisal, evaluation and benefits criteria were identified. These criteria were assessed and evaluated by the Project Steering Group and subsequently reviewed by the Reference Group and are set out below:

1. ***Promotion of normality in birth***- promotion of midwifery-led care during labour and birth in a setting with a home-like ambience for women identified as being low risk.

2. ***Safe Care***- all services facilitate normal child birth where possible with medical interventions recommended only when they are of benefit to the

woman and/or her baby. Immediate safe transfer available for any mother or baby who requires transfer to consultant care in labour or after delivery. Consultant led services have adequate facilities, expertise, capacity and backup for timely and comprehensive emergency obstetric care.

3. ***Continuity of care***- One to one care from a named midwife during labour and birth.

4. ***Better care closer to home***- Availability of midwifery led care in appropriate locations for low risk women in addition to Consultant led services provided for high risk women in hospital. Low risk midwifery led care delivered in a range of community settings.

5. ***Increased choice and control for service users***- Every woman is able to choose the most appropriate place and professional to attend her during child birth based on her wishes and cultural preferences and any medical and obstetric needs she or her baby may have.

6. ***Improved Patient Experience***- In addition to high quality clinical care women should have a positive experience with regard to all other aspects of labour and birth including facilities, choice, personalised care, information, physical and emotional well being.

7. ***Maintain and improve public confidence***- The majority of the public have confidence in the service model and find it acceptable. Women who use the service are involved in planning and reviewing the service provision.

8. ***Ensure that the future workforce is fit for purpose***- Develops skills, capacity and capability through the recruitment and retention of high quality experienced staff. Supports new roles and ways of working. Underpinned by sound education/training

9. ***Service can be maintained and developed to a high standard***- Deliverable, workable, affordable and right for the population served for the next 5-10 years.

10. ***Value for money***- High quality service delivered within agreed financial envelope.

    - ***Is there expert clinical support for this option***- based on feedback from the Royal College of Obstetricians and Gynaecologists, NCAT, the clinical lead for Obstetric Services for the Trust, Head of Midwifery for the Trust.

    - ***Is there staff support for this option***- based on staff opinions of service models expressed at the staff engagement events - included midwives, doctors, specialists, service managers and support staff.

    - ***Does this option provide local health economy strategic fit***- based on the planned future model of care agreed within the Right Care Right Here Programme and National Standards and Policy Frameworks.

    - ***Does this option have an impact on other clinical specialities which are interdependent***- these may be acute and/or community services, or

services available within other Trusts. The option must not adversely affect the service or business continuity of interdependent specialities.

- ***Is the option achievable***- based on capacity, facilities available, scale of any buildings work, timeliness, availability of clinical expertise, EWTD, training needs analysis, clinical risk, facilities and business continuity.

The Steering Group considered whether to weight the evaluation criteria but decide against this on the basis that the number and range of criteria gave sufficient emphasis to the criteria that would have attracted a higher weighting (i.e. clinical safety, public confidence, etc). A retrospective sensitivity analysis with weighted criteria has since been undertaken and produced the same results in terms of short listed options.

- **Evaluation of Long List**

Evaluation of the long list of 7 options was carried out in three separate phases.

Phase 1
The Steering Group scored the 7 options included in the 'long list' using the criteria already described. These scores and recommended short list were shared with the Reference Group. Subsequent feedback on the methodology used and the potential short list was received by the Steering Group.

Phase 2
The long list was also shared with a small group of stakeholders/users. A stakeholder/user event was held for potential service users, who currently reside in Sandwell and HoB pct areas. Users were invited to evaluate each of the 7 options using the same template that the Steering Group had used to evaluate each of the options. However, criteria, which it was felt users could not be expected to comment on, such as clinical expert opinion, were made available for information purposes only. Users were presented with the scoring template with a number of criteria shaded through indicating that they would not be required to provide a score for particular criteria.

Phase 3
The Steering Group received the scores from the stakeholder/user event and compared these to the Steering Group scores and comments from the Reference Group. A short list of options was drawn up based on support for the option (in the form of at least 50% of the total possible score) from at least two of the Steering Group, Reference Group and Stakeholder/User event. This was subsequently reviewed following feedback from pre-consultation user engagement work undertaken by Sandwell PCT (see below) and further consideration of the 'do-ability' of the short listed options. Two issues were identified that then changed the short list. These being:

- Women wanting as much antenatal care as possible closer to home and so the retention of some consultant antenatal clinics in Sandwell was felt important.

- Women wanting to understand more about the stand alone midwifery led unit ahead of being able to be clear about whether they would prefer such a unit. In addition there was clear clinical agreement that a stand alone midwifery led unit should not be on the Sandwell Hospital site as this may be misleading in terms of women's understanding about available back up

support in an emergency. However, an alternative location has not been identified and so there would be a lead in timescale to do this and undertake any necessary building work. Furthermore it was recognised that there would be a lead in time to develop a team of suitably trained and experienced midwives to staff such a unit. This resulted in the decision to remove the option of developing a stand alone midwifery led unit in Sandwell ahead of transferring consultant led care to City Hospital.

- **Short Listed Options**

Further to the process described above the short listed options for the medium term configuration of maternity services are:

Option 1. (Not supported by scores but guidance requires its inclusion)
Retain all consultant led and maternity services at Sandwell Hospital and improve standards. There would be no change to the current service model with the requirement to improve the facilities to achieve the recommended standards, and also the need to improve clinical leadership, operational management and workforce capacity.

Option 2a
Transfer all births and consultant activity to City Hospital and retain low risk Midwifery led antenatal services at Sandwell and City Hospitals including routine screening (scans). There would be no births at Sandwell Hospital and all Consultant antenatal clinics would transfer to City Hospital concentrating all high risk care to one site. All Neonatal care would be provided at City Hospital.

Option 2b
All births and in-patient maternity care would be located at City Hospital. There would also be a full range of antenatal services at City Hospital. A small number of Consultant antenatal clinics would remain at Sandwell Hospital along with a full range of Midwifery antenatal services including routine screening. There would be no births or inpatient maternity care at Sandwell Hospital. High risk in-patient care will be provided at City Hospital. All Neonatal care would be provided at City Hospital.

Option 3b
All consultant led care and, all in-patient services and, temporarily all births would transfer to City Hospital. A Stand Alone Midwifery Led Birth Centre would be developed within Sandwell and, once operational, some midwifery led low risk births would relocate to the new centre in Sandwell. Low risk midwifery led antenatal care and routine screening will be available in Sandwell and at City Hospital. Consultant led antenatal care would be relocated to City Hospital. All Neonatal care would be provided at City Hospital.

These short listed options form the basis of the proposed public consultation and were the subject of discussion with the Joint Health Scrutiny Working Group. Following this it was agreed that in order to ensure the consultation document is clear and offers the public choice over a realistic and feasible set of options that option 1 should be included as a statement of what would need to happen if there was no change to the configuration of services but is not supported by the local health economy partners especially from a clinical perspective and that the other short listed

options should be re numbered so as not to cause confusion. These will therefore now be known as:

- Option 1 will be short listed option 2a
- Option 2 will be short listed option 2b
- Option 3 will be short listed option 3b.

A diagram of each option (including the short listed option 1) can be found in Appendix 4.

- **Consultation**

Wide engagement is a significant feature of good project management for reviews with the potential to involve service change. The Project Steering Group recognises and supports this view and so in developing the options the medium term review has involved engagement work with users and front line clinical staff.

- **Pre-Consultation Engagement with Users**

The Health Act 2006 (Section 242) requires NHS organisations as soon as they start to develop change proposals to involve patients and the public in:

1. All planning of service provision; and
2. If there is likely to be an impact on services,
3. The development of service change proposals and
4. Decisions affecting the operation of those services.

In line with this requirement pre-consultation work with service users regarding maternity services was undertaken to gain views on broader aspects of maternity services including midwifery led units. This work was led by the Communication and Engagement sub group within the project and involved asking people within Sandwell and West Birmingham to take part in two sets of activities:

- People were asked to complete a questionnaire which focused on their preferences with regard to the type of maternity services they would like to receive.

- Focus groups were held with mothers in order to ascertain the views and experiences of mothers using maternity and newborn services available in Sandwell and West Birmingham.

Questionnaires were completed by 544 people across Sandwell and West Birmingham, the large majority of whom were women. The key findings were:

- Most people said they would choose to go to their GP (51%) or Family Planning Clinic (29%) if they needed information about getting pregnant.

- When asked about antenatal services 63% of people said they would choose to go to their GP surgery but added that the most important factor in making their choice is that the antenatal appointments are close to home.

- 87% of people said they would choose to give birth in hospital with the most important reason for their choice being safety. However, a significant number of people were interested in exploring other options such as a Midwifery Led Unit (29%) or home birth (13%) but were unsure about what these choices

would entail. More people in Sandwell (than West Birmingham) were interested in giving birth in locations other than the hospital.

- The top three services people wanted from the Community Midwifery Service were, receiving care from the same midwife, 24 hour phone line support and midwives that are based in the community.

- 29 women from the Heart of Birmingham PCT area took part in four separate focus groups which focused on their experiences of pregnancy and giving birth. Women from Handsworth were more positive overall about their experiences than women from Sparkbrook. All women reinforced the message about a preference for antenatal care being close to home.

- Additional comments focused on additional support for mothers giving birth for the second or subsequent times, more support around breast feeding as well as a greater degree of postnatal support in general.

A number of significant issues were highlighted and these have initially been used to test and amend the short list of options (see above).

1. Pre-Consultation Engagement with Staff

Three staff engagement workshops were held at an early stage with frontline staff involved in providing maternity services within the Trust. These workshops followed the principles of *Listening into Action* and asked staff to consider a number of potential service models and to highlight benefits and issues with each for women and staff. 110 staff attended the workshops and included staff based at each of Sandwell Hospital and City Hospital as well as from a range of professional backgrounds and specialities involved in delivering maternity services.

These events were an important element of the review and in particular engaging staff views on how to improve the quality of services from a woman-centred, clinical and staff perspective. Staff felt positive about the types of service models put forward recognising the need for changes to the service models in order to ensure they remain sustainable and develop further. A number of important points were raised about each service model in terms of potential impact on women and staff. Staff also identified a number of criteria that they felt should be included in any evaluation of options.

The feedback from these events was used to inform the development of options and the evaluation criteria.

o **Pre-Consultation Engagement with the Joint Health Scrutiny Working Group**

Section 7 of the *Health and Social Care Act 2001* requires consultation by Strategic Health Authorities (SHAs), PCTs, NHS and Foundation Trusts with Overview and Scrutiny Committees when considering 'any proposal for a substantial development of the health service in the area of a local authority, or for a substantial variation in the provision of such service.' Therefore, as part of the pre-consultation engagement work members of the Project Steering Group have attended two Joint Health Scrutiny Working Group meetings to share proposals, short listed options, the draft consultation document and proposed consultation framework. At the second meeting representatives from NHS West Midlands were also present. Discussion at these meetings has raised some important issues and resulted in helpful changes to the short listed options to be included in the consultation, draft consultation document

and framework. There will be a public meeting of the Joint Health Scrutiny Committee in mid October.

1. Public Consultation

All of the short listed options for the medium term review (once option 1 is excluded as not realistic) involve service change and in particular changes in location for the provision of services. Therefore a formal public consultation is required. This needs to take place over a 12 week period and in line with the medium term review project timetable it is proposed that public consultation starts on 12th October 2009 and finishes on 18th January 2010.

The Communication and Engagement Sub Group 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. This has been shared with the Joint Health Scrutiny Working Group (see above) with several amendments being made based on feedback and advice from this meeting. The proposed consultation framework can be found in Appendix 5.

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 other key stakeholders including comments from the Joint Health Scrutiny Working Group (see above). The final draft of the consultation document can be found in Appendix 6.

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.

• Detailed Analysis of Short Listed Options

In developing the options a level of detailed analysis has been undertaken around a number of areas. The findings from this work have confirmed that the short listed options are viable in terms of affordability, capacity and feasibility. It is important however, that further, more detailed work is 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. The work is summarised below but described in more detail in Appendix 7.

a. Activity, Capacity and Financial Analysis

Activity related to the birth element of maternity services is commissioned through Payment by Results and so funding is via tariff and therefore the financial risk associated with the options sits primarily with SWBH NHS Trust as the provider of the service. On this basis undertaking the financial and associated activity and capacity analysis has been primarily the responsibility of the Trust.

In order to define affordability, manageability and whether or not the option is achievable within the proposed timeframe for each of the potential options work has been undertaken to look at issues such as:

- Recent and assumed future activity regarding the number of births within Sandwell and West Birmingham.

- Bed capacity and length of stay.
- Activity within essential support services for maternity within the acute Trust.
- Capital costs of refurbishment and temporary relocation of services.
- Changes in local demography.
- Staffing costs recurring and non-recurring.

In terms of activity this analysis has shown that by 2012/13 the Trust will be delivering an increased number of births in all options with there being the highest number of births in option 3.

Table 1: Predicted Birth Numbers:

	2009/10			2013/14		
	Sandwell	City	Trust	Sandwell	City	Trust
No change to configuration of services	2 645	3 752	6 397	2 790	4 078	6 868
Option 1 (no births & no consultant antenatal clinics in Sandwell)				0	6 676	6 676
Option 2 (no births but some consultant antenatal clinics in Sandwell)				0	6 728	6 728
Option 3 (Stand alone MLU in Sandwell and no consultant antenatal clinics in Sandwell)				400	6676	7076

The activity analysis has formed the basis of a review of the capacity required taking into account changes to service models including the co-located midwifery led birth centre at City Hospital. This has been used to identify facility requirements and the development of a high level design brief to identify building work requirements, high level costs and feasibility for each option. This has included the requirements if there is no change to the configuration of services with the issues associated with the current delivery suite accommodation at Sandwell in terms of clinical safety and privacy and dignity having been identified and considered. The analysis has shown this would have the highest capital cost and would require an extension of the existing space with a relocation of the delivery suite to a temporary location which would be highly disruptive to the running of the clinical service in the interim and costly. All of the short listed options require some investment and development of facilities.

In terms of revenue costs work has been undertaken around the staffing requirements for each option and additional capital charges associated with the above work on facilities. Consideration has also been given to the income associated with the activity outlined above.

The activity, capacity and financial analysis undertaken for the short listed options is at a sufficiently robust position to confirm that SWBH NHS Trust is comfortable that the short listed options are financially feasible.

b. Staffing

The successful recruitment and retention of high calibre clinical staff, both doctors and midwives, is essential to the sustainability of a high quality, safe maternity service and as a result has been a key driver for change.

With regard to medical staff the further recruitment and retention of high calibre, specialist obstetricians will partly be dependent upon having a critical mass of patients in order to maintain skills and expertise and to justify specialist equipment and support staff. The size of the Trust's maternity service is such that this is possible if specialist services are consolidated on one site but would remain a challenge if these specialist services are fragmented, needing to be provided and therefore duplicated on two sites. In addition consolidation of consultant led births on one site would enable a consultant to be present on the delivery suite for more hours.

In recent years the Trust has found it increasingly difficult to recruit to vacant midwifery posts and this has been compounded by the national shortage of midwives. There is evidence that recruitment and retention of midwives is improved when there are robust and varied career pathways including specialist roles and opportunities to deliver and support midwifery led care. The concentration of specialist services and the development of midwifery led units are key elements of achieving these opportunities. It is important however that midwifery led units are established with midwives with the skills and experience in delivering midwifery led births with this being especially the case for stand alone units.

c. Risks

At a project level a number of project risks have been identified by the project Steering Group. A risk register has been established and includes mitigating actions. There is ongoing work to develop this and the related issues log further and the Project Steering Group will continue to monitor risks and issues on a regular basis.

There continues to be a robust process for managing and monitoring the mitigation plan relating to the clinical risks associated with the current maternity services configuration. Clinical safety and quality of care have been key drivers for the medium term review and form the basis of the clinical case for change (see above). In addition the evaluation criteria used for the short listing of options include criteria relating to clinical safety and quality of care.

Work is ongoing around identifying the clinical risks associated with each of the short listed options and describing in more detail the mitigating actions that need to be included when developing an implementation plan once a preferred option has been identified. This work will continue as part of developing the business case that will be included in the decision making process to identify a preferred option and that will take place post consultation.

d. Equality Impact Assessment

Undertaking an Equality Impact Assessment will help to identify any potential equality risks on divers groups associated with the short listed options. It will help to determine if certain groups are left disadvantaged by any of these options compared to other groups. An equality impact assessment will be undertaken to cover the six strands of equality i.e. race, disability, gender (including transgender), age, religion and sexual orientation. In addition consideration will be given to socio-economic groups. This assessment will be led by the Sandwell PCT and facilitated by the Head of Equality and Diversity.

The assessment process will take place over 2 phases. The first phase is currently underway and involves an equality impact screening to identify potential risks to each

group associated with each of the short listed options and collate evidence to substantiate these risks. The outcome of this is whilst not available for this report will be available for the Board meeting in September. The findings will then influence the consultation plan to ensure there is focused consultation activity for each group with substantiated equality risks.

This phase will be further enhanced by collating additional evidence including that arsing from the consultation process and mitigating actions that will be required during implementation. This will be fed into the decision making process for agreeing the preferred option.

Stage 2 will take place once a preferred option is agreed and will involve ensuring the implementation plan has robust and detailed mitigating actions for any diversity risks and then after implementation collection of evidence around the impact of the changes in relation to the diversity risks and further review of mitigating actions.

- **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.

- **Consultation**

The final decision to undertake a formal public consultation of the short listed options arising from the medium term review into maternity services will be taken by Sandwell PCT Board at its meeting in September 2009. This will be based upon the case for change presented in this report.

In making this decision Sandwell PCT will seek agreement to the consultation from Sandwell and West Birmingham NHS Trust Board through the case for change being presented at its meeting in September 2009.

Sandwell PCT will also require agreement to the consultation from Heart of Birmingham teaching PCT Board. Due to the timing of the PCT's Board meeting chairman's action will initially be required and will be endorsed at the Board meeting in October 2009.

- **Preferred Option**

The project plan is for final approval of a preferred option to be undertaken by Sandwell PCT Board at its meeting in February 2010. In making this decision Sandwell PCT will require agreement from Sandwell and West Birmingham Hospitals NHS Trust Board through its meeting in February 2010 and from Heart of Birmingham teaching PCT Board – due to timing of Board meetings this may again initially require chairman's action in February 2010 with endorsement at the Board meeting in March 2010.

In approving a preferred option the Boards will consider the outcome of the consultation and a detailed business case which will be presented in February 2010 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.

- **Implementation**

Once a preferred option has been approved a detailed implementation plan will be developed and will include user and staff engagement. This will be developed over a

couple of months and will be subject to a further Gateway Review. The aim will be to present the implementation plan to and seek approval to implement from the Board meetings of Sandwell PCT, Sandwell and West Birmingham Hospitals NHS Trust and Heart of Birmingham teaching PCT in April 2010.

- **Conclusion**

This report has outlined progress with the medium term review of maternity services. There is a clear clinical case for change to the intra-partum and consultant led elements of the maternity services provided by the Trust in order to ensure medium term sustainability of these services in a way that best promotes a safe and high quality service. 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 detailed analysis and significant engagement with users and frontline staff. 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.

- **Recommendations**

The Board are recommended to:

- NOTE the progress that has been made with the medium term review to date.
- AGREE the case for change to the configuration of maternity services in the medium term.
- AGREE that a formal public consultation of the short listed options is undertaken.
- AGREE the consultation framework (Appendix 5).
- AGREE the consultation document (Appendix 6).
- AGREE the decision making process to identify an approved option.

Appendix 1

Project Steering Group

Membership:

Andy Williams, Director of Commissioning/Deputy CE, Sandwell PCT (Chair)
Janine Brown, Joint Director of Partnership and Commissioning (C&YP), Sandwell PCT
Jayne Dunn, Redesign Director Right Care Right Here (SWBHT)
Kerry Forward, Commissioning Manager, HoB tPCT
Elaine Newell, Head of Midwifery, SWBHT

In attendance:

Paul Bosio, Clinical Director, SWBHT
Simon Mitchell, Director of Clinical Quality, Sandwell PCT
Shirley Weston-Hayles, Project Manager, Sandwell PCT
Gill Gadd, interim Project Manager Sandwell PCT /service redesign manager SWBHT

Jayne Salter Scott –PPI Lead, Sandwell PCT (as Chair of the Consultation sub group)

Other co-opted attendees 'as required':

James Green, Finance Manger, Sandwell PCT
Emma Mackaness, Head of Communications, Sandwell PCT
Jessamy Kinghorn, Head of Communications and Engagement, SWBHT
Martin Stevens, Contract manager, Sandwell PCT

Purpose:

1. Ascertain Case for Change and undertake Review

- To lead the project to review SWBHT maternity services for the medium term (up to the opening of a new acute hospital in 2015) in the context of the longer term Right Care, Right Here SMOC.
- To fulfil the requirements as outlined in the PID
- To define the benefits to be realised from the project
- To establish criteria for evaluation of options for the future configuration of maternity services.
- To develop the list of options for the future and undertake a full and inclusive option appraisal in liaison with the Reference Group (see below)
- To present the outcome of the review to Sandwell PCT Commissioning Board.
- To develop recommendations to be reported to the three Trust Boards in September.
- To ensure that the SMOC group (as detailed below) are engaged and consulted at all stages of development, and to ensure pre-consultation engagement in the review.
- To ensure the engagement of all stakeholders.
- To produce an outline business case for reconfiguration of services if this is the preferred option

2. Prepare for Public Consultation within the defined timescale

3. Subject to redefined Terms of Reference to oversee the implementation phase of change

Frequency of Meetings:

- Fortnightly
- Duration – development of a Business Case and overseeing of the implementation phase.

Presenting of information to:

- Sandwell PCT Commissioning Board
- S&WB Hospital Trust – Maternity Task Force

Accountability

To Sandwell PCT and HOB tPCT Boards

The Steering Group will also establish a consultation process with the reference group to ensure stakeholder involvement in the process throughout.

Process

The Steering Group will:

- Ensure the review includes robust risk assessments, robust benefits realisation plan and financial analysis and financial plan
- Review the options identified for the configuration of maternity services for the medium term (i.e. up to the opening of the new acute hospital in 2015).
- Undertake a robust analysis of clinical implications and requirements, staffing, facilities and resource requirements, risks and benefits of each option as identified in the PID.
- Describe how each option meets commissioning specification for maternity services.
- Take account of local consultation/engagement work undertaken around maternity services.
- Undertake any further pre-consultation engagement with stakeholders as identified in the PID.
- Ensure full involvement with NCAT reviewers and StHA advisors.
- Prepare a report presenting the findings of the review for Sandwell PCT Commissioning Board and for onward reporting of recommendations.
- Participate in preparing an agreed public consultation plan and document if required.
- Undertake preparation for the Gateway Review (if required).
- Involve the Joint Overview & Scrutiny Committee at the design, planning and implementation phase.
- Report progress to Sandwell PCT Commissioning Board and SWBHT Maternity Taskforce

Appendix 2

Reference Group

The SMOC Group, acting as a reference group for this work, will be developed to include all those on the Steering Group, plus:
Brenda Jumi, Workforce Lead, Right Care, Right Here
Sue Murray, Divisional Manager, SWBHT
Linda Bird, Deputy Head of Midwifery, SWBHT
Kathryn Gutteridge, Consultant Midwife, SWBHT
Eva Parchment, Community Midwifery Manager, SWBHT
Phil Symmonds, Consultant Neonatologist
Julie Nycyk, Consultant Neonatologist
John Cliff, Consultant Anaesthetist, SWBHT
Professor David Leusley, Clinical Director Gynaecology, SWBHT
Paul Bosio, Clinical Director Obstetrics, SWBHT
Jenny Chen, Consultant in Public Health, Sandwell PCT
Su Edwards, Senior Joint Commissioning Manager, Sandwell PCT
Stephen Phillips, Wednesbury and West Bromwich Practice Based Commissioning Cluster Manager, Sandwell PCT
Sandra Fitzpatrick, Head of Children & Families, Sandwell Community Healthcare
John Lees, Assistant Director of Commissioning Children and Young People, HoB tPCT
Helen Radbourne, Health and Family Support Manager, HoB tPCT
Peter Forth, Senior Joint Commissioning Manager, Children Centres
Lucille Arlidge, Service Director – Specialist Services
Pam Jones [or nominated representative LINKs]
Sue Knight, PEC Maternity Lead, Sandwell PCT
Dr Nick Harding, Clinical Lead HoB tPCT
Dr Sharad Pandit, Clinical Lead HoB tPCT
Dr Samar Mukherjee, Clinical Lead HoB tPCT
Rhana Ahmed, PPI Lead HoB tPCT
Cindy James, Commissioning Officer (Sandwell MSLC)
Wendy Ewins Chair of HoB tPCT MSLC

In addition Fay Baillie & Bill Mackenzie – SHA Clinical Leads for Maternity Services, and Jon Cook WMSHA, will be consulted as stakeholders.

Appendix 3

Options Long List

The Project Steering Group and Project Team developed a number of options for the configuration of acute maternity services in the medium term. From these a long list of seven options was agreed. These were:

Option 1.
Retain all consultant led and maternity services at Sandwell Hospital and improve standards. There would be no change to the current service model with the requirement to improve the facilities to achieve the recommended standards, and also the need to improve clinical leadership, operational management and workforce capacity.

Option 2a
Transfer all births and consultant activity to City Hospital and retain low risk Midwifery led antenatal services at Sandwell and City Hospitals including routine screening (scans). There would be no births at Sandwell Hospital and all Consultant antenatal clinics would transfer to City Hospital concentrating all high risk care to one site. All Neonatal care would be provided at City Hospital.

Option 2b
All births and in-patient maternity care would be located at City Hospital. There would also be a full range of antenatal services at City Hospital. A small number of Consultant antenatal clinics would remain at Sandwell Hospital along with a full range of Midwifery antenatal services including routine screening. There would be no births or inpatient maternity care at Sandwell Hospital. High risk in-patient care will be provided at City Hospital. All Neonatal care would be provided at City Hospital.

Option 3a
Develop a Stand Alone Midwifery Led Birth Centre within Sandwell (location to be determined). Once this centre is fully operational all maternity in-patient services and consultant led high risk births would transfer to City Hospital. All Consultant led antenatal clinics would transfer to City Hospital. Midwifery led low risk births would be provided within Sandwell and at City Hospital. Low risk midwifery led antenatal services including routine screening will be available in Sandwell and at City Hospital. All Neonatal care would be provided at City Hospital.

Option 3b
All consultant led care and, all in-patient services and, temporarily all births would transfer to City Hospital. A Stand Alone Midwifery Led Birth Centre would be developed within Sandwell and, once operational, some midwifery led low risk births would relocate to the new centre in Sandwell. Low risk midwifery led antenatal care and routine screening will be available in Sandwell and at City Hospital. Consultant led antenatal care would be relocated to City Hospital. All Neonatal care would be provided at City Hospital.

Option 3c
All high risk births and maternity in-patient beds would be located at City Hospital. A full range of antenatal services would also be at City Hospital. Some Consultant-led clinics and midwifery led antenatal services and routine screening would remain at Sandwell Hospital. Develop a Stand-Alone Midwifery Led Birth

Centre in Sandwell, once fully operational some low risk births would relocate to Sandwell. All Neonatal care would be provided at City Hospital.

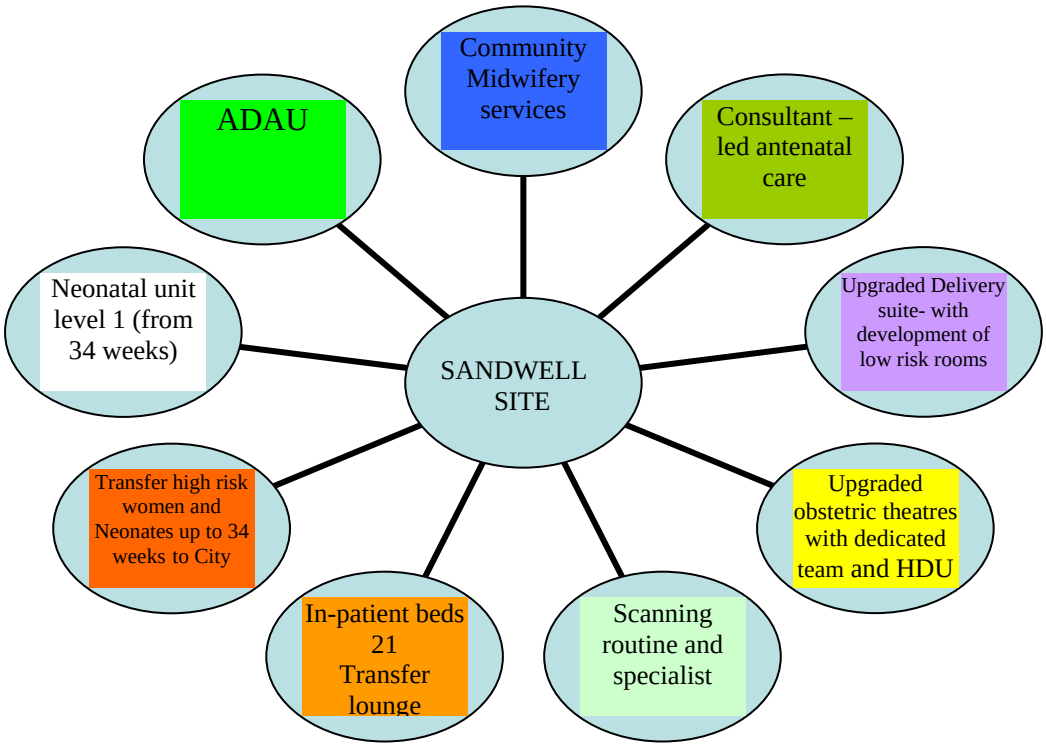
Option 4

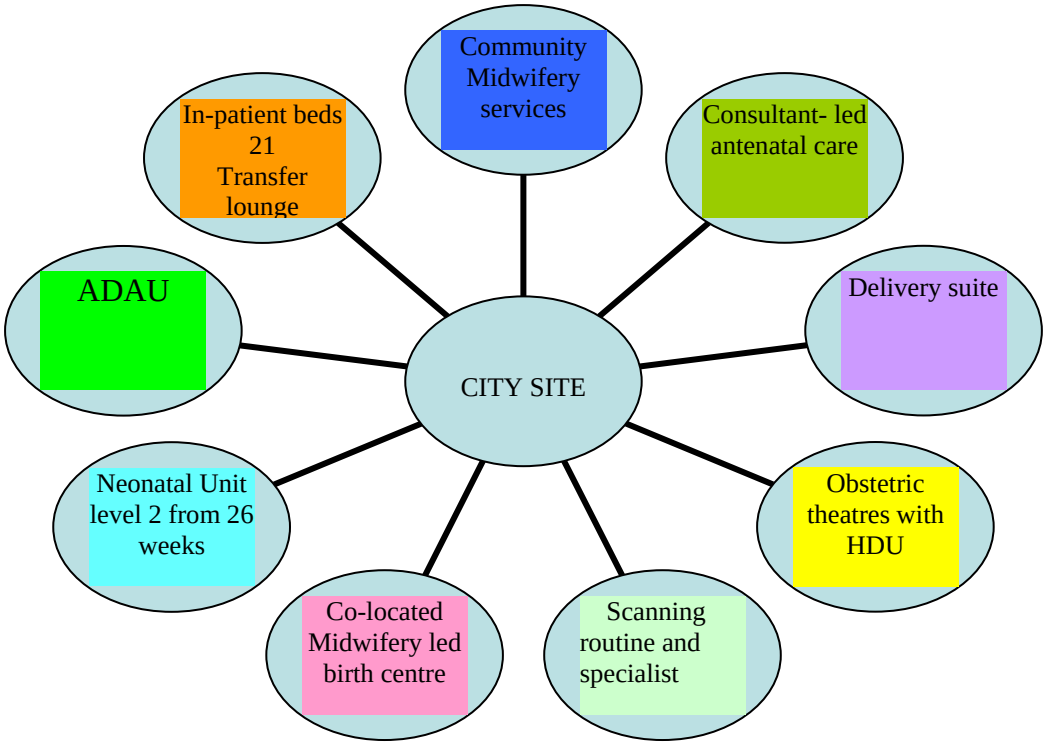
All Consultant led services and all high risk births at Sandwell. A Stand Alone Midwifery Led Birth Centre at City Hospital. No in-patient beds (maternity) and no Consultant antenatal care at City Hospital. Level 2 Neonatal Unit to remain at City Hospital.

Appendix 4

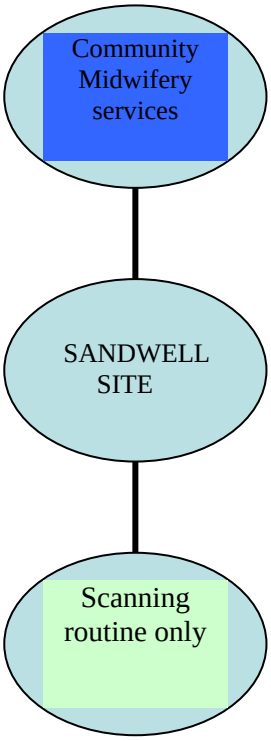
Diagrams of Short Listed Options

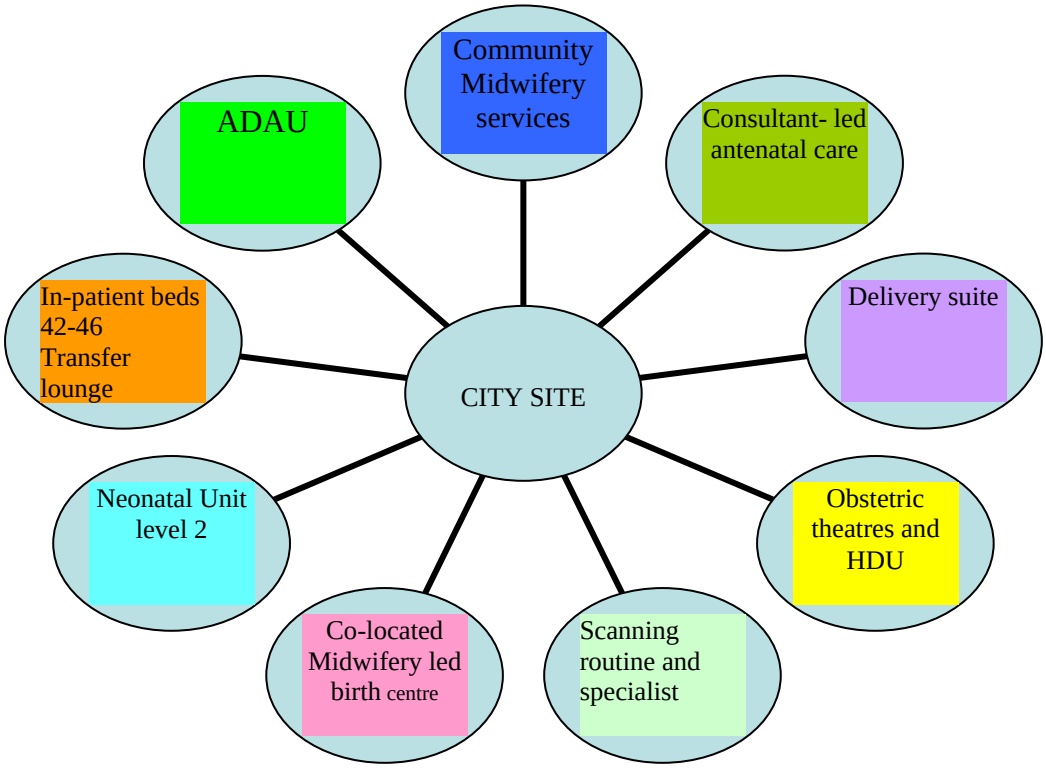
If No Change to Configuration of Services:



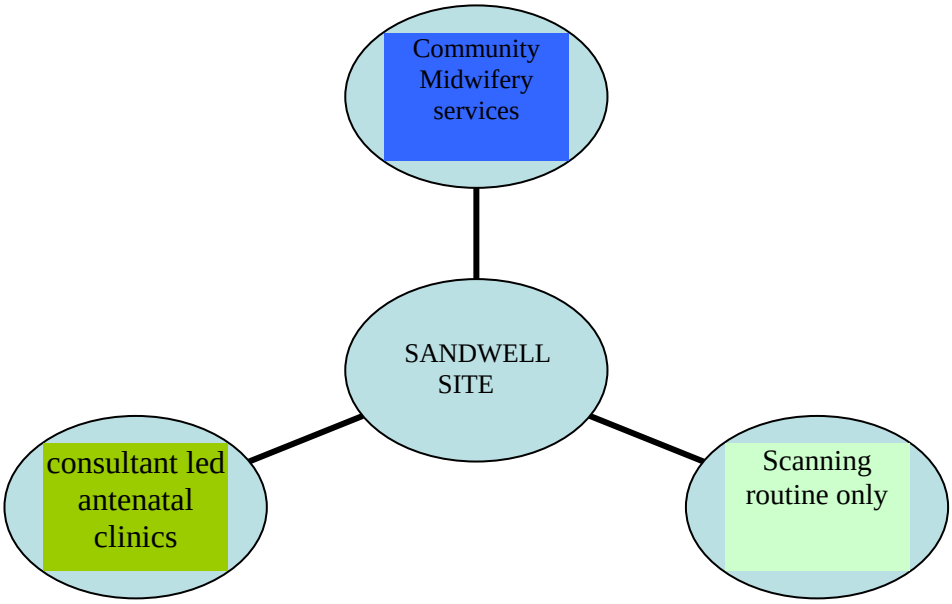


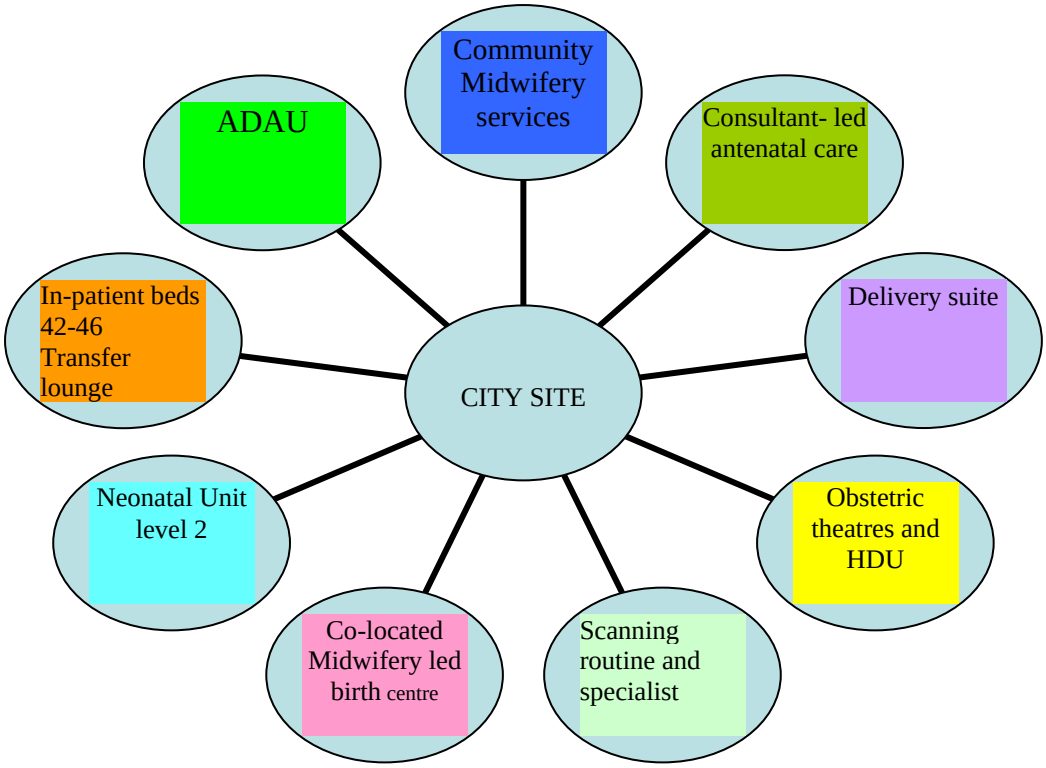
Option 1:


Community Midwifery services
SANDWELL SITE
Scanning routine only

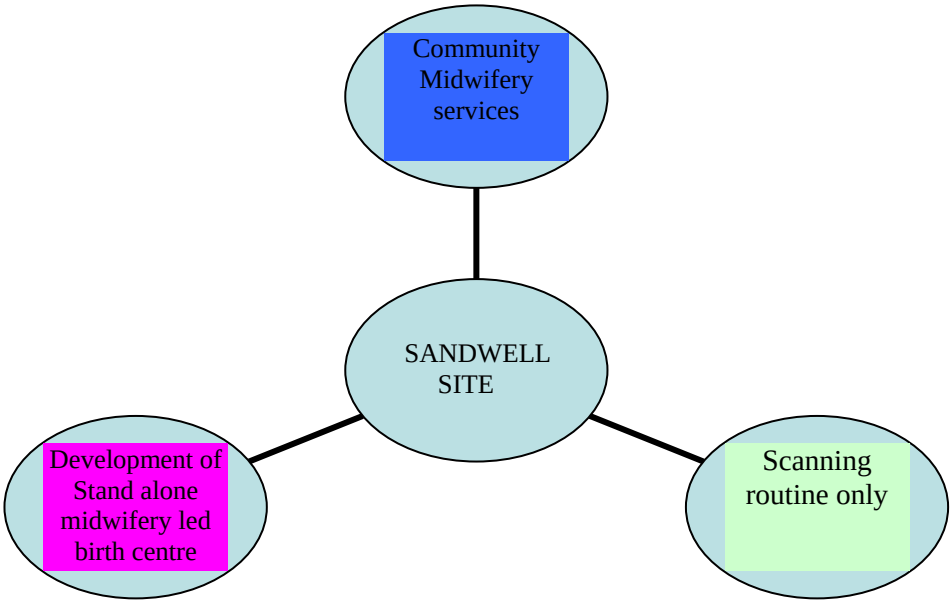

Community Midwifery services
ADAU
Consultant- led antenatal care
In-patient beds 42-46 Transfer lounge
Delivery suite
CITY SITE
Neonatal Unit level 2
Obstetric theatres and HDU
Co-located Midwifery led birth centre
Scanning routine and specialist

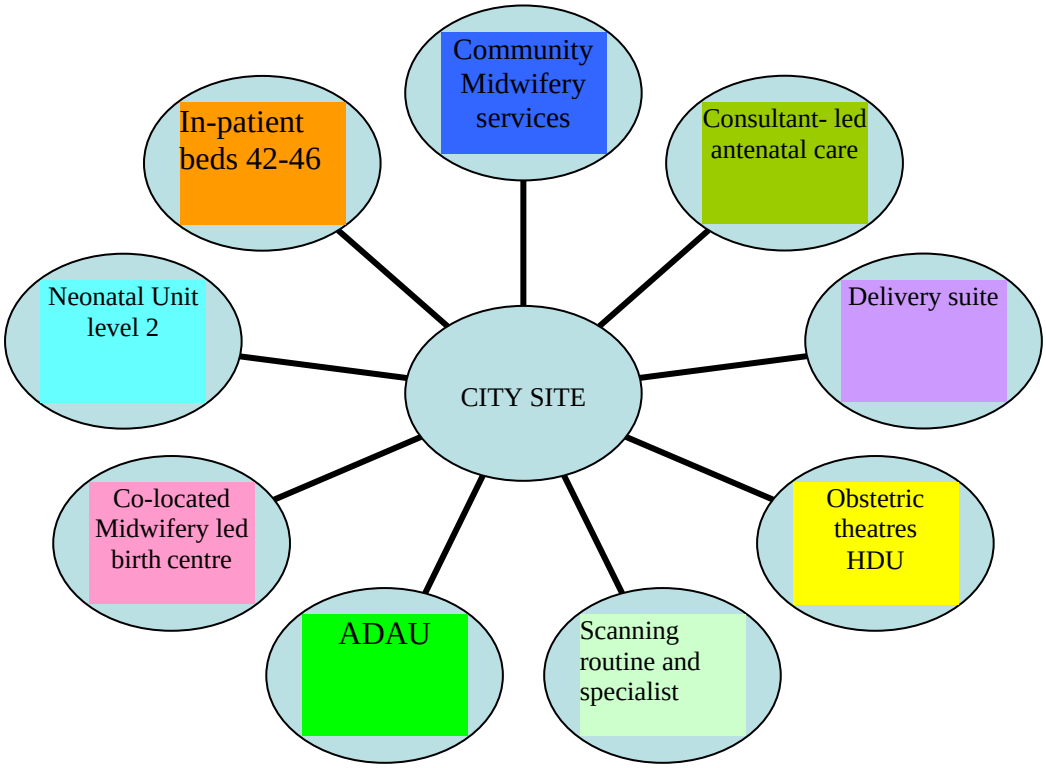
Option 2:


Community Midwifery services
SANDWELL SITE
consultant led antenatal clinics
Scanning routine only


Community Midwifery services
ADAU
Consultant- led antenatal care
In-patient beds 42-46 Transfer lounge
Delivery suite
CITY SITE
Neonatal Unit level 2
Obstetric theatres and HDU
Co-located Midwifery led birth centre
Scanning routine and specialist

Option 3:


Community Midwifery services
SANDWELL SITE
Development of Stand alone midwifery led birth centre
Scanning routine only


Community Midwifery services
In-patient beds 42-46
Consultant- led antenatal care
Neonatal Unit level 2
Delivery suite
CITY SITE
Co-located Midwifery led birth centre
Obstetric theatres HDU
ADAU
Scanning routine and specialist

Appendix 7

Detailed Analysis of Short Listed Options

In the sub sections below a summary is given of the work undertaken in each of the areas of Activity, Capacity, Facilities, Finance and Staffing and the ongoing work that will be undertaken leading up to the decision making process.

1. Activity Analysis

Activity related to the birth element of maternity services is commissioned through Payment by Results and so funding is via tariff and therefore the financial risk associated with the options sits primarily with SWBH NHS Trust as the provider of the service. On this basis undertaking the financial and associated activity and capacity analysis has been primarily the responsibility of SWBH NHS Trust.

In order to define the both affordability, manageability and whether or not the option is achievable within the proposed timeframe for each of the potential options work has been undertaken to look at issues such as:

- Recent and assumed future activity regarding the number of births within Sandwell and West Birmingham.
- Bed capacity and length of stay
- Activity within essential support services for maternity within the acute Trust
- Capital costs of refurbishment and temporary relocation of services
- Changes in local demography
- Staffing costs recurring and non-recurring

In terms of activity, patient flows have been mapped on the basis of the following assumptions:

- Timescale for first full year when all short listed options could be fully implemented is 2012/13 (some options may be earlier)
- Activity baseline of 2009/10 contracted activity levels
- Annual growth in births of 2% (and related inpatient spells of 3%) resulting from local demographic changes based on that agreed for the Right Care Right Here Activity and Capacity Model (version 5)
- No change to home births
- In option where no births or consultant antenatal clinics remain in Sandwell a catchment loss of 22% based on change in geographical location
- In the option where no births remain in Sandwell but there are some consultant antenatal clinics at Sandwell Hospital a catchment loss of 16% based on change in geographical location
- In the option where there is a stand alone midwifery led unit in Sandwell additional births remaining in Sandwell
- In all options as a result of improvements in the quality of maternity services, additional births from West Birmingham being delivered in the Trust rather than at other Hospitals.

This analysis results in the following birth numbers:

	2009/10			2013/14		
	Sandwell	City	Trust Total	Sandwell	City	Trust Total
No change to configuration of services	2 645	3 752	6 397	2 790	4 078	6 868
Option 1				0	6 676	6 676
Option 2				0	6 728	6 728
Option 3				400	6676	7076

2. Capacity Analysis

The activity above has been used to determine the capacity required along with assumptions about improved service models. These assumptions include:

- Average length of stay in main Delivery Suite of 12 hours
- Average length of stay in MLU (collocated or stand alone) 18 hours
- Women who give birth in the MLU are discharged home 6 hours after birth
- Women who give birth in main Delivery Suite are admitted to a maternity bed on a ward after birth
- Average length of stay in maternity bed on a ward is 1.8 days
- Average occupancy in all areas is 75%

In summary the capacity proposed is:

	Delivery Rooms		Maternity Beds	
	Sandwell	City	Sandwell	City
2009/10	8	12 in Delivery Suite (& 4 triage rooms)	21	21
No change to configuration of services	8 (no triage rooms or induction beds)	12 (& 4 triage rooms, no induction beds) in Delivery Suite & 5 in MLU	21	21
Option 1	0	11 (& 6 triage rooms and 2 induction beds) in Delivery Suite & 5 in MLU	0	42
Option 2	0	11 (& 6 triage rooms and 2 induction beds) in Delivery Suite & 5 in MLU	0	42
Option 3	3	11 (& 6 triage rooms and 2 induction beds) in Delivery Suite & 5 in MLU	0	42

3. Facilities

From the above activity and capacity analysis a review of facilities has been undertaken. In addition issues associated with the current delivery suite accommodation at Sandwell in terms of clinical safety and privacy and dignity have been identified and considered. This has led to a design brief being identified for each option and the Trust's Capital Project Team undertaking a high level feasibility and cost study. For option 3 because no location has been identified for a stand alone MLU in Sandwell the facilities analysis has been considered using a location on Sandwell Hospital site as a proxy in order to identify high level capital costs. All options require refurbishment work and so have capital costs. Further detailed analysis will be required to confirm the capital costs but in summary:

1. No change to configuration of services would have the highest capital cost because of the building work required to improve the current Delivery Suite facilities in Sandwell Hospital. This would require an extension of the existing space and a relocation of the delivery suite to a temporary location which would be highly disruptive to the running of the clinical service in the interim and costly.

2. Option 3 would have the next highest capital cost because of the need to create a suitable environment for a stand alone MLU and undertake the work required at City Hospital in options 1 and 2.

3. Options 1 & 2 would have the same capital costs associated with improving the patient flow in the Delivery Suite at City and accommodating the additional 21 maternity beds.

4. Financial Analysis

In terms of revenue costs work has been undertaken around the staffing requirements for each option and additional capital costs associated with the above work on facilities. Consideration has also been given to the income associated with the activity outlined above.

In summary the analysis undertaken in the above areas for the short listed options is at a sufficiently robust position to confirm that SWBH NHS trust is comfortable that the short listed options are financially feasible.

There will be further ongoing and more detailed analysis as part of developing the business case that will be included in the decision making process to identify a preferred option and that will take place post consultation.

5. Staffing

The successful recruitment and retention of high calibre clinical staff, both doctors and midwives, is essential to sustainability of a high quality, safe maternity service and as a result has been a key driver for change.

In terms of medical staff , given the size of the maternity service within the Trust, the profile of the population and number of high risk women it is important that specialist consultant obstetricians in addition to consultants who are generalists and cover obstetrics and gynaecology, are recruited. To date one specialist consultant obstetrician is in post with a second recently appointed and due to start in the

autumn. The remaining consultants within the maternity services are generalists in obstetrics and gynaecology. In addition to the issues this creates with clinical leadership and supervision there are issues relating to professional and service development. Further recruitment and retention of high calibre, specialist obstetricians will partly be dependent upon having a critical mass of patients in order to maintain skills and expertise and to justify specialist equipment and support staff. The size of the Trust's maternity service is such that this is possible if specialist services are consolidated on one site but would remain a challenge if these specialist services are fragmented, needing to be provided and therefore duplicated on two sites. If there were no further change to the configuration of maternity services relating to birth an additional consultant would be required. The consolidation of these services onto one site would also enable consultant presence on delivery suite for a longer period each day and a separation of on call responsibilities for consultants and middle grade doctors with dedicate doctors for Obstetrics and dedicated doctors for Gynaecology.

In recent years the Trust has found it increasingly difficult to recruit to vacant midwifery posts and currently has a 13% vacancy rate. This has been compounded by the national shortage of midwives. The ability to recruit high calibre midwives will be increasingly important given the age profile of the Trust's midwifery staff with the average age of qualified midwives in 2007 being 45 years and with 25% being over 50 years. There is evidence that recruitment and retention of midwives is improved when there are robust and varied career pathways including specialist roles and opportunities to deliver and support midwifery led care. The concentration of specialist services and the development of midwifery led units are key elements of achieving these opportunities. It is important however that midwifery led units are established with midwives with the skills and experience in delivering midwifery led births with this being especially the case for stand alone units and that robust training plans are in place to eventually develop these skills across the midwifery team. Consideration has also been given to the impact of options on the Trust's midwife to birth ratio (currently 1:31.7) and how this compares to the recommended national standard of 1:28.

PRE-ENGAGEMENT AND FORMAL CONSULTATION PLAN FOR MEDIUM TERM MATERNITY SERVICES REVIEW

Target audience	Method	Date	Location	Carried out by	Comms/ PPI lead	Comments	Consultation team	Management support	Scribe
PRE-ENGAGEMENT ACTIVITY									
Ante Natal Clinics (Sandwell)	Questionnaire face to face	Aug-09	Sandwell Antenatal Clinics	Lisa Jacob/Kat Meredith	PPI				
Ante Natal Clinics (HOB)	Questionnaire and face to face	Aug-09	HOB Antenatal Clinics	CPO's to help	PPI				
Family Planning Clinics (Sandwell)	Questionnaire face to face	Aug-09	The Lyng, Sandwell	Lisa Jacob/Kat Meredith	PPI				
Family Planning Clinics (HOB)	Questionnaire	Aug-09			PPI				
Children's Centres (Sandwell)	Questionnaire	Aug-09	Sandwell		CC staff				
Children's Centres (HoB)	Questionnaire and various	Aug-09	HOB		PPI and CC staff	Parents forums at children's centres			
Joint Health Scrutiny Working Group	Presentation and discussion	20/07/2009	Birmingham Council House	Janine Brown, Shirley Weston Hayles and	Commissioning				
HoB pre-engagement activities	Focus Groups			Amanda Smith and Naila Ahmed + CPO's		Saheli, Ashiana, Handsworth Wood medical centre, Rookery Road children's centre,Soho Children's Centre, Ante-Natal (City Hospital), Cherry Orchid Children's Centre, Farm Road Community Centre,City Hospital,Prime Care Centre,Sparkbrook Family Centre,			
Clinical and non-clinical hospital staff of Sandwell and City Hospital (including maternity teams and community midwifery staff)	Workshop	09/08/2009	City Hospital, Postgraduate Centre.	Service redesign team/ Gillian Gadd					
Clinical and non-clinical hospital staff of Sandwell and City Hospital (including maternity teams and community midwifery staff)	Workshop	15/08/2009	City Hospital, Postgraduate Centre.	Service redesign team/ Gillian Gadd					
Clinical and non-clinical hospital staff of Sandwell and City Hospital (including maternity teams and community midwifery staff)	Workshop	29/08/2009	Sandwell Hospital, medical centre	Service redesign team/ Gillian Gadd					
Joint Health Scrutiny Working Group	Presentation and discussion	11/09/2009	Sandwell Council House, Oldbury	Andy Williams, Janine Brown, Elaine Newell, Paul Bosio, Jayne Salter-Scott plus	Commissioning				
FORMAL CONSULTATION									
Partnership Boards									
Trust Board HoB						Chairman and Chief Officer action			
Trust Board SWBH		24/09/09 2:00pm							
Trust Board Sandwell		24/09/2009 4:00pm	Kingston House						
Target audience	**Method**	**Date**	**Location**	**Carried out by**	**Comms/ PPI lead**	**Comments**	**Consultation team**	**Management support**	**Scribe**

RCRH Partnership Board	Presentation, discussion and circulation of consultation document	26/10/2009	Anne Gibson Board Room, City Hospital			Papers to circulated one week in advance of meeting. Consultation team to be detailed to Les Williams once confirmed.There is a projector in the room but need to advise if bringing a laptop.	Andy Williams, Janine Brown, Jayne Dunn and Clinician	Shirley Weston-Hayles	Jayne Salter-Scott
Sandwell Children and Young People's Partnership Trust Board	Presentation and discussion	30/11/2009	TBC			To email Shane Parkes who will approach chair.	Janine Brown, Jayne Dunn and Clinician	Shirley Weston-Hayles	Jayne Salter-Scott
Birmingham Health and Wellbeing Partnership	Presentation and discussion						Janine Brown, Jayne Dunn and Clinician	Shirley Weston-Hayles	Jayne Salter-Scott
Sandwell Health and Wellbeing Board	Presentation and discussion					Comment received from Health & Wellbeing unit questioning appropriateness of agenda item - Been advised not appropriate.			
High Influence Stakeholders									
Joint Health Scrutiny Working Group	Presentation and discussion	Early October	Birmingham Council House		Commissioning		Andy Williams, Janine Brown, Elaine Newell, Paul Bosio, Jayne Salter-Scott plus HoB rep.	Jayne Salter-Scott	Jayne Salter-Scott
Elected Members - HoB	Circulation of consultation document	Early October				Council briefing for HOB.Ward Committees, Constituency Committees			
Elected Members - Sandwell	Circulation of consultation document and members briefing	TBC	TBC				Richard Nugent, Rob Bacon, Janine Brown, John Adler, Jayne Dunn plus Clinicians	Shirley Weston-Hayles	Jayne Salter-Scott
Members of Parliament - Sandwell	Discussion at CEO level and Circulation of consultation document	More information required	TBC		Communications	CEO's PA extending invitation to local MP's	Rob Bacon, Richard Nugent, Janine Brown, Andy Williams (TBC)		
Members of Parliament - HoB	Discussion at CEO level and Circulation of consultation document	More information required	TBC		Lynda Scott	Lynda to offer briefing to Claire Short, Roger Godsiff and Khalid Mahmood	TBC		
Maternity Services Liaison Committee - Birmingham	Presentation and circulation of consultation document	TBC	TBC		PPI	Request agenda item in November meeting	Clinician, commissioning lead	Member of HoB PPI team	Member of HoB PPI team
Maternity Services Liaison Committee - Sandwell	Presentation and circulation of consultation document	Arranged as agenda item for November meeting. Waiting for confirmation of date from Cindy James	Greets Green Children Centre		PPI	Request agenda item in November meeting	Clinician, commissioning lead	Jayne Salter-Scott	Jayne Salter-Scott
National Childbirth Trust	Circulation of consultation document				PPI	Explore possible representation at one of their future meetings.			
Target audience	**Method**	**Date**	**Location**	**Carried out by**	**Comms/ PPI lead**	**Comments**	**Consultation team**	**Management support**	**Scribe**
Patient Representatives									

Sandwell LINk	Presentation and circulation of consultation document	23/10/09 or 10/11/09	TBC		PPI	Provisional - Stephanie Hardy to confirm which date. 0121 561 1969 Email: sandwelllink@BCHA.CO.UK	Clinician and commissioning lead	Katy Bunn	Sandwell PPI team
Birmingham LINk	Presentation and circulation of consultation document	TBC	TBC		PPI	link into Maternity and children's work stream (meanaz' group)	Clinician and commissioning lead	HoB PPI team	HoB PPI team
Sandwell Patient Experience Forum	Presentation of circulation of consultation document	Email sent 15th September requested agenda slot	The Lyng Health and Social Care Centre		PPI	Request agenda item in November meeting	Clinician and commissioning lead	Jayne Salter-Scott	Jayne Salter-Scott
HOB Patient Networks	presentation and circulation of consultation documents to membership	TBC	TBC		PPI	Agenda item in Patient Network meetings	HoB PPI team	HoB PPI team	HoB PPI team
Patient participation groups	Circulation of consultation document				PPI				
Staff									
Consultants and medical staff, midwives (including community midwives), neonatal and other staff connected to SWBH maternity services	Internal briefing / engagement sessions, email, team leaders (possible use of text messages)	TBC	TBC	Jayne Dunn, Paul Bosio, Elaine Newall	Communications	Similar arrangements to April briefings			
All SWBH staff	Hot topics and team brief, staff communications, intranet	TBC	TBC		Communications				
All staff connected with maternity services (include health visitors) - Sandwell	Internal communications via core brief, Friday feedout and lunch and learn.	Early October			Communications	More information required on staff teams			
All staff connected with maternity services (include health visitors) - HoB	Internal communications via Friday lunch box and staff meetings	Early October			Communications	More information required on staff teams			
Other Health Related Organisations									
Sandwell Antenatal Clinics	Face to face questionnaires and circulation of consultation document	Clinics booked for 15/10. 19/10, 29/10, 5/11, 12/11, 19/11, 25/11, 2/12 all at 9-1	Sandwell Hospital Antenatal Clinic		PPI		PPI Team		PPI Team
Sandwell Hospital Maternity Unit	Face to face questionnaires and a focus group	To be arranged with Maternity Unit	Sandwell Maternity Unit		PPI	PPI teams to conduct face to face questionnaires. Merida Associates to run focus groups. Contact made with Jacquie Whittaker (Matron AnteNatal) to ask for most appropriate contact (16.9.09	Merida Associates		Merida Associates
City Hospital Maternity Unit	Face to face questionnaires and a focus group	TBC	TBC		PPI	PPI teams to conduct face to face questionnaires. Merida Associates to run focus groups.	Merida Associates		Merida Associates
Heartlands Maternity Unit	Consultation leaflet linked to website				PPI				
Birmingham Women's Maternity Unit	Consultation leaflet linked to website				PPI				

Target audience	Method	Date	Location	Carried out by	Comms/ PPI lead	Comments	Consultation team	Management support	Scribe
Standalone Midwife Led Unit	Visit	To be organised by HOB during the consultation	Samuel Johnson Maternity, Victoria Hospital, Friary Road, Lichfield, WS13 6QN, Tel: 01543 442000						
Walsall Maternity Unit	Consultation leaflet linked to website				PPI				
Wolverhampton Maternity Unit	Consultation leaflet linked to website				PPI				
Dudley Maternity Unit	Consultation leaflet linked to website				PPI				
Sandwell and West Birmingham Hospitals NHS Trust members	Consultation leaflet linked to website to be sent out to FT members; members newsletter				Communications				
Sandwell Mental Health and Social Care NHS Foundation Trust members	Consultation leaflet linked to website to be sent out to FT members				Communications				
Birmingham and Solihull Mental Health NHS Foundation Trust members	Consultation leaflet linked to website to be sent out to FT members				Communications				
Neonatal Network	Circulation of consultation document				PPI				
Fertility Clinics	Consultation leaflet linked to website				PPI				
Sandwell Family Planning Clinics	Consultation leaflet linked to website				PPI				
HOB Family Planning Clinics	Consultation leaflet linked to website				PPI	Whittal Street Clinic,St. Patricks, Soho Health Centre, Safe Project, Teenage Pregnancy			
HoB Antenatal Clinics	Face to face questionnaires and circulation of consultation document	TBC	See comments panel		PPI	Aston HC,Soho HC,Broadway HC,Heathfield HC,Newton HC,Summerfield HC,Laurie Pike HC,Tower Hill HC, Colston HC,Handsworth Wood Medical Centre	PPI Team		PPI Team
HoB GP's, surgeries and Health Centre	Circulation of formal consultation document with some face to face questionnaires at appropriate clinics e.g. baby weighing				PPI	Aston Health Centre, Balsall Heath HC,Bloomsbury HC,Broadway HC,Colston HC,Farm Road HC,Heathfield HC,Ladywood Health and Community Centre,Landsdowne Health Centre,Newtown HC,Greet HC,St Patrick's HC,Small Heath HC,Soho HC,Sparkhill HC,Aston Pride HC,Finch Road PCC,Summerfield PCC and **see attached GP list**			
Sandwell GP's, surgeries and Health Centres	Circulation of formal consultation document with some face to face questionnaires at appropriate clinics e.g. baby weighing				PPI	Contact made with Sue Hill (SCHS) re Health Visitor Lead for access to baby weighing clincs (16.9.09)			
HoB Pharmacies	consultation leaflet linked to website				PPI	**See attached list**			
Sandwell Pharmacies	consultation leaflet linked to website				PPI				
HOB Dentists	consultation leaflet linked to website				PPI				

Sandwell Dentists	consultation leaflet linked to website				PPI				
Birmingham Children's Hospital	Circulation of consultation document								
West Midlands Ambulance Service	Circulation of consultation document				PPI	Gill Bennett - Director of Nursing & Primary Care - 01384 215 555 gill.bennett@wmas.nhs.uk		Kat Meredith	
Target audience	**Method**	**Date**	**Location**	**Carried out by**	**Comms/ PPI lead**	**Comments**	**Consultation team**	**Management support**	**Scribe**
Voluntary and Community Sector Organisations including women only groups									
Relevant VCS organisations (local, regional and national)	Circulation of formal consultation document	TBC	TBC		PPI	Ashiana, Saheli,Martha's Oasis, Aston Pride COFS, Contact Family Centre,UK Asian Women's' centre,Health Exchange, Chinese Community Centre,Cocoa,Piers Road,St Georges,St Thomas community association,Farm Road family centre, Karis Neighbour scheme,Hall Green Health Centre,Sparkhill Women's centre, Enterprising Communities distribution list, Khidmat Centre Group, see also attached list - also see **Places of worship list attached for Churches**		Robina and Neville	Robina and Neville
Sandwell Council of Voluntary Organisations	Article in SCVO.info and link to website and possible event aimed at voluntary sector	TBC	TBC		Communications & PPI				
Organisations supporting new migrant communities	Circulation of formal consultation document and focus groups	List of groups in Sandwell in detailed plan. Contact made with RES re focus group	To be arranged with Lara Angell		PPI	Benginagen Community Project, Brushstokes, Cameroon Children and Women Project in the UK, Cape Hill Medical Centre: Asylum Seekers and Refugees, Macho, SARC (RES Sandwell), Sandwell New Migrants Communities Network	Merida Associates		Merida Associates
Women's Organisations	Consultation leaflet linked to website and possible focus group.				PPI	ASHA; Mothers at Heart; netmums.com; SWAN, Women in Sandwell; SWEDA; Victoria Women's Centre;	Merida Associates		Merida Associates
Faith Organisations	Circulation of formal consultation document	TBC	TBC		PPI	Anderton Rd Mosque,Clifton Rd Mosque,Pershore Road-Synangogue,Carrs Lane Church,Birmingham Faith Network,Black Churches together,Small Health Musalmat, Nishkam Centre,Grove Lane Temple,Church on Soho Road,Aberdeen Street,St Paul's & St Silas Church Centre,St Francis,Council of Sikh Gurdwaras,Central mosque,Jamia Mosque,Arya Samaj,Eritrean chuches,Congolese churches,South Aston Church Centre,St Martins,Polish Centre, **see attached list - Places of Worship**			
Domestic Violence Groups	Circulation of formal consultation document				PPI		Arvi Sagoo		Arvi Sagoo
Mens Groups	Focus group for Fathers				PPI		Saeed		Saeed
Sandwell Community Health Network	Presentation and circulation of formal questionnaires	TBC	TBC		PPI	May need to run separate consultation sessions with members of the network	TBC	Jayne Salter-Scott	TBC
General Public									
Members of the Public - OLDBURY Neighbourhood Forum Langley	Short presentation and invite to public meeting	07/10/2009 6:30 - 8:00pm	Ebenezer Wesleyan Reform Church, Langley High Street, Oldbury		PPI	Provisional - To be confirmed by Parmjit Sahota		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
Members of the Public - ROWLEY REGIS Neighbourhood Forum Cradley Heath & Old Hill	Short presentation and invite to public meeting	07/10/2009 6:30 - 8:00pm	Cradley Heath Salvation Army, Meredith Street, Cradley Heath		PPI	To email confirmation of dates to diane_wright@sandwell.gov.uk		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	

Members of the Public - WEDNESBURY Neighbourhood Forum - Wednesbury Central & Wood Green	Short presentation and invite to public meeting	08/10/2009 6:00 - 8:00pm	The Wesley Centre, Spring Head, Wednesbury		PPI	To discuss with Angela Lemont on return from leave.		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
Target audience	**Method**	**Date**	**Location**	**Carried out by**	**Comms/ PPI lead**	**Comments**	**Consultation team**	**Management support**	**Scribe**
Members of the Public - ROWLEY REGIS Neighbourhood Forum Rowley Regis	Short presentation and invite to public meeting	08/10/2009 7:00 - 9:00pm	Rowley Christian Fellowship, Hanover Road, Rowley Regis, B65 9EE		PPI	To email confirmation of dates to diane_wright@sandwell.gov.uk		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
Members of the Public - OLDBURY Neighbourhood Forum Old Warley	Short presentation and invite to public meeting	12/10/2009 6:30pm	St. Huberts Primary School, Clent Road, Oldbury		PPI	Provisional - To be confirmed by Parmjit Sahota		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
Members of the Public - WEST BROMWICH Neighbourhood Forum - Yew Tree & Tamebridge	Short presentation and invite to public meeting	13/10/2009 6:30pm	Yew Tree Community Centre, Redwood Road, Yew Tree		PPI	To confirm dates with Jez Hall.		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
Members of the Public - WEDNESBURY Neighbourhood Forum - Harvills Hawthorn, Hill Top and Millfields	Short presentation and invite to public meeting	15/10/2009 6:00 - 8:00pm	Community Classroom, Harvills Hawthorn Primary School		PPI	To discuss with Angela Lemont on return from leave.		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
Members of the Public - TIPTON Neighbourhood Forum - Ocker Hill, Glebefields & Gospel Oak	Short presentation and invite to public meeting	15/10/2009 6.30 - 8:00pm	Main Hall, St. John's Church, Upper Church Lane, Tipton, DY4 9HN		PPI	To email further information to Rajvinder Shoker when available. Rajvinder will be on annual leave for this date but she will notify the chair.		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
Members of the Public - WEST BROMWICH Neighbourhood Forum - Hallam & Sandwell Valley	Short presentation and invite to public meeting	19/10/2009 6:00pm	Hallam Street Project, Lewisham Street, West Bromwich		PPI	To confirm dates with Jez Hall.		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
Members of the Public - OLDBURY Neighbourhood Forum Oldbury	Short presentation and invite to public meeting	20/10/2009 6:30 - 8:00pm	Christ Church, Birmingham Street, Oldbury		PPI	Provisional - To be confirmed by Parmjit Sahota		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
Members of the Public - WEST BROMWICH Neighbourhood Forum - Hateley Heath, Black Lake & Tantany	Short presentation and invite to public meeting	21/10/2009 6:30pm	Menzies CLC Centre, Hateley Heath		PPI	To confirm dates with Jez Hall.		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
Members of the Public - ROWLEY REGIS Neighbourhood Forum Blackheath	Short presentation and invite to public meeting	21/10/2009 7:00pm	Central Methodist Church, High Street, Blackheath		PPI	To email confirmation of dates to diane_wright@sandwell.gov.uk		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
Members of the Public - WEDNESBURY Neighbourhood Forum - Wednesbury Parkway & Leabrook	Short presentation and invite to public meeting	22/10/2009 6:00pm	Leabrook Methodist Church, Leabrook Road North, Wednesbury		PPI	To discuss with Angela Lemont on return from leave.		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
Members of the Public - WEST BROMWICH Neighbourhood Forum - Beeches Road & Europa	Short presentation and invite to public meeting	22/10/2009 6:00pm	Holy Trinity Church, Mary Road, West Bromwich		PPI	To confirm dates with Jez Hall.		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
Members of the Public - WEST BROMWICH Neighbourhood Forum - Great Barr & Hamstead	Short presentation and invite to public meeting	22/10/2009 6:30pm	St. Bernard's Church, Broome Avenue		PPI	To confirm dates with Jez Hall.		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	

Members of the Public - WEST BROMWICH Neighbourhood Forum - Greets Green	Short presentation and invite to public meeting	26/10/2009 6:00pm	Gunns Village Primary School		PPI	To confirm dates with Jez Hall.		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
Target audience	**Method**	**Date**	**Location**	**Carried out by**	**Comms/ PPI lead**	**Comments**	**Consultation team**	**Management support**	**Scribe**
Members of the Public - ROWLEY REGIS Neighbourhood Forum Tividale	Short presentation and invite to public meeting	26/10/2009 6:30 - 8:00pm	Oakham Evangelical Church, City Road, Tividale		PPI	To email confirmation of dates to diane_wright@sandwell.gov.uk		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
OLDBURY Neighbourhood Forum Bristnall	Short presentation and invite to public meeting	27/10/2009 6:30 - 8:00 pm	Londonderry Baptist Church, Bristnall Hall Road, Oldbury		PPI	Provisional - To be confirmed by Parmjit Sahota		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
General Public - Rowley Regis	Public Meeting	28/10/2009 6:00pm	Salvation Army, Cradley Heath Corps, Meredith Street, Cradley Heath, B64 5EP		Communications and PPI	Public meetings to follow on from attendance to neighbourhood forums	Senior management, NED's and clinicians	Jayne Salter-Scott, Lisa Jacob, Kat Meredith	Merida Associates
Members of the Public - WEST BROMWICH Neighbourhood Forum - Charlemont & Stone Cross	Short presentation and invite to public meeting	29/10/2009 6:30pm	St Mary Magdalene Church		PPI	To confirm dates with Jez Hall.		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
Members of the Public - WEST BROMWICH Neighbourhood Forum - Kenrick & Lyng	Short presentation and invite to public meeting	04/11/2009 6:00pm	The Lyng Primary School, Horton Street, West Bromwich		PPI	To confirm dates with Jez Hall.		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
Members of the Public - WEDNESBURY Neighbourhood Forum - Friar Park & Mesty Croft	Short presentation and invite to public meeting	04/11/2009 6:00 - 8:00pm	Friar Park Millennium Centre, Friar Park Road, Wednesbury		PPI	To discuss with Angela Lemont on return from leave.		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
General Public - Wednesbury/ West Bromwich	Public Meeting	11/11/2009 6:00pm	Medical Education Centre, Sandwell Hospital, Lewisham Street (Entrance on Hallam Street) West Bromwich		Communications and PPI	Public meetings to follow on from attendance to neighbourhood forums	Senior management, NED's and clinicians	Jayne Salter-Scott, Lisa Jacob, Kat Meredith	Merida Associates
Members of the Public - TIPTON Neighbourhood Forum - Great Bridge, Toll End & Horseley Heath	Short presentation and invite to public meeting	17/11/2009 6:30 - 8:00pm	Great Bridge, Primary School, Mount Street, Great Bridge, Tipton, DY4 7DE		PPI	To email further information to Rajvinder Shoker when available.		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
Members of the Public - TIPTON Neighbourhood Forum - Park Estate & Tipton Green	Short presentation and invite to public meeting	23/11/2009 6:30 - 8:00pm	St. Paul's Community Centre, Brick Kiln Street, Tipton, DY4 9BP		PPI	To email further information to Rajvinder Shoker when available.		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
Members of the Public - SMETHWICK Neighbourhood Forum - Abbey	Short presentation and invite to public meeting	25/11/2009 6:00pm	St Mary's Church, St Mary's Road, Bearwood, B67 5DG		PPI	To discuss with Santokh Singh.		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
Members of the Public - TIPTON Neighbourhood Forum - Princes End & Tibbington Estate	Short presentation and invite to public meeting	01/12/2009 6:30 - 8:00pm	Brook Street Community Centre, Brook Street, Tipton, DY4 9DD		PPI	To email further information to Rajvinder Shoker when available.		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
General Public - Tipton	Public Meeting	02/12/2009 6:00pm	The New Testament Church of God, Horseley Heath, Dudley Port, Tipton, DY4 7QT		Communications and PPI	Public meetings to follow on from attendance to neighbourhood forums	Senior management, NED's and clinicians	Jayne Salter-Scott, Lisa Jacob, Kat Meredith	Merida Associates
Members of the Public - SMETHWICK Neighbourhood Forum - Soho & Victoria	Short presentation and invite to public meeting	3/12/2009 6:00pm	Windmill Community Centre, Messenger Road, Smethwick, B66 3DX		PPI	To discuss with Santokh Singh.		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	

General Public - Oldbury / Smethwick	Public Meeting	8/12/2009 10:30am	Asra Smethwick, Health & Social Care Centre, Fenton Street, St Pauls,.		Communications and PPI	Public meetings to follow on from attendance to neighbourhood forums	Senior management, NED's and clinicians	Jayne Salter-Scott, Lisa Jacob, Kat Meredith	Merida Associates
Target audience	**Method**	**Date**	**Location**	**Carried out by**	**Comms/ PPI lead**	**Comments**	**Consultation team**	**Management support**	**Scribe**
Members of the Public - SMETHWICK Neighbourhood Forum - St Paul's	Short presentation and circulation of consultation documents	15/12/2009 6:00pm	St. Albans Community Centre, St. Albans Road, Smethwick, B67 7ML		PPI	To discuss with Santokh Singh.		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
Members of the Public - SMETHWICK Neighbourhood Forum - Smethwick central	Short presentation and circulation of consultation documents	06/01/2010 6pm	Dorothy Parkes Centre, Church Road, Smethwick, B67 6EH (Jan)		PPI	To discuss with Santokh Singh.		Jayne Salter-Scott, Lisa Jacob, Kat Meredith	
Women who expressed an interest in being kept informed and involved following on from pre-engagement activity.	Database of names - circulation of consultation document, invite to public meeting, visit to MLU and to focus group					Database in PPI Folder			
Members of the Public - HoB	Circulation of consultation document & public meetings			Robina & Nev, PPI team	Communications & PPI	residents groups,neighbourhood forums,neighbourhood management boards, Contacts through pre=consultation questionnaire,3 public meetings -1 per month,venues identified are:1) End Oct - Summerfield Community Centre on Dudley Road/Lime Tree/Mayfield School 2) Fire Station/Soho Road Children's Centre 3) Hansdworth Methodist Church 3) Farm Road Family Centre.Cherry Orchard Children's Centre - possible event. Event plan: daytime,preferably Saturday meetings to get mums in,face painting,clowns,balloonist. PROVISIONAL PUBLIC MEETINGS X 3 Sat 14/11/09, 26/11/09 (evening), 2/12/09 (afternoon) - TBC			
Supermarkets	Circulation of leaflets linked to websites			Robina & Nev, PPI team		Tesco 5 ways, Tesco Aston, Lidl -Dudley Road,Lidl top of Soho Road, Lidl- Moseley Road,Asda - One stop,Morrisons and Asda on Coventry Road.			
Shops on High Street	Circulation of leaflets linked to websites			Robina & Nev, PPI team		Lozells Road,Witton Road and other bust high streets			
Neighbourhood Forums - HoB	Short presentation and invite to public meeting	TBC	TBC		PPI			PPI team	
Schools, Parents and Children									
All schools in Sandwell	Circulation of leaflet linked to websites				PPI				
All schools in HoB	Circulation of leaflet linked to websites				PPI	list to be attached			
Parent and children groups and activities - Sandwell	Circulation of leaflet linked to website				PPI	Make use of childcare information services database in Sandwell and children's centres.			
Parent and children groups and activities - HoB	Circulation of leaflet linked to website				PPI	Make use of childcare information bureau's database in HoB - Robina to identify.			
Nurseries (affiliated to schools and private nurseries) in Sandwell	Circulation of leaflet linked to website				PPI	Make use of childcare information services database in Sandwell			

Nurseries (affiliated to schools and private nurseries) in HoB					PPI	Make use of childcare information bureau's database in HoB - Robina to identify.			
Target audience	**Method**	**Date**	**Location**	**Carried out by**	**Comms/ PPI lead**	**Comments**	**Consultation team**	**Management support**	**Scribe**
Teenage Pregnancy Support Unit	Face to face questionnaires and a focus group	Contact made with Anne Savage (16.9.09) agreement for focus group waiting to arrange with Sarah	Batmans Hill Unit		PPI	Head of service Anne Savage 0121 557 5047 Batmans Hill Unit, Adam's Close, Princes End, Tipton, DY4 9LJ; anne.savage@batmanshill.sandwell.sch.uk NEW CONTACT: Sarah (sarah.colclough1@batmanshill.sandwell.sch.uk)	Merida Associates		Merida Associates
Mother and Baby- Heathfield Road (Teenage mums)	Focus Group	TBC	TBC		PPI		Merida Associates		Merida Associates
Other parent support groups - HoB	Circulation of consultation document and possible focus group	TBC	TBC		PPI	Autistic Group, Deaf Cultural Centre Parents Group	Merida Associates		Merida Associates
Other parental support groups (Disability) - Sandwell	Circulation of consultation document and possible focus group	TBC	TBC		PPI	Contact Ideal for All with regards to Sandwell Parent in Need of Support. Contact Sandwell Asian Family Support Services.	Merida Associates		Merida Associates
HOB Carers Forum	Consultation leaflet with link to website				PPI				
Women's Help Centre	Send consultation document				PPI				
Roshni	Send consultation document				PPI				
The Doli Project	Send consultation document				PPI				
Somali Children and Women Focus Group	Send consultation document				PPI				
Somali Women - Sandwell	Focus Group	Contact made with Sara Leaker	be arranged with Somali Womens		PPI		Merida Associates		Merida Associates
National Young Carers association	Consultation leaflet linked to website			Amanda Smith	PPI	liaise with Pam Bloor			
Sandwell Youth Cabinet	Presentation and circulation of consultation document	Email sent to Tariq Karim re agenda item (16.9.09)	Sandwell Youth Cabinet		PPI		Commissioning and PPI lead	Jayne Salter-Scott	Jayne Salter-Scott
Other agencies									
Job centres - Sandwell	Consultation leaflet linked to website				PPI				
Job Centre - HoB	Consultation leaflet linked to website				PPI				
FE Colleges Sandwell	Consultation leaflet linked to website				PPI				

FE colleges HoB	Consultation leaflet linked to website				PPI	Mathew Bolton,South Birmingham, City College, Student services at Universities (Aston and Birmingham)			
Sandwell Community Centres	Consultation leaflet linked to website				PPI				
Target audience	**Method**	**Date**	**Location**	**Carried out by**	**Comms/ PPI lead**	**Comments**	**Consultation team**	**Management support**	**Scribe**
HoB Libraries	Consultation leaflet linked to website				PPI				
HoB Community Centres	Consultation leaflet linked to website				PPI				
Gateway Family Services	Consultation leaflet linked to website				PPI				
Leisure Centres - HoB	Consultation leaflet linked to website				PPI	Small Heath, Sparkhill,Handsworth,Nechells,Aleander Stadium,Moseley Baths, Beeches Road- Perry Barr			
Leisure Centres - Sandwell	Consultation leaflet linked to website				PPI				
Public Transport Providers/ forums	Consultation leaflet linked to website				PPI	Please refer to email from Andy Thorpe		Kat Meredith	
Communications									
General population	Comprehensive communication plan to include communication with staff, social networking sites, local media and websites.				Communications	Sandwell PCT taking lead on developing communications plan in partnership with colleagues across SWBH and HoB.		Julie Salt	
Radio, TV and community press - HoB					Communications	Newstyle Radio, Untiy FM, , Excel Radio,Noor TV. Standard article for community press,school newsletters,residents newsletters,community papers. Put article also in HOB Magazines: In-Touch magazine, My Health, GP Bulletin.			
Local media network - Sandwell					Communications				

KEY	
	HoB
	Sandwell PCT
	SWBH
	Further information required

SWBTB (9/09) 174 (c)

Sandwell NHS
Primary Care Trust

Heart of Birmingham NHS
Teaching Primary Care Trust

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Improving services for giving birth

Proposed changes to Maternity Services from 2010 to 2015 in Sandwell and West Birmingham

PUBLIC CONSULTATION

12 October 2009 to 18 January 2010

SWBTB (9/09) 174 (c)

Improving services for giving birth

This document explains why maternity services in Sandwell and West Birmingham need to be improved and sets out three different ways that services could be delivered in the run up to the opening of a new hospital in Smethwick in 2015.

You are being asked to tell us the option you prefer and to give your opinion on where women and their families should receive care during childbirth for the next 5 years.

If you would like printed copies of this document in large print or another language or format, including audio or Braille, please contact (email address) or phone (number).

Sandwell Primary Care Trust has been leading a review of maternity services in the run up to 2015.

The review came up with a list of 7 options. Those options have been talked about and scored with partners from Sandwell & West Birmingham Hospitals Trust, Heart of Birmingham Teaching Primary Care Trust, specialist doctors (consultants), midwives and interested people, including local women who are pregnant or have given birth in the area, and other patient representatives.

The 3 options in this document have come out of those discussions.

INSIDE

What is this about?

Across the UK, maternity services are changing. The government has made the need to improve care for women during pregnancy and childbirth a national priority. They want to see:

- Improved safety
- More choice
- Women having normal births and receiving one-to-one care from midwives during birth
- Doctors concentrating on care for women with complications in pregnancy.

It takes time to put in place the changes needed to make these improvements. In Sandwell and West Birmingham there is a long-term commitment to offer local women and their partners antenatal and postnatal care near to where they live. There will be a midwife-led birth centre and specialist care facility at the new hospital that is due to open in 2015 on the Grove Lane site in Smethwick.

Before the new hospital is ready there are some changes that need to be made.

This document explains why changes are needed and sets out some options for how maternity services in Sandwell and West Birmingham can be made even safer and of a higher quality, ready to transfer into the new hospital when it opens.

Current services → **Improving services** → **Future services in new hospital**

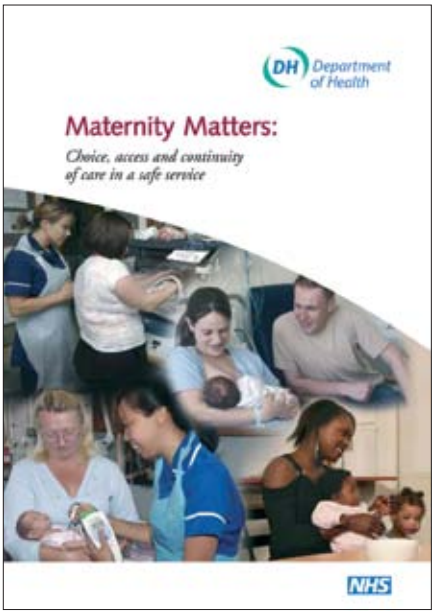
Your views, as a woman or family member who may come in contact with maternity services, will play an important part in deciding which option is agreed.

Please see the back page and the *Tell us your views* feedback form, at the end of this leaflet, for ways you can have your say.

Why do we need to change Maternity Services now?

We need to keep up-to-date on safety measures

In recent years, independent reviews of maternity services in Sandwell and the Heart of Birmingham have raised some concerns about quality and safety. Immediate measures were put in place to tackle these concerns, including the appointment of additional experienced staff including specialist doctors (consultants) and midwives, and the quality and safety of services are much better. Since then, the government has introduced new national standards for the care of women during and after pregnancy and childbirth, so there are still areas for improvement.



There are high levels of local need for extra care

People in Sandwell and the Heart of Birmingham have poorer health than people in England generally. Expectant mothers are more likely to have complications in pregnancy due to high levels of poverty, poor diet, smoking and other health conditions such as diabetes, which means there is a high demand for specialist maternity services.

We need to recruit more specialist staff

At present, maternity services are provided at both City Hospital and Sandwell General Hospital. This means there are two staff teams and two delivery suites, with consultants dividing their time between both sites. The new national standards say there must be higher numbers of specialist doctors (consultants) and midwives to cover each delivery unit. It is difficult to recruit specialist staff to smaller services where there are fewer occasions for them to use and develop their specialist skills.

We need to provide more choice for women with normal pregnancies

Women who do not experience any complications during their pregnancy should be offered more choice about how they have their babies. They should be offered the chance to give birth in a comfortable, more home-like environment with a midwife available to provide consistent one-to-one support during labour and delivery.

Sandwell General Hospital

- Consultant-led Delivery Suite with labour ward
- One theatre for operations e.g. caesarean sections
- Consultant-led antenatal clinics
- Special baby care for babies over 34 weeks. Women in labour who are less than 34 weeks pregnant must be transferred to a unit offering more complex care.

City Hospital

- Consultant-led Delivery Suite with labour ward
- Two theatres for operations e.g. caesarean sections with 24 hour staffing
- Consultant-led antenatal clinics
- Special baby care unit for premature babies from 26 weeks and for babies needing very complex baby care.

What do Maternity Services look like now?

People have already told us that it important to pregnant women to be able to get good quality antenatal care as close to where they live as possible.

Most women get antenatal support from their community midwife at either their surgery or at Children's Centre while they are pregnant. Women who have an existing health condition or who have previously had difficulties in pregnancy or labour go to a specialist doctor (consultant) led antenatal clinic at one of the hospitals.

Most women then go on to have their babies in hospital; very few choose to have their babies at home.

A New midwife-led Birth Centre opens in 2010 at City Hospital

Women with uncomplicated pregnancies are going to be offered more choice to give birth in more home like surroundings in the hospital-based midwife-led Birth Centre at City Hospital. It will be set up near to the main Delivery Suite and is how services will be set up at the new hospital in Smethwick.

About 30% of women giving birth will be eligible to give birth to their babies in the Birth Centre, which is expected to open in April 2010.

"I think [safety means] having midwives there… and knowing that they're around and trusting that they're doing what they should be doing, basically."

This is an example of a modern Birth Centre room, intended to provide a more home-like environment for giving birth

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What is a midwife-led Birth Centre?

Birth Centres are small maternity units which are staffed and run by midwives. They offer a comfortable, low-tech environment where birth is treated as a 'normal' process rather than a medical one.

"Birth centres are known for providing friendly, individualised care in an atmosphere that is informal and unhurried," writes midwifery consultant Jilly Rosser in RCM Midwives Journal. "[They] have evolved to help women and their families experience the best possible start to parenthood."

What do Birth Centres offer?

Birth Centres offer a homely, relaxed atmosphere, and are well-equipped and staffed with highly skilled midwives. They can offer facilities such as family accommodation, birthing pools, complementary therapies and comfortable, low-tech birthing rooms.

You are more likely to have one-to-one care from a midwife throughout your labour in a Birth Centre than in a consultant-led hospital unit.

What are the benefits?

Studies show that if you have an uncomplicated, low risk pregnancy and give birth in a Birth Centre you are more likely to be able to:

- Deliver your baby without the need for interventions such as a forceps delivery or an episiotomy
- Deliver your baby without being induced
- Deliver your baby without having a caesarean
- Deliver your baby using natural pain relief methods such as a birthing pool
- Breastfeed your baby.

Community Birth Centres

Birth Centres can also be set up in a separate location to the hospital, somewhere else in the community, offering the choice of delivery closer to home.

If you got into difficulties during labour and you needed the help of a doctor or emergency facilities, good transport systems would be in place for you to be transferred to hospital by ambulance with your midwife. Experience suggests that this may happen to 1 in 5 women.

Hospital Birth Centre

Hospital Birth Centres, like the one that will be available at City Hospital, can be located in a hospital, ideally alongside an existing labour ward or maternity unit with easy access to emergency facilities, doctors and special baby care units, where you would be transferred should you get into unexpected difficulties during labour.

"Giving birth is a celebration and I want every woman who comes through our door to have a great experience on the day they will remember for the rest of their lives.

By being more active, women can ease their pain and progress through their labour more easily, so our rooms are large areas with a number of options for women to choose their preferred position."

Kathryn Gutteridge, Consultant Midwife for Sandwell and West Birmingham Hospitals NHS Trust

Can things stay as they are now?

Keeping all maternity services as they are now is not going to be possible. Improvements have been made and specialist staff are spending more time at Sandwell, but it will be impossible to keep these arrangements in place until the new hospital is built in 2015.

- Continuing with these arrangements does not improve the choice for women
- Consultants and midwives are still splitting their time over two sites
- It is very hard to recruit the specialist staff needed
- It will be difficult to achieve higher standards of choice and care
- This option is not supported by consultants and midwives.

What are the options for changing Maternity Services?

OPTION 1

Pros

- A more effective consultant team.
- Able to provide more specialist services for people with complications.
- There is a special baby care unit already on site.
- Women with low risk/normal pregnancies will be able to get antenatal care at Sandwell Hospital.

Cons

- Reduces choice for women hoping to give birth in Sandwell.

All births, except for home births, will take place at City Hospital.

This will include low risk births in the midwife-led Birth Centre at City Hospital. All consultant-led antenatal clinics will take place at City Hospital, where there will also be routine antenatal clinics, including scans, run by midwives.

There would be no births or in-patient maternity care at Sandwell Hospital.

There will be some antenatal clinics, including routine scans, run by midwives at Sandwell Hospital.

All special baby care would be provided at City Hospital.

OPTION 2

Pros

- A more effective consultant team.
- Able to provide more specialist services for women with complications.
- There is a special baby care unit already on site.
- Women can get their antenatal care at Sandwell Hospital.

Cons

- Reduces choice for women hoping to give birth in Sandwell, including some women who need specialist care.

All births, except for home births, will take place at City Hospital. Some women with complicated pregnancies, who need specialist antenatal care, will be able to get it at Sandwell Hospital.

This will include low risk births in the midwife-led Birth Centre at City Hospital. There would be both consultant-led antenatal clinics and routine antenatal clinics, including scans, run by midwives at City Hospital.

There would be no births or in-patient maternity care at Sandwell Hospital.

There will be some antenatal clinics, including routine scans, run by midwives and also a small number of specialist/consultant-run antenatal clinics at Sandwell Hospital.

All special baby care would be provided at City Hospital.

OPTION 3

Pros

- There will be a more effective consultant team.
- Able to provide more specialist services for people with complications.
- Offers choice of delivery closer to home for women with uncomplicated pregnancies (medium term).
- Offers more choice for those women having a normal delivery (medium term).

Cons

- Reduces choice of delivery closer to home in the short term.
- It will take time to develop a stand-alone community birth centre in Sandwell.
- It isn't going to be suitable for everyone, and some women may have to transfer to hospital once their labour has started.

Temporarily relocate all births (normal and complicated) to City Hospital, and then set up a Community Birth Centre in Sandwell that is not attached to a hospital site.

Routine antenatal clinics for women with normal pregnancy will continue at Sandwell Hospital.

Once the Birth Centre is open, women with normal pregnancies will have the additional choice of having their babies in a midwife-led Birth Centre in Sandwell.

Consultant antenatal clinics and births for women with complications will all be at City Hospital.

All special baby care would be provided at City Hospital.

How will the best option be chosen?

Each option will be scored to see how it achieves the following:

- Ability to offer women and their families a safe, normal birth.
- Ability to offer care by the same midwives throughout pregnancy and birth.
- Better care closer to home.
- Increased choice and control for women.
- Women have improved experience of maternity services.
- Improved public confidence in the service and facilities.
- The employment and retention of highly skilled midwives and consultants.
- A high quality service that can continue to keep up to national standards.

The people who are in charge at the highest (Board) level of maternity services in Sandwell and West Birmingham will read what you tell us during the consultation, and will take these views into account when they make their decision.

The final option must be realistically achievable and affordable.

The option must move services towards the planned long-term model of care that has been approved for the new hospital in 2015.

High quality care and safety must be the main priority.

How can I have my say?

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By filling in the feedback form in the middle of this booklet and returning it by FREEPOST to the address shown on the form. The **closing date** for receipt of forms is [fill in closing date].

By completing the feedback form online at:
[weblink]

By phone - please call:
[named contact] on [phone number]

By coming along to one of these public meetings:
[dates, times and places, inc. accessibility info, eg crèche facilities, interpreters]

Comments, concerns and queries about healthcare

The Patient Advice & Liaison Service (PALS) is a confidential service based at the Lyng Centre in West Bromwich which will listen to any comments, concerns or queries you may wish to raise regarding healthcare provided in Sandwell. They can be contacted on freephone 0800 030 4654.

If you need this leaflet in another format, such as audio or large print, please contact Communications on 0845 155 0500.

اذا كنت بحاجة الى هذا المنشور على شكل خطوط مطبعية كبيرة او على شكل شريط كاميت او مطبوع بهذه اللغة, يرجى الاتصال بمركز الاتصالات على هاتف رقم 0121 612 1679.

ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਵੱਡੇ ਛਾਪੇ ਵਿੱਚ, ਆਡਿਓ ਤੇ ਜਾਂ ਇਸ ਭਾਸ਼ਾ ਦੇ ਵਿੱਚ ਚਾਹੀਦਾ ਹੋਵੇ ਤਾਂ ਕਮਿਊਨੀਕੇਸ਼ਨ (ਸੰਚਾਰ) ਵਿਭਾਗ ਨੂੰ ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ 0121 612 1679 ਤੇ ਫ਼ੋਨ ਕਰਨ ਦੀ ਕ੍ਰਿਪਾਲਤਾ ਕਰਨੀ।

Aby otrzymać tę ulotkę w wersji dużym drukiem, audio lub w tym języku, proszę się skontaktować z działem komunikacji pod numerem: 0121 612 1679.

اگر آپ کو یہ کتابچہ بڑے پرنٹ، آڈیو یا اردو میں درکار ہو تو براہ مہربانی ٹیلی فون نمبر 0121 612 1679 پر کمیونیکیشنز (communications) سے رابطہ کیجئے

Published by: Sandwell PCT, Kingston House, 438 High Street, West Bromwich B70 9LD. 0845 155 0500 www.sandwell-pct.nhs.uk

FEEDBACK FORM

Tell us your views

SWBTB (9/09) 174 (c)

We want to know what you think about improving Maternity Services. Please fill in and return this form so that we can make sure that people from across the communities in Sandwell and West Birmingham have had their say. **The information will only be used for the planning of health services and not for any other purpose**.

Returning your form

Please post your completed form to the following FREEPOST address (no stamp needed – just write the address on an envelope) by [fill in closing date]:

Merida Associates
FREEPOST RRHT-STZH-AEUT
5 Redhill
Stourbridge
DY8 1NA

Online form

Don't forget, if you prefer, you can go online to complete the form. Go to:
[weblink]

How do I know my views will be listened to?

Your responses to this consultation will be collected and analysed by Merida Associates, an independent organisation that will prepare a report about what people say for the Maternity Services review steering group.

The Maternity Services review steering group will take the views of everyone who takes part in this consultation into account when judging the options. There is the opportunity for the chosen option to be amended if strong public opinion suggests a change. After the consultation the (Trust Board) is expected to decide, by XXXXXXX 2010, on which option to implement for maternity services up to 2015.

The results of the consultation and the decision on which option is chosen will be available on the websites of all three Trusts:
[website 1]
[website 2]
[website 3]

Would you like to receive a copy of the results of the consultation?

If you would like to get a copy of the summary of consultation replies please fill in your name and address here:

If you would like to get a copy by email please fill in your email address below:

1. About you

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Are you: ✔

- ❑ Female
- ❑ Male

Are you: (please tick one) ✔

- ❑ A parent
- ❑ A grandparent
- ❑ A pregnant woman/partner
- ❑ Guardian

What is your postcode:

☐☐☐ (first 3 figures only)

Do you have children? (please tick one) ✔

❑ No ❑ 1 child ❑ 2 children ❑ 3 or more children

How old are you? (please tick one) ✔

❑ under 16 ❑ 16-18 ❑ 19-29 ❑ 30-39 ❑ 40-49 ❑ 50-64 ❑ 65 or over

What do you consider to be your ethnic origin? (please tick one) ✔

Asian or Asian British
- ❑ Pakistani
- ❑ Bangladeshi
- ❑ Indian
- ❑ Other Asian background

Black or Black British
- ❑ African
- ❑ Caribbean
- ❑ Other Black background

White
- ❑ White British
- ❑ Irish
- ❑ Polish/ Latvian/ Eastern European
- ❑ Other White background

Chinese or Chinese British
- ❑ Chinese

Mixed
- ❑ White and Black Caribbean
- ❑ White and Black African
- ❑ White and Asian
- ❑ Other mixed background

Other
- ❑ Please tell us: _____
- ❑ I prefer not to say

Do you consider yourself to be a disabled person? (please tick one) ✔

❑ Yes ❑ No ❑ Not sure

2. About giving birth

If you were giving birth, which would you prefer? (please tick one) ✔

- ❑ A community widwife-led Birth Centre
- ❑ A hospital-based midwife-led Birth Centre
- ❑ Home birth
- ❑ A consultant-led hospital Delivery Suite
- ❑ Other – please tell us: _____

3. Maternity Services in Sandwell (for **Sandwell residents** only)

If maternity services in Sandwell are all relocated to City Hospital, where would you prefer to go to have your baby? (please tick one) ✔

- ❑ City Hospital
- ❑ Russells Hall Hospital
- ❑ Birmingham Women's Hospital
- ❑ Walsall Manor Hospital
- ❑ New Cross Hospital
- ❑ Home birth

4. About the options for Maternity Services

You can see details about the options on pages 6-7 of the booklet.

Which option for Maternity Services do you think is best you and your family? (please tick one) ✔

❑ OPTION **1**

All births, except for home births, will take place at City Hospital.

- This will include low risk births in the midwife-led Birth Centre at City Hospital. All consultant-led antenatal clinics will take place at City Hospital, where there will also be routine antenatal clinics, including scans, run by midwives.
- There would be no births or in-patient maternity care at Sandwell Hospital.
- There will be some antenatal clinics, including routine scans, run by midwives at Sandwell Hospital.
- All special baby care would be provided at City Hospital.

❑ OPTION **2**

All births, except for home births, will take place at City Hospital. Some women with complicated pregnancies, who need specialist antenatal care, will be able to get it at Sandwell Hospital.

- This will include low risk births in the midwife-led Birth Centre at City Hospital. There would be both consultant-led antenatal clinics and routine antenatal clinics, including scans, run by midwives at City Hospital.
- There would be no births or in-patient maternity care at Sandwell Hospital.
- There will be some antenatal clinics, including routine scans, run by midwives and also a small number of specialist/consultant-run antenatal clinics at Sandwell Hospital.
- All special baby care would be provided at City Hospital.

❑ OPTION **3**

Temporarily relocate all births (normal and complicated) to City Hospital, and then set up a Community Birth Centre in Sandwell that is not attached to a hospital site.

- Routine antenatal clinics for women with normal pregnancy will continue at Sandwell Hospital.
- Once the Birth Centre is open, women with normal pregnancies will have the additional choice of having their babies in a midwife-led Birth Centre in Sandwell.
- Consultant antenatal clinics and births for women with complications will all be at City Hospital.
- All special baby care would be provided at City Hospital.

5. Any other comments? Please write them below:

Thank you for filling in this form. Your views are important to us.

Sandwell NHS Primary Care Trust
Heart of Birmingham NHS Teaching Primary Care Trust
Sandwell and West Birmingham Hospitals NHS NHS Trust

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Trust Assurance for Preparedness on Pandemic Influenza (H1N1)
SPONSORING DIRECTOR:	Richard Kirby, Chief Operating Officer
AUTHOR:	Matthew Dodd, Deputy Chief Operating officer Andrew Dunn, Emergency Planning Officer
DATE OF MEETING:	24 September 2009

SUMMARY OF KEY POINTS:

The Trust has robust plans to deal with a second wave of H1N1. These have been developed in conjunction with partner agencies.

Further actions include:

- Finalising the winter plan for the local health economy
- Establishing a senior group to oversee any decisions impacting on clinical services or treatment criteria
- Agreeing indemnity arrangements for SWBHT staff working on an outreach basis to support other organisations as part of mutual aid

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

1. NOTE the Trust's preparedness for H1N1
2. NOTE the actions identified as the next steps in preparation for H1N1
3. APPROVE the Trust's state of readiness for a further wave of H1N1

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	
Annual priorities	Business Continuity & Contingency Planning
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

Financial	**X**	Costs of additional equipment and staff Loss of elective income streams
Business and market share	**X**	Escalation plans have the potential to involve cessation of some routine activity
Clinical	**X**	Clinical practice for H1N1 patients Clinical priorities for treatment/cessation of activity
Workforce	**X**	Staff vaccination and sickness & absence
Environmental	**X**	Conversion of adult clinical areas into critical care/paediatric facilities
Legal & Policy	**X**	Ensuring indemnity for staff offering mutual aid
Equality and Diversity	**X**	Arrangements for deciding on clinical priorities
Patient Experience	**X**	Treatment expectations during an influenza pandemic
Communications & Media	**X**	Arrangements for internal and external communications identified
Risks		• Clinical attack and complication rates higher than national planning assumptions • Staff absence higher than national planning assumptions

PREVIOUS CONSIDERATION:

Not previously considered by Trust Board

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

TRUST BOARD ASSURANCE ON PREPAREDNESS FOR PANDEMIC INFLUENZA (H1N1)

1.0 INTRODUCTION

The DH has requested that all Trust Boards receive a statement of their organisation's preparedness for a further wave of H1N1 at their September 2009 meeting.

SWBHT was at the centre of the first wave of H1N1 in England during the summer. The lessons learnt from this have been incorporated into our planning and have also been shared with other NHS Trusts across the country.

This paper outlines the Trust's current state of preparedness and is accompanied by a full report on the work and planning that has been undertaken to date.

2.0 CURRENT POSITION

2.1 Health Economy-Wide Issues

There are robust multi-agency planning groups in both Sandwell and Birmingham where SWBHT has shared H1N1 plans and assumptions with partner agencies. Planning has also recognised the need for local decisions to be taken in advance of central guidance and locally there has been an emphasis on ensuring that this will be undertaken in close coordination with partners.

2.2 Patients:

The PCTs have developed plans for anti-viral distribution and for vaccination within the community. Our pharmacy department has agreed plans with PCTs regarding stock levels and supply issues

2.3 Winter Resilience Plans

The Trust has developed winter plans which have been shared with PCTs and WMAS via the local winter planning forum. An area which remains to be agreed regards turnaround protocols with WMAS.

2.4 Flu Pandemic Second Wave Resilience

SWBHT has undertaken its activity and surge capacity modelling based on the planning assumptions provided by the Department of Health. Essential services have been identified and buffer supplies of consumables have been purchased.

2.5 Specific Organisational Capacity Issues

The Trust has identified the capacity escalation arrangements for medicine, surgery, paediatrics, and maternity services. This has taken into account the implications of service change for other parts of the organisation. There are plans to double the capacity of critical care. The Trust has identified the need for there to be a group within the Trust to provide senior leadership regarding

the clinical impact of decisions on capacity and service provision. This group remains to be established.

In addition the Trust is developing plans for mutual aid with other Acute Trusts as well as Sandwell PCT, Sandwell Mental Health & Social Care Trust and social care. This will require the board to approve that the Trust indemnifies SWBHT staff to work in other health and social care organisations should the need arise.

2.6 Staffing

A vaccination strategy has been developed for staff with regards to seasonal flu and the H1N1 vaccines. It must be noted that current indications from staff are that there will be a low take up of the seasonal flu vaccine, however the Trust is seeking to work towards 80% vaccination.

Sickness management, redeployment and leave issues have also been addressed and a comprehensive human resources guide produced by the Trust in consultation with staff side is included in the full report.

3.0 NEXT STEPS

The areas identified as requiring further work are being addressed. Further planning sessions will take place with divisional management teams, while the Trust will start to implement some of the training packages for nursing staff to prepare them to work in different clinical areas.

4.0 CONCLUSION AND RECOMMENDATIONS

The Trust has planned appropriately for a further wave of H1N1. There is a need for ongoing work to ensure that staff remain prepared and that plans are refined in the light of further information on the spread and severity of H1N1.

The Trust Board is recommended to:

1. NOTE the Trust's preparedness for H1N1
2. NOTE the actions identified as the next steps in preparation for H1N1
3. APPROVE the Trust's state of readiness for a further wave of H1N1

Matthew Dodd
17th September 2009

Winter and Flu Resilience plans checklist

Organisation name: Sandwell & West Birmingham Hospitals NHS Trust Board meeting date: 24th September 2009

Q	Action	Relevant to organisation (Y/N)	Included in resilience plan (Y/N)	Organisation overall assessment of readiness against criteria GREEN - assured and ready now AMBER - in progress complete as planned RED - in progress not expected to complete as planned	Comments
	Health economy wide issues				
1	**Leadership** - organisations in the Health Economy demonstrate joined up multi-agency approach to planning. Flu Resilience plans for each organisation in the Health Economy have been shared and agreed. Agreements in place on any local cross borough border issues to ensure patient care is seamless.	Y	Y		
2	**Local leaders** - every organisation has senior leadership arrangements in place to manage Flu and Winter resilience which is clearly documented. There is a reliable system in place for keeping the CEO, Board and Flu Lead Director appraised of progress, receiving exception reports and for escalating their involvement as required.	Y	Y		
3	**SITREP reporting** - every organisation has in place robust procedures to comply with all SITREP reporting processes.	Y	Y		
4	**Resilience plans tested** - assurance that both Winter and Flu resilience plans have been tested or exercised particularly known stress points in the plan.	Y	Y		
5	**Infection control** - plans take into account both Swine Flu and also major increase in activity in 'surge' conditions.	Y	Y		
6	**Escalation processes** – there is a clear well communicated multi-agency plan for health economy response to 'surge' demand that is owned and shared with all key health and social care partners in the health economy. The trigger levels to move to each escalation level are well defined and understood by all agencies.	Y	Y		Indemnity agreement for staff to provide mutual aid is outstanding
	Patients				
7	**Antiviral Collection Points - f**acilities in place so that anyone with suspected swine flu gets issued with antivirals within 48 hours including those patients without a GP and vulnerable groups - include PCTs full roll out plan of ACPs.	N	N		Sandwell PCT has assessed this as GREEN
8	**Vaccination programme** for each PCT's patients is in place and is flexible enough to respond to vaccine supply issues and priority group issues.	N	N		Sandwell PCT has assessed this as GREEN
	Winter resilience plans				
9	**Discharge processes** – multi-agency co-ordination to minimise the number of delayed transfers of care.	Y	Y		Confirmation of social services surge contingency plan is awaited
10	**A&E performance** - specific plans to cope with 2 known dips in A&E performance early December and early January.	Y	Y		
11	**Business continuity** - evidence that organisation has a robust plan to respond to issues such as bad weather (snow).	Y	Y		
	Flu Pandemic second wave resilience				
12	**Enhanced capacity in 'surge' demand**- details of capacity that can be made available in each organisation for each key service including staffing and equipment resources. Details of the trigger levels to release this capacity into the organisation.	Y	Y		SWBHT group to consider ethical implications to be established
13	**Capacity modelling** - each health economy has taken account of worst case scenario set out by DH in July 2009 and has plans in place to respond to the peak weeks of the pandemic.	Y	Y		
14	**Essential services** - plan identifies clinical and non-clinical essential services that must continue to be provided or that can be scaled back in a pandemic, as well as identifying critical and non-critical functions	Y	Y		
15	**Logistics** - plans identify and regularly review key vital supplies, without which the trust could not function, and include local plans as to how these supplies can be maintained (e.g. utilities, food, linen, medical supplies).	Y	Y		
16	**Communication** - plan for effective communication to staff, patients and the wider community before, during and after the pandemic.	Y	Y		
17	**Recovery from pandemic** -plan includes detail on recovery from a pandemic.	Y	Y		

Winter and Flu Resilience plans checklist

Organisation name: Sandwell & West Birmingham Hospitals NHS Trust

Board meeting date: 24th September 2009

Q	Action	Relevant to organisation (Y/N)	Included in resilience plan (Y/N)	Organisation overall assessment of readiness against criteria GREEN - assured and ready now AMBER - in progress complete as planned RED - in progress not expected to complete as planned	Comments
	Specific organisational capacity issues				
18	**Acute hospital capacity**– senior clinical decision making for initial assessment of emergency admissions / inpatient capacity / A&E - UCC interface / Maternity Services Capacity – clear policies exist which prioritise women who need hospital care and limit unnecessary admission.	Y	Y		
19	**Critical care capacity**– organisation has been through critical care checklist provided by DH (available early August) and have specific plans to increase capacity by 100% to respond to Flu and clear and agreed prioritisation plans.	Y	Y		
20	**Primary care capacity** - including normal GP capacity and out of hours services. Plans in place to ensure that those most likely to access healthcare services have care plans to reduce the likelihood that they will be admitted.	N	N		Sandwell PCT has assessed this as AMBER
21	**Intermediate care capacity** – implementing simplified access criteria, enhancing admission avoidance and palliative care services.	N	N		
22	**Social care capacity** – streamlining placement process, understanding total potential nursing and residential home capacity in each Borough with ability to utilise capacity. Plans in place to ensure social care workforce resilience	Y	Y		Resilience of independent providers of packages of care
23	**Mental Health capacity**- robust acute psychiatric liaison services to minimise A&E breaches and timely assessment of inpatients.	Y	Y		
24	**Ambulance capacity** - plans from each hospital to deliver the required 'hand over' waiting time targets.	Y	Y		Actions to be agreed via local health economy winter planning forum
25	**Diagnostic and therapy capacity** – enhanced levels of services working 7 days per week in both primary and secondary care.	Y	Y		
	Staffing				
26	**Seasonal and Swine Flu vaccination plans** for organisation's staff, that prioritises staff to be vaccinated according to service needs.	Y	Y		
27	**Medical staff plans** - demonstrate that have recruited sufficient staff to cover EWTD rotas in all critical services and that number of medical staff available take account of the busiest times of day. If the decision is taken nationally for a temporary derogation of WTD compliance to be instated, the terms and conditions of job offers to all medical staff are amended to reflect this.				PPE Fit testing programme not completed
28	**Maximise available staffing levels** in all roles during an influenza pandemic, including arrangements for temporary postponement of all training, appropriate re-deployment of staff, re-employment of newly retired staff or staff who have left recently, flexible working arrangements (part-time to full-time, working at home, etc) and refresher course for staff who have a clinical background, but who no longer practice.	Y	Y		Still to develop return to work packages for recently retired staff
29	**Response to likely absence levels** due to sickness, carer responsibilities and the impact of the anticipated closure of schools, that are not reliant on temporary staffing solutions. Cover arrangements are in place for all key members of staff who may be taken ill, such as CEO, the Board, senior clinicians, and Flu Resilience team. Review of all policies that may affect staff attendance to ensure that they clarify how staff should report sickness during the pandemic.	Y	Y		Training packages for staff to work in other areas have been developed but not implemented
30	**Engagement with the Trade Unions** to ensure their contribution and support for staff arrangements over the period of the pandemic	Y	Y		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Trust Assurance for Preparedness on Pandemic Influenza (H1N1)

September 2009

SWBHT Pandemic Flu Resilience Plan
State of Readiness Report

CONTENTS

Appendices:

SWBHT Pandemic Flu Resilience Plan
State of Readiness Report

1.0 Introduction

The DH has requested that all Trust Boards receive a statement of their organisation's preparedness for pandemic flu lu at their September 2009 meeting. The requirements for this are outlined in **Appendix 1**.

1.1 Experience to date

Key lessons have been learnt over the last few months as Birmingham and Sandwell health economies experienced some of the highest levels of H1N1-related activity within the UK. This knowledge has been used to inform our next stage of planning and also has been circulated nationally to support other organisations with the development of their plans (**Appendix 2**).

2.0 Health Economy-Wide Issues

2.1 Local Decision Making

One of the early lessons was that the national planning assumptions around an influenza pandemic did not match the actual challenges that H1N1 presented to this Trust. Pockets of disease activity meant that the Trust was experiencing service pressures before they occurred elsewhere in the country. Guidance and support from central bodies did not keep pace with the service challenges, consequently many key decisions had to be taken in a timely fashion at a local level while being mindful of the need to ensure that SWBHT's response was coordinated with other key local partners. This principle has been incorporated into local systems of command and control for further stages of the H1N1 pandemic.

2.2 Strategic Groups: Multi-Agency Planning and Response

There are different arrangements across the local health economy for planning & dealing with H1N1. The following is an outline of the different strategic groups:

2.2.1 Emergency Response Management Arrangements (ERMA)

ERMA is part of the local command & control structure to provide strategic decision making across Birmingham & the Black Country. This group is made up of NHS Chief Executives and Senior Directors of primary & secondary care organisations. During the H1N1 outbreak in the summer, a flu subgroup of ERMA met regularly to review management arrangements for antiviral distribution within primary care and to liaise between organisations. It is planned that the role of this group will be expanded to cover Acute Trust issues such as surge capacity.

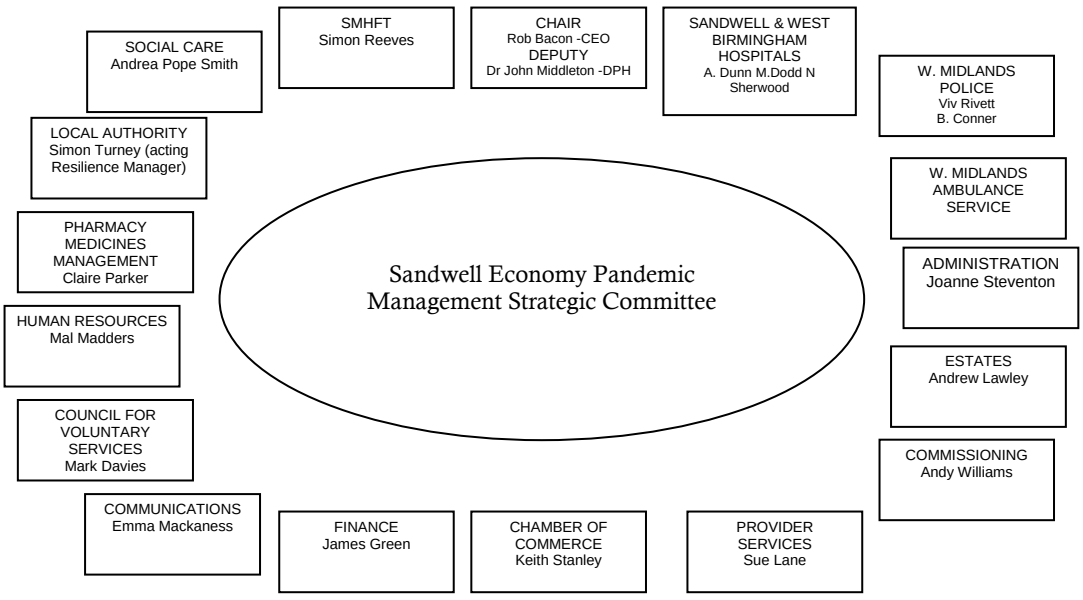
2.2.2 Local Health Resilience Forum

The local health resilience forum for the Birmingham and Black Country area (in which SWBHT participates) has provided an opportunity for all stakeholders to share good practice, communicate plans and debate key issues. It has been the forum to agree on overall strategy both with multi-agency health partners and the wider local resilience community. The LHRF has been involved in the stress testing exercise undertaken by the Strategic Health Authority on 3rd September 2009 and will be further tested by the Department of health regionally on 21st September where the Acute Commander and Tactical adviser will be drawn from this Trust

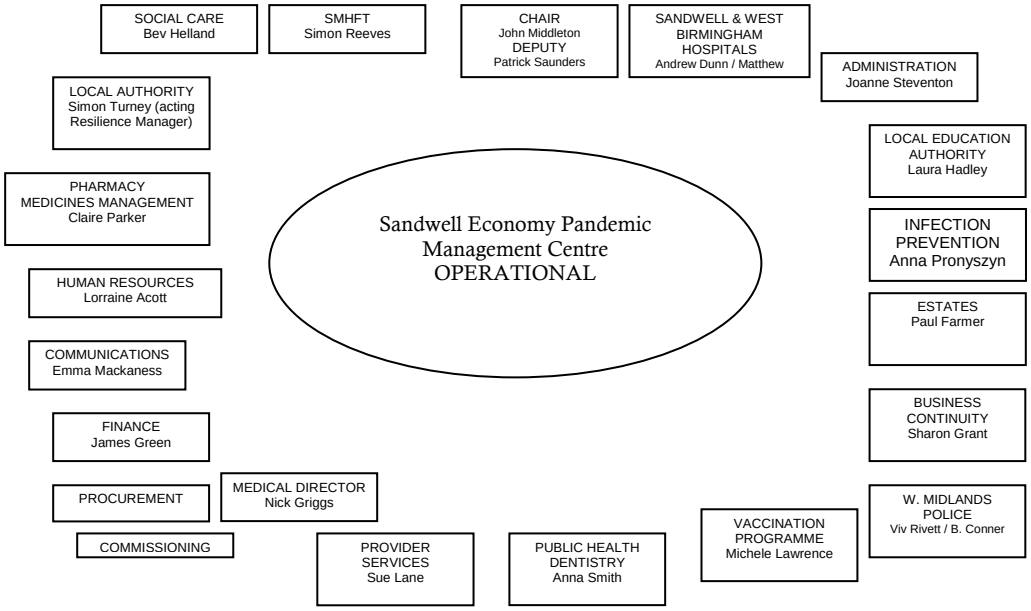
2.3 Sandwell flu groups: strategic and tactical

Sandwell health economy has developed robust multi-agency strategic and operational groups. During the initial outbreak over the summer, these groups dealt with challenges such as provision of antiviral distribution, prophylactic countermeasures and early surge capacity issues. These groups are now planning for the second wave of H1N1.

2.3.1 *Sandwell Strategic H1N1 Strategic Management Group*



2.3.2 Tactical and Operational management group for Sandwell Health Economy



2.4 Birmingham Resilience Group

The Birmingham resilience group has provided a similar avenue for the coordination of resources and responses within the Birmingham area. This multi-agency group is made up of the Birmingham PCT's, Birmingham City Council (including Adults & Communities Services) as well as representatives from the acute provider trusts, specialist trusts and ambulance, fire and police services.

2.5 SWBHT Management Arrangements:

2.5.1 Influenza Pandemic Planning and Management Team

Prior to the outbreak of H1N1, a group was already in place to oversee the planning for and management of an influenza pandemic. This was comprised of senior managers, clinicians, communications team, emergency planning officer, HR, Occupational Health, Infection control staff side and specialties. This group assumed responsibility for the operational management of H1N1. The management group has been expanded to include representatives from other agencies. For details of membership, see **Appendix 3**.

Strategic management of the Trust response to H1N1 is overseen by the Chief Operating Officer.

2.5.2 Training for Silver commanders

Managers who will be expected to undertake the silver commander role as part of the Trust's internal command & control structure during an influenza pandemic, have attended mandatory exercises. These

sessions have been designed to ensure awareness of the core triggers, issues and the impact of their management plans on other parts of the organisation. This has resulted in a much clearer understanding of the day to day management of an outbreak, identified key pinch points and has provided both quantitative and qualitative triggers for action. An ongoing programme of training, including media handling is scheduled throughout September and October 2009

2.6 SITREP Reporting

A robust system exists at present for daily reporting to a number of external sources including the Strategic Health Authority and Health Protection Agency. A system of internal reporting for the numbers of H1N1 actual & suspected cases and related issues was utilised as part of the Trust's response during the initial outbreak of flu. This will be expanded to include staffing sickness and absence levels, working time directive issues and other key management information requirements as dictated by the developing pandemic scenario, and will be a key part of daily management at pandemic peak

2.7 Resilience Plans Communicated to Staff and Tested

Communication of plans began in late 2008 after approval of the Influenza Pandemic Plan. During the initial outbreak of H1N1, the resilience plans that were implemented were communicated internally and externally using the following methods:

- local exercises
- local staff awareness sessions
- intranet based learning programmes
- face to face staff briefings (Team Brief)
- clinical briefings for medical staff and clinical directors
- multi-agency briefings and exercises run in conjunction with multi agency partners from the local authority, PCT and Mental Health Trust.

There has also been a debrief session which reviewed the effectiveness of the Trust's actions and responses during the initial outbreak (**Appendix 4**). The lessons learnt have been incorporated into planning for the second wave.

2.7.1 ***Testing:*** Two internal exercises were undertaken, based on Trust experience plus the need to redefine and expand our core activities and triggers. These were Exercise Tight Fit (July 09) and Exercise Shoe Horn (September 09). The exercises were aimed at Divisional managers, senior clinicians and service managers. The sessions allowed participants to explore a second wave of pandemic activity based on the then current planning assumptions. See **Appendix 5**.

In addition, the Trust attended a flu confirm and challenge workshop on 3rd September with PCTs to review plans from a local health economy perspective.

2.8 Infection Control

SWBHT Infection Control team have had a strong role in developing the isolation and cohort strategies for patients presenting with flu-like symptoms. The Trust Microbiologists in the early outbreak played a key role in ensuring appropriate diagnosis and clinical care for admitted patients and in dealing with this workload alongside the existing challenges of TB and C.Difficile. Guidance on personal protective equipment, cleaning regimes, swabbing and clinical testing procedures, isolation procedures and use of side rooms/cohort bays were all produced during the summer, and these have informed the procedures that the Trust will follow for the second wave of H1N1.

2.9 Escalation Processes:

Key lessons from the first wave surrounded the ability to react in a timely manner to increasing numbers of patients and the resultant service pressures. Delays in the emergence of national guidance did not become a barrier to making effective decisions which were coordinated with other partners.

2.9.1 Internal

Key (flu-specific) indicators and internal triggers for action have been identified and incorporated into divisional plans. Examples are:

- patients with flu-like symptoms attending the Emergency Department (at peak in excess of 100 extra patients per day)
- activity on D12 and Priory 5 and subsequent availability of side rooms
- numbers of patients ventilated on Critical care
- the availability of side ward accommodation on critical care
- staff sickness and absence
- availability of essential supplies

These run alongside existing indicators and escalation plans for individual areas in the Trust such as admissions, ambulance activity, delayed discharges.

2.9.2 External:

Work has been undertaken with external partners to identify indicators of pressure across the health economy and to consider mutual aid where possible. These include numbers of presentations to GP and out of hours services, pressures on PCT's caused by the need to establish antiviral distribution centres and the need to undertake mass vaccination. The coordination of this data and the mutual aid that may be offered within the local area is being led by the Sandwell Strategic Flu Management Group.

3.0 Winter Resilience Plans

3.1 Discharge Processes and A&E Performance

Sandwell and West Birmingham Hospitals has a robust and tested approach to dealing with the pressures it faces during winter. These plans have been updated in accordance with current guidelines and relevant sections concerning discharge processes, A&E performance and WMAS capacity and turnaround are included in **Appendix 6**

3.2 Business Continuity

The Trust as a Category 1 responder in the Civil Contingencies Act 2004, is statutorily obliged to have a plan to ensure that wherever possible, it can continue to deliver its core and essential services. The Trust has a Business Continuity Plan which was last updated in April 2009. The plan has already been tested, both through exercises overseen by the Contingency Planning Group and through the actual experience of adverse weather and power shortages.

Planning exercises with Divisions have also focused upon recovery from a pandemic and to identify the sequence in which services would be reinstated.

4.0 Flu Pandemic Second Wave Resilience

4.1 Enhanced Capacity in 'Surge' Demand

There are plans to expand capacity to meet surges in demand during a flu pandemic. These plans cover the expansion of critical care, as well as increasing the numbers of paediatric and medical beds. More details of these are included later in this report. The Trust has agreed with partners in Sandwell that the key priority of the local health economy will be to keep existing capacity open and to adjust the use of that facility and the thresholds for admission and discharge, rather than trying to open additional capacity at a time when staffing numbers will be lower.

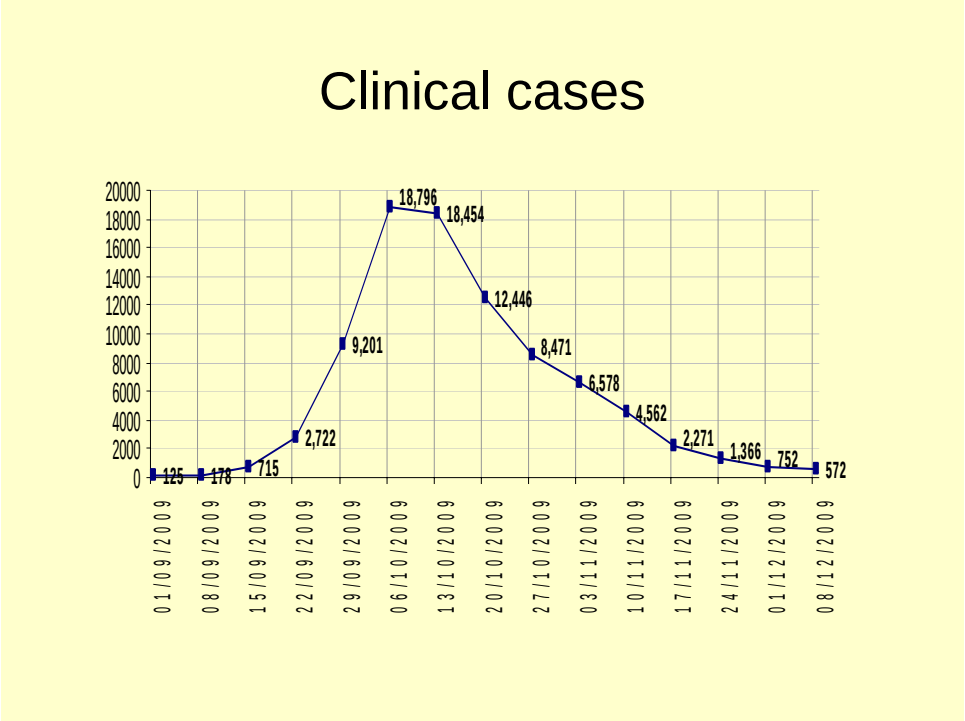
4.2 Capacity Modelling

The planning exercises undertaken within the Trust have been based upon the following assumptions from the Cabinet Office:

		SWBHT catchment population: 500,000
Clinical Attack Rate	30%	150,000
Peak Clinical Attack Rate	4.5 - 8%	22,500 – 40,000
Complication Rate	Up to 15% of clinical cases	22,500
Hospitalisation Rate	Up to 1% of clinical cases	1,500
Case Fatality Rate	0.1% of clinical cases	150
Peak Absence Rate	12% of workforce (based on 6,400 staff)	768
Critical Care Admission Rate	Up to 25% of hospitalised cases	375

The distribution modelling of clinical cases undertaken by Sandwell PCT has been used by the Trust to inform its understanding of the potential profile of the surge and how this might translate into ED attendances and in-patient admissions.

Chart 1: Modelling by SPCT of potential profile of influenza cases in Sandwell over a 15 week period (based on a 330,000 population)



4.3 Essential Services

The Trust's Business Continuity Plan (April 2009) and the Influenza Pandemic Plan (March 2009) have identified the following as core functions of the organisation:

- A&E services
- EAU & MAU
- Paediatric assessment areas
- Inpatient bed capacity for emergency admissions & urgent cancer cases
- Critical Care
- Labour Wards
- Neonatal Unit
- Emergency & urgent cancer theatre capacity
- Mortuary
- Infection Control Team
- Pathology services to support the above
- Pharmacy services to support the above

- Imaging services to support the above
- Facilities & Estates services to support the above
- Health care records functions to support the above
- Core Occupational Health function
- Management capacity to support the above and run the Trust and Hospital Control Teams

Capacity plans have taken account of this assessment to identify areas where services may be scaled down to enable staff redeployment to occur

4.4 Logistics

As part of the approach to preparedness, SWBHT now holds a six week buffer of essential clinical supplies, as opposed to the usual three day call off system utilised prior to the increase in pandemic activity. Lessons learnt from the first wave of H1N1 about levels of use of key items have been incorporated into the stocks of supplies. An example of this is that there has been a switch from disposable FFP3 face masks to re-usable ones, since the volumes of use of the former (cheaper) item were such that it has proved more cost effective to purchase the more expensive re-usable model.

The Trust has also increased fuel supplies, certain medications and levels of food stocks. The proactive acquisition of buffer stocks means that the Trust has a greater degree of resilience for any further second wave activity.

4.5 Communication

There is a pre-existing communication plan within the Trust Influenza Pandemic Plan. This clarifies communications roles and responsibilities for SWBHT during the pre-, peri- and post- phases of a flu pandemic. A key element is to ensure consistency of messages to staff, patients and other stakeholders through close working with the Strategic Health Authority (SHA), local Primary Care Trusts (notably Sandwell and Heart of Birmingham), Health Protection Agency (HPA), and partner agencies such as local authorities, police, ambulance and wider stakeholders

5.0 Specific Organisational capacity Issues

5.1 Acute Hospital Capacity

The divisions responsible for medicine, surgery, women's health and paediatrics have developed contingency arrangements to deal with staffing shortages and surge capacity. In essence, there will be a focus upon maintaining patient throughput by reducing admissions and ensuring that there are no delays to discharges. Many of the escalation measures identified will result in changes in the level and range of services that the Trust is able to provide. In order to oversee this and to provide leadership and guidance on any ethical issues

which may arise, the Trust is in the process of establishing a group of senior clinicians and managers to review plans in advance and to provide a daily point of reference for clinicians during the outbreak.

Key areas relating to acute capacity include:

5.1.1 Emergency Admissions:

The Trust will maintain the current process of acute physicians being based in the assessment units at City and Sandwell General Hospitals in order to ensure that senior clinicians are making the initial decision on whether to admit or discharge patients. Since IP beds will be a scarce resource and there may be a need to review admission criteria, it is felt essential to ensure that senior clinicians are undertaking these clinical reviews.

5.1.2 A&E – Urgent Care Centre Interface:

The Trust has agreed with HoB and Sandwell PCT that the UCC stream at both City and SGH will be used to provide additional capacity to support any surge in attendances at the Emergency Department as witnessed in the first wave of H1N1.

5.1.3 In-Patient Capacity: Isolation Facilities:

In the first wave, one of the factors that enabled routine activity to be maintained was the ability to keep flu patients isolated in side rooms without having to cohort them on open wards. Plans have been reviewed regarding the isolation strategy employed in the first wave. Some changes have been made to the strategy to reflect the fact that other wards at City in addition to D12 are able to deal with the isolation procedures involved in looking after H1N1 patients.

5.1.4 In-Patient Capacity: Additional Beds:

The medical divisions have identified where they would cohort flu patients once they are no longer able to restrict them to the side rooms. It is recognised that increasing numbers of flu patients will impact on surgical capacity as escalation plans are implemented:

- The expansion of critical care will use some theatres equipment and staff
- The expansion of paediatric beds may require the use of Priory 2
- Flu patients will be cared for on surgical wards

Surgery's plans to deal with reduced capacity include:

- Shift of activity to day case/23 hour units
- Protection of small number of surgical beds at each site
- Review of clinical need of patients and cessation of routine IP activity

5.1.5 Paediatric Capacity:

Paediatrics have a plan to expand by 28 beds within the current paediatric area. Once this capacity is used, additional beds will be found by converting Priory 2 into a children's ward.

5.1.6 Maternity:

Maternity are planning on the basis that numbers of deliveries will remain stable but the service may have staffing shortages, while some women may be acutely ill from H1N1. This has involved agreement with critical care regarding treatment protocols and patient pathways between the two units.

5.1.7 Diagnostic & Therapy Capacity:

Imaging and Pathology have worked with the divisions to understand what their needs would be during a second wave, and to develop their own business continuity arrangements. These discussions have also included the resumption of activity following the second wave and the order of services to be restarted.

5.1.8 Critical Care Capacity:

Critical care have developed a plan to expand capacity from 36 points at present to a range of 70 -130 points. This involves expanding onto existing medical & surgical wards and converting their use. A copy of the expansion plan is provided in **Appendix 7**

5.2 External Capacity

This is an area where the Trust has least direct control but which has a significant impact on the Trust's own capacity and patient flows. SWBHT has worked with partner organisations to identify pressures within each sector and to agree escalation triggers and communication mechanisms for during an influenza pandemic. Contingency plans by SWBHT to raise thresholds for admission or lower those for discharge will impact upon health and social care services in the community. The Trust has been sharing these plans with local partners.

There has been a general agreement within the Sandwell health economy that the main priority will be for each organisation to maintain the current levels of capacity, in order to avoid any unscheduled closures of nursing/residential homes/GP practices and remove the need to displace patients at short notice (in most cases to the acute Trust). There have been discussions around developing a shared bank whereby it may be possible to move staff between organisations to enable that organisation to maximise its capacity. In order to do this it will be necessary for SWBHT to indemnify staff to work within other health and social care organisations, should the Trust Influenza Management Group (Silver Command) deem it necessary.

There is no agreement within the Birmingham Health Economy for this to occur, hence there will be greater emphasis on the need for each organisation to manage the situation themselves. On their own initiative however, the acute trusts in Birmingham are meeting to develop plans for mutual aid.

5.2.1 Primary Care Capacity

The PCTs are looking at systems to ensure business continuity including steps to maintain GP services (buddying up of practices) and community nursing/therapy services, as well as staffing the anti-viral distribution centres and flu vaccination teams.

5.2.2 Social Care Capacity

Social Care for both Birmingham and Sandwell are reviewing their systems for business continuity. SWBHT has expressed its concern at the multi-agency planning meetings regarding the need to ensure that there is adequate resilience within the providers of packages of care, in order to ensure that patients may be maintained at home and that delayed discharges will not build up during this period. A fall back option of opening additional beds at Rowley Regis Hospital to cohort delayed discharges has been considered, but it has been discounted due to the fact that the predicted level of staffing shortages within each organisation will preclude the opening of any additional capacity. Instead the Sandwell health economy is signed up to using staff flexibly to maintain existing capacity throughout the pandemic.

5.2.3 Mental Health capacity

Through the Birmingham and Sandwell strategic planning groups, SWBHT has had the opportunity to consider the business continuity work undertaken by the mental health trusts. In addition there have been discussions with the Sandwell Mental Health and Social Care NHS Foundation Trust regarding mutual aid.

6.0 Staffing

6.1 Seasonal & H1N1 Vaccination Plans for Staff

The Trust has planned on the following assumptions:

- High demand for seasonal flu vaccination & for H1N1 vaccine
- H1N1 vaccine will be delivered in small numbers over the course of 6 – 12 months

A flu immunisation plan has been developed by Occupational Health which involves mass vaccination clinics as well as training staff to administer vaccinations in the workplace settings. See **Appendix 8.**

6.1.1 Seasonal Flu: SWBHT has ordered 6,000 supplies of seasonal flu vaccine for staff (90%+ coverage) which is due to arrive in early October. It is of concern that recent feedback from staff via Hot Topics has indicated that there will be a take up of only 20%. It is anticipated that this rate will increase by making it easier to access and by the publicity accompanying the vaccination programme, and the aim is to achieve 80% uptake.

6.1.2 H1N1: The Trust has identified key groups to be prioritised for the H1N1 vaccination. These include:

- Medical staff on the on-take rotas
- ED staff
- Critical Care staff
- Paediatric staff
- Maternity staff

As further supplies become available the vaccination will be offered to wider staff groups.

6.2 Personal Protective Equipment

The Trust developed a set of guidelines during the first outbreak which identified the level of PPE required when dealing with flu patients. The PPE varies according to the type of procedure or contact being undertaken, and it is only small numbers of staff who need to use FFP3 level protection (the highest). An extensive programme of fit testing for FFP3 masks was also undertaken for those staff dealing with flu patients. This will need to continue given the turnover of staff (junior doctors on rotation in particular).

In preparation for the second wave, there has been a move to using more reusable FFP3 masks and allocating key staff with their own mask. Training and testing was provided for the new intake of junior doctors in August and divisions have been working with other key medical staff.

The Trust currently holds a stock of 2,300 FFP3 reusable masks and 3,000 disposable masks which have not been allocated. In the initial wave approximately 10,000 disposable and 1,000 reusable masks were distributed.

6.3 Medical Staff Plans

There is an agreement with the Deanery that medical juniors on surgical wards will help care for medical patients during a flu pandemic. The medical divisions are agreeing arrangements whereby physicians will oversee the care for flu patient on surgical wards rather than expected that this is undertaken by the surgeons.

6.4 Maximise available staffing levels

In consultation with staff side, Human Resources have developed a plan for dealing with workforce issues during an influenza pandemic. This covers areas such as managing sickness absence, carers leave, annual leave, working time regulations, redeployment of staff, training, Criminal Record Bureau checks and the use of volunteers. See **Appendix 9**

Other actions include:

- Frequently asked questions covering flu-related HR issues were sent out with each staff wage slip in July

- Recently retired staff have been contacted to see if they are willing to return to work in a second wave
- Occupational Health have developed flu-related sickness monitoring, swabbing and information procedures

6.5 Response to likely absence levels

Divisions have been told to plan on the basis of high sickness absence levels and to consider what work could be suspended, which staff could be reallocated and the training that they would need to put in place to achieve this. Over the summer, divisions were provided with details of all staff which they used to confirm contact details and also to discuss with staff their own contingency arrangements and flexibility should they need to be absent from work for carer reasons. For nursing in particular, training programmes have been identified to enable qualified nursing staff to undertake alternative roles within critical care for example. These have not been rolled out to staff but it is intended to do so during the autumn period.

These themes have been further explored in the planning exercises undertaken in July and September with the divisions

6.6 Engagement with the Trade Unions

The Trust convenor has been a member of the group looking at flu issues, while influenza planning has been a standing item on the agenda for the JCNC since June 2009. As identified above, the human resources influenza pandemic plan has been discussed with the JCNC.

APPENDIX 1

Our Ref: IC/RS/09081003

10 August 2009

To: PCT Chief Executives
NHS Trust Chief Executives

Cc: NHS Foundation Trust Chief Executives
PCT and NHS Trust Chairs

Dear Colleague

BOARD ASSURANCE FOR PREPAREDNESS ON PANDEMIC FLU

You will be aware that there is a requirement on Boards to undertake a self-assessment of their organisation's preparedness for a surge in the number of pandemic flu cases in autumn and beyond. No doubt you have already begun work on this. I have attached to this letter a template which has been designed by NHS London and which has been adopted by a wide range of NHS organisations as the format they are using to provide the detailed assessment to Boards. We will be using this format for our own assessment to the SHA Board and we recommend that you use it in your assessments. These reports are likely to be the subject of significant public and media scrutiny and there are clear benefits in trying to ensure a degree of consistency in how Boards carry out their self-assessments without imposing rigid uniformity.

It is critical that Pandemic Flu preparedness is seen as a Board Governance issue. We felt it was important that we gave you our high-level overview of the current governance challenges for Boards and the key risks which will have to be managed in the current months and how Boards should seek assurance on these risks.

1. **Oversight of capacity across the Local Health Economy within LHRF areas**: Whilst all organisations now have detailed plans for their own preparedness, the ability of organisations to work across the system will be critical when pressures increase. Each local health economy must have the capability to monitor pressures across the primary and secondary care, respond to pressures promptly, and have a shared agreement on local escalation procedures, including the establishment of major incident arrangements. They key test here is less about the documentation and procedures but instead is about practical preparedness and shared understanding of working arrangements.

2. **Clear action plans for likely pressure points**: Boards will need to be assured that realistic and implementable plans are in place to ensure a resilient NHS response in service areas which may be particular points of pressure. This list of services is likely to include general practice, critical care, general paediatric services, ambulance services, blood transfusion services and other key supply-chain services (e.g. home oxygen), social care and mental health. Boards will need to understand the steps taken to maximise capacity and response in times of pressure. It is not acceptable for a PCT Board to assume that their local providers have adequate plans in place. Both the PCT and trust will need to know that these plans are in place and know your organisation's response when they are implemented. These should include any additional training requirements

3. **Engagement with Multi-Agency Partners**: Boards will need to assure themselves that their organisation is now fully engaged with multi-agency partners at both a strategic and operational level. The basic tests here are:

a. Do your multi-agency partners know your plans in detail (and do you know theirs)?

b. Have they accepted their responsibilities in supporting you in implementing these plans (and reciprocally can you guarantee similar support to your partners).

4. **Vaccination**: The response to the NHS to the launch of the national vaccination programme will need to be uniformly excellent. Public confidence in the NHS will be damaged if access to vaccination is variable and depends on the quality of preparation of each individual PCT. It follows that detailed scrutiny and risk assessment of vaccination plans is a critical priority for PCT Boards. You will need to ensure that your plans are robust and properly resourced. The vaccination programme will require significant organisational and management support from PCTs well beyond the resource available to your existing immunisation and vaccination co-ordinators.

5. **Anti-Viral Collection Points**: The launch of the ACP network happened relatively smoothly in the West Midlands and in most parts of the Region the number of patients or Flu Friends arriving at ACPs is falling. However, this position can change quickly and we still need to be prepared for a sudden increase in ACP activity. PCT Boards will need to be assured that their ACP network is able to meet demand both currently and in the future. We have expressed concerns to PCTs which are reliant on community pharmacy arrangements about the resilience of these arrangements, and Boards will need to understand the risks and mitigations associated with this approach. You will also want to know that stock management systems are robust so that no

ACP runs out of anti-virals.

6. **Leadership and Resources**: You will need to ensure that your organisation continues to treat pandemic flu preparedness as a key corporate priority with visible senior leadership and not as the province of one of two flu specialists. The resource your organisation devotes to this issue should not be reduced simply because the number of cases is falling. A second wave surge in activity in autumn is still likely and all organisations should now be engaged in a detailed programme of preparedness as set out above.

We hope this letter helps in focusing Board attention on the key governance challenges we all face over the coming months.

Yours sincerely

Ian Cumming OBE
Chief Executive

Cc: Dr Rashmi Shukla
Steve Allen

APPENDIX 2

Sandwell & West Birmingham Hospitals NHS Trust

Swine Flu: Reflections from an Acute Trust's perspective
July 2009

1.0 Background

The cluster of swine flu patients in Birmingham was centred around the Handsworth area of the city. Sandwell & West Birmingham Hospitals NHS Trust is the main acute provider for this area and these reflections are based on our experience of dealing with rising numbers of flu-like cases amongst the local population.

2.0 Clusters and Localised Impact:

There are two acute hospitals (each with an Emergency Department) within the Trust which are five miles apart. The demand and pressure from the flu cases have hit one hospital to a far greater extent than the other despite both of them bordering onto the affected part of the city. It indicates that the outbreak of swine flu may be very localised and in the initial outbreak stage it may be just one hospital in an area which is having the impact. This has been helpful to us as we have been able to focus attention onto one site while the less affected site has provided us with the resilience to cope with any additional demand.

3.0 Response to Swine Flu

SWBHT's response to initial reports of Mexican flu was to accelerate its business continuity work. After an initial burst of activity, this settled into a weekly review undertaken by a group with representatives from across the organisation. Detailed plans were drawn up but were essentially at the 'needing to know what we had to do' stage rather than the nuts and bolts of how we were going to do it. With the outbreak of swine flu at a local primary school we quickly moved to an implementation footing.

4.0 What does the surge look like?

As one would expect the increased demand manifested itself in a rise in attendances at our Emergency Department. Attendances increased by approximately 25%, mainly of people with flu like symptoms who were well enough to be discharged into the community. We only admitted 2-3% of this cohort of attenders. It is worth noting however that in terms of non-elective admissions for the hospital as a whole, we have not witnessed an increase during this period. 7 weeks after the initial outbreak we are now beginning to experience increased cases being admitted to critical care, but this equates to 2-3 beds on a 12 bedded unit.

5.0 Lessons learnt:

5.1 Be prepared for the confusion and delays that will happen in the initial stages of the outbreak:

As is inevitable, while local agencies all responded well, the plans were activated at a slightly different pace. Thus for short periods, there were vacuums in terms of service provision. Examples would be distribution of anti-virals and local arrangements for swabbing large numbers of people & turning around the results. As a consequence the acute trust found itself picking up queries from the public and other providers by default. This proved

to be incredibly time consuming, particularly in areas such as microbiology who ended up acting as the bridge between the general public and the HPA. It is essential to have regular (daily at some stage) meetings with your local PCT and the HPA to ensure that actions and responses are coordinated.

With the move to treatment rather than containment and the change in swabbing requirements along with distribution of anti-virals, there should be less of a problem in this area.

5.2 Work out and test your PPE strategy now:

Prior to this localised outbreak we felt that we had a clear strategy for PPE. We decided that we would use PPE3 facemasks for staff undertaking aerosol generating procedures on confirmed and suspected swine flu patients. Specific members of staff were fit tested and masks identified. The number of suspected swine flu patients presenting to the ED (over 80 per day) and the numbers that we are admitting meant that we have had to have a rapid expansion of fit testing and FFP3 provision for staff. In our initial containment phase we were using significant numbers of FFP3 masks for a wide range of patient contacts. We have taken the opportunity of the change in national response to swine flu to government to tighten up the criteria for using FFP3 masks and to promote the use of surgical masks for the vast majority of patient contacts.

Key things that we found:

- Despite this being a mild disease, PPE is the area that staff have seized upon as a tangible issue in our response to swine flu
- It is essential to clarify to the whole workforce who is going to receive masks and when (and you need to illustrate this with actual examples of care/treatment).
- Supplies of FFP3 masks and surgical masks are in short supply so your strategy needs to be tailored to availability of product. Promising staff PPE3's and then being unable to deliver will increase uncertainty when they actually have to care for flu patients. Also, keep central control of mask strategy, ordering and distribution as different responses from departments will create concern and resentment amongst staff
- Fit testing is time consuming and needs to be able to provide a member of staff with the knowledge that there are masks available which will fit them. Testing one type of mask only which a member of staff fails on will only increase concern.
- Identify where your flu patients will go and ensure that adequate numbers of staff are fit tested to provide 24 hrs care. This means checking staff rosters for nursing and medical staff and confirming that staff have been trained.
- In areas where there will be high usage of FFP3's our experience is that it is better (in terms of cost and availability) to move towards reusable masks and ensure that they are cleaned thoroughly between each patient

5.3 Understand how people access your services

The increased demand from swine flu doesn't just happen in ED and assessment units. We have found that people with flu like symptoms were turning up in maternity, direct access services such as sickle cell & thalassaemia and GUM, while outreach staff were also encountering such patients. Remember also that a community outbreak may be spread within the hospital by visitors and we have had a comprehensive campaign to ensure that those with symptoms do not come in to visit

5.4 Isolating patients awaiting results will be a bottleneck:

We have maintained an aggressive isolation policy throughout the outbreak for swine flu patients. We have cohorted confirmed patients, but not the suspected ones. In-patients with flu-like symptoms, who need to be isolated until swab confirmation or negative results constitute a significant bottle neck. There is only a finite number of side rooms and these are also required for the plethora of communicable diseases we encounter every day. We have worked with the local laboratory to ensure prioritisation and a rapid turn around of in-patient swabs. This helps to provide better churn through the side rooms and thus less pressure on core business. Ensure your plans are flexible to deal with expansion of possible and confirmed cases rapidly and effectively as there are different strategies for each group.

We are reviewing how long we will be able to sustain the current approach to isolation and it is recognised that this will have to be relaxed as numbers increase, however the strategy to date has resulted in no hospital spread of swine flu.

5.5 Understand which In-Patient areas will be affected first:

Critical Care: this has been where the pressure to escalate our expansion plans has been greatest. At some stages there have been 5 confirmed or suspected swine flu patients on a 12 bedded unit. We have had to develop strategies to ensure that throughput on the unit has been maintained, and these have included giving greater priority to discharges from critical care, enhancing the outreach service, putting additional medical cover onto the unit.

Medical & Paediatric Wards: We have limited the number of wards that swine flu patients are admitted to in order to ensure that staff (clinical, administrative, facilities) are trained and comfortable in basic infection control measures and the use of PPE. Although all clinical areas should be able to deal with these admissions, experience to date has been that quite a bit of work in reassuring staff and confirming policies and procedures is generated by a receiving ward.

Maternity, Surgical and Trauma Wards: these have all had suspected swine flu cases admitted as non-elective activity and it is prudent to ensure that time is spent preparing a receiving area for each speciality.

5.6 Do not assume that your medical teams are adequately prepared:

Our medical teams are dealing (or have the potential to deal) with patients on a daily basis for whom staff PPE is a requirement. Discussions at the start of the outbreak with the ED and medical teams who would be working with swine flu patients, were that they would be able to cope (and in many respects the impression gained was that they thought the reaction to swine flu was over-hyped).

This assumption was erroneous. Once swine flu patients were being admitted it soon became apparent that the teams needed significant support regarding PPE, isolation requirements, treatment regimes and anti-viral medication

On isolated occasions, swine flu patients were not reviewed on ward rounds as none of the medical staff felt confident with the PPE requirements to go into side rooms.

Briefings for senior medical staff outlining the clinical strategy were required. Our recommendation would be to do this at a very early stage and make clear the Trust's expectation that they have a responsibility to ensure that they and their team/juniors are able to deal with swine flu patients appropriately.

5.7 Communicate with your staff:

We have tried to pass on as much information throughout the organisation as possible about the numbers of flu patients we are dealing with and how we are responding. There is considerable concern amongst staff and an information vacuum will only be filled by speculation. Think of alternative ways to communicate with staff who may not receive Trust e-mails such as domestics and facilities staff as well as junior doctors. We have used our briefings to push our business continuity planning and discuss with staff their contingency arrangements for things such as school closures or other carer needs. Finally check that staff actually have received the information and ensure that line managers understand the importance of giving their staff time to be informed.

5.8 Occupational Health:

Significant demand has been placed upon Occupational Health in terms of managing staff contacts with flu cases and those staff with flu-like symptoms. At an early stage we identified that sickness from 'flu' was being managed differently by line managers across the organisation and quickly centralised this under Occupational Health (which had to move to a 7 day service to accommodate the demand). Ensure that your sickness pathways are communicated to staff and we would recommend that you have a telephone line in place for enquiries from staff and managers.

6.0 Conclusion:

The challenges from swine flu to date have not been about bed capacity and staff sickness. In essence, the surge in demand has been contained within the Emergency Department/Assessment Units. The main pressures have come from a rapid implementation of PPE strategy & training, operational constraints involved in isolating these patients and finally the need to communicate our evolving strategy quickly and effectively to all parts of the organisation.

M Dodd
9th July 2009

APPENDIX 3

SWBHT Influenza Pandemic Planning and Management Team

In line with requirements in the specific guidance for pandemic planning for acute trusts the Trust pandemic management and planning committee comprises of:

- Influenza pandemic preparedness lead: Matthew Dodd, DCOO
- Emergency planner: Andrew Dunn, EPO
- Infection prevention and control leads: Dr Beryl Oppenheim, Rebecca Evans
- PCT representation: Mary Tooley, SPCT; Dr John Middleton, SPCT; Jennifer Wallace HOB
- Clinical leads: Mr Colin Holburn A&E Lead, Dr Nick Sherwood ICU; Dr John Bleasdale
- Nursing lead Chief Nurse representative: Linda Pascall
- Pharmacy lead: Steve Horton
- Diagnostics - pathology/radiology: Rob Ashley
- Medicine & Surgery: Karen Roberts; Caroline Rennalls, Corinne Bromley; Paul Bytheway
- Communications: Jessamy Kinghorn, Vanya Rogers
- Estates and Security: Steve Lawley , Kevin Reynolds, Peter Finch
- Supplies and logistics: Leroy Prince; Danny O'Sullivan
- Human Resources: Nick Bellis
- Finance: Paul North
- Staff side/union representation: Judith Whalley
- Occupational Health: Chris Ritchie; David Riley

APPENDIX 4

Swine Flu De-brief Meeting
Friday 24th July 2009
11am, Seminar Room 6, Summerfield House, City

Attending: M.Dodd, B. Oppenheim, N. Bellis, N.Sherwood, J.Whalley, N.Ratnaraja, C Ritchie, S Horton, N Howells, B Higgins, I Agoston, N Makwana, D.Situnayake, R Evans, H Peakman

Aim: To identify lessons learnt and actions required in order to plan for the next wave.

Issue	Description/Action	Who
Update: 1st June – 21st July	• 237 patients admitted so far. • 102 confirmed swine flu positive. • 80% of admissions at City Hospital, 20% at Sandwell. • 2,040 attendances at A&E. 90% of attendances to City A&E.	
Pressures	Mainly at the front door, critical care and side rooms, however, did not result in suspended activity.	
Guidance \ Information received	***Observations:*** National strategy confusing and patchy – unable to depend on advice before making decisions. ***Critical Care:*** Guidance regarding mutual aid, ITU, paediatrics awaited from SHA. NS has produced a pandemic support tool that is being used as a basis for critical care units within the SHA region to ensure all units measure up to the same standards use the same triage criteria for critical care. Concerns raised as DH Guidance stated ITU support should be withdrawn if patients show no improvement, all patients admitted to ITU did not improve after 48 hours but did recover eventually. A national guidance for Paediatrics is expected within the next 4 weeks. Expect to make own decisions locally. Ethical group approval will be required. **Action:** • (Ethics) Group to be set up to interpret guidance received – thresholds for admission/discharge; change in use of neonatal equipment	MD
PPE	MD circulated paper detailing options for future use of	

	FFP3 masks. Agreed that FFP3 masks should only be used when carrying out aerosol generating procedures and that high users in key areas should be provided with their own re-usable mask. **Swabbing is not identified as an aerosol generating procedure.** **Action:** • Identify key areas. • Junior Doctors to be issued with re-usable masks at induction. • FFP3 masks to be provided to other areas will be dependent on supplies (reusable/disposable). • Surgical masks are sufficient for short term use. • Additional stocks of disposable FFP3 masks to be ordered	MD MD CB
Impact	Maternity identified as high risk area. **Action:** Review with maternity the triage of patients into labour ward and antenatal clinic to minimise risk/spread.	AD
Isolation / Swabbing	**Action** • ***A&E:*** Consider issuing all patients with masks at height of pandemic as symptomatic patients do not keep masks on while waiting. • Communications plans to be heightened, clarify with GP's and public that Tamiflu is not available at A&E. Lansdowne service required from HOB so patients can be triaged at the front door and re-directed. • Agreed to continue swabbing inpatients but need to identify trigger point to cease (?when 80% of those tested show as positive) Local decision required as no guidance will be available. Plans are in place for analysis to be carried out in house.	IG MD / AD MD BAO
Divisional\Medical Staffing Preparation	Information needs to be readily available in varying formats and ownership for dissemination to lie within individual Divisions through agreed distribution paths. **Actions:** • Plan required how to best to deliver messages. Junior Doctors to be picked up during induction week. • Consider attending each Grand Round. • Consultants need to lead Juniors – consider tutorials with Juniors providing information. • Comprehensive Divisional plans for expansions required.	MD / AD DS MD

	• Triage on D12 worked well but individual team needs to take ownership with defined triggers to be in place. Need to pre-empt problems now. • Plans required for management of displaced patients. • Medicine B plans for expansion need communicating. • Sandwell A&E to liaise with City A&E regarding lessons learnt. • Levels to be identified for changes in activity, when to cancel clinics, redeployment etc. • Agreed to run facilitated scenario training sessions over the Summer to test Divisional Plans. • N.Sherwood to look at suitability of D7B as a critical care expansion area after D29. • Paediatrics to check if Priory 2 and D20 at City are able to function as a paeds ward if required.	HP HP C R'nnlls A Fergs n MD AD NS NM
Comms: Pockets of staff not receiving information.	**Action:** ***Staff*** • Consider other means of communication such as SMS. • Flow diagrams popular with ward areas. • WHO checklist from John Bleasdale is a good way to communicate information. • Divisions need to encourage staff briefings (ITU hold briefings 3 times per day at handover). • Consider team group briefings. • Include cleaning of phones etc in comms. ***Patients*** • Self care on discharge, pre-op and antenatal key message leaflets and general population information to be planned.	NH
Swabbing of Staff	146 swabs taken, 29 positive. Results available within 2 to 3 days. At present allows identification and prophylaxis for patients at high risk, enables faster return to work and reassures staff **Action:** • Agreed that staff swabbing and provision of Tamiflu should continue • Trigger point to stop to be agreed	MD / BAO
External Partners	Action: Need to improve arrangements for mutual support and engagement.	MD
Supplies	4 weeks buffer in place.	MD / AD

	Action: • Need to check business continuity plans for supplies	
Information	5 data sets currently being produced by Critical Care. 2 daily sitreps being produced by Operations Division. HPA to publish paper on first 20 critical care cases.	
Immunisation Program	No definite delivery dates yet. H1N1 expected in September, Seasonal vaccine expected in October. Action: • Dates for Vaccination training to be arranged	C Ritchie

APPENDIX 5

Pandemic Flu Exercise
Wednesday 29th July
10am, Board Room, Medical Education Centre, Sandwell

Attending:
Matthew Dodd, Andy Dunn, Jenny Donovan, Kathy Collins, Philip Thomas-Hands, Caroline Rennalls, Rob Ashley, Kevin Reynolds, Carol Potts, Corinne Bromely, Sue Murray, Jackie Morton, Mike Bevridge, Paul BythEway

Introduction
Matthew Dodd summarised events over the past 2 months detailing number of admissions, A&E attendances, disease type etc. Andy Dunn presented a powerpoint presentation (copy attached for information).

What worked well?

A&E

- Access to primary care within A&E allowed a fast turnaround of worried well.

- The flu centre at Lansdowne allowed patients to be easily diverted during the short period it was open.

- Paediatric GP referrals were diverted to A&E rather than attending directly to the ward which helped curb potential spread.

What needs changing

- A&E segregation, patients did not keep masks on once issued. Consider separate area or issuing masks to all patients as a preventative measure.

- Communications regarding masks was felt to be confusing. Needs re-clarification as guidance has changed i.e FFP3 for aerosol generating procedures, otherwise surgical masks to be used. Key areas identified are A&E, Paediatrics, ITU, Maternity and Theatres.

- Communication with community and ethnic groups required early, consider using flyers in free papers etc to enforce message not to attend A&E.

- Managers require knowledge of other areas and options available within other Divisions in order to be able to manage the hospital during peak absence of colleagues.

Exercise

Paediatrics

- Plan to segregate positive or suspected patients in side rooms until results received (23 cubicles available). Able to double up in cubicles once results received. Once full, plan to expand into paediatric ward area (clean/dirty wards).
- Plan to consolidate service on Sandwell site - trigger to be identified. 2 nurses, Consultant and Registrar to remain on City site to filter patients. Communications required with PCT/GPs to attend SGH for paediatric cases once triggered.

- GP referred patients to attend A&E rather than presenting directly to the ward. Paeds Consultants to attend A&E when patients arrive. Trigger point to be identified for permanent paediatric presence within A&E.

- Priory 2 identified as expansion ward for paediatrics. Need to agree with Surgery, how much notice required, how quickly it can be emptied, how it will be staffed etc. Agreed that before paediatrics becomes full, surgery need to start cancelling routine admissions.

- Trigger point to be identified to stop elective paediatric work within the BTC in order to release staff to cover ward areas.

- One parent to be encouraged to stay in order to be primary carer for the patient – contingency for reduced staffing. No swapping of parents to be permitted in order to curb spread. Need to agree strategically change in nursing care provision and trigger for this.

- Paediatric training program and identification of staff to be trained required.

- Need to agree triggers for changing admission and ITU criteria for paeds.

Intensive Care

- 16 beds available on Sandwell site. 2 isolation beds at present but works underway to increase this to 5.

- Expansion plans for Sandwell are to cohort clean patients to Newton 1.

- 10 ITU Staff have expertise in children. 10 have received training (2 week placement). Plan to have 1 paediatric expert per shift.

- Plan to utilise theatre staff with experience of ventilation and alter staffing ratios to provide a mix of ITU and non ITU staff per shift. Staff names to be identified.

- Ventilators to be taken from anaesthetic rooms initially and then from theatres to support ITU expansion. Emergency theatre to remain.

- Trigger for stopping all non elective surgery required.

Surgery

- 3 surgical wards will be lost quickly once non elective surgery is stopped and will become cohort wards. Trigger points to be identified and agreed.
- Staff to be trained to work with medical, paediatric or ITU patients.

- Blood supplies expected to be affected due to lack of donors and supplies to Afghanistan. Plan required to review clinical protocols and prioritise use of blood stocks.

- Consultant surgeons to be re-deployed once surgical activity reduced. Education required and identification of who goes where.

Maternity

- Plan to consolidate onto one site.

- Identification of staff with previous midwifery experience required to help cover during reduced staffing levels.

Staffing

- Outpatient staff – training plans required how to skill staff to work on ward areas.

- Retired staff groups – check contact has been made.

- Cancellation of leave is possible, trigger points to be identified and levels\methods of compensation identified.

- Volunteer pools and plans to allocate to key areas to be identified.

Supply Chain

- All Divisions to identify division specific essential stocks. Awareness required that supply chains may be affected and local plans are required to manage this.

Peak Pandemic

- Admission criteria to be restricted.

- Discharge thresholds to be identified and reviewed.

- Empty wards at RRH to be utilised, staffing plans required.

- Hotel facilities to be considered to aid early discharge.

- Staff communications – briefing structure required, consider 3 briefings a day, agreed that face to face is ideal.

Next Meeting

- Agreed to hold exercises monthly and to include all On Call Managers and Clinical Directors and Matrons
- Date to be confirmed.

APPENDIX 6

WINTER PLANS (AS AT 04/09/09)

RAG Status: **GREEN** - assured and ready now; **AMBER** - in progress complete by end Sept; **RED** - in progress complete after end Sept

Best Practice on Ambulance Turnaround

McDonald Review: Progress on implementing the agreed actions of the 'McDonald review' on ambulance turnaround, escalation and associated issues, including use of the performance improvement tools identified in the NHS South West report on best practice in ambulance turnaround

Number	Description	Progress/Action	Who	Status
1	Health communities must operate in a way which is consistent with the principles about minimising and monitoring ambulance turnaround times.	Local health economy is signed up to working together to minimise ambulance turnaround times as well as other access targets An update is required regarding the joint work undertaken last December in response to the McDonald review	Winter Forum	Oct 2008
2	Standards for turnaround Times Year 1: 90% Turnaround < 30 minutes: Max Turnaround times 60 minutes	Daily analysis of over 60 mins turnarounds undertaken by SWBHT when the information is sent through from WMAS There needs to be agreement that this data will have been validated before being sent through to SWBHT and that any amendments to data identified by SWBHT will be made	LAPRG	
3	Where performance is consistently below the agreed standard, local health economies and WMAS must agree an action plan to ensure that standards are met.	For agreement at Winter Forum	LAPRG	
4	Implementation of monitoring arrangements for WMAS turnaround	• Local Ambulance Performance Review Group to develop protocols • Monitoring of 60+ mins turnarounds are received from WMAS they are investigated (see Rec. 2 above)	LAPRG	
5	Handover: Clinical Task & finish group to agree a formal definition of handover All trusts should identify at which stage in their procedure handover and crew release should be, agree this with WMAS and put in place systems to ensure that handover is formally recorded.	• Agree local handover arrangements	LAPRG	
6	**Escalation:** A commonly agreed and consistent escalation policy should be agreed and implemented across WMAS and Trusts. The Emergency Management System (EMS) policy agreed and currently used by all acute trusts should be adopted by all parties	LHE Escalation Plan being drafted.	LAPRG	
7	Cohorting of Patients should only be adopted at times of pressure and would be triggered during the escalation process. Cohorting should not be seen as part of normal operating practice	• Local meetings to develop protocols. • Awaiting outcome of meetings of central task and finish group	LAPRG	
8	Escalation Escalation levels should be agreed across the SHA and used by all organisations. These should be based on the EMS levels used by all acute	LHE Escalation Plan being drafted. SWBH & WMAS submitted updated plans	LAPRG	

Number	Description	Progress/Action	Who	Status
	trusts, modified to clarify the role that ambulance turnaround times play in triggering escalation levels	• First meeting of central task & finish group 02/12/08 • Final proposal by end of December 08 This needs to be ratified and implemented regionally		
9	Escalation to SHA level This should be limited to instances where resilience and business continuity is threatened across Resilience Forum boundaries; where major incidents are being triggered or where a serious untoward incident has occurred	LHE Escalation Plan being drafted. SWBH & WMAS submitted updated plans	Winter Forum	
10	Diverts Wherever possible organisations should 'consume' their own smoke. In some cases divert policies should also reflect geographical consideration where a hospital outside the Trust would be closer for the ambulance. The rules by which ambulances may be diverted should be agreed by acute trusts in partnership with their PCT and WMAS within three months of the date of this report	LHE Escalation Plan being drafted. SWBH & WMAS submitted updated plans	Winter Forum	
11	Diverts: Where diverts may be needed to other Trusts, either for geographical or capacity constraints, these should be requested as part of an escalation procedure	LHE Escalation Plan being drafted. SWBH & WMAS submitted updated plans	Winter Forum	
12	Basing an ambulance liaison officer within each A&E / trust will enable better communication, improved understanding of pressures and earlier notice of divert. Ambulance liaison officers should be established in trusts where there are significant pressures and long turnaround times. When the findings of the Heart of England pilot have been evaluated, consideration should be given to establishing ambulance liaison officers in all trusts.	HALO in place at City & Sandwell Hospitals Need to clarify the role that the HALO will take at each site during the period Oct 09 – March 10 since their on-site role has reduced	LAPRG	Completed
13	ECN A recognition by all organisations of the leadership role of the Emergency Care Network with senior and consistent representation;	• ECN (Winter Forum) signing off the winter plans	Winter Forum	Ongoing
14	Emergency Care Networks should continue to seek ways to increasing the proportion of patients seen at Urgent Care Centres, Walk In Centres, etc; treat patients at home so avoiding a trip to hospital, and reduce clustering	• Work programme of ECN (Winter Forum) to incorporate all of these elements • Urgent Care Centres now open in LHE • Walk-in Centre operating extended hours Sandwell UCC currently being reviewed by SPCT and role may change during Autumn	Winter Forum	
15	Extend the authority of ambulance crews to enable them to take patients directly to minors, walk in centres or treat patients at home. This will need to be within agreed clinical protocols and commissioning contracts		LAPRG	
16	Weekly joint reviews by each Trust and WMAS of the performance and agreement on actions to be taken;	• Formal mechanisms still to be identified • Local meetings being established to resolve	LAPRG	
17	Individual reviews by WMAS and the Trust following any ambulance having a turnaround time of over 60 minutes	• Daily analysis of over 60 mins turnarounds undertaken by SWBHT when the information is sent through from WMAS	LAPRG	

Best Practice on A&E operations

Number	Description	Progress/Action	Who	Status
1	Visible leadership & management in A&E	Clinical Directors for Emergency Care have been appointed at both City and Sandwell General Hospitals. Their role is to provide clinical leadership for the departments. In addition, the management structures identify senior managers and senior nurses responsible for these departments. There are clear escalation processes in operation within each ED to identify pressures and to escalate to managers at an early stage. These include escalation to other agencies such as PCT and local authority	Matthew Dodd (SWBH)	
2	Staffing levels & organisation	Medical Staff: Recruitment is taking place for middle grade vacancies and contingency measures for medical staffing for the winter are being discussed with the Clinical Directors. Nursing Staff: 4 ENPs are due to start at SGH which will increase the range of activities that nursing staff are able to undertake within the Department	As above	
3	Forensic use of breach analysis	The escalation system in operation for the Trust requires that the COO (Executive on call) is notified of all potential breaches in order to ensure that all possible measures to avoid them have been taken Breaches are reviewed on a daily basis and further considered at weekly site meetings	As above	
4	Effective triage and streaming	The Urgent Care Centres at City and SGH enable patients with minor injuries to be streamed away from the main A&E and to create greater capacity within each Department	As above	
5	Early assessment by a senior grade decision-maker	Consultants and SpRs are available within each Department and they have a role not only in ensuring clinical quality, but also in dealing with patient flow	As above	
6	Plan to admit / discharge within 2 hours	The ED clinical teams have internal escalation processes based on the amount of time that patients have waited. Where patients are nearing 2 hours without a decision to admit or discharge, then they must be escalated to more senior staff within the Department	As above	
7	Real time bed information	Within the ED, there are specific modules for the PAS which show real time patient events. This allows staff to identify how long each patient has waited and also gain an overview of how much activity there is in each ED.	As above	

Number	Description	Progress/Action	Who	Status
		Bed Management teams enable an assessment to be undertaken on the number of beds currently available as well as those being freed up later. There are 3 x daily bed management meetings at both sites, while out of hours, the Hospital at Night team assume the responsibility for bed management (both in terms of identification and allocation of beds)		
8	Effective 'simple timely' discharge processes downstream to ensure flows through ED	The escalation plans for dealing with ED pressures, focus upon the actions required downstream to enable discharges to take place. These involve liaison with PCT and the local authorities to support discharges	As above	

Additionally, the Urgent Care Centre is in operation at City Hospital, 7 days a week from 10am to 11.30pm. This service enables lower priority patients to be seen by primary care clinicians (GPs) on site, reducing the burden on the Emergency Department, supporting the A&E 98% performance target and increasing patient access to primary care.

Best Practice on Discharge

Number	Description	Progress/Action	Who	Status
1	Daily monitoring of delays by category, with agreed trigger points for action & weekly reporting across the health economy	Delays are reviewed on a daily basis by SWBHT, via the discharge teams. There are weekly meetings at each site with the local authorities to review discharges and agree actions for any delays/pressures. SWBHT has agreed with each LA and PCT, the numbers of delays that it will consider as the trigger for escalation within and between organisations	Heather Butler; Angela Young (HoB) Matthew Dodd (SWBH)	
2	Revisit local health and social care economy demand – capacity plan to ensure best fit	There are discussions within Sandwell about community capacity in order to support keeping delayed discharges to a minimum. ACS and SPCT are considering whether to invest in enhanced community support to enable patients to be discharged to interim care where more appropriate assessments about their future care needs may be made	As above	
3	Best practice policy on applying timescales to choice directives	The Trust already has a policy of informing patients that they are not entitled to stay in beds once they have been deemed ready for discharge. Where patients and their carers feel that they wish more time to exercise choice, beyond that which the Trust considers reasonable, this is escalated to senior managers and will result in discussion with the patient and their representatives to identify the best course of action	As above	
4	Capacity in place to do assessments, using a fast-track process where possible	There are discharge teams at each site with the ability to undertake assessments which will be accepted by other agencies	As above	
5	Consider facilitating assessment in community rather than acute facilities where appropriate	See 4.2	As above	
6	Use of community staff to 'pull' patients out to appropriate community settings	At both sites community staff are empowered to come onto the wards to 'pull' patients out	As above	
7	Clear agreements with social care partners re: the availability of social care capacity over the holiday period	The trust requests that social care operate throughout the holiday period, even if in a reduced capacity. There are periods when the only support is via the emergency teams however.	As above	
8	Creative local solutions with social care partners	The Trust uses Care Home Select to support the discharge of patients	As above	

Best Practice on Admission Avoidance

Number	Description	Progress/Action	Who	Status
1	Reducing Admission for Short stay patients	At both City and Sandwell General Hospitals there has been the development of a model of care in the ED aimed at reducing admissions. This involves the use of Acute Physicians who are based on the assessment units and will turn patients around by means of regular reviews on the unit, hot OPD clinics, fast track access to diagnostic services. In some cases the acute physicians act as the reception point for GP calls and manage to divert some patients away before they even arrive at the Trust. This model will be maintained throughout the winter	Mark Curran; Heather Butler; Angela Young (HoB) Matthew Dodd (SWBH)	

Capacity

Number	Description	Progress/Action	Who	Status
1	Availability of additional acute capacity	**City:** • Stage 1: 16 additional beds (4 x D7; 6 x D47; 6 x D43) • Stage 2: Move ward from D30 to D16 (+ 5 beds) • Stage 3: Move D29 to D17 (+ 12 beds) • Stage 4: Use of D20 as winter ward (= 19 beds) Also will be the use of Care Home Select to provide up to 10 interim care beds in nursing homes **SGH:** • Stage 1: Open up wards to 34 beds (+ 4 beds) • Stage 2: Expand Lyndon 4 to 32 (+ 6 beds) • Stage 3: Expand Newton 4 to 34 beds (+ 14 beds) • Stage 4: Use of bays on surgical wards (+ 6 beds)	Matthew Dodd (SWBH) James Shanahan (BCH)	
2	Additional Services	<u>Birmingham Walk-in Centre</u> ▪ Monday-Friday: 8am – 7pm ▪ Saturday: 9am-6pm; Sunday: 11am-4pm <u>Greet Urgent Care Centre</u> ▪ Monday – Sunday; 8am – 8pm	Mark Curran (HoB) Mark Curran (HoB)	October 2008 April 2009

APPENDIX 7

Introduction

This document describes how Critical Care Services (CCS) at Sandwell and West Birmingham Hospitals (SWBH) NHS Trust will increase capacity to cope with sustained increased demand and forms part of a Trust wide response to such an event. It is based on the Department of Health document "Pandemic flu: managing demand and capacity in health care organisations (surge)" published May 2009. (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098769).

This document provides a framework for reacting to a surge in demand for critical care. It is NOT a rigid plan and accepts that a degree of flexibility is essential to respond to varying threats. Surge management is not an "all or nothing" event and that critical care response will vary dependant on the threat.

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Capacity

The Department of Health expects each Trust to be able to increase baseline critical care capacity by 100% within 48 hours. In April 2009 SWBH critical care capacity amounts to 19 points of care at City site and 17 Sandwell site. This equates to 18.0 Level 3 (ICU) beds.

Overwhelming, rapid surge

Use of non-CCS staff to provide bed side care supervised by trained CCS staff will allow us to provide a higher level of capacity. Capacity will have to flex depending primarily on available nurse staffing. Staff will not work cross-site during surge periods.

Expansion will occur in the following phases:

City:

1. Initially use 4 side rooms on CCS
2. Then move "clean" patients from CCS to D29
3. Admit infected patients to CCS (L2 & L3)
4. When CCS full implement triage for admissions and all CCS inpatients
5. As "clean" patients reduce on D29 increase capacity in Endoscopy L2 area for infected patients
6. If staffing adequate continue some additional capacity on D29 or Th 9&10 recovery

Sandwell

1. Initially use 2 CCS side rooms
2. Then move "clean" patients to Newton 1
3. Admit infected patients into CCS
4. Triage when at maximum CCS capacity (16 beds full)
5. As "clean" patients decrease on Newton 1 option of consolidating service into CCS by doubling bed spaces or maintaining capacity on Newton 1

By assuming a 40% staff absence rate and a 1:3 / 1:4 trained nurse ratio we anticipate being able to provide the following **maximum** capacity during a surge period:

City	Beds	Level	Points
CCS	16	3	32
D29 Level 2	4	2	4
D29 Level 3	7	3	14
Endoscopy	12	2	12
Total	39	-	62

Sandwell	Beds	Level	Points
CCS	16	3	32
Doubling CCS	12	3	24
Newton 1	4	3	8
	4	2	4
Total	36	-	68

However these figures represent maximal capacity and may not be sustainable in the event of staff shortages.

Allowing for a 40% absence rate we predict the following minimum service provision that will be delivered in the most appropriate clinical areas:

	Points
City	36

Sandwell	34

Equipment for each area will be provided by:

City	Monitors	Ventilators
CCS	Stock	Stock
D29	Datex anaesthetic from BTC	Aestiva 5 from BTC
Endoscopy	BTC	CPAP / NIV units from CCS

Sandwell	Monitors	Ventilators
CCS	Stock	Stock
Doubling CCS	Recovery Theatre	Theatre
Newton 1	Day case unit	NIV units from CCS

Equipment transfer will be coordinated by Medical Engineering. Removing equipment from non CCS area will impact on service provision elsewhere. A decision to do this will be made by the Trust Executives as part of the escalation procedure. Where possible use of non standard CCS equipment will be limited to a single monitoring / ventilator platform to maximize patient safety.

Sustained, low level surge

It is possible that early on in a pandemic there may be a relatively low level of hospitalisation (implying relatively normal elective hospital function) but a high level of in patient requirement for critical care. In this scenario CCS could not expand by utilizing theatre staff or equipment.
In this exceptional situation CCS would attempt to cope "in house" using the following plan escalating to the next step only when required to do so:

City:

1. Initially use 2 side rooms on CCS
2. Move "clean" patients to CCS "blue" side (2 side rooms and 7 beds)
3. Admit infected patients to CCS "green" side (2 side rooms and 5 beds)
4. Patients nursed on a 1 nurse : 2 patient ratio (9 nurses per shift)
5. Consultant care from 2 consultants – 1 "blue" and 1 "green"
6. If more than 7 "infected" beds are required than this could only be accommodated by initiating the full expansion plan above transferring clean patients to D29 and by using theatre staff and equipment with an inevitable effect on theatre capacity.

Sandwell

1. Initially use 2 side rooms on CCS
2. Move all "clean" patients to beds 6-16
3. Partition beds 3-5
4. Admit further infected patients into cohorted area beds 3-5
5. Patients nursed on a 1 nurse : 2 patient ratio
6. Consultant care from 2 consultants
7. If more than 5 "infected" beds are required than this could only be accommodated by initiating the full expansion plan above transferring clean patients to Newton 1 and by using theatre staff and equipment with an inevitable effect on theatre capacity

It should be emphasized that this model of care is suboptimal compared to our traditional 1:1 level 3 ratio and inevitably is a balance between risk and benefit both to the individual patient and the Trust as a whole.

Staffing

Additional medical and nursing staff will be required to manage these additional beds. In addition to this staff absence (illness, family illness) will reduce availability We anticipate that absence rates nay be as high as 40%. Staff with transferable skills from other areas will be allocated to critical care.

Medical staff

Projected requirements per shift are:

City	Consultant	SpR	F1/F2/ST1
CCS	1	1	2
D29	1	1	1
Endoscopy	0	1	2

Sandwell	Consultant	SpR	F1/F2/ST1
CCS	1	2	2
Newton 1	1	1	1

At night the SpR and F1/F2/ST1 numbers will reduce to 1 each per unit. A single consultant will cover each site.
Additional staff could be drawn from the following areas:

Consultant	Consultant anaesthetists	8 (4 City, 4 SGH)
SpR	Anaesthetic SpRs	All trainees
F1/F2/ST1	CCS F1/F2/ST1, Previous CCS F1/F2/ST1, Anaesthetic F1/F2/ST1	All trainees

Transferring anaesthetic trainees to CCS will require all theatre work to be covered by remaining consultant anaesthetists (including night cover)

Initially staff will work to current working patterns. As staff availability decreases and demand increases it is likely that the current restrictions (EWTD) will be relaxed. At this point it is planned for medical staff to work 12.5 hour shifts for up to 7 consecutive days, followed by 7 days off. There may be scope for individual staff to work for fewer days (followed by a correspondingly fewer number of days off).

Nursing

It is anticipated that nursing staff will work in a similar 7 day on / off pattern.
During peak periods the majority of nursing care will be delivered by non-ICU trained staff. These staff will be supervised by ICU trained staff in a ratio of 1 trained to 3 or 4 non-ICU staff. Staffing ratios for level 2 and 3 patients will remain at pre-surge levels. Each area will also be managed by supernumerary shift leaders. We will provide a Senior nurse with each nursing team on each site (on each shift) for advice, support and co-ordination. The Senior Nursing Team (including both PDS staff and the deputy unit manager (city site) will not be included in the staffing calculations. They will be allocated a site and a team and will base themselves on this site for the duration of the Pandemic

City	Non-ICU	ICU	Supervisor
CCS	16	4	2

D29	9	3	1
Endoscopy	6	2	1

Sandwell	Non-ICU	ICU	Supervisor
CCS	20	6	4
Newton 1	14	4	2

In the event of staff shortages care will be concentrated in the City CCS, Endoscopy and SGH CCS areas

We will try and maintain an additional pool of staff separate to the teams in their 7 day work or rest periods who will replace staff members who are unable to work. Many staff members have dependant children or working partners. All staff are encouraged to plan with their partners / families how their work and child care responsibilities will be balanced during a pandemic.

Training

Medical

Staff with no CCS experience will receive the following training

Consultant	Rotational training in CCS
F1/F2/ST1	1 day basic training package

Nursing

Staff with no CCS experience will receive the following training

Nursing	BBCCCN competence based training package supervised by PDS

Accommodation

Staff may wish to stay on-site, particularly during extended periods of duty. Efforts are underway to locate appropriate accommodation, possibly by using office and OPD space. Catering services will also be expanded.

Patients

It is likely that demand for critical care will out-strip capacity.Some form of health care rationing may well be required to ensure that scarce resources are directed towards the largest group of individuals who have the highest chance of survival. A triage tool based on SOFA scoring (advocated by the Department of Health) has been developed to assist ward consultants refer appropriate adult patients. A similar tool will be used across the whole of Birmingham (see below).
It is anticipated that patients will present with severe type 1 respiratory failure. Initially a full range of organ support will be offered. However as demand increases care will have to be limited to maximize treatment for as many patients as possible. In this situation the following treatments will may NOT be offered:

Respiratory	High frequency oscillation (HFO)
Renal	Renal replacement therapy

Other limitations in care will be led by the review triage process (see below).
Level 2 areas will offer CPAP delivered by the "hood" system augmented by bacterial filters on expiratory ports. NIV via traditional "open" masks presents an unacceptable risk to staff and will not be used. NIV via a "closed" mask system may be used.
It is likely that Birmingham Children's Hospital will not be able to accommodate all level 3 patients from across the City. We do not usually admit children apart from for their short term care or stabilization prior to transfer. During surge periods we will admit children. It is recognized that few medical and nursing staff possess the requisite skills to optimally care for these patients, however the lack of alternative care facilities oblige us to provide the best service we can under the circumstances.

Triage

Adults – admission triage

Adult patients will be triaged using a 3 part tool comprising inclusion criteria, exclusion criteria and a physiological score (SOFA Score). In the event of two patients being referred to the last CCS bed the patient with the lowest SOFA score will take priority. Triage will be performed by ward based medical consultants.

Adults – review triage

Adults will be re-triaged at 48 hours and 120 hours. At these points treatment may be limited in line with the guidance on the respective documents. Patients will be SOFA scored every 12 hours (after the initial 48 hour review). Any patient scoring >11 will also be subject to treatment limitation. Decisions on treatment limitation will be confirmed by a second ICU consultant. Review triage will apply at all times UNLESS there are 2 beds available in the respective unit at which point it will be suspended until there are no longer 2 beds available.

Paediatrics – admission triage

There is no national or regional guidance. SWBH Paediatricians (in association with Birmingham Children's Hospital PICU) have developed a triage system based on inclusion and exclusion criteria. There is no validated physiological score to assist in admission triage. Paediatric triage will be applied to all patients aged less than 16 years of age.

Paediatric – review triage

Paediatric patients will also be reviewed at 48 and 120 hours. Discussions with BCH are on-going to find a scoring system that provides comparable predictive information to the SOFA score.

Treatment Limitation

During surge periods we have a primary duty to provide care to those patients who have the greatest chance of survival. This will inevitably lead to individuals who would ordinarily be offered continuing care having their treatment limited so that other individuals (with a greater chance of survival) can benefit from that scarce resource.

Treatment limitation will take the form of a one-way wean over a defined, standardized time period.

Changes to current practice

We will need to maximize throughput to ensure care can be delivered to as many individuals as possible. To facilitate this we will need to ensure sedation and paralysis levels are kept at an absolute minimum. This may lead to greater use of haloperidol, clonidine and physical restraints.

Infection control

Infection control is vital to protect our patients and our staff.

Sickness

Staff who are symptomatic should NOT come to work but instead should access appropriate treatment via Occupational Health, SWBH or primary care. Staff who become unwell whilst at work should contact to Occupational Health immediately. After staff recover from any infective illness they should be immune to further infection.

Cohorting

It is important to keep infected cases together in isolated areas to limit the spread of infection to non-infected patients.

- Initially infected cases will be admitted to side rooms in the CCS areas.
- Infected patients can then be grouped within open CCS areas
- Patients with possible infection will need to be isolated until their status is confirmed
- If staffing permits "clean" critical care areas will be opened on D29 (City) and Newton 1 (SGH)
- Infected level 2 patients will be cared for in Endoscopy and possibly Newton 1

Limiting cross infection

The key points are

- Effective hand decontamination between patients and after contact with hard surfaces
- Use of gloves and aprons
- Normal uniforms should not be worn. If available theatre scubs should be worn.
- Use of personal protective equipment (PPE)
- Staff flow – where possible units will be accessed by separate entrance and exits with decontamination facilities available on exit

PPE

Health Protection Authority advice is that standard surgical masks should be worn when delivering basic patient care. During high risk (aerosol generating) procedures PPE should be upgraded to FFP3 mask, visor and gown.
It is likely that supplies of FFP3 masks will become depleted. While these masks are designed for short-term use staff may wish to retain and use them for longer periods. However they should be aware that the external mask surface may be contaminated with virus after leaving an infected area and that use of FFP3 masks outside of standing guidelines from the HPA/manufacturer is at their own risk.
It is planned to issue each member of critical care staff with their own reusable FFP3 mask.
FFP3 mask "fit testing" ensures maximum protection and will be offered in all critical care areas.
Further information can be found in the DoH publication "Pandemic Influenza: Guidance for infection control in critical care"

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084178

Security

It is unlikely that external agencies will be available provide on-site security.
In the interests of infection control and staff and patient safety relatives will NOT be permitted to visit infected patients unless their presence is essential to deliver active patient care.
Paediatric patients may be visited by a single parent or guardian.
There will not be facilities for relatives to sleep overnight in separate accommodation.

Supplies

Stocks of PPE and key disposables have been created but are inadequate to last for a sustained surge. It may become necessary to re-use single use products where the risk/benefit argument is favorable (i.e. washing CPAP hoods between patients).
Clinicians should simplify treatment and look to conserve drugs and disposables whenever possible. It may be necessary to use alternative therapies (i.e. using anaesthetic vapour to sedate patients ventilated with anaesthetic machines).
In the event of equipment shortages alternative solutions may be required (i.e. use of transport ventilators, use of burettes instead of syringes drivers)

Communication

Critical care staff are vital to successfully dealing with a surge in demand. They must be regularly briefed with up to date information. This will be done using the professional team structure to cascade key messages.
Staff working for prolonged periods should be given access to email and telephones to communicate with their families.
Written information for relatives of patients will also be required, particularly to explain issues regarding treatment limitation and triage.

Latest guidance

Guidance is revised on a regular basis so these documents may soon be replaced

Infection control
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080771

Surge capacity planning
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080771

Ethical aspects
http://www.dh.gov.uk/en/Publichealth/Flu/PandemicFlu/DH_065163

Swine flu clinical tools
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_100941

WHO swine flu
http://www.who.int/csr/disease/swineflu/en/

HPA – includes alert levels
http://www.hpa.org.uk/webw/HPAweb&Page&HPAwebAutoListName/Page/1240812234677?p=1240812234677

APPENDIX 8

Sandwell and West Birmingham Hospitals NHS Trust
Occupational Health & Safety Service

Flu Immunisation Programme for Seasonal and H1N1 vaccines 2009

Introduction

The process for carrying out a combination of mass vaccination and local departmental clinics is outlined below.

Latest guidance recommends that H1N1 vaccine be prioritised to patient facing groups. This will require a flexible approach to vaccination to include both mass and local vaccination clinics to ensure all appropriate staff are vaccinated.

On the basis that delivery of seasonal vaccine is expected late September it is planned to offer clinics over a three week period commencing 5 October 2009. On the basis that H1N1 vaccine is due mid October vaccination for the first dose to commence 26 October 2009.

Sufficient seasonal flu vaccine will be available to vaccinate all Trust staff, however H1N1 vaccine will be prioritised to identified patient facing groups and smaller volumes of the vaccine are expected. This will require a flexible approach to vaccination and both mass vaccination and local clinics will be offered.

Areas to be addressed

1. Identify and develop a flexible approach to the provision of Flu vaccination to Trust employees

2. Identify Staff vaccination priorities in line with national guidance and trust needs

3. Identify staff and resources necessary to deliver the programme

4. Ensure staffing resources identified for delivery of the programme receive appropriate training.

5. Marketing

1. Identify and develop a flexible approach to the provision of Flu vaccination to Trust employees

A flexible approach to vaccinating staff within the Trust is necessary. For large numbers to be vaccinated over a short period of time mass vaccination clinics will be the most efficient process. However with limited quantities of H1N1 vaccines available to the Trust, local clinics would be more appropriate.

When developing the programme for seasonal and H1N1 Flu vaccination it is important to use an approach to ensure efficiency, maximise use of resources and reduce risks associated with the process.

Proposed model for mass vaccination clinics

1 x nurse to triage consent forms 6x nurses to vaccinate and 1 admin for 5 days/week = 40 clinical/non clinical day shifts per week.

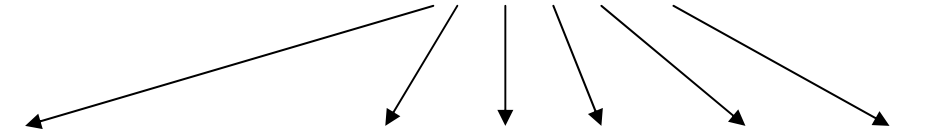
Need to vaccinate 6,000 staff over a 3-4 week period
Example:-
6 x nurses, 10 vaccines/hour, 7.5 hours/day = 450 vaccines per day, 450 x 5 days = 2250 per week, 6750 over 3 week period

Key Roles

Admin – (meet and greet provide documentation for Completion)

↓

Nurse clinical knowledge – To check and triage forms
Problem cases to nurse 1 others to vaccinators



Nurse 1 vacs2 vacs3 vacs4 vacs5 vacs 6
Clinical knowledge
Vaccinates/problem cases

This model allows flexibility for an increase and decrease in demand.
Having the form checker allows problem cases to be triaged and allocated to one person, this prevents blocking of the system. The vaccinators are then free to just vaccinate and do not have to check forms. This increases through put and avoids queues forming.

Risks

Risks associated with the vaccination of large numbers of staff need to be considered:

- Staff vaccinated with vaccines from different manufacturers. There is a potential risk of immunising staff with different flu strain, as there are 2 manufacturers.

  It is proposed that use of different coloured forms are used for different H1N1 manufacturers to reduce the risk.
  All consent forms need to be returned to Occupational Health within a short time frame to allow for recall for 2nd H1N1 vac. Otherwise 2nd H1N1 would be delayed. It is imperative that all documentation is completed and recorded properly, a controlled approach is therefore essential.

  It is necessary to retain half of the stock received so that the 2nd dose is available from the same manufacturer.

- Needle-stick injuries – Due to the large numbers of vaccines being given there is the potential for an increase in needlestick injuries. To reduce this it is necessary to ensure vaccinators receive adequate training, develop skills and competencies.

- Breaking of cold chain – Delivery storage and transport methods need to be considered when looking at the method of provision. Also the ability to store large numbers of vaccines to avoid braking of the cold chain and wastage of vaccine.

Venues :

- City – D.46
- Sandwell – Old HR Offices
- Rowley – Westwood Ward

Benefit for mass immunisation Clinic

- To control documentation, vaccine delivery, vaccine storage and recall for 2nd dose.
- Most efficient method to carry out large number of vaccinations over a shorter period of time
- Support from other colleagues
- Storage delivery of vaccines and possible reduction of wastage (H1N1 10 dose vial)
- Delivery of vaccines to 3 separate sites
- Co-ordination of recall for H1N1
- Ability to cope with large numbers of staff over a short period of time

Local clinic provision

Vaccination of small numbers of prioritised staff would be more appropriately managed by local clinics supported by the Occupational Health Department.

Staffing

Matrons co-ordinate clinics within there responsibility. Volunteers who attend the Flu training would vaccinate the staff within their areas.

Resources

Each area would be responsible for identifying the resources i.e. documentation from Occupational Health, vaccine to be collected from Pharmacy. Pharmacy would manage the stock to ensure there was sufficient same manufacturer vaccine available for the 2nd dose. Co-ordination of the 2nd vaccination would need to be coordinated by the local depts/wards to ensure all staff receive their 2nd vaccination.

For H1N1 both 1st and 2nd vaccine will be recorded on the same consent form. Therefore the consent forms will need to be retained until the 2nd vaccine has been administered. It is then imperative that all consent forms are returned to Occupational Health for recording purposes.

Benefit for local immunisation

- Staff convenience as they do not have to leave their place of work
- Managers would not have to arrange cover whilst staff attend clinic for vaccination
- Dependent on the numbers of H1N1 vaccines received local clinics could be more appropriate for the provision to small numbers of prioritised staff.

2. Priorities for delivery (based on most recent guidance)

Due to the limited availability of H1N1, this vaccine will need to be offered to staff in the following priority groups, (*Further reprioritisation may be necessary dependant on numbers of H1N1 vaccine doses available.*)

- A & E both sites
- EAU, MAU both sites
- ITU
- Wards designated as swine flu patient admission wards to include wards included in the surge planning
- Oncology
- Women & Child Health *neonates, paediatrics, maternity, theatre staff)
- Haematology
- Occupational Health
- Senior Management/Pandemic Flu Planning group
- Staff with underlying medical conditions i.e. chronic respiratory condition including asthma, chronic heart disease, chronic liver disease, chronic neurological disease, immunocompromised, diabetes, mellitus, pregnant staff

3. Staffing

- Matrons and Nurse groups have agreed to assist with the staffing of the mass vaccination and local clinics.
- Rotas and clinic provision are to be agreed dependent on the staffing availability.

4. Training

Training will be provided by the PCT, at the three Trust sites, additional training will also be provided at the Bethel Convention Centre. All volunteers must attend one of the training sessions in order to administer vaccines which will be held week commencing 14/21 September 2009.

Content of training
The Seasonal/H1N1 training will consist of:

- The basic principles of giving vaccine
- Anaphylaxis
- Competency/PGD/paper work

A separate user pack will be provided for all vaccinators identifying the process of the immunisation clinic together with consent forms. Also all vaccinators will also be provided with PGD documentation.

5. Marketing

To raise awareness it is intended to market the process by using Trust communication facilities.

17.08.09

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Human Resources

Flu Pandemic Plan

Human Resources Flu Pandemic Plan

CONTENTS

1. Introduction

This plan relates to the staffing issues associated with a pandemic flu outbreak and the arrangements necessary to ensure priority services are staffed and managed.

This document is designed to support the Trust's Pandemic Flu Major Incident Plan and co-ordination of the plan will be undertaken on a centralised basis by the Major Incident Planning Committee and the principals contained within this plan will be followed by all Trust staff

2. Scope

This plan applies to all Trust employees, agency, temporary, locum, bank staff, students/trainees and volunteers working at the Trust.

3. Background

It is anticipated that there will be a number of waves, each lasting approximately 16 weeks and that cases likely to peak during the autumn of 2009.

In the event of a pandemic, it is estimated that there will be significant pressures on staffing levels, owing to high levels of absence. Absence is likely to occur for reasons relating to sickness, caring responsibilities, and fear of staff contracting the virus.

It is estimated that absence due to sickness will be for between 7 and 10 days, per employee. Sickness absence levels are expected to remain at a higher than normal rate following the end of the pandemic. .It has been estimated that between 25% and 50% of staff will be affected.

Further more there will extra staffing pressures on services caused by

- Parents being asked to keep children away from school at the first sign of flu symptoms
- Schools being closed at short notice
- Employees requiring time off work to care for immediate family members e.g. Partners, spouses, Children, Parents, Parents in Law.
- Potential difficulty with public transport.

The Trust's expectation is that all employees will make every reasonable effort to attend work and where necessary assist by carrying out a different

role than normal in order to maintain service provision. In doing this however employees are not expected to compromise their own health and safety or that of others. It is expected that all staff, regardless of role, will conduct themselves in a professional manner, act within their scope of practice, and will maintain their own and patient safety at all times.

The Trust will identify specific relevant skills which may be required to support a pandemic flu outbreak and an appropriate database will be maintained by the Workforce Directorate and made available to the Major Incident Planning Committee.

4. Managing Sickness Absence

The Trust will continue to utilise its sickness absence arrangements to enable the recording of levels of absence during a pandemic. There will be a requirement for managers to continue to ensure robust recording of sickness absence to allow the recording of absence that is due to influenza, and to identify areas that are most affected.

It is important to minimise the spread of infection and employees should not attend work if they are showing symptoms of the flu virus. If employees start to show symptoms then they should contact the Occupational Health Department on the flu line - City 5998 or Sandwell 3769 prior to being sent home.

Symptoms could include temperature or history of temperature, cough, runny nose, sore throat, limb/joint pain, headache.

Employees must continue to report sickness absence in the usual way to their immediate line manager, and in accordance with the Trust's Sickness Absence Policy.

Sickness absence due to pandemic flu will not be counted as part of normal absence controls and trigger points will be suspended in a pandemic situation. Employees will be entitled to normal sick pay provisions under the Trust's policy.

Where a member of staff has been absent for reasons of pandemic flu; which has been verified by the Occupational Health Department, managers will not take this period into consideration when deciding whether to award a sickness absence warning. However, it should be noted that all other sickness absence taken during the pandemic flu outbreak will be recorded and counted.

To relieve pressure on GP's surgeries employees will only need to attend for treatment purposes and will not be required to obtain medical certificates unless absence exceeds 14 days. A completed sickness absence statement form will be required (see the Trust's Sickness Absence Policy) for absence up to and including 14 days.

Employees will be expected to follow advice provided by the Occupational Health Department, their GP's and that of public health broadcasts before returning to work (as appropriate).

Employees who have had the flu virus and recovered will be expected, if necessary, to cover essential key workers on their return to work therefore it is important that managers are kept fully informed about the reasons for absence and expected date of recovery/return to work.

It is anticipated that in a pandemic situation, it may not be possible for the formal return to work interviews or sickness absence review meetings to be followed in a timely manner, due to lack of managerial capacity. However, these should be undertaken as soon as pandemic is downgraded.

5. Carers Leave

Employees who are required to be at home to care for immediate family members (i.e. Partners, Spouses, Children, Parents, Parents in Law) in relation to the flu pandemic will be allowed reasonable time off with pay for a maximum of 6 days, to undertake caring responsibilities. The list above is not exhaustive and will be at the manager's discretion.

It is recognised that in some circumstances there will be a need for employees to be required to care for greater than a six day period. In these circumstances the employee can request:

a) Annual leave.

b) Full contractual pay for working up to 50% of contracted hours (limited to one week) if the employee is prepared to work reduced hours flexibly, or

c) A further 5 days' carer leave at half pay (these conditions are to be authorised by the major incident planning committee).

Staff will be required to report their request for carers leave honestly. Clearly the arrangements set out in this plan for the management and reporting of absence rely on Trust and will only be successful if employees are honest about time off required. For this reason, abuse of these arrangements will be treated as gross misconduct and may result in dismissal.

In some areas it may be appropriate to allow staff to work remotely from home or offer a flexible working pattern to allow staff to care for dependants. This will be considered on an individual basis according to the needs of the service.

Note:

It is intended that the six days paid carer leave referred to above, will be the total amount of carer leave that may be granted during a given emergency flu pandemic episode. Only in highly exceptional circumstances may Divisional General Managers authorise additional paid leave, to be limited to a further five days.

6. Annual Leave

It may be necessary to limit annual leave to sustain services, although it is not proposed to instigate a blanket ban on leave. Time away from work is essential for health and safety reasons and for staff morale. Requests for annual leave will therefore be considered on their own merits giving due consideration to service continuity and patient safety as well as the need to allow staff to recuperate from the intense pressure of a pandemic.

Staff may be requested to cancel annual leave which has been previously authorised. In these circumstances managers will need to discuss with individuals concerned to identify how this may be achieved.

The Trust will reimburse employees for all reasonable expenses incurred in cancelling annual leave arrangements.

7. Working Time Regulations

Full and part time staff may be asked to work additional hours during a pandemic. The Working Time Regulations will remain in force but it is envisaged that application of the regulations will need to be reviewed during a full pandemic.

In general staff should not be asked to work in excess of 48 hours per week, nor work without appropriate rest breaks. In an emergency situation, it is important to ensure that staff continue to receive appropriate rest breaks or compensatory rest and that they are not asked to work more 48 hours on average (per week) over a 26 week reference period, in accordance with the Working Time Regulations.

In recognition that there maybe a significant number of staff for whom the above approach is not practicable even with a 26 week period as due to their specialist skills they are likely to be in heavy demand.

In these cases, individual staff will be asked to voluntarily waive their right to not work more than 48 hours a week to allow for flexibility (and to sign an ‘opt-out’ form) which will be relevant to the Flu Pandemic emergency situation only.

It may be necessary that certain key staff members may be required to work different shift patterns to ensure continuity of service. In these situations managers will be expected to discuss with individuals concerned and take into

account individual circumstances (e.g. single parent families/elderly dependants).

Staff will be approached during the alert phase once the need for them to work longer hours is identified. This 'opt out' will be for the duration of the pandemic only and will not be applied unless necessary.

Staff will not be subject to detriment if they choose not to comply with the request.

8. Redeployment of Staff

All employees will be required to attend work if they are fit and well and able to do so.

All non essential work may be ceased and employees may be called upon either to provide cover or additional support for key essential workers in the event of a flu pandemic under direction or with minimal training being given.

This will include front line clinical staff who will be expected to cover alternative duties as and when required in order to ensure that all essential services are maintained.

Managers receiving re-deployed staff into a department are responsible for ensuring that they undertake a local induction with the employee in accordance with the Trust's Induction, Statutory, Mandatory and Risk Management Policy.

The expectation is that unless any exceptional circumstances e.g. hours of work due to caring responsibilities, location due to transport difficulties etc, are identified by individual staff why they cannot be redeployed to support the maintenance of a service area that the employee will be redeployed for a temporary period of time.

During a pandemic all professional groups have to comply with their professional guidelines. Staff who hold clinical qualifications but who no longer work in clinical roles will be required to move to clinical areas providing their training/registration has been updated. It is the responsibility of the receiving manager to ensure that these requirements are met.

It is essential that all staff should carry their ID cards with them at all times. This will ensure that managers can check the authenticity of staff transferring between departments.

Allied Health Professionals who are not registered with the appropriate professional body cannot work as a Health Professional. They can, however, be utilised in a supportive capacity. If utilised in this way, their role must be clearly identified in order to protect the public.

In some circumstances, a line manager may agree that someone who would otherwise not be able to attend their normal workplace at this time can work productively at home.

A Matrix of all staff has been undertaken to identify key skills, caring responsibilities, travel to work etc and will be utilised to ensure service delivery during the pandemic phase.

In the event of an employee not being able to get to their place of work there may be a requirement for them to present themselves for work at their nearest NHS premises. It is recognised that whilst the Criminal Records Bureau do not endorse portability of CRB disclosures, in the event of a flu pandemic it is the responsibility of the receiving organisation as to whether they will accept a disclosure undertaken by another organisation.

Where employees are unable to attend their normal place of work they are required to notify their manager in the normal manner.

If this situation arises, it is anticipated that individuals with appropriate skills will provide support to hospitals/PCT's nearer to their home locality.

9. Travel

Non essential meetings and journeys will be postponed until a later date and employees should be prepared to cancel meetings at short notice.

Any excess expenditure involved as a result of temporary relocation to SWBH sites or other sites will be met by the Trust under existing excess travel terms and conditions of employment.

Where the major incident involves fuel shortages contingencies should be discussed at team meetings so that car sharing and travel to work contingencies may be planned to ensure continuity of service provision. This may involve ensuring staff supporting high risk patients in the community are prioritised for access to fuel.

10. Study Leave/Training

All planned time off for training and study leave will be reviewed and only essential training days/time will be honoured. "Essential" training days/time is defined as training which is a material and immediate requirement of the needs of the service.

Corporate Induction may be postponed and will re-commence when the pandemic has subsided and staff will be allocated onto the next available course. Managers will need to ensure that all new staff receive a local induction upon commencement.

11. Criminal Records Bureau Checks (CRB)

It is a requirement that any staff who are temporarily redeployed within the Trust will require satisfactory CRB checks to minimise risk to patients. It is the responsibility of the receiving manager to contact the Workforce Directorate to verify that the employee has the relevant clearance requirements. Whilst it maybe necessary for staff to be internally redeployed during the pandemic and additional staff employed, it is essential that relevant checks are maintained to ensure the safe provision of service.

Where there is a requirement for CRB/POCA clearance, it is the responsibility of the receiving manager to ensure that staffs are supervised and not working in isolation with children/vulnerable patients/service users.

In the event of an individual from another Trust presenting for work at the Trust due to being unable to attend their place of work, providing the post they will be undertaking attracts a CRB clearance, the Trust will accept a disclosure undertaken by another organisation providing proof of clearance/appropriate identity check documentation has been received. If proof cannot be obtained managers should NOT commence the individual.

12. Volunteers

During a pandemic, volunteers will be used as additional support in non clinical roles and will be provided with on the job training upon commencement.

Volunteers will need to undertake an Occupational Health clearance and may need to undertake a CRB disclosure dependent upon the role they occupy. Managers need to ensure that all volunteers are issued with an honorary contract to ensure they are covered by the NHS Indemnity Insurance...

13. Staff Absent on Maternity Leave

Staff absent on maternity leave will be asked to consider whether they would be willing to break their maternity leave in order to return to work to provide emergency cover. In the event that staff on Maternity Leave agree to return to work staff will be able to retake the remainder of their maternity leave at a later date. In such cases managers should complete a form documenting the amount of maternity leave taken and the amount left on the return of an employee to work from maternity leave.

14. Students/Trainees

Students/trainees on placement with the Trust undertaking training will be asked to remain with their mentor and asked to work under supervision in wards/clinics/departments during the critical period of a flu pandemic.

Student practitioners will continue under their current line management arrangements.

15. Workforce Policies and Terms & Conditions

NHS Terms and Conditions of Service will remain in place for all staff. All non-statutory functions e.g. undertaking appraisals, will however be postponed for the duration of the pandemic. Incremental progression as a consequence of not undertaking KSF will not be adversely affected.

Any incidents that may warrant formal investigation will also be affected for the duration of a pandemic as conducting investigations and hearings is likely to be impracticable at the height of a pandemic. Employees concerned will be advised to create a written account of their version of events for their own future reference.

Where necessary, suspension from work will need to be used as a precautionary measure pending return to more normal conditions. Once the pandemic is over, any disciplinary or grievance issues will need to be followed up, taking into account the circumstances that prevailed during the pandemic and learning from adverse events.

16. Pay

Managers are required to provide monthly enhancement/additional hours/absence details for payroll purposes using either WEBDE or paper systems in accordance with normal procedures.

Employees should be aware that in the event of a major incident the payroll function may be affected and potentially only basic contractual pay will be made. Any overtime payments or enhancements will be paid after the emergency is over and the Payroll Department has regained the capacity to do so.

Staff may be asked or may volunteer to undertake additional hours to cover services. Directorates will need to agree with members of staff whether these additional hours can be taken back at a later stage or for the hours to be paid.

Employees who are unable to attend their normal place of work, but attend work at another NHS service provider, will continue to receive their normal pay from the Trust.

<u>Redeployed Staff</u>

Where a member of staff has been redeployed into a role with a lower band than their substantive post then they will retain their existing terms and conditions of employment for their normal contractual hours. .

Shift patterns and other working arrangements may need to be revised but unsocial hours provisions and payments will remain in force as per Agenda for Change Terms & Conditions.

Any additional hours worked will be paid at the appropriate nurse bank rate or AfC terms and conditions as appropriate. Acting-up arrangements will be in line with Agenda for Change terms and conditions and Trust procedures

Staff who would not normally receive unsocial hour's payments and/or who would not normally receive overtime payments will be paid at the rate that is equivalent to the role they are undertaking if required to work these hours.

Where staff have been redeployed to another area it will be the responsibility of the receiving manager to complete the necessary WEBDE/Paper monthly payroll return.

17. Occupational Health and Staff Counselling Support Service

Occupational Health Department will provide a health screening service to Trust employees to determine whether staff have been affected by the Flu virus and providing appropriate advice and support.

Staff who are being redeployed to other work areas, and volunteer staff who have not previously worked at the Trust, will also need to be appropriately health cleared.

A staff counselling support service will be available as normal provided by BDMA

It is acknowledged that the Staff Counselling and Support Services may be in high demand due to the anxiety caused by a pandemic and additional service hours may need to be offered as a consequence.

The Trust may require staff members to attend Occupational Health for assessment at any time during a Major Incident to establish contamination or infection issues to minimise risk of further infection or contamination wherever possible.

18. Communication

It is essential that staff maintain communication with their line managers and their team to receive the most up to date information on the progress of any

major incident. The employee/member of staff is equally responsible for ensuring that they are up to date with events.

19. Review of Arrangements

This plan will be reviewed on a regular basis in the light of guidance received nationally. A revised plan will be issued if appropriate.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	NHS Injury Benefits Scheme Award of Permanent Injury Benefit to and Ex-employee of City Hospital NHS Trust
SPONSORING DIRECTOR:	Colin Holden, Director of Workforce
AUTHOR:	Colin Holden, Director of Workforce
DATE OF MEETING:	24 September 2009

SUMMARY OF KEY POINTS:

The Trust Board is asked to consider and approve a request for the payment of a permanent injury benefit to an ex-employee of City Hospital NHS Trust.

The background to the case is discussed in the attached report.

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 authorise the payments detailed in the report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:N/A

Strategic objectives	None
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

Financial	**X**	Initial payment of £370,550.85 plus an ongoing liability of c. £24k per annum.
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		If payment is not approved, the matter will be referred to the Secretary of State. The DH have stated that the Secretary of State will be asked to make a Direction which will oblige the Trust to make the payment.

PREVIOUS CONSIDERATION:

Not previously considered.

Purpose

The Board is asked to authorise the payments detailed in the report.

Introduction and Background

The NHS Injury Benefit Scheme allows for a monetary payment to be made to any NHS employee who is assessed as suffering from a permanent incapacity that is the result of an injury wholly or mainly attributable to their NHS duties.

The staff member concerned was employed as a senior officer by City Hospital NHS Trust. He retired on 12 May 1996.

Following a claim made by him for the payment of Permanent Injury Benefit (PIB) which included a number of appeals he has been awarded PIB. The Trust was not given the opportunity to be represented at these appeals.

The NHS Business Services Agency, which adminsters payments under the scheme, maintains that Sandwell and West Birmingham Hospitals NHS Trust has to assume liability for the arrears and ongoing payment of the award.

Our own legal advice from Counsel is that this is not clear and liability may not fall to this Trust. This view was communicated to the BSA in October 2007.

Unfortunately there have been significant delays in receiving any response from the Business Services Agency.

We have now received written communication from the Department of Health Pensions Policy Unit insisting that liability does fall to this Trust and that a payment of £370,550.85 is made within one month from the date of their letter, i.e. by 4th September 2009. (NB: this deadline has been extended until 5th October 2009).

If payment is not made the matter will be referred to the Secretary of State. The DH have stated that the Secretary of State will be asked to make a Direction which will oblige the Trust to make the payment.

Discussion

Legal advice is conflicting and the only way to resolve this conflict would be via some form of legal review (e.g. judicial review), the possibility for which is entirely theoretical. If we continue to challenge the decision, the Secretary of State will in all probability issue a Direction which we cannot ignore.

It is clear that the Trust and its relevant personnel followed the laid down procedures applicable at the time and every possibility to argue our case was taken. However, all the rulings have not been in our favour.

Recommendation

The Trust should now reluctantly accept liability and the required payment of arrears is should be made immediately. The sum requested at this stage has been accrued in the Trust's

accounts and will not therefore adversely affect the Trust's reported financial performance. The ongoing payments of c £24K per annum should be accepted and paid as and when requested.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Right Care Right Here Progress Report
SPONSORING DIRECTOR:	Richard Kirby, Chief Operating Officer
AUTHOR:	Jayne Dunn, Redesign Director – Right Care Right Here
DATE OF MEETING:	24 September 2009

KEY POINTS:

The paper provides a progress report on the work of the *Right Care Right Here Programme* as at the end of July 2009 and includes a copy of the Right Care Right Here Programme Director's report to the Right Care Right Here Partnership.

The paper covers:

- Progress of the Programme including performance data for exemplar projects against targets for April – May 2009.

PURPOSE OF THE REPORT:

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

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

NOTE the progress made with the Right Care Right Here Programme.

NOTE the proposals to strengthen the service redesign elements of the Programme and to ensure early, strong engagement from clinicians in this.

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

3.1 - Deliver new models of care through the first wave exemplar projects and begin to deliver new models of care for community-based outpatients in the second wave of exemplar specialties.

IMPACT ASSESSMENT:

FINANCIAL	☐	
ALE	☐	
CLINICAL	☑	The Right Care Right Here Programme sets the context for future clinical service models.
WORKFORCE	☑	
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

RIGHT CARE RIGHT HERE PROGRAMME: PROGRESS REPORT AUGUST 2009

INTRODUCTION

The Right Care Right Here Programme is the partnership of S&WBH, 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 August 2009.

This report is in three sections:

a) Overview of the work of the Right Care Right Here Programme
b) Right Care Right Here Exemplar Project Performance for 2008/09 (Appendix 1 – separate spreadsheet)

OVERVIEW

This section provides an overview of the work of the Right Care Right Here Programme. 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 Right Care Right Here Implementation Board meetings. The most significant issues arising this month are as follows:

Project Performance – Appendix 1 shows the performance of exemplar projects (first and second wave) for the period April – June 2009. Five projects rated as 'green' due to over performance in all elements of the project. A number of projects are rated 'amber' because of lack of data (partly due to annual leave) or some under performance issues. Two projects are rated as red. These are:

- Urgent Care – Sandwell, where confirmation of the activity diverted to the Darzi GP Practice in Parsonage Street has not yet been received, and
- Cardiology where there is no data due to there not being a Project Lead yet in place.

Service Redesign Activity - The Strategic Model Of Care Steering (SMOCS) Groups continue to make progress in developing the three key deliverables (Clinical Strategy, Overall Model of Care and Priorities for Service Redesign). Dates have now been agreed for the presentation of these to the Clinical Group through the autumn. The Programme Director met with the SMOCS Chairs on 31st July and this resulted in a number of agreed actions including:

- Additional principles should be added to those agreed by Partnership Board for the Review of the Programme – public engagement and alignment of Programme and Commissioning objectives
- A half day session to be held to identify top 10 areas for service redesign i.e. where clinicians could work more effectively and the current barriers to this being achieved , involving SMOCS Chairs, other key professionals and to include Finance and Commissioning colleagues.

The Clinical Group have agreed to establish a series of Clinical Reviews for a range of clinical specialties, pathways or conditions.

- Each clinical review will be undertaken by the relevant acute hospital specialist, from SWBH and one GP from both Heart of Birmingham and Sandwell PCTs.
- Appropriate input from other clinicians and professionals will need to be identified for each care pathway, specialty or condition.
- Supported by commissioning managers and the Programme Team, these colleagues will use the Map of Medicine care pathway for that specialty, condition or pathway to determine both the current and future care pathway that is required.

- This will include the negotiation and agreement of referral and admission thresholds and triggers to achieve much greater clarity and consistency of clinical approach in the local health and social care economy.

These reviews offer an approach to developing care pathways which is clinically acceptable and likely to attract support from front line clinicians. It offers the potential to provide an agreed set of care pathways for clinicians and professionals to use immediately they are agreed, so that the use of Map of Medicine is introduced with considerable clinical and professional support. In addition, it offers the potential to agree future planned care pathways, designed to be effective within the constraints of affordability, workforce and physical infrastructure, which also attract widespread clinical support. This process will need to work in combination with the outputs from the SMOCS Groups and further service redesign workstreams that are established through the Review of the Programme as these develop.

Review of the Programme - There is a growing view that the size, shape and affordability of the Programme needs to be reviewed in the light of changed economic circumstances facing the NHS. At the a Joint Board meeting in July members agreed provisionally changed Objectives and a set of Principles within which partners will work. Members wanted the partner organisations which were not represented at the meeting to be offered the opportunity to comment on the Objectives and Principles. This has taken place and a revised set of Objectives and Principles were presented to the August meeting of the Partnership Board.

As proposed at the July meeting, a session to develop further the thinking around the Review of the Programme was held on Wednesday 19th August. This included senior executive and clinical representation from all the partner organisations, with the exception of Birmingham City Council. Partners were keen to pursue a range of initiatives which will include consideration of economy-wide systems changes, some 'industrial scale' service redesign projects and crucially an active process to ensure both clinical and professional engagement and early involvement of clinicians and professionals in small scale, local service redesign changes, possibly through the use of the Clinical Review process identified above.

Travel and Access Strategy - The Transport Group is developing a travel and access strategy and has identified the main principles to be used as the basis of the strategy. The analysis of travel times is based on planned acute and primary and community facility infrastructure and so these will need to be confirmed by PCTs before the strategy can be finalised.

RECOMMENDATIONS

The Trust Board is recommended to:

1. NOTE the progress made with the Right Care Right Here Programme.
2. NOTE the proposals to strengthen the service redesign elements of the Programme and to ensure early, strong engagement from clinicians in this.

Jayne Dunn
Redesign Director – Right Care Right Here
17th September 2009

RIGHT CARE, RIGHT HERE PROGRAMME

Project Performance Report April-June 09/10

Key: **CL OPs** Consultant Led Outpatients **NCL Ops** Non Consultant Led Outpatients

PROJECT	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	% Over/ Under YTD	2008/09 Yearend Target	Status	PROJECT LEAD	Comments
URGENT CARE - SANDWELL																		
Target (Attendances)	976	976	976	0	0	0	0	0	0	0	0	0	2,928		11,710		Matthew Dodd SWBH	Activity is below target, explained to be the result of the reduction in hours provided by the clinical assistant and Prime Care since April 2009. Sandwell PCT have formally proposed project closure 30/09/09 and this is subject to continuing discussions.
Actual	842	855	972	0	0	0	0	0	0	0	0	0	2,669					
Variance													**-259**	**-9**				
URGENT CARE - HoB																		
Targets (Attendances):																		
City	2,500	2,500	2,500	0	0	0	0	0	0	0	0	0	7,500		30,000		Mark Curran HOB PCT	Activity below target. Project Lead has advised that additional activity owing to extra GP deployed to assist with swine flu to be added when figures confirmed (estimated 1000 patients June/July)
Actual	2,424	2,433	2,113	0	0	0	0	0	0	0	0	0	6,970					
Variance													**-530**	**-7**				
Primary Care	0	0	0	0	0	0	0	0	0	0	0	0	0		13,000			
Actual	0	0	0	0	0	0	0	0	0	0	0	0	0					
Variance													**0**	**n/a**				
REHAB BEDS - SHELDON																		
Targets:																		
Community - D43 (OBDs)	647	647	646	0	0	0	0	0	0	0	0	0	1,940		7,760		Angela Young HOB PCT	Project exceeding targets overall. Project closure report received at July Programme Delivery Group - decision deferred to next meeting.
Actual	638	783	631	0	0	0	0	0	0	0	0	0	2,052					
Variance													**112**	**6**				
Care Centres (OBDs)	571	571	571	0	0	0	0	0	0	0	0	0	1,713		6,850			
Actual	595	657	592	0	0	0	0	0	0	0	0	0	**1,844**					
Variance													**131**	**8**				
Comm. Alternatives Sub-Acute D47 (?)	0	0	0	0	0	0	0	0	0	0	0	0	0		2625*			
Actual	0	0	0	0	0	0	0	0	0	0	0	0	0					
Variance													**0**	**n/a**				
Comm. Alternatives Rehabilitation (Patient Package)	292	292	292	0	0	0	0	0	0	0	0	0	876		3,500			
Actual	836	977	1,022	0	0	0	0	0	0	0	0	0	**2,835**					
Variance													**1,959**	**224**				
	Note: Target for Community Alternatives Sub-Acute D47 is HoBPCT only - Sandwell target to be agreed.																	
REHAB BEDS - ROWLEY																		Project Lead leaving 18 August, Project Lead temporarily overseen by Chris Gibbs
Targets:																		
Community Step Up - ET Ward (OBDs)	317	317	317	0	0	0	0	0	0	0	0	0	951		3,800		Wendy Godwin SPCT	
Actual	48	231	246	0	0	0	0	0	0	0	0	0	525					
Variance													**-426**	**-45**				
Community Step Down - Mc Ward (OBDs)	642	642	642	0	0	0	0	0	0	0	0	0	1,926		7,700			
Actual	1,526	1,663	1,611	0	0	0	0	0	0	0	0	0	4,800					
Variance													**2,874**	**149**				
STAR (Av Admits)	83	83	84	0	0	0	0	0	0	0	0	0	250		1,000			
Actual	60	77	75	0	0	0	0	0	0	0	0	0	212					
Variance													**-38**	**-15**				
MUSCULOSKELETAL (includes Orthopaedic beds & outpatients, Rheumatology outpatients & Pain Managemen																		Report not submitted - Project Lead on annual leave
Targets:																		
HoB Orthopaedics Triage (NCL OPs)	545	545	0	0	0	0	0	0	0	0	0	0	1,090		6,535		Paul Hazle SWBH	
Actual	641	556	n/a	0	0	0	0	0	0	0	0	0	1,197					
Variance													**107**	**10**				
Sandwell Orthopaedics Triage (NCL OPs)	574	574	0	0	0	0	0	0	0	0	0	0	1,148		6,885			
Actual	585	508	n/a	0	0	0	0	0	0	0	0	0	1,093					
Variance													**-55**	**-5**				
Community Rheumatology (CL OPs)	381	381	0	0	0	0	0	0	0	0	0	0	762		4,564			
Actual	387	397	n/a	0	0	0	0	0	0	0	0	0	784					
Variance													**22**	**3**				
Primary Care Rheumatology (CL OPs)	0	0	0	0	0	0	0	0	0	0	0	0	0		140			
Actual	n/a	n/a	n/a	0	0	0	0	0	0	0	0	0	0					
Variance													**0**	**n/a**				
Community Orthopaedics (CL OPs)	74	74	0	0	0	0	0	0	0	0	0	0	148		889			
Actual	50	4	n/a	0	0	0	0	0	0	0	0	0	54					
Variance													**-94**	**-64**				
Community Pain Management (CL OPs)	59	59	0	0	0	0	0	0	0	0	0	0	118		702			
Actual	11	13	n/a	0	0	0	0	0	0	0	0	0	24					
Variance													**-94**	**-80**				
	Note; Community Pain Management actual activity only includes Lyng activity																	

RIGHT CARE, RIGHT HERE PROGRAMME

Project Performance Report April-June 09/10

PROJECT	MONTH (2008/09) April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	% Over/ Under YTD	2008/09 Yearend Target	Status	PROJECT LEAD	Comments
OPHTHALMOLOGY																		Project Lead leaving 18 August, no Project Lead allocated as yet.
Target (CL OPs)	1,273	1,273	1,273	0	0	0	0	0	0	0	0	0	3,819		15,274		Wendy Godwin	
Actual	1,162	973	1,000	0	0	0	0	0	0	0	0	0	3,135				SPCT	Underperformance partly due to locations still to be identified for additional community clinics.
Variance													**-684**	**-18**				
	Note: June actual excludes Lyng and Rowley - data to follow																	
DERMATOLOGY																		Project Lead leaving October, replacement not confirmed.
Targets:																		
Community (CL OPs)	267	267	267	0	0	0	0	0	0	0	0	0	801		3,198		Kayode	Project exceeding target overall. No venue for Rowley identified. SWBH formally requested
Actual	220	249	251	0	0	0	0	0	0	0	0	0	720				Odetayo	to cease community activity at Soho.
Variance													**-81**	**-10**			HOB PCT	
Community - GPwSI (OPs)	134	134	134	0	0	0	0	0	0	0	0	0	402		1,602			
Actual	178	187	260	0	0	0	0	0	0	0	0	0	625					
Variance													**224**	**56**				
RESPIRATORY																		
Targets:																		
Community - Nurse-led (OPs)	80	80	90	0	0	0	0	0	0	0	0	0	250		1,034		Sally Sandel	Actual activity has exceeded target (includes clinics being undertaken at Sandwell that have
Actual	295	281	153	0	0	0	0	0	0	0	0	0	729				SPCT	been redesigned).
Variance													**479**	**192**				
Primary Care - GP/Nurse/GPwSI (OPs)	0	0	0	0	0	0	0	0	0	0	0	0	0		432			All funding applications made via HoB LDP process in relation to the project have not been
Actual	0	0	0	0	0	0	0	0	0	0	0	0	0					supported which Project Lead has highlighted may impact upon primary care target and
Variance													**0**	**n/a**				future years' activity.
	Note: Primary Care service planned to commence in October																	
ENT																		Project exceeding targets. Work is continuing to develop triggers and thresholds for two
Target (CL Outpatients)	822	822	822	0	0	0	0	0	0	0	0	0	2,466		9,860		Jane Clark	conditions: Hearing loss and Discharging ear / hearing loss. The group is also exploring the
Actual	852	883	978	0	0	0	0	0	0	0	0	0	2,713				SWBH	Rhinology pathway.
Variance													**247**	**10**				
																		Provision of equipment for the development of Community Ear Care Clinics is still an
																		outstanding issue.
CARDIOLOGY																		
Targets:																		Report not submitted by Project Lead - Project Lead is leaving the PCT and as works on a
Community (CL OPs)	0	0	0	0	0	0	0	0	0	0	0	0	0		782			term-time only contract no report expected until September. Confirmation of future
Actual - Rowley & Neptune	n/a	n/a	n/a	0	0	0	0	0	0	0	0	0	0				Ruth Westerby	arrangements for this project being sought via the Programme Delivery Group.
Variance													**0**	**n/a**			SPCT	
Community (NCL OPs)	0	0	0	0	0	0	0	0	0	0	0	0	0		1,867			
Actual	n/a	n/a	n/a	0	0	0	0	0	0	0	0	0	0					
Variance													**0**	**n/a**				
GYNAECOLOGY																		
Target (CL OPs)	89	89	89	0	0	0	0	0	0	0	0	0	267		1,053		Therese	Project slightly overperforming
Actual	100	101	88	0	0	0	0	0	0	0	0	0	289				McMahon	
Variance													**22**	**8**			HOB PCT	
DIABETES																		
Targets:																		Project underperforming. Project Lead investigating.
Community (CL OPs)	553	553	553	0	0	0	0	0	0	0	0	0	1,659		6,635		Olivia Amartey	
Actual	379	463	631	0	0	0	0	0	0	0	0	0	1,473				HOB PCT	
Variance													**-186**	**-11**				
Primary Care (NCL OPs)	0	0	0	0	0	0	0	0	0	0	0	0	0		361			
Actual	n/a	0	0	0	0	0	0	0	0	0	0	0	0					
Variance													**0**	**n/a**				

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:	24 September 2009

SUMMARY OF KEY POINTS:

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

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	
Core Standards	
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 PERFORMANCE MONITORING REPORT - AUGUST 2009

SWBTB (9/09) 180 (a)

EXECUTIVE SUMMARY

<table>
<tr><th>Note</th><th>Comments</th></tr>
<tr><td>a</td><td>Cancelled Operations during August reduced to 0.6% across the Trust, with reductions in the absolute number of cancellations in the majority of specialties.</td></tr>
<tr><td>b</td><td>Overall Delayed Transfers of Care in August reduced to 2.1%, reducing the year to date level to 2.5%. This compares with a level of 3.7% for the corresponding period last year.</td></tr>
<tr><td>c</td><td>Stroke Care - the proportion of patients spending at least 90% of their hospital stay on a Stroke Unit reduced to 55.4% during July. This represents 31 of 56 patients overall during the month. Comparative performance for Quarter 1 nationally (NHS Performance Framework) averaged 52.0%, compared with the Trust's performance of 53.5% for the same period.</td></tr>
<tr><td>d</td><td>Accident & Emergency 4-hour waits - performance during the month of August was 99.2%, with performance for the year to date 99.13%.</td></tr>
<tr><td>e</td><td>Cases of C Diff increased slightly to 15 across the Trust during August, of these a disproportionally greater number (12) were at City. There were no cases of MRSA Bacteraemia reported during the month. The Trust continues to meet National and Local performance trajectories.</td></tr>
<tr><td>f</td><td>Referral to Treatment Time targets for Admitted and Non-Admitted patient care were both met during August. Audiology data completeness improved from the previous month to within the 90 - 100% range for achievement.</td></tr>
<tr><td rowspan="7">g</td><td>CQUIN:</td></tr>
<tr><td>Outpatient source of Referral - Performance remains well within the trajectory set for this target.</td></tr>
<tr><td>Caesarean Section Rate - The overall rate across the Trust increased slightly during August to 21.8%, but remains well within the trajectory set for the period.</td></tr>
<tr><td>Brain Imaging - During the month of August the proportion of patients admitted as an emergency following a stroke who received a brain scan within 24 hours of admission reduced to 50.9%. Year to date performance similarly reduced to 62.9%.</td></tr>
<tr><td>Hip Fracture - During the period to date 88.2% of patients have received an operation within 48 hours of admission with a fracture of the hip. Performance during August was 100%.</td></tr>
<tr><td>Smoking Cessation Referrals - A total of 402 referrals to PCT smoking cessation services have been made during the year to date.</td></tr>
<tr><td>Inpatient Patient Satisfaction Survey - The initial survey as reported previously has as intended informed the future composition of this indicator, with formal assessment against coverage of a further survey scheduled to be conducted later in the year.</td></tr>
<tr><td>h</td><td>Detailed analysis of Financial Performance is contained within a separate paper to this meeting.</td></tr>
<tr><td>i</td><td>Switchboard activity and response time data is included in the report, with comparative data from 2008/09.</td></tr>
<tr><td>j</td><td>
Activity to date is compared with the contracted activity plan for 2009 / 2010.
<table>
<tr><th></th><th>Sandwell</th><th>City</th><th>Trust</th></tr>
<tr><td>IP Elective</td><td>-4.9%</td><td>16.4%</td><td>7.7%</td></tr>
<tr><td>Day case</td><td>8.9%</td><td>6.4%</td><td>7.6%</td></tr>
<tr><td>IPE plus DC</td><td>6.3%</td><td>8.7%</td><td>7.6%</td></tr>
<tr><td>IP Non-Elective</td><td>2.9%</td><td>-0.3%</td><td>1.1%</td></tr>
<tr><td>OP New</td><td>-2.0%</td><td>2.4%</td><td>0.8%</td></tr>
<tr><td>OP Review</td><td>-1.2%</td><td>7.9%</td><td>4.4%</td></tr>
</table>
Overall performance against the various components of the contracted activity plan is reflected in the table opposite. Increases from data presented last month are seen in overall Elective activity (+6.4% to +7.6%), OP New activity (-1.1% to +0.8%) and OP Review activity (+3.2% to 4.4%). Non Elective activity reduced from +3.6% to +1.1%.

When activity to date is compared with 2008 / 09 for the corresponding period
<table>
<tr><th></th><th>Sandwell</th><th>City</th><th>Trust</th></tr>
<tr><td>IP Elective</td><td>-8.6%</td><td>6.6%</td><td>0.6%</td></tr>
<tr><td>Day case</td><td>5.4%</td><td>1.4%</td><td>3.2%</td></tr>
<tr><td>IPE plus DC</td><td>2.7%</td><td>2.7%</td><td>2.7%</td></tr>
<tr><td>IP Non-Elective</td><td>4.7%</td><td>-1.8%</td><td>0.9%</td></tr>
<tr><td>OP New</td><td>4.3%</td><td>9.3%</td><td>7.4%</td></tr>
<tr><td>OP Review</td><td>5.1%</td><td>14.7%</td><td>11.0%</td></tr>
</table>
Overall Elective, Non-Elective and Outpatient activity delivered during the first 4 months exceeds that delivered during the corresponding period last year by the level indicated.
</td></tr>
<tr><td>k</td><td>Nurse Bank and Agency - the number of Nurse Bank shifts worked increased during the month, although there was a more than compensatory reduction in the number of Nurse Agency shifts worked during the same period, as such overall shifts and costs remain within the profile set for the period to date. A reduction in Medical Locum costs is part offset by an increase in Medical Agency costs. Overall spend on agency staff increased to 2.64% in month (2.38% year to date).</td></tr>
<tr><td>l</td><td>2013 completed PDRs have been reported to Learning and Development during the first 5 months of the year. This represents almost 38% of the total for the year.</td></tr>
</table>

SANDWELL AND WEST BIRMINGHAM HOSPITALS CORPORATE QUALITY AND PERFORMANCE MONITORING REPORT - AUGUST 2009

Exec Lead	NATIONAL AND LOCAL PRIORITY INDICATORS			April	May	June	July			August			To Date	TARGET		Exec Summary Note	THRESHOLDS			06/07 Outturn	07/08 Outturn	08/09 Outturn
				Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	09/10							
RW	Net Income & Expenditure (Surplus / Deficit (-))		£000s	162	357	-5	→		364	→		177	1053	1239	2269		0%	0 - 1%	>1%	3399	6547	2535
RK	Cancer	2 weeks	%	93.2	92.9	93.3	→		93.0	→			93.1	=>93	=>93		No variation		Any variation	100	97.1	98.6
		31 Days	%	100	100	99.4	→		100	→			99.8	=>96	=>96		No variation		Any variation	99.9	99.9	100
		62 Days	%	92.6	91.4	88.1	→		86.0	→			89.5	=>85	=>85		No variation		Any variation	99.3	99.7	98.6
RK	Cancelled Operations	Elective Admissions Cancelled at last minute for non-clinical reasons	%	0.5	0.8	1.1	0.8	1.1	1.0	0.6	0.7	0.6	0.8	<0.8	<0.8	a	<0.8	0.8 - 1.0	>1.0	0.9	0.9	1.0
		28 day breaches	No.	0	0	0	→		0	→		0	0	0	0		3 or less	4 - 6	>6	4	0	0
	Delayed Transfers of Care	Total	%	2.2	3.2	2.6	2.3	2.6	2.5	2.0	2.1	2.1	2.5	<3.0	<3.0	b	<3.0	3.0 - 4.0	>4.0	4.0	2.7	3.1
RK	Coronary Heart Disease	Primary Angioplasty (<90 mins)	%	53	82	93							75	80	80		>80	75-80	<75	n/a	63.0	70.5
		Rapid Access Chest Pain	%	100	98.4	100	100			100			99.5	=>98	=>98		>99	98 - 99	<98	99.7	99.6	100.0
		Revascularisation >13 weeks	No.	0	0	0	→		0	→		0	0	0	0		0		>0	0	0	0
		Thrombolysis (60 minutes)	%	no pts	no pts	no pts							no pts	80	80		>80	75-80	<75	57	50	0
DO'D	Stroke Care	>90% stay on Stroke Unit	%	52.6	47.6	61.11	→		55.36	→			53.7	66.5	70	c	+>70	65 - 70	<65	n/a	n/a	36.5
RK	A/E 4 Hour Waits		%	99.3	99.5	99.2	99.2	99.1	99.1	99.3	99.1	99.2	99.13	=>98	=>98	d	=>98		<98	98.20	98.28	98.16
RK	GUM 48 Hours	Patients seen within 48 hours	%	90.2	81.8	89.6	→		89.6	→		91.2	88.6	=>95	=>95		No variation	0 - 10% variation	>10% variation	n/a	n/a	81.0
		Patients offered app't within 48 hrs	%	99.8	100	99.1	→		100	→		100	99.7	100	100		No variation	0 - 10% variation	>10% variation	35.8	80.7	98.3
R0	Infection Control	C. Diff - EXTERNAL (DH) TARGET	No.	14	11	7	5	9	14	3	12	15	61	114	264	e	No variation		Any variation	n/a	355	163
		C. Diff - INTERNAL (LHE) TARGET	No.	14	11	7	5	9	14	3	12	15	61	95	220		No variation		Any variation	n/a	355	163
		MRSA - EXTERNAL (DH) TARGET	No.	2	1	2	0	1	1	0	0	0	6	15	33		No variation		Any variation	61	43	15
		MRSA - INTERNAL (LHE) TARGET	No.	2	1	2	0	1	1	0	0	0	6	10	23		No variation		Any variation	61	43	15
RK	Data Quality	Valid Coding for Ethnic Category (FCEs)	%	94	94	94	→		95	→			94	90	90		>/=90	89.0-89.9	<89	90.0	89.0	87.0
RO	Infant Health & Inequalities	Maternal Smoking Status Data Complete	%	→	→	96.9	→			→			96.9	=>99.0	=>99.0		>99	98 - 99	<98	99.9	99.5	99.9
		Breast Feeding Status Data Complete	%	→	→	99.1	→			→			99.1	=>99.0	=>99.0		>99	98 - 99	<98	98.3	99.8	97.8
		Maternal Smoking Rates	%	→	→	12.3	→			→			12.3	<12.0	<12.0		<12.0	12-14	>14.0	13.2	13.1	12.6
		Breast Feeding Initiation Rates	%	→	→	62.9	→			→			62.9	>57.0	>57.0		>57.0	55-57	<55.0	52.5	55.0	54.2
RK	Patient Access	Inpatients >26 weeks	%	0	0	0	→		0	→		0	0.000	0	0		<0.03		>0.03	1	0	0
		Outpatients >13 weeks	%	0	1 breach	0	→		0	→		0	0.002	0	0		<0.03		>0.03	4	0	5
RK	RTT Milestones	Admitted Care (RTT <18 weeks)	%	98.2	98.5	97.2	→		97.7	→		96.5	96.5	=>90.0	=>90.0	f	=>90.0		<90.0	52.0	90.6	98.6
		Admitted Care - Data Completeness	%	102.5	101.3	101.7	→		101.1	→		102.0	102.0	90-110	<90 or >110		90-110		<90 or >110	n/a	n/a	100.4
		Non-Admitted Care (RTT <18 weeks)	%	98.2	98.7	98.6	→		97.9	→		98.0	98	=>95.0	=>95.0		=>95.0		=<95.0	n/a	95.5	98.8
		Non-Admitted Care - Data Completeness	%	96.2	108.0	101.0	→		109.6	→		105.0	105.0	90-110	<90 or >110		90-110		<90 or >110	n/a	n/a	98.1
		Audiology Direct Access Waits (<18 wks)	%	100	99.7	100	→		100	→		100	100	=>95	=>95		=>95		<95	n/a	n/a	99.0
		Audiology Data Completeness	%	102.0	97.0	91.0	→		84.0	→		91.0	91.0	90-110	<90 or >110		90-110		<90 or >110	n/a	n/a	96.0
		Diagnostic Waits greater than 6 weeks	No.	23	18	23	→		21	→		14	14	0	0		0		>0	996	25	26
DO'D	Mortality in Hospital	Hospital Standardised Mortality Rate	HSMR	104.2 Jan '09	96.8 Feb '09	89.1 March '09	→		82.0 April '09	→		85.5 May '09	83.8	Rate only	Rate only					101.1	100.2	99.0
		Peer (SHA) HSMR	HSMR	101.1	95.5	88.7	→		88.4	→		89.2	89.0	Rate only	Rate only					110.7	106.1	96.5
RK	CQUIN	OP Source of Referral Information	%	0.93	0.87	1.77	→		2.02	→		1.11	1.44	7.5	5.0	g	No variation		Any variation	n/a	n/a	10.0
DO'D		Caesarean Section Rate	%	22.5	22.7	23.9	16.9	23.2	20.5	21.2	22.4	21.8	22.3	26.5	26.0		=<26.0		>26.0	n/a	27.7	27.0
		Brain Imaging for Em. Stroke Admissions	%	61.7	74.2	66.2	→		59.2	→		50.9	62.9	72.0	72.0		=>72.0		<72.0	n/a	n/a	72.0
		Hip Fracture Op's <48 hours of admission	%	89.7	74.9	91.7	→		89.5	→		100	88.2	81.0	87.0		No Variation	0 - 2% Variation	>2% Variation	63.6	70.1	77.8
		Smoking Cesssation Referrals	No.	→		167	40	45	85	89	61	150	402	417	1000		=>83	per month	<83	n/a	n/a	7
RO		IP Patient Satisfaction (Survey Coverage)	%														=>90		<90	n/a	n/a	n/a

Exec Lead	CLINICAL QUALITY			Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust	To Date	YTD	09/10	Summary Note				06/07 Outturn	07/08 Outturn	08/09 Outturn
RK	Readmission Rates	(Within 28 days of discharge)	%	12.0	12.3	10.9	11.0	11.4	11.2				11.4	No. Only	No. Only					10.1	n/a	11.6
		(Within 14 days of discharge)	%	8.6	9.1	8.1	8.4	7.8	8.1				8.3	No. Only	No. Only					n/a	n/a	7.3
R0	Infection Control	Savings Lives Compliance	%	99	99	99	→		99	→		99	99	>95	>95		< YTD target		> YTD target	n/a	n/a	99.0
		Phlebitis Rate	%	1.08	0.97	0.43	→		0.54	→		0.49	0.49	<5	<5		< YTD target		> YTD target	n/a	1.77	
		Phlebitis Compliance	%	76.6	80.7	84.9	→		86.1	→		83.7	83.7	>95	>95		>95%	75-95%	<75%	n/a	78	
		MRSA Screening (Elective)	No.	1822	1692	2007	→		1782	→		1871	9174	No. Only	No. Only		0 - 10%	10 - 15%	>15%	n/a	n/a	6495
		MRSA Screening (Non-Elective)	No.	1074	527	678	→		595	→		332	3206	No. Only	No. Only		0 - 10%	10 - 15%	>15%	n/a	n/a	n/a
DO'D	Obstetrics	Post Partum Haemorrhage (>2000 ml)	No.	1	3	1	0	0	0	1	0	1	6	20	48		=<2	3 - 4	>4	n/a	n/a	
		Admissions to Neonatal ICU	%	6.6	6.3	6.7	3.7	6.3	5.2	4.2	6.1	5.3	6.0	=<10	=<10		=<10	10.0-12.0	>12.0	n/a	9.6	
		Adjusted Perinatal Mortality Rate	/1000	9.5	7.5	17.1	8.0	9.1	8.6	n/a	n/a	n/a	8.6	<8.0	<8.0		<8	8.1 - 10.0	>10	n/a	n/a	
	FINANCE & FINANCIAL EFFICIENCY																					
RW	Gross Margin		£000s	2361	2569	2206	→		2565	→		2382	12083	12237	29805		0%	0 - 1%	>1%	26429	33250	26436
	CIP		£000s	2542	949	949	→		1060	→		1105	6720	7014	15075		0 - 2.5%	2.5 - 7.5%	>7.5%	19679	14027	11084
	In Year Monthly Run Rate		%	9.5	0.3	-102	→		1.11	→		4.12	-15.0	0	0		NO or a + variation	0 - 5% variation	>5% variation	329	45	1.4
RK	Income / WTE		£s	4955	4991	4908	→		4998	→		4917	4949	5127	5127		No variation	0 - 5% variation	>5% variation	5460	4924	5014
	Income / Open Bed		£s	29321	32944	32662	→		32615	→		32904	32422	31184	31184		No variation	0 - 5% variation	>5% variation	24774	29065	30498
	Income per Spell	Total Income	£s	2714	2836	2719	→		2649	→		3082	2801	2762	2762		No Variation	0 - 4% Variation	>4% Variation	2635	2740	2701
		Clinical Income	£s	2456	2561	2448	→		2389	→		2760	2524	2454	2454		No Variation	0 - 4% Variation	>4% Variation	2317	2449	2400
		Non-Clinical Income	£s	258	275	272	→		260	→		322	277	308	308	h	No Variation	0 - 4% Variation	>4% Variation	318	291	301
	Cost per Spell	Total Cost	£s	2700	2803	2720	→		2618	→		3065	2782	2742	2742		No Variation	0 - 4% Variation	>4% Variation	n/a	2643	2682
		Total Pay Cost	£s	1788	1882	1834	→		1751	→		2077	1867	1825	1825		No Variation	0 - 4% Variation	>4% Variation	1772	1737	1785
		Medical Pay Cost	£s	517	547	515	→		506	→		609	538	544	544		No Variation	0 - 4% Variation	>4% Variation	543	517	532
		Nursing Pay Cost (including Bank)	£s	619	666	648	→		605	→		711	650	639	639		No Variation	0 - 4% Variation	>4% Variation	609	615	625
		Non-Pay Cost	£s	912	921	886	→		867	→		988	915	917	917		No Variation	0 - 4% Variation	>4% Variation	n/a	906	897
		Mean Drug Cost / IP Spell	£s	114	110	107	→		114	→		122	113	123	123		No Variation	0 - 4% Variation	>4% Variation	n/a	95	120
		Mean Drug Cost / Occupied Bed Day	£s	56	44	44	→		42	→		48	48	48	48		No Variation	0 - 4% Variation	>4% Variation	n/a	35	47
	PATIENT EXPERIENCE																					
KD	Complaints	Number Received	No.	→	→	228	→			→			228	No. Only	No. Only					673	697	789
		Response within initial negotiated date	%	→	→	75.9	→			→			75.9	85	85		80%+	70 - 79%	<70%	77.4	81.2	81.1
	Thank You Letters		No.	→	→	411	→			→			411	No. Only	No. Only					6026	3491	2912
RK	Elective Access Contact Centre	Number of Calls Received	No.	11985	11244	13516	→		12366	→		11117	60228	No. Only	No. Only					n/a	n/a	190434
		Average Length of Queue	mins	1.14	0.39	0.50	→		1.03	→		1.00	1.00	0.5	0.5		No variation	0 - 10% variation	>10% variation	n/a	n/a	0.44
		Maximum Length of Queue	mins	20.5	13.4	22.5	→		17.5	→		12.5	12.5	6.0	6.0		No variation	0 - 10% variation	>10% variation	n/a	n/a	17.4
	Telephone Exchange	Number of Calls Received	No.	116384	110735	121140	→		93372	→		77550	519631	No. Only	No. Only	i				n/a	1826476	1559688
		Calls Answered	%	79.9	76.0	75.2	→		87.3	→		88.8	80.6	No. Only	No. Only					n/a	81.0	82.3
		Answered within 15 seconds	%	42.8	44.2	43.0	→		48.8	→		46.7	46.7	No. Only	No. Only					n/a	n/a	39.1
		Answered within 30 seconds	%	58.3	56.9	55.9	→		64.5	→		63.0	63.0	No. Only	No. Only					n/a	n/a	55.5
		Average Ring Time	Secs	23.8	22.5	22.6	→		24.9	→		26.9	26.9	No. Only	No. Only					n/a	n/a	28.8
		Longest Ring Time	Secs	1023	741	917	→		741	→		719	719	No. Only	No. Only					n/a	n/a	695
	STRATEGY																					
RK	Referrals	Total By Site	No.	16509	15739	17532	→		17029	→			66809	59832	178070		No Variation	0 - 2% Variation	>2% Variation	138580	151755	178070
		Total GP Referrals	No.	10583	9990	11462	→		10782	→			42817	40457	120138		No Variation	0 - 2% Variation	>2% Variation	98476	95857	120138
		Total Other Referrals	No.	5926	5749	6070	→		6247	→			23992	19345	57932		No Variation	0 - 2% Variation	>2% Variation	40104	55898	57932
		By PCT - Heart of B'ham	No.	4617	4342	4800	→		4747	→			18506	16703	49859		No Variation	0 - 2% Variation	>2% Variation	40394	41628	49859
		By PCT - Sandwell	No.	8405	7894	8870	→		8475	→			33644	29318	87779		No Variation	0 - 2% Variation	>2% Variation	72580	77592	87779
		By PCT - Other	No.	3487	3503	3862	→		3807	→			14659	13811	40453		No Variation	0 - 2% Variation	>2% Variation	25606	32535	40453
		Conversion (all referrals) to New OP Att'd	%	84.5	79.6	81.8	→		84.6	→			82.6	No. Only	No. Only					91.5	87.0	85.9

Exec Lead	ACTIVITY			Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust	To Date	YTD	09/10	Summary Note				06/07 Outturn	07/08 Outturn	08/09 Outturn
RK	Spells	Elective IP	No.	1084	1080	1204	435	750	1185	375	703	1078	5642	5239	13077	j	No Variation	0 - 2% Variation	>2% Variation	13887	13395	13106
		Elective DC	No.	4393	4062	4451	2243	2472	4715	1703	2136	3839	21391	19884	49636		No Variation	0 - 2% Variation	>2% Variation	45831	46304	50873
		Total Elective	No.	5477	5142	5655	2678	3222	5900	2078	2839	4917	27033	25123	62713		No Variation	0 - 2% Variation	>2% Variation	59718	59699	63979
		Non-Elective - Short Stay	No.	1584	1323	1406	712	787	1499	702	750	1452	7862	5612	13745		No Variation	0 - 2% Variation	>2% Variation	12414	11575	12770
		Non-Elective - Other	No.	4255	4453	4338	1973	2460	4433	1561	2124	3685	20415	22362	54971		No Variation	0 - 2% Variation	>2% Variation	52662	55163	56226
		Total Non-Elective	No.	5839	5776	5744	2685	3247	5932	2263	2847	5137	28277	27974	68716		No Variation	0 - 2% Variation	>2% Variation	65076	66738	68996
	Outpatients	New	No.	13948	12521	14333	5197	9208	14405	4132	8275	12407	66426	65926	159666		No Variation	0 - 2% Variation	>2% Variation	127449	131941	152923
		Review	No.	37057	33914	35633	12762	22821	35583	11531	19751	31282	169061	161908	385680		No Variation	0 - 2% Variation	>2% Variation	370970	361113	374867
	A/E Attendances	Type I (Sandwell & City Main Units)	No.	16650	14984	17984	7091	9228	16319	6777	8638	15415	83976	85413	197122		No Variation	0 - 2% Variation	>2% Variation	200561	195093	191141
	A/E Attendances	Type II (BMEC)	No.	2885	3197	2923	→	2854	2854	→	2955	2955	14961	13324	30749		No Variation	0 - 2% Variation	>2% Variation	31373	29803	30800
PATIENT ACCESS & EFFICIENCY																						
RK	Length of Stay	Average Length of Stay	Days	4.6	4.4	4.5	4.6	4.0	4.3				4.4	5.0	5.0		No Variation	0 - 5% Variation	>5% Variation	5.7	5.0	5.0
		All Patients with LOS > 14 days	No.	306	305	257	143	179	322	134	158	292	292	No. Only	No. Only					n/a	345	312
		All Patients with LOS > 28 days	No.	179	161	145	71	83	154	73	84	157	157	No. Only	No. Only					190	174	152
		Min. Stay Rate (Electives (IP/DC) <2 days)	%	92.2	92.4	92.2	93.8	91.3	92.44	93.5	90.2	91.59	92.2	92.0	92.0		No Variation	0 - 5% Variation	>5% Variation	88.3	90.5	91.6
	Admissions	Day of Surgery (IP Elective Surgery)	%	82.4	82.6	86.1	87.0	85.4	86.0	87.6	85.5	86.3	84.4	82.0	82.0		No Variation	0 - 5% Variation	>5% Variation	63.2	76.5	79.4
		Day of Surgery (IP Non-Elective Surgery)	%	72.6	66.2	69.8	63.86	63.72	63.78	69.8	69.58	69.68	68.5	No. Only	No. Only					n/a	68.3	70.2
		With no Procedure (Elective Surgery)	%	9.2	9.2	10.2	13.5	8.3	10.1				9.8	No. Only	No. Only					10.6	n/a	10.6
		Per Bed (Elective)	No.	6.07	4.89	5.27	5.90	7.00	6.47	4.37	5.74	5.08	5.56	5.90	5.90		No Variation	0 - 5% Variation	>5% Variation	4.66	4.87	5.33
	Discharges	Pt's Social Care Delay	No.	15	14	10	6	10	16	5	6	11	11	<18	<18	b	No Variation	0 - 10% Variation	>10% Variation			
		Pt.'s NHS & NHS plus S.C. Delay	No.	8	12	8	2	1	3	1	4	5	5	<10	<10		No Variation	0 - 10% Variation	>10% Variation			
	Beds	Occupied Bed Days	No.	26268	26257	25305	11951	14550	26501	11706	13889	25595	129926	141683	342000		No Variation	0 - 5% Variation	>5% Variation	378060	348676	342793
		Occupancy Rate	%	86.2	83.57	85.71	86.0	84.5	85.2	83.4	85.2	84.3	85.1	86.5-89.5	86.5-89.5		86.5 - 89.5	85.5-86.4 or 89.6-90.5	<85.5 or >90.5	88.6	90.8	90.3
		Open at month end (exc Obstetrics)	No.	986	940	949	465	496	961	462	480	942	942	975	975		No Variation	0 - 2% Variation	>2% Variation	1039	1007	975
	Day Case Rates	All Procedures	%	78.7	79.0	76.3	82.2	75.4	78.5	80.3	73.2	76.2	77.6	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation	76.0	76.9	79.0
		BMEC Procedures	%	76.4	79.5	80.2		80.74	80.74		79.09	79.09	78.9	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation	71.5	77.2	79.7
	Non-Admitted Care	New : Review Rate	Ratio	2.66	2.71	2.49	2.46	2.48	2.47	2.79	2.39	2.52	2.55	2.30	2.30		No Variation	0 - 5% Variation	>5% Variation	2.91	2.74	2.45
		DNA Rate - New Referrals	%	11.8	16.3	15.3	13.5	15.2	14.6	15.6	15.2	15.3	13.8	9.0	9.0		No Variation	0 - 5% Variation	>5% Variation	10.8	10.9	12.0
		DNA Rate - Reviews	%	14.5	14.5	13.8	13.7	12.7	13.1	13.1	12.3	12.6	12.4	9.0	9.0		No Variation	0 - 5% Variation	>5% Variation	12.8	13.5	13.5
	Pathology	Cervical Cytology Turnaround	Weeks	3.8	4.3	4.3	→		3.3	→			3.3	<4.0	<4.0		<4.0	4.0-6.0	>6.0	1.7 - 4.0	1.5 - 2.9	2.7
	Ambulance Turnaround	In Excess of 30 minutes	%	17	17	17	n/a	n/a	n/a	n/a	n/a	n/a	17	<10.0	<10.0		<10	10 - 12.5	>12.5	n/a	29.1	19.0
		(West Midlands average)	%	20	20	19	→		n/a	→		n/a	19	No. Only	No. Only					n/a	31.1	21.0
		In Excess of 60 minutes	No.	7	9	26	n/a	n/a	n/a	n/a	n/a	n/a	26	0	0		0	1 - 5	>5	n/a	n/a	
THEATRE UTILISATION																						
RK	Sitrep Declared Late **Cancellations** by Specialty	General Surgery	No.	6	5	16	8	5	13	1	0	1	41	25	60	a	0-5% variation	5 - 15% variation	>15% variation	n/a	75	104
		Urology	No.	3	1	2	1	3	4	1	0	1	11	20	48		0-5% variation	5 - 15% variation	>15% variation	n/a	67	102
		Vascular Surgery	No.	0	0	1	0	0	0	0	0	0	1	1	3		0-5% variation	5 - 15% variation	>15% variation	n/a	1	7
		Trauma & Orthopaedics	No.	3	0	5	3	8	11	5	2	7	26	30	72		0-5% variation	5 - 15% variation	>15% variation	n/a	100	75
		ENT	No.	0	0	3	0	2	2	0	0	0	5	5	12		0-5% variation	5 - 15% variation	>15% variation	n/a	19	23
		Ophthalmology	No.	9	19	14	6	6	12	1	4	5	59	45	108		0-5% variation	5 - 15% variation	>15% variation	n/a	139	153
		Oral Surgery	No.	2	0	6	0	0	0	0	4	4	12	3	8		0-5% variation	5 - 15% variation	>15% variation	n/a	10	19
		Cardiology	No.	0	1	1	1	0	1	1	0	1	4	9	21		0-5% variation	5 - 15% variation	>15% variation	n/a	28	31
		Gynaecology	No.	3	1	6	3	1	4	3	7	10	24	23	54		0-5% variation	5 - 15% variation	>15% variation	n/a	69	71
		Plastic Surgery	No.	1	0	1	1	4	5	0	0	0	7	5	12		0-5% variation	5 - 15% variation	>15% variation	n/a	17	21
		Dermatology	No.	0	10	1	0	0	0	0	0	0	11	10	24		0-5% variation	5 - 15% variation	>15% variation	n/a	4	24
		TOTAL	No.	27	37	56	23	29	52	12	17	29	201	176	422		0-5% variation	5 - 15% variation	>15% variation	n/a	529	630

Exec Lead	WORKFORCE			Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust	To Date	YTD	09/10	Summary Note				06/07 Outturn	07/08 Outturn	08/09 Outturn
RK	WTE in Post	Total	No.	6178 ▲	6232 ▼	6315 ▼	→		6271 ▲	→		6304 ▼	6304	6363	6241		No Variation	0 - 1% Variation	>1% Variation	6000	5875	6042
		Medical and Dental	No.	759 ▼	756 ▲	744 ▲	→		739 ▲	→		770 ▼	770	777	761		No Variation	0 - 1% Variation	>1% Variation	822	736	755
		M'ment, Admin. & HCAs	No.	1966 ▼	1972 ▲	2015 ▼	→		2016 ▼	→		2050 ■	2050	1998	1952		No Variation	0 - 1% Variation	>1% Variation	1806	1765	1852
		Nursing & Midwifery (excluding Bank)	No.	2317 ▼	2346 ▼	2355 ▼	→		2344 ▲	→		2337 ▲	2337	2583	2547		No Variation	0 - 1% Variation	>1% Variation	2481	2255	2259
		Scientific and Technical	No.	935 ▲	942 ▼	935 ▲	→		949 ▼	→		959 ▼	959	1004	981		No Variation	0 - 1% Variation	>1% Variation	891	869	913
		Bank Staff	No.	201	216	266	→		223	→		188	188	No. Only	No. Only					n/a	250	260
		Gross Salary Bill	£000s	20168 ■	20556 ■	20906 ▼	→		20724 ▲	→		20887 ▲	103241	101997	243342		No Variation	0 - 1% Variation	>1% Variation	220244	219667	238674
RK	Bank & Agency	Nurse Bank Fill Rate	%	86.3	87.7	82.8	→		86.4	→		87.2	86.3	No. Only	No. Only	k				n/a	87.6	81.8
		Nurse Bank Shifts covered	No.	5199 ■	5225 ▼	5136 ▲	→		5261 ▼	→		5370 ■	26191	25765	61836		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	67330	68707	69675
		Nurse Agency Shifts covered	No.	299 ▲	264 ▲	466 ■	→		495 ▲	→		223 ■	1747	2072	4972		0 - 5% Variation	5 - 10% Variation	>10% Variation	2879	5524	4765
		Nurse Bank AND Agency Shifts covered	No.	5498 ■	5489 ▲	5602 ▼	→		5756 ▼	→		5593 ▲	27938	27837	66808		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	70209	74231	74440
		Nurse Bank Costs	£000s	472 ■	536 ▼	529 ▲	→		530 ▼	→		510 ▲	2577	2676	6423		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	6883	6980	6844
		Nurse Agency Costs	£000s	66 ■	24 ▲	24 ■	→		103 ■	→		89 ■	306	413	992		0 - 5% Variation	5 - 10% Variation	>10% Variation	474	1078	832
KD		Medical Agency Costs	£000s	119 ▲	109 ■	277 ■	→		174 ▲	→		238 ▼	917	497	1192		0 - 5% Variation	5 - 10% Variation	>10% Variation	693	1296	2026
RK		Other Agency Costs	£000s	239 ▲	198 ▲	331 ▼	→		240 ▲	→		224 ▲	1231	587	1410		0 - 5% Variation	5 - 10% Variation	>10% Variation	1661	2223	3759
KD		Medical Locum Costs	£000s	256 ▼	200 ▲	174 ■	→		293 ■	→		238 ▲	1161	938	2250		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	2566	2445	2747
RK/KD		Agency Spend cf. Total Pay Spend	%	2.10 ■	1.61 ■	3.02 ■	→		2.49 ▲	→		2.64 ▼	2.38	<2.00	<2.00		<2	2 - 2.5	>2.5	1.50	2.15	2.77
CH	Sickness Absence	Long Term	%	2.50 ▲	2.58 ▼	2.60 ▼	→		n/a	→			2.56	<3.00	<3.00		<3.0	3.0-3.35	>3.35	2.50	3.52	3.16
		Short Term	%	1.09 ▲	1.10 ▼	1.26 ■	→		n/a	→			1.15	<1.25	<1.25		<1.25	1.25-1.40	>1.40	2.17	1.26	1.22
		Total	%	3.59 ▲	3.68 ▼	3.86 ▼	→		n/a	→			3.71	<4.25	<4.25		<4.25	4.25-4.75	>4.75	4.67	4.78	4.38
	Recruitment & Retention	Permission to Recruit	wte	83	72	91	→		79	→		72	397	No. Only	No. Only					n/a	1143	1124
		New Starters	wte	85	69	56	→		54	→		274	538	No. Only	No. Only					n/a	855	1066
		Leavers	wte	36	57	35	→		53	→		245	426	No. Only	No. Only					n/a	1004	999
		Inductions	No.	59	88	72	→		71	→		104	394	No. Only	No. Only					n/a	442	896
	Learning & Development	PDRs (includes Junior Med staff)	No.	227 ▼	337 ▲	460 ■	→		514 ▲	→		475 ▼	2013	2225	5341	l	0-5% variation	5 - 15% variation	>15% variation	n/a	1963	4518
		Mandatory Training	No.	n/a	n/a	n/a	→		n/a	→		n/a			5163		0-5% variation	5 - 15% variation	>15% variation	4313	2770	4044
		Conflict Resolution Training	No.	159 ■	298 ▲	270 ▼	→		253 ▼	→		171 ▼	1151	833	2000		0-5% variation	5 - 15% variation	>15% variation	1441	1712	1050

KEY TO PERFORMANCE ASSESSMENT SYMBOLS

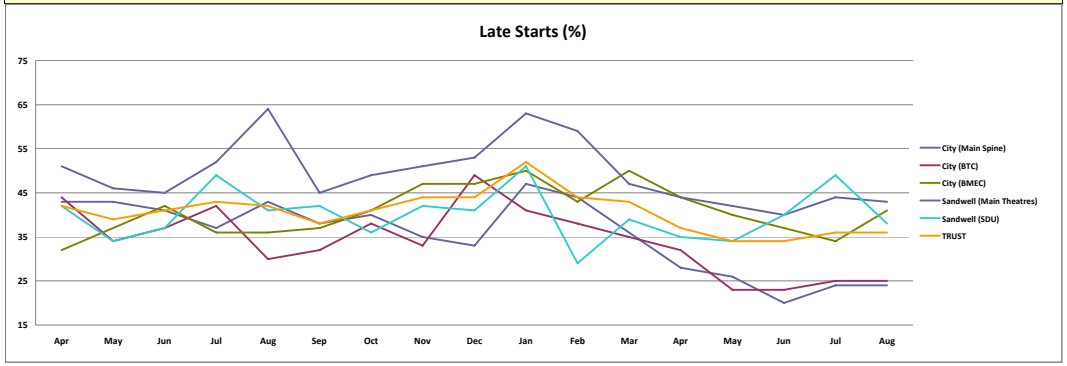
▲	Fully Met - Performance continues to improve
■	Fully Met - Performance Maintained
▼	Met, but performance has deteriorated
▲	Not quite met - performance has improved
■	Not quite met
▼	Not quite met - performance has deteriorated
▲	Not met - performance has improved
■	Not met - performance showing no sign of improvement
▼	Not met - performance shows further deterioration

Please note: Although actual performance within the period may have improved, this may not always be reflected by a symbol which reflects this, if the distance from trajectory has worsened

SUPPLEMENTARY DATA THEATRE UTILISATION

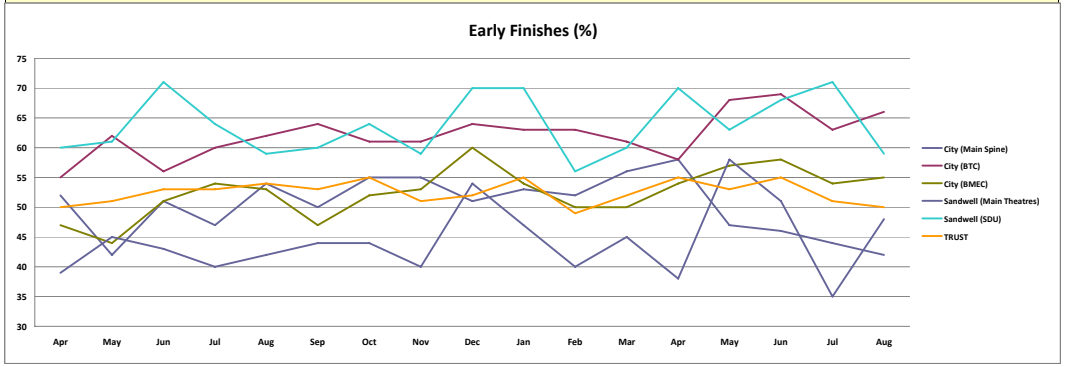
LATE STARTS (%)	2008 / 2009												2009 / 2010				
Theatre Location	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
City (Main Spine)	43	43	41	37	43	38	40	35	33	47	44	36	28	26	20	24	24
City (BTC)	44	34	37	42	30	32	38	33	49	41	38	35	32	23	23	25	25
City (BMEC)	32	37	42	36	36	37	41	47	47	50	43	50	44	40	37	34	41
Sandwell (Main Theatres)	51	46	45	52	64	45	49	51	53	63	59	47	44	42	40	44	43
Sandwell (SDU)	42	34	37	49	41	42	36	42	41	51	29	39	35	34	40	49	38
TRUST	42	39	41	43	42	38	41	44	44	52	44	43	37	34	34	36	36

KEY: GREEN = <5.1% deviation from target, AMBER = 5.1 - 15.0% deviation, RED = >15.0% deviation



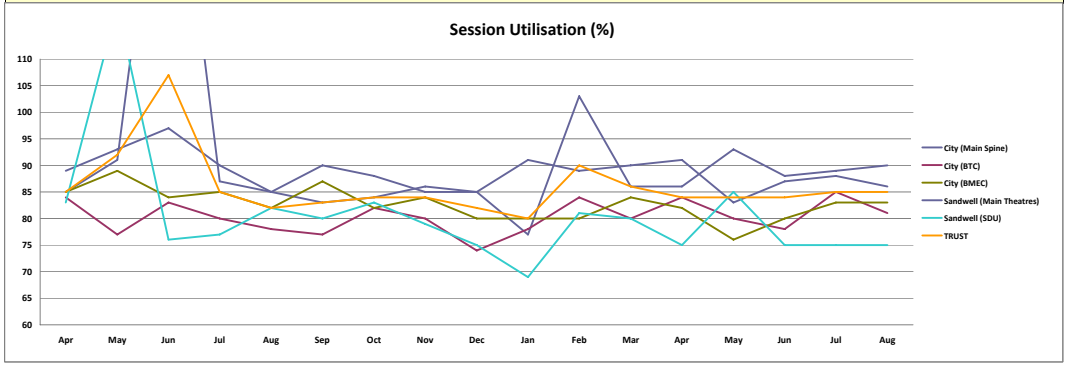
EARLY FINISHES (%)	2008 / 2009												2009 / 2010				
Theatre Location	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
City (Main Spine)	52	42	51	47	54	50	55	55	51	53	52	56	58	47	46	44	42
City (BTC)	55	62	56	60	62	64	61	61	64	63	63	61	58	68	69	63	66
City (BMEC)	47	44	51	54	53	47	52	53	60	54	50	50	54	57	58	54	55
Sandwell (Main Theatres)	39	45	43	40	42	44	44	40	54	47	40	45	38	58	51	35	48
Sandwell (SDU)	60	61	71	64	59	60	64	59	70	70	56	60	70	63	68	71	59
TRUST	50	51	53	53	54	53	55	51	52	55	49	52	55	53	55	51	50

KEY: GREEN = <5.1% deviation from target, AMBER = 5.1 - 15.0% deviation, RED = >15.0% deviation



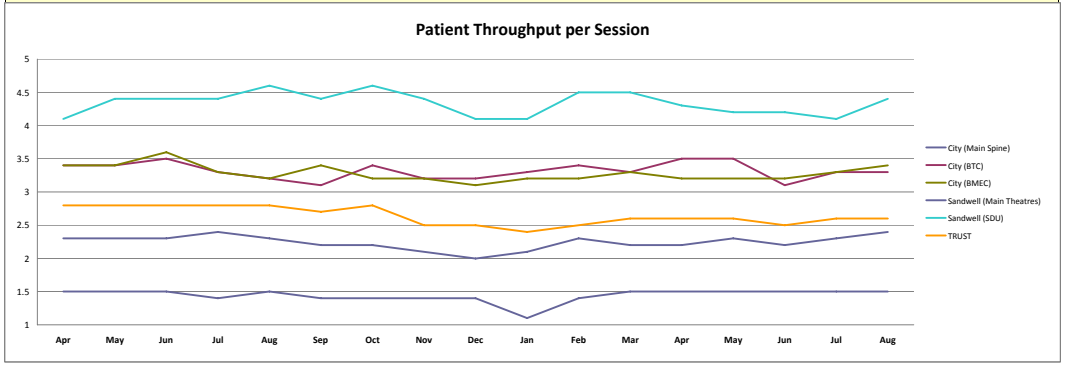
SESSION UTILISATION (%)	2008 / 2009												2009 / 2010				
Theatre Location	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
City (Main Spine)	85	91	165	87	85	83	84	86	85	77	103	86	86	93	88	89	90
City (BTC)	84	77	83	80	78	77	82	80	74	78	84	80	84	80	78	85	81
City (BMEC)	85	89	84	85	82	87	82	84	80	80	80	84	82	76	80	83	83
Sandwell (Main Theatres)	89	93	97	90	85	90	88	85	85	91	89	90	91	83	87	88	86
Sandwell (SDU)	83	120	76	77	82	80	83	79	75	69	81	80	75	85	75	75	75
TRUST	85	92	107	85	82	83	84	84	82	80	90	86	84	84	84	85	85

KEY: GREEN = <5.1% deviation from target, AMBER = 5.1 - 15.0% deviation, RED = >15.0% deviation



THROUGHPUT / SESSION	2008 / 2009												2009 / 2010				
Theatre Location	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
City (Main Spine)	1.5	1.5	1.5	1.4	1.5	1.4	1.4	1.4	1.4	1.1	1.4	1.5	1.5	1.5	1.5	1.5	1.5
City (BTC)	3.4	3.4	3.5	3.3	3.2	3.1	3.4	3.2	3.2	3.3	3.4	3.3	3.5	3.5	3.1	3.3	3.3
City (BMEC)	3.4	3.4	3.6	3.3	3.2	3.4	3.2	3.2	3.1	3.2	3.2	3.3	3.2	3.2	3.2	3.3	3.4
Sandwell (Main Theatres)	2.3	2.3	2.3	2.4	2.3	2.2	2.2	2.1	2.0	2.1	2.3	2.2	2.2	2.3	2.2	2.3	2.4
Sandwell (SDU)	4.1	4.4	4.4	4.4	4.6	4.4	4.6	4.4	4.1	4.1	4.5	4.5	4.3	4.2	4.2	4.1	4.4
TRUST	2.8	2.8	2.8	2.8	2.8	2.7	2.8	2.5	2.5	2.4	2.5	2.6	2.6	2.6	2.5	2.6	2.6

KEY: GREEN = <5.1% deviation from target, AMBER = 5.1 - 15.0% deviation, RED = >15.0% deviation



Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance – Month 5
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Robert white/Tony Wharram
DATE OF MEETING:	24 September 2009

SUMMARY OF KEY POINTS:

The report is provided to update the Board on financial performance for the five months to 31st August 2009.

In-month surplus is £177k against a target surplus of £170k; £7k above plan.

Year to date surplus is £1,053k against a plan of £1,239k, £186k below plan.

In-month WTEs are 61 below plan, excluding the effect of agency staff.

Cash balance is £0.5m above revised plan at 31st August.

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

Approval	Receipt and Noting	Discussion
X	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

- To receive and note the monthly finance report.
- To endorse any actions taken to ensure that the Trust remains on target to achieve its planned financial position.
- To approve the amendments to the capital programme.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Deliver the financial plan including achieving a financial surplus of £2.269m and a CIP of £15m.
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	Reporting and management of financial position.

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

Financial		Potential to fail to meet statutory financial targets.
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		Potential to fail to meet statutory financial targets.

PREVIOUS CONSIDERATION:

Financial Management Board and Trust Management Board on 15 September 2009; Finance and Performance Management Committee on 17 September 2009

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – August 2009

EXECUTIVE SUMMARY

• For the first five months of the financial year, the Trust generated an overall I&E surplus of £1,053k which is £186k less than the planned position. In month, the Trust generated a net surplus of £177k which is £7k better than planned and continues the trend from last month of overall in month performance broadly in line with plan.

• Fully coded and priced activity information is available for July and patient related SLA income included within this report is based on this position.

• At month end WTEs (whole time equivalents) excluding the impact of agency staff were 61 below plan and total pay expenditure £28k above plan. This includes £551k of agency expenditure during August.

• The cash balance is approximately £0.5m better than the revised cash profile.

• All but three operational divisions generated net in month surpluses but these surpluses were eliminated by the relatively high deficits in Medicine A, Surgery B and, to a lesser extent, Medicine B.

Financial Performance Indicators

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	7	-186	> Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	13	-154	> Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	-28	-1,244	< Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	-191	-797	< Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	61	109	< Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	502	502	> = Plan	> = 95% of plan	< 95% of plan
CIP Actual v Plan £000	-31	-294	> 97½% of Plan	> = 92½% of plan	< 92½% of plan

Note: positive variances are favourable, negative variances unfavourable

Performance Against Key Financial Targets

Target	Year to Date Plan £000	Year to Date Actual £000
Income and Expenditure	1,239	1,053
Capital Resource Limit	2,875	1,874
External Financing Limit	---	14,688
Return on Assets Employed	3.50%	3.50%

2009/2010 Summary Income & Expenditure Performance at August 2009	Annual Plan £000's	CP Plan £000's	CP Actual £000's	CP Variance £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's	Forecast Outturn £000's
Income from Activities	329,692	27,700	27,745	45	137,705	139,580	1,875	333,767
Other Income	36,993	3,064	3,251	187	15,322	15,334	12	37,005
Operating Expenses	(338,022)	(28,395)	(28,614)	(219)	(140,790)	(142,831)	(2,041)	(342,069)
EBITDA	28,663	2,369	2,382	13	12,237	12,083	(154)	28,703
Interest Receivable	150	13	7	(6)	63	31	(32)	70
Depreciation & Amortisation	(17,246)	(1,437)	(1,437)	0	(7,186)	(7,186)	0	(17,246)
PDC Dividend	(9,258)	(772)	(772)	0	(3,858)	(3,858)	0	(9,258)
Interest Payable	(40)	(3)	(3)	0	(17)	(17)	0	0
Net Surplus/(Deficit)	**2,269**	**170**	**177**	**7**	**1,239**	**1,053**	**(186)**	**2,269**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – August 2009

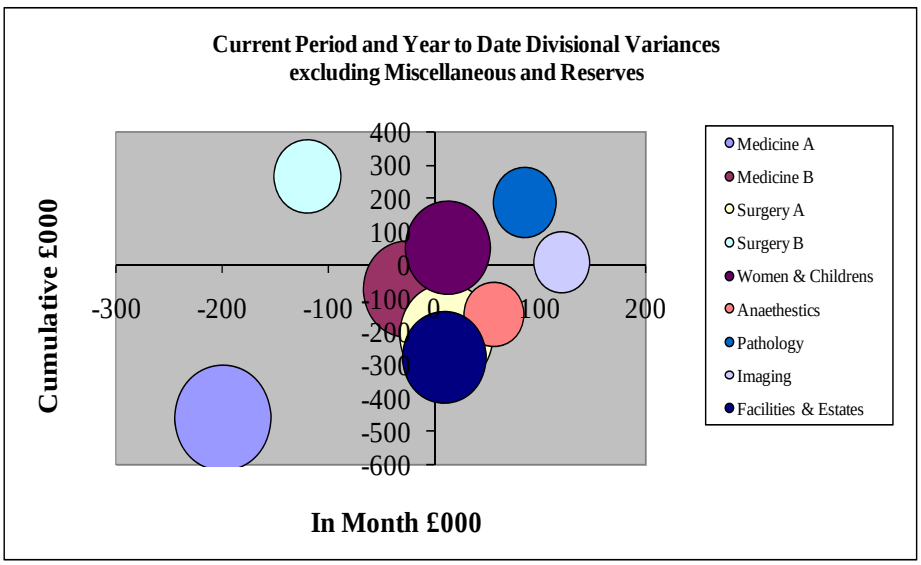
Divisional Performance

• Compared with the previous month, the overall position of the Trust has improved marginally with an in month bottom line performance £7k better than planned. This improvement has primarily been driven by additional income, primarily "other" income (the biggest single contributor to this is pathology tests undertaken for other organisations). Pay performance has been broadly stable in month although this is masked by one off in month budget adjustments and the underlying trend is still one of over spending. The non pay position also continues to deteriorate primarily driven by medical equipment and consumables.

•In month, Medicine A, Surgery B and, to a much lesser extent, Medicine B, have generated deficits. Medicine A's performance continues to be driven by high levels of bank and agency spending and, in month, a sizeable shortfall in patient related income. Surgery B continues to spend in excess of planned levels on waiting list and other additional activity to cope with demand. The downturn in its performance is primarily linked case mix adjustments to income. Medicine B' s position continues to be heavily influenced by high pay costs, including bank and agency.

•The performance for the Trust overall is assisted by favourable budget positions within corporate divisions with a year to date performance of £259k better than plan and £67k in month.

• An additional £69k expenditure was incurred on specific pandemic flu related issues (primarily in Medicine A and Operations) bringing the year to date total to £383k. To date this expenditure has been funded from Trust reserves.



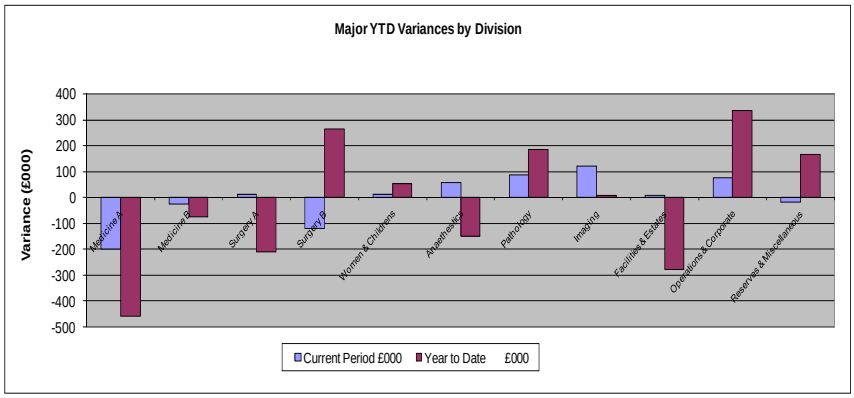
The tables adjacent and overleaf show a mixed position across divisions. Stabilisation of overall performance in August has brought more divisions into or closer to a break even position although some sizeable outliers remain.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – August 2009

Divisional Variances from Plan

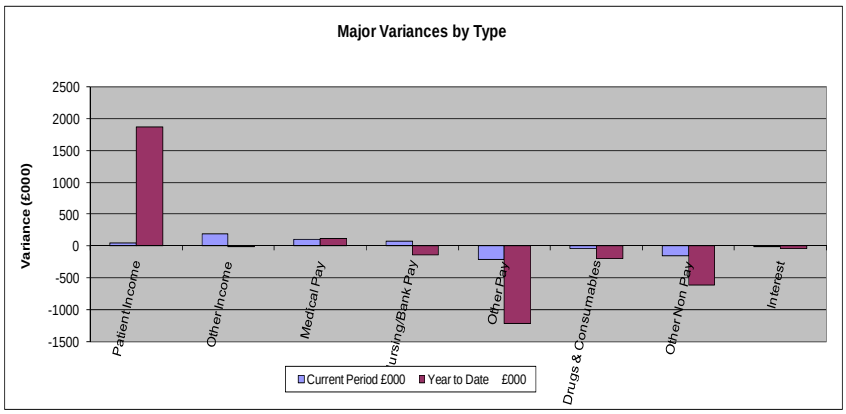
	Current Period £000	Year to Date £000
Medicine A	-200	-458
Medicine B	-25	-75
Surgery A	11	-211
Surgery B	-120	265
Women & Childrens	13	53
Anaethestics	57	-149
Pathology	86	187
Imaging	121	8
Facilities & Estates	10	-277
Operations & Corporate	77	335
Reserves & Miscellaneous	-19	167



The tables below illustrate that overall income has performed better than plan for the year to date, this month primarily driven by income from pathology tests. Although patient related SLAs continue to over perform, these have been slightly adjusted for coding adjustments linked to case mix. Overall pay expenditure is broadly in line with plan for the month although high levels of spend on bank and agency staff continue and significant pressures on pay budgets remain. In month, non pay expenditure is significantly in excess of plan particularly in respect of medical equipment and consumables.

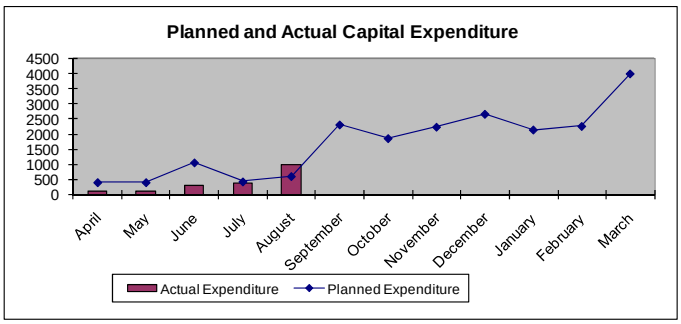
Variance From Plan by Expenditure Type

	Current Period £000	Year to Date £000
Patient Income	45	1875
Other Income	187	12
Medical Pay	100	120
Nursing/Bank Pay	78	-144
Other Pay	-206	-1220
Drugs & Consumables	-33	-190
Other Non Pay	-158	-607
Interest	-6	-32



Capital Expenditure

• Planned and actual capital expenditure by month is summarised in the adjacent graph. Expenditure of £987k was incurred in August mainly relating to the Urgent Care Centre, mixed sex accommodation and statutory standards. This brings total capital expenditure for the year to date up to £1,874k.



Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – August 2009

Proposed Updates to Capital Programme

Proposed additions to and reductions in the capital programme made by SIRG as follows:

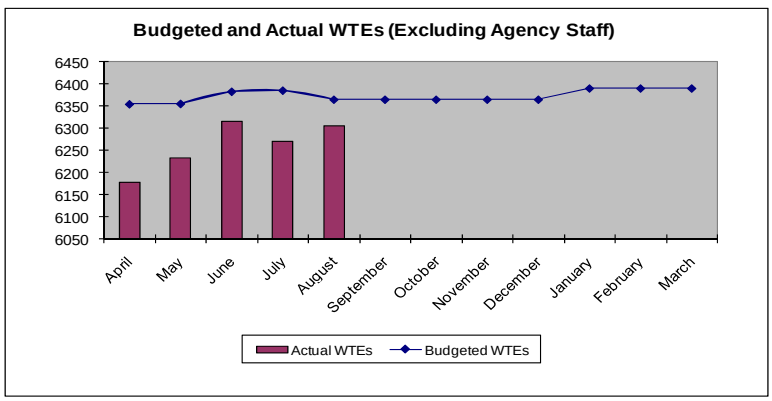
- Refurbishment of city maternity block £400k
- Pathology sample reception £120k
- Rowley out-patient facilities £150k
- Sandwell ESC 2 nd triage room £17k
- Security provision £200k
- Additional medical equipment b/f £1,500k
- Sandwell replacement CT scanner b/f £800k
- Decontamination – Cardiology £95k
- Cardiology – IT expansion £70k
- Neurophysiology out-patients £300k
- Hygiene initiatives £300k
- Pharmacy automation £70k
- MAU redevelopment £645k reduction
- Sandwell capacity changes £540k reduction
- Land purchases £2,028k
- Slippage management (£1,700k)

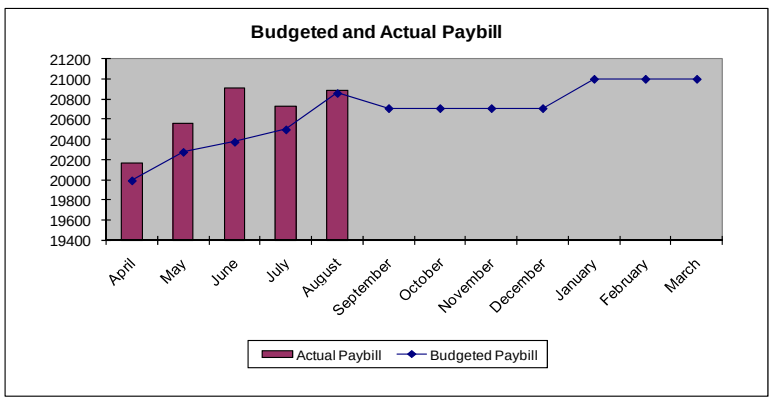
Paybill & Workforce

• Overall workforce numbers (wtes), excluding the effect of agency staff, are 61 below plan for August, which is a reduction on the position for July of approximately 53 wte's. Taking an estimate of the wte effect of agency staff, wte numbers are effectively almost 99 above plan.

•Paybill (including agency staff) is £28k above budgeted levels for the month and £1,244k for the year to date. This represents only a slight worsening in month but the position is improved by one off/backdated funding included in the August position and the underlying trend remains one of significant pay over spending.

•In month expenditure on agency staff was £551k, a further increase of £35k compared with expenditure in July. This compares with a year to date monthly average of £490k.





Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – August 2009

Pay Variance by Pay Group

• The table below provides an analysis of all pay costs by major pay group by removing both bank and agency costs and allocating these into the appropriate main pay group.

•The table demonstrates that the major areas of pay overspend lie within medical staffing and healthcare assistants and support staff, the latter group being broken down primarily into two sub groups: healthcare assistants in clinical divisions and support staff (primarily domestics) within Facilities.

Analysis of Total Pay Costs by Staff Group

	Year to Date to August					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	30,020	29,777		917	30,694	-674
Management	5,781	5,390			5,390	391
Administration & Estates	11,438	11,181		513	11,694	-256
Healthcare Assistants & Support Staff	5,039	4,972	788	611	6,371	-1,332
Nursing and Midwifery	35,882	33,369	1,802	304	35,475	407
Scientific, Therapeutic & Technical	13,818	13,495		108	13,603	215
Other Pay	19	14			14	5
Total Pay Costs	101,997	98,198	2,590	2,453	103,241	-1,244

Balance Sheet

• The opening balance sheet for the year at 1st April reflects the final audited accounts for 2008/2009.

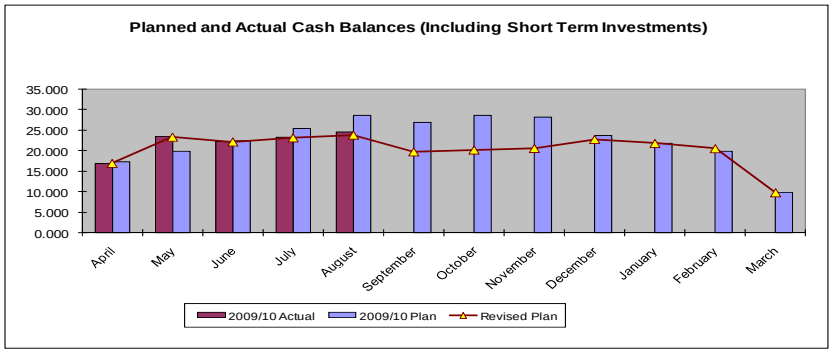
•Cash balances at 31th August are approximately £0.5m higher than the revised plan, driven by slightly higher than planned non SLA receipts (mainly Sandwell PCT paying outstanding lucentis related invoices). The Trust is still planning to hold the same year end cash balance as included in its original financial plan for the year.

Sandwell & West Birmingham Hospitals NHS Trust
BALANCE SHEET

		Opening Balance as at March 2009 £000	Balance as at August 2009 £000	Forecast at March 2010 £000
Fixed Assets	Intangible Assets	547	480	522
	Tangible Assets	255,007	249,695	256,327
	Investments	0	0	0
Current Assets	Stocks and Work in Progress	3,295	3,300	3,300
	Debtors and Accrued Income	20,242	19,186	18,500
	Investments	0	0	0
	Cash	8,752	24,438	9,751
Current Liabilities	Creditors and Accrued Expenditure Falling Due In Less Than 1 Year	(27,328)	(38,852)	(24,753)
	Loan Repayments Due in Less Than 1 Year	0	0	0
Long Term Liabilities	Creditors Falling Due in More Than 1 Year	0	0	0
Provisions for Liabilities and Charges		(7,633)	(4,312)	(5,500)
		252,882	253,935	258,147
Financed By				
Taxpayers Equity	Public Dividend Capital	160,231	160,231	161,047
	Revaluation Reserve	60,699	60,699	63,199
	Donated Asset Reserve	2,531	2,531	2,391
	Government Grant Reserve	1,985	1,985	1,805
	Other Reserves	9,058	9,058	9,058
	Income and Expenditure Reserve	18,378	19,431	20,647
		252,882	253,935	258,147

Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – August 2009



Cash Flow

• The table below shows cash receipts and payments for August 2009 and a forecast of expected flows for the following 12 months.

Sandwell & West Birmingham Hospitals NHS Trust
CASH FLOW

12 MONTH ROLLING FORECAST AT August 2009

ACTUAL/FORECAST	Aug-09 £000s	Sept-09 £000s	Oct-09 £000s	Nov-09 £000s	Dec-09 £000s	Jan-10 £000s	Feb-10 £000s	March-10 £000s	April-10 £000s	May-10 £000s	Jun-10 £000s	Jul-10 £000s	40,391 £000s
Receipts													
SLAs: Sandwell PCT	**13,013**	13,040	13,040	13,040	13,040	13,040	13,040	13,040	13,236	13,236	13,236	13,236	13,236
HoB PCT	**7,195**	7,198	7,198	7,198	7,198	7,198	7,198	7,198	7,306	7,306	7,306	7,306	7,306
South Birmingham PCT	**1,275**	1,264	1,264	1,264	1,264	1,264	1,264	1,264	1,282	1,282	1,282	1,282	1,282
BEN PCT	**1,733**	1,732	1,732	1,732	1,732	1,732	1,732	1,732	1,757	1,757	1,757	1,757	1,757
Pan Birmingham LSCG	**1,213**	1,213	1,213	1,213	1,213	1,213	1,213	1,213	1,231	1,231	1,231	1,231	1,231
Other PCTs	**2,584**	2,496	2,496	2,496	2,496	2,496	2,496	2,496	2,534	2,534	2,534	2,534	2,534
Over Performance Payments	**0**	750	0	0	750	0	0	0	1,000				
Education & Training	**1,295**	1,501	1,501	1,501	1,501	1,501	1,501	1,501	1,523	1,523	1,523	1,523	1,523
Loans	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Interest	**6**	7	6	6	6	6	7	6	11	8	8	8	8
Other Receipts	**3,065**	2,412	2,412	2,412	2,412	2,412	2,412	2,412	2,090	2,090	2,090	2,090	2,090
Total Receipts	31,379	31,611	30,861	30,860	31,610	30,861	30,861	30,861	31,971	30,968	30,968	30,968	30,968
Payments													
Payroll	**12,287**	12,272	12,311	12,350	12,350	12,520	12,520	12,520	12,673	12,673	12,673	12,673	12,673
Tax, NI and Pensions	**8,146**	8,402	8,429	8,456	8,456	8,571	8,571	8,571	8,677	8,677	8,677	8,677	8,677
Non Pay - NHS	**1,581**	2,773	2,465	2,465	2,157	2,465	2,465	3,096	2,490	2,490	2,490	2,490	2,490
Non Pay - Trade	**6,780**	6,789	6,035	6,035	5,281	6,035	6,035	7,579	5,940	5,940	5,940	6,440	6,930
Non Pay - Capital	**959**	462	771	771	771	1,850	2,158	4,932	500	500	500	501	501
PDC Dividend	**0**	4,629	0	0	0	0	0	4,629	0	0	0	0	0
Repayment of Loans	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Interest	**0**	0	0	0	0	0	0	0	0	0	0	0	0
BTC Unitary Charge	**340**	325	325	325	325	325	325	325	335	335	335	335	335
Other Payments	**109**	70	70	70	70	70	70	70	355	355	356	357	358
Total Payments	**30,202**	35,723	30,406	30,472	29,409	31,835	32,144	41,722	30,969	30,969	30,970	31,472	31,963
Cash Brought Forward	**23,261**	24,438	20,326	20,781	21,170	23,371	22,397	21,114	10,253	11,254	11,253	11,250	10,745
Net Receipts/(Payments)	**1,177**	(4,112)	455	389	2,201	(975)	(1,283)	(10,861)	1,001	(2)	(3)	(505)	(996)
Cash Carried Forward	**24,438**	20,326	20,781	21,170	23,371	22,397	21,114	10,253	11,254	11,253	11,250	10,745	9,750

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – August 2009

SLA Performance

•The table below shows a summary of both activity and financial performance for major patient types across the Trust's SLA's. This demonstrates that the majority of the financial gain is the result of higher than planned levels of out-patient activity. Final SLA performance remains subject to data processing rules generated via the CBSA. The Trust has challenged the interpretation of activity performance levels by the CBSA and PCT and is working collaboratively in resolving these.

Year to Date Key Performance Against SLA

PERFORMANCE UP TO JULY	Activity			Finance		
	Planned	Actual	Variance	Planned £000	Actual £000	Variance £000
Accident & Emergency	79,601	80,239	638	5,850	5,886	36
Admitted Patient Care - Elective	20,727	21,870	1,143	18,793	19,404	611
Admitted Patient Care - Non Elective	19,085	19,906	821	30,251	29,667	-584
Excess Bed Days	11,934	12,037	103	2,471	2,410	-61
Other	0	0	0	25,591	25,783	192
Out-Patients First Attendance	53,449	54,864	1,415	8,978	9,144	166
Out-Patients Follow Up	126,313	134,230	7,917	10,972	11,780	807
Out-Patients With Procedure	2,536	7,409	4,873	527	1,667	1,140
Unbundled Activity	4,918	19,303	14,385	3,675	3,712	37
Total	**318,564**	**349,858**	**31,294**	**107,109**	**109,452**	**2,343**

Note: This analysis does not cover all services provided under SLAs

SLA Performance by Commissioner

• The table adjacent shows overall financial performance by commissioner for the Trust's major commissioners. This demonstrates that over performance is spread over a large number of commissioners including specialised service agencies.

Year to Date SLA Performance for Major Commissioners

PERFORMANCE UP TO JULY	Finance		
	Planned £000	Actual £000	Variance £000
SANDWELL PCT	51,691	51,964	273
HEART OF BIRMINGHAM TEACHING	28,701	28,948	247
BIRMINGHAM EAST & NORTH PCT	6,920	6,977	57
SOUTH BIRMINGHAM PCT	5,053	5,531	479
PAN BIRMINGHAM LSCG	4,841	5,362	520
WALSALL PCT	2,146	2,074	-73
WEST MIDLANDS SCT	1,752	1,784	32
DUDLEY PCT	1,505	1,662	156
WORCESTERSHIRE PCT	900	1,021	121
SOLIHULL CARE TRUST	784	892	108
TOTAL	**104,292**	**106,213**	**1,921**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – August 2009

SLA Performance by Specialty

• The table adjacent shows overall financial performance by specialty or service area for those services making the largest contribution to the Trust's net over performance.. This is a summary of all types of activity within any given specialty or service area and includes both admitted patient care and out-patients. It therefore needs to be considered only as broad indication of performance within each area as there may be different issues affecting different patient types within a service.

Year to Date SLA Performance: Major Variances From Plan

PERFORMANCE UP TO JULY	Finance		
	Planned £000	Actual £000	Variance £000
Cardiology	3,399	4,468	1,069
Gastroenterology	1,537	2,467	930
Urology	2,329	2,930	601
Elderly	6,492	6,962	470
Respiratory Medicine	852	1,316	464
Clinical Haematology	1,342	1,763	421
Direct Access	1,707	2,031	323
Other	7,688	7,981	293
ENT	1,716	1,989	274
Rehabilitation	0	251	251
Gynaecology	3,017	3,262	244
Neurology	670	909	239
Ophthalmology	7,767	7,983	216
Paediatrics	3,325	3,536	211
Oral Surgery	336	504	168
Vascular Surgery	795	956	161
General Surgery	6,806	6,450	-356
A&E	6,998	6,502	-496
Trauma & Orthopaedics	8,551	8,008	-543
General Medicine	12,416	9,050	-3,366
TOTAL	**77,746**	**79,319**	**1,573**

Note: the performance of general medicine needs to be viewed alongside other medical specialties with planned general medicine activity actually delivered within medical sub specialties.

Risk Ratings

Measure	Description	Value	Score
EBITDA Margin	Excess of income over operational costs	8.5%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	98.7%	4
Return on Assets	Surplus before dividends over average assets employed	2.1%	2
I&E Surplus Margin	I&E Surplus as % of total income	0.7%	2
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	5.1	1
Overall Rating			**2.2**

Risk Ratings

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

•The only significantly weak area remains liquidity which will only be substantially corrected with the introduction of a working capital facility.

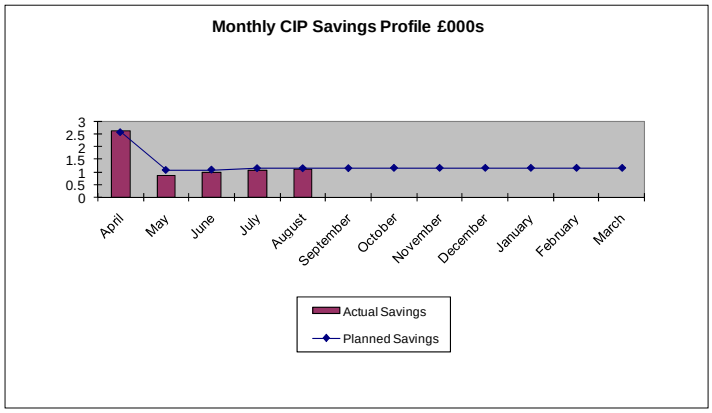
Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – August 2009

Cost improvement Programme

•The adjacent graph shows the monthly profile of the Trust's cost improvement programme and actuals achieved up to July.

•As at August, there is a shortfall against planned levels of £294k or 4.2% which is a significant improvement on the 5.1% shortfall reported for July.



External Focus and Forward Look

• The overall economic climate and public sector financial position remains largely unchanged and the Trust and wider Health Economy must prepare for the well documented reduced health spending after 2010/11. At the moment, the extent to which the NHS will be affected by reductions in public expenditure remains uncertain but what is certain is that future years will include much tighter overall financial settlements than have been experienced in previous years with increased expectations of efficiency and value for money savings.

• For 2011/2012, the first year following the end of the current Comprehensive Spending Review, it is expected there minimal, if any, scope for growth in any health sectors and a realistic expectation of real terms reductions in funding. This will clearly have a significant impact on the local health economy and preparations for this period need to occur over the next 12-18 months.

•Based on performance up to July, Sandwell and West Birmingham Hospitals is also forecasting fairly significant over performance against its Service Level Agreements with PCTs. Although there are still outstanding data challenge issues, this over performance will impact on the financial position of PCTs, particularly if they are experiencing over performance elsewhere in the acute sector. In addition, the Right Care, Right Here proposals are based upon a common understanding and agreement of expected activity levels and the extent to which actual activity, if sustained, is out of line with these assumptions. Consequently, efforts will need to be focussed on moving back towards the agreed activity trends.

• Clearly, if the Trust is to meet its Income and Expenditure target at the end of the year, it is imperative that performance is sustained and improved for the remainder of the year. This particularly applies to pay expenditure which is generally more difficult to control in the shorter term.

• Given the expectation of a very tight financial settlement, particularly from 2011/2012 onwards, it is essential that the Trust is in the best possible financial position to move forward over the next few years. Part of this process will need to be to ensure that underlying financial performance is sound.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – August 2009

Conclusions

•For the year to 31st August 2009, the Trust has generated an overall income and expenditure surplus of £1,053k which is £186k below plan. For the current month, the actual surplus of £177k was £7k above plan.

•Capital expenditure in month has increased significantly although it still remains well below planned levels for the year to date. Amendments to the programme have been considered by SIRG to recover any potential under spending and proposed amendments are included within this report.

•At 31st August, cash balances are approximately £0.5m higher than the revised cash plan.

• Although there has been an improvement in divisional performance, a number of key divisions remain in significant year to date deficit and the performance of these divisions largely offsets the net surpluses being generated elsewhere.

•Expenditure against pay budgets has improved in month with only a marginal over spend against plan. However, this is to some degree masked by one off adjustments to pay budgets in month and the underlying trend is still one of sizeable over spending. Numbers of whole time equivalents (wtes) in post has increased by 33 in month and the variance against budgeted wtes has decreased. Taking into account an estimated effect on wtes of agency staff, wte numbers are almost 100 greater than planned. It remains imperative that staff costs, and particularly the use of agency staff, are realigned to budgeted levels.

•Meetings between operational divisions and the Chief Operating Officer and Director of Finance have been concluded with action plans agreed to rectify problems although review of those divisions still generating significant deficits is ongoing and further action will need to be taken where appropriate. In addition, the actions previously take to slow down expenditure remain in place, specifically strengthening vacancy approval procedures, evaluation of non contracted payments, selective establishment review and an assessment of use of bank and agency staff in targeted areas.

Recommendations

The Trust Board is asked to:

i. NOTE the contents of the report;

ii. ENDORSE actions taken to ensure that the Trust remains on target to achieve its planned financial position; and

iii. APPROVE the amendments to the capital programme outlined above.

Robert White

Director of Finance & Performance Management

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:	24 September 2009

SUMMARY OF KEY POINTS:

The **NHS Performance Framework Monitoring Report** provides an assessment of the Trust's performance mapped against the indicators which comprise the framework. The area of underachievement identified in the report, which relates to July is:

- Stroke (Stay on Stroke Unit) – performance is reported as 55.36%. Performance nationally for this indicator for Quarter 1 averaged 52.0%, compared with the Trust's performance of 53.5%.

Foundation Trust Compliance Report – the overall performance score for August remains 0.4 and the overall Governance Risk Rating remains GREEN.

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	
Core Standards	
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 on 17 September 2009.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2009/10

Operational Standards and Targets

Indicator	Weight	Thresholds		2009 / 2010											
		Achieve	Fail	Q1	Score	Weight x Score	July	Score	Weight x Score	August	Score	Weight x Score	Q2	Score	Weight x Score
A/E Waits less than 4-hours	1.00	98.00%	97.00%	99.39%	3	3.00	99.10%	3	3.00	99.20%	3	3.00			
Cancelled Operations - 28 day breaches	1.00	5.0%	15.0%	0	3	3.00	0	3	3.00	0	3	3.00			
MRSA Bacteraemia	1.00	0	>1.0SD	5	3	3.00	1	3	3.00	0	3	3.00			
Clostridium Difficile	1.00	0%	>1.0SD	32	3	3.00	14	3	3.00	15	3	3.00			
18-weeks RTT (Admitted)	1.00	90.0%	85.0%	98.0	3	3.00	97.7	3	3.00	96.5	3	3.00			
18-weeks RTT (Non-Admitted)	1.00	95.0%	90.0%	98.5	3	3.00	97.9	3	3.00	98.0	3	3.00			
• Achievement in all specialties (inc. DAA Audiology, exc. Orthopaedics)	0.50	95.0%	90.0%	>95.0%	3	1.50	>95.0%	2	1.00	>95.0%	3	1.50			
• Achievement in Orthopaedics	0.50	95.0%	90.0%	>95.0%	3	1.50	97.3	3	1.50	>95.0%	3	1.50			
Cancer - 2 week GP Referral to First Outpatient Appointment	1.00	93.0%	90.0%	93.1%	3	3.00	93.0%	3	3.00	>93.0%*	3	3.00			
Cancer - 31 day second or subsequent treatment (surgery and drug)	0.50	98.0%	94.0%	100%	3	1.50	100%	3	1.50	>98.0%*	3	1.50			
Cancer - 31 day diagnosis to treatment for all cancers	0.50	96.0%	94.0%	99.8%	3	1.50	100%	3	1.50	>96.0%*	3	1.50			
Cancer - 62 day referral to treatment from screening	0.33	90.0%	80.0%	99.8%	3	0.99	>90.0%*	3	0.99	>90.0%*	3	0.99			
Cancer - 62 day referral to treatment from hospital specialist	0.33	90.0%	80.0%	66.70%	0	0.00	>90.0%*	3	0.99	>90.0%*	3	0.99			
Cancer - 62 day urgent referral to treatment for all cancers	0.33	85.0%	80.0%	90.6%	3	0.99	86%	3	0.99	>85.0%*	3	0.99			
3-month revascularisation breaches (as % admissions)	1.00	0.1%	0.2%	0.0%	3	3.00	0.0%	3	3.00	0.0%	3	3.00			
2-week Rapid Access Chest Pain	1.00	98.0%	95.0%	99.50%	3	3.00	100%*	3	3.00	100%*	3	3.00			
48-hours GU Medicine Access	1.00	98.0%	95.0%	99.60%	3	3.00	100.00%	3	3.00	100.00%	3	3.00			
Delayed Transfers of Care	1.00	3.5%	5.0%	2.60%	3	3.00	2.50%	3	3.00	2.10%	3	3.00			
Stroke (Stay on Stroke Unit)	1.00	80%	50.0%	53.50%	2	2.00	55.36%	2	2.00	50 - 80%	2	2.00			
Outpatient Waits >13 weeks (% of First OP Attendances)	0.50	0.03%	0.5%	0.002%	3	1.50	0.000%	3	1.50	0.000%	3	1.50			
Inpatient Waits >26 weeks (% of Elective Admissions)	0.50	0.03%	0.5%	0.000%	3	1.50	0.000%	3	1.50	0.000%	3	1.50			
							*projected			*projected					
Sum	**16.00**					**45.98**			**46.47**			**46.97**			**0.00**
Average Score						**2.87**			**2.90**			**2.94**			**0.00**

Scoring:	
Fail	0
Underachieve	2
Achieve	3

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

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

Financial Indicators				SCORING			2009 / 2010								
Criteria	Metric	Weight (%)		3	2	1	July	Score	Weight x Score	August	Score	Weight x Score	Q2	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	3	0.15	0	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	-0.05%	3	0.6	-0.05%	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.	7.83%	3	0.15	7.79%	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			
	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.	7.77%	3	0.15	7.74%	3	0.15			
	Rate of Change in Forecast Surplus o 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			
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	0.61%	3	0.15	0.61%	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	7.78%	3	0.15	7.75%	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	70.00%	2	0.05	74.00%	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	73.00%	2	0.05	67.00%	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	1.23	3	0.15	1.21	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	17.75	3	0.15	18.88	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	38.83	2	0.1	41.43	2	0.1			
						Weighted Overall Score			2.9			2.9			

*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

DELIVERING SAME SEX ACCOMMODATION

PROGRESS REPORT
SEPTEMBER 2009

INTRODUCTION

The Trust's approach to delivering same-sex accommodation in the light of new tougher standards from the Department of Health was approved at Trust Board earlier in the year. This paper provides a progress report as at September 2009.

DSSA NATIONAL SUPPORT TEAM REVIEW

The Trust received a visit from the DSSA National Support Team in August 2009. Although the team's final report has not been received at the time of writing, their feedback on the day recognised our commitment to this issue and that some progress had been made. They stressed, however, that the Nightingale wards at City presented a particular challenge that we had not yet fully addressed and that the Trust had more work to do to ensure consistently high standards of privacy and dignity and same-sex accommodation across all areas.

Actions in response to the NST's recommendations once finalised will be included in the Trust's broader same-sex accommodation action plan.

REPORTING BREACHES

The Trust's project team has agreed new arrangements for reporting breaches of the same-sex standards so that these can be tracked by TMB and Trust Board. The arrangements put wards / departments into two categories:

- If breaches are not expected (the majority of wards) then if they occur they will be reported as incidents using the IR1 form;

- in a small number of areas there will continue to be breaches until further physical and operational changes are made and these areas will be report through a weekly summary from the DGM.

These arrangements will be launched from Monday 21st September. It is intended to incorporate a summary of breaches into the Trust's monthly performance report from end of October 2009.

PROGRESS WITH ACTION PLAN

The latest version of the Trust's ward level action signed-off by the project team is attached. As will be seen our approach to a small number of areas (theatre recovery and critical care) remains to be finalised but we have made some significant progress in many areas:

- installation of screens for ends of bays on wards at Sandwell Hospital completed on schedule. Work commenced on Sheldon block wards at City;

- agreement that both EAU at Sandwell and MAU at City will operate on same-sex bay policy (apart from the monitored bays at this stage);

- agreement that BTC surgical recovery will operate a same-sex bay policy;

- agreement of approach for children and adolescents.

Major improvements in same-sex accommodation have also been a key consideration in the development of plans for a major refurbishment of MAU at City as part of the capital programme for 2010/11.

Work has also continued on the options for the Nightingale wards at City Hospital including the option of moving to same-sex, mixed specialty wards. The previous Trust Board report identified the main advantages and disadvantages of this approach. The project team is beginning a more detailed option appraisal of three options:

- retain current configuration and focus on high standards of privacy and dignity;

- move all wards to same-sex, mixed specialty model;

- “mix and match” option which retains single-specialty wards where there is a strong clinical case but moves to same-sex wards where appropriate.

This option appraisal will be undertaken during the autumn and it is intended to present the results to the Trust Board in December 2009. At this stage the detail of any national penalties to be imposed for non-compliance may be clearer as will the extent of breaches under current arrangements from our internal monitoring system. A change in ward configuration in advance of this further stage of the work is not recommended.

ENGAGEMENT

A series of engagement events have taken place since July.

- Sandwell PCT, HoB tPCT and NHS West Midlands have been briefed on our progress and our plans.

- Two LiA events have been held for staff to consider what further action can be taken.

- One event has been held and a further event is planned for our FT members to become involved in the discussion.

- Representatives of the Sandwell LINK have visited wards at Sandwell and City. A formal report on their perspectives is expected soon. Members of the Birmingham LINK have been briefed on our plans.

- Discussions have been held with physicians and with the Surgery A clinical directors on the impact of moving to same-sex wards at City.

NEXT STEPS

The most important next steps in this work are:

- to launch the new arrangements for monitoring breaches;
- to continue to address the issues arising from the ward-level action plan;
- to link the DSSA work more closely to wider privacy and dignity work being led by the Chief Nurse;
- to develop the detailed option appraisal of three possibilities for future ward configuration at City comprising (a) status quo (b) move to same-sex, mixed-specialty wards and (c) "mix and match" including increased use of same-sex wards but retaining mixed-specialty wards where judged clinically important to do so.

CONCLUSION AND RECOMMENDATIONS

This report and the accompanying papers have provided a progress report on our work to deliver same-sex accommodation. Trust Board is recommended to:

1. NOTE the progress that has been made and the next steps that are planned
2. REQUEST a further progress report in December 2009.

Richard Kirby
16th September 2009

Sandwell and West Birmingham Hospitals NHS
NHS Trust

DELIVERING SINGLE-SEX ACCOMMODATION
WARD-LEVEL ACTION PLAN

SEPTEMBER 2009

RAG Status

Green: compliant with new standards
Yellow: as compliant as possible within current ward configuration
Amber: not compliant, plan agreed but not yet fully implemented
Red: not compliant / compliance not clear, no plan agreed yet

Summary

Site	Wards / Units				
	Red	Amber	Yellow	Green	Total
City	6	7	14	13	40
Sandwell & Rowley	5	1	0	19	25
Total	11	8	14	32	65

CITY HOSPITAL

Division	Ward / Unit	Current Use	Status / Action Planned	Lead	R/A/G
Surgery A / Anaesthetics & Critical Care	D6	Planned Admissions	Split into separate male and female areas.		
	D17	Male surgery & urology	D17 due to transfer to D30 in Nov 09. Split M / F but shared access. Single-sex use.		
	D25	Female surgery	Single-sex ward		
	D21	Vascular / ENT	Split M / F but shared access.		
	D26	Orthopaedics	Split M / F but shared access.		
	D30	Decant for D16	Current plan for D17 to move to D30 in Nov 09. Split M / F but shared access.		
	D42	SAU	Split assessment / observation areas. Investigating options for screening patients. Plan to be agreed by end Sept.	MB	
	BTC Surgical Unit		Recovery pods now operating on same-sex basis.		

Division	Ward / Unit	Current Use	Status / Action Planned	Lead	R/A/G
	Main Theatres Recovery		Possible changes identified following review. Detail of implementation to be agreed.	CB	
	Critical Care Unit		Separate review of critical care to be arranged in light of guidance – to be done by end September.	RK	
Medicine A	D5	CCU / PCCU	Aiming to create separate male and female sections but with shared access. At least £330k capital required. Timetable TBC.	AB	
	D7	Cardiology	Split M / F but shared access		
	D7b	DC cardiology	Develop plan for to use D7b and D8 as med DC unit – split M/F. Timescales TBC.	AB	
	D8	Poisons Unit	To be transferred to D41 (short stay medicine). Transfer in October 09.	AB	
	D11	Stroke unit	Split M / F but shared access.		
	D12	Side rooms	No issues.		
	D15	Gastro	Split M / F but shared access.		
	D16	Acute Med	Undergoing major refurbishment. Split M / F but shared access.		
	D18	MRSA unit	Split M / F but shared access.		
	D24	Respiratory	Split M / F but shared access.		
	D28	Gen Med	Split M / F but shared access. Single-sex use currently.		
	D29	Renal / Diabetes	Split M / F but shared access.		
	D41	Short Stay	Will accommodate Poisons unit from Oct. Split M / F but shared access.		
	D43	Rehab	Partitions to be added across end of bays by end Sept.	AB	
	D47	Rehab	Partitions to be added across end of bays by end Sept.	AB	
	D48	Dermatology	Separate male and female bays.		
	M8	Medical DC	Separate male and female areas.		
	Hospital Lounge		Include medical DC activity as part of plan for D7b /D8. Detail TBC.	AB	
	Endoscopy – Main Unit		Operational changes required to ensure segregation in existing unit.	AB	
	Endoscopy - BTC		Separate male and female bays.		
	Medical Assessment Unit		Major capital scheme planned. Unlikely to be delivered until autumn 2010. Action agreed to separate bays in the meantime.	RK / AB	
Surgery B	BMEC Theatres recovery		Separate review of theatre recovery at both sites to be arranged in light of guidance.	RK	

Division	Ward / Unit	Current Use	Status / Action Planned	Lead	R/A/G
	Eye Ward		Separate male and female areas.		
Women & Children	M1	ADAU / Transfer Lge	Single sex use.		
	M2	Post natal	Single sex use		
	D19	PAU	PAU reviewed against national guidance. Cubicles available for adolescents.		
	Neo-Natal Unit (L2)		Assume not applicable.		
	D27	Gynaecology	Single sex use.		
Other	D20	Decant	Currently being refurbished. Split M / F but shared access.		
	D14	Renal Dialysis	Not operated by SWBH. ? Need to review for completeness.		

SANDWELL GENERAL AND ROWLEY REGIS HOSPITALS

Division	Ward / Unit	Current Use	Status / Action Planned	Lead	R/A/G
Surgery A / Anaesthetics & Critical Care	N1	Gynae / female surg	Single sex use. But need to consider screens in case of future change of use.		
	N2	Surgery	Complies with guidance.		
	L2	General surgery	Complies with guidance.		
	P2	General Surgery	Complies with guidance.		
	N3	Trauma	Complies with guidance.		
	L3	Trauma	Complies with guidance.		
	Critical Care Unit		Separate review of critical care to be arranged in light of guidance – to be done by end September.	RK	
	Sandwell Day Unit		Initial review identified areas for improvement. Detail to be confirmed. May need broader refurbishment.	CB	
	Main Theatres Recovery		Initial review identified areas for improvement. Detail to be confirmed. May need broader refurbishment.	CB	
Medicine B	P3	Rehab	Complies with guidance.		
	P4	Elderly Care	Complies with guidance.		
	L4	Cardiology	Complies with guidance.		
	N4	Medicine	Complies with guidance.		

Division	Ward / Unit	Current Use	Status / Action Planned	Lead	R/A/G
	N5	Haematology	Complies with guidance.		
	P5	Respiratory	Complies with guidance.		
	L5	Gastro	Complies with guidance.		
	Emergency Assessment Unit		Agreement to move to same sex bays including monitored beds. Timetable to be confirmed.	RK / PTH	
	CCU		Currently 2 x five bed mixed bays – approach to agreed by end September.	RK / PTH	
Women & Children	PG	Paediatrics	Complies with guidance.		
	LG	Paediatrics	Complies with guidance.		
	L1	Paediatrics	Shared bay for adolescents not compliant with guidance. Exploring options.	CP	
	Mat 1	Maternity	Single sex use.		
	Neo-Natal Unit (L1)		Assume not applicable.		
Rowley	ET	Rehab	Already compliant.		
	McA	RCRH beds	Already compliant.		

Richard Kirby
14th September 2009

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Mortality Update
SPONSORING DIRECTOR:	Donal O'Donoghue, Medical Director
AUTHOR:	Donal O'Donoghue, Medical Director Simon Parker, Head of Clinical Effectiveness
DATE OF MEETING:	24 September 2009

SUMMARY OF KEY POINTS:

This paper reviews the systems of assurance with respect to mortality at SWBH and updates the Board in respect of work undertaken by the Mortality Steering Group.

The Board is asked to note that mortality trends have been on a downward trend for some time and that work is being done to understand the reasons for this trend.

Proposed improvements in reporting processes are outlined. There is an expectation that these will be in place from January 2010.

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 NOTE the contents of the report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High quality of care
Annual priorities	
NHS LA standards	
Core Standards	SfBH Core Standard C1a
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:

A summary of this report was considered at the Governance and Risk Management Committee on 17 September 2009

Mortality Update

Introduction

Over the last fifteen months the Trust has been working to overhaul the system for assurance around hospital mortality. A steering group has been established to oversee the development and implementation of a new framework for reviewing mortality within the organisation.

In the period since the last update to the Board in April of 2009, the group has continued reviewing issues and has developed a work plan identifying the key work streams. This plan was approved at a meeting of the group held at the end of June 2009.

Current position

The current system for assurance with respect to mortality has a number of strands.

The board receives the overall hospital standardised mortality rates (HSMR) monthly as part of the Performance Monitoring Report. The data behind the HSMR are analysed in a variety of ways by the Clinical Effectiveness Department and the output of this work is considered by the Mortality Steering Group. It is worth noting that the HSMR for this Trust appears to have followed a downward trend in recent years. For the most recent reported month (May 2009) the HSMR for the Trust was 85.5. (Appendix 1). This compares favourably with an average HSMR for our peer hospitals in this region of 89.2 for the same period.

A similar trend has been observed across the region, although it is not as marked. The Trust is currently undertaking work with the SHA in order to understand the factors that might be influencing these trends.

A second process of assurance involves the serious untoward incident reporting system, which is expected to identify any adverse events leading to patient mortality and to develop appropriate action plans. These are then monitored through the Adverse Events Committee. The Board are sighted on the red incident report and are made aware of any individual cases that might have led to serious or potential harm to patients.

The third strand of assurance relates to our subscription to Dr Foster Intelligence. We receive alerts whenever our mortality rates for particular health-related groups lie outside of an expected range. These alerts do not, of themselves, indicate that there is an issue. This is because the Dr Foster data are highly sensitive to local factors, to coding issues, and to the size of the sample to population.

At the larger population level, the standard mortality ratios are generally accepted to be a reasonable index of the quality of care, at least in the 80% of health-related groups that are included in the Dr Foster calculations. When the data are analysed for much smaller populations, however, such as departments and individuals, the headline rates become much less predictive of the quality of care.

What the alerts do achieve is to prompt a detailed analysis of the cases contributing to a particular alert. At Sandwell and West Birmingham Hospitals NHS Trust, these audits are co-ordinated by the Department of Clinical Effectiveness and are undertaken by clinicians with expertise in the management of the relevant conditions. Where possible, these audits are undertaken by clinicians other than

those looking after the patients in question. The results of these alerts are then fed back to the Medical Director ,Mortality Steering Group and to the Governance Board.

When the last twelve months of data uploaded to the system is examined (July 08 – Jun 09) this shows that, in terms of mortality, 11 diagnoses or procedure groups have alerted.

Of these: **7** were positive alerts suggestive of high quality

4 were negative suggesting areas of potential concern

Of the negative alerts two have been recently notified whilst the investigation into the remaining two are nearing completion. Examination of previous alerts has not identified any significant concerns about the quality of clinical care. The vast majority of alerts relate to patients with terminal conditions in whom either the deaths were expected or for whom there was no hospice provision for terminal care. Many of these patients had DNAR orders in place.

In order to add to the above strands, SWBH applied to join an SHA pilot project for the systematic review of hospital mortality. In October 2008, whilst continuing with existing processes in respect to benchmarked (Dr Foster) data, the Trust received its first reports in respect of the deaths in lower risk patients from the SHA.

These deaths were monitored and reviewed over the next six months. The SHA project was reviewed in January and March 2009. At the last review, a number of observations were made:

- Cases reviewed to date, although identified as low risk by the system, were all expected deaths.

- The use of the global track and trigger tool in this population did identify some minor issues and areas for potential improvement, but was exceptionally labour intensive and did not identify any episodes in the group reviewed in which death might have been avoided.
- It was not clear that this technique for identifying relevant cases added significantly to the assurance already provided through Dr Foster alerts and the incident reporting system.
- It was concluded by at least three of the pilot sites that, in order to provide the best possible assurance, it was necessary to ensure that **all** deaths were reviewed at the specialty level.

Next Steps

In the period since April 2009, the Mortality Steering Group has continued reviewing issues relating to mortality and has progressed the implementation of a robust system for reviewing mortality within the Trust. A work plan identifying the key work streams was approved at the meeting held at the end of June 09

The Steering Group has been working to establish best practice in reviewing mortality data both internally and externally and to ensure that the lessons learnt from national reports are considered when developing local systems. This has involved the piloting of a mortality data extraction form for Dr Foster alerts and the development of specialty specific variants of these forms in some areas.

The Group has also been working to ensure that there are effective systems in place for providing information on deaths to the appropriate specialties. This has included incorporating Directorate specific mortality data into the Quality management Framework Reports.

Further work has surrounded the exploring the infrastructure required to support the initial review of all deaths by Clinical Directors, This has included:

- The feasibility of scanning patient records relevant to a death
- Completion of a data extraction form online
- Provision of central reports supported by a mortality database.

A business case is being developed to support the scanning of death records and to ensure that these are presented to the relevant Clinical Director as soon as possible after a death is reported to the Death Certificate Office.

There are ongoing discussions with the IT departments about the development of a mortality database. This will need to be accepted as a priority development.

Guidance is being developed on how mortality reviews should be conducted, including on feeding back and responding to findings arising from the case reviews.

Data arising from the specialty mortality reviews will be received and evaluated at the mortality steering group, initiating further review or other action as required.

To widen the use of mortality data in the Quality Management Framework for the purpose of Directorate review and to ensure that any action plans are tracked and fed into the adverse events committee.

The aim is to have regular and robust reports from each specialty from January of 2010.

Appendix 1 Specialty Mortality Rates April 2008 – June 2009

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	2008/09 Annual Report on the Handling of Complaints
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Debbie Dunn, Head of Complaints and Litigation
DATE OF MEETING:	24 September 2009

SUMMARY OF KEY POINTS:

- There were 791 formal complaints in 2008/09 compared with 695 in 2007/08
- Of these, 8 (1%) were graded as red, the same as in the previous year
- Of the 715 complaints with a target response time of 25 working days, 81% were responded to on time
- The most frequently occurring area of concern was that of clinical treatment

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: None

Strategic objectives	High quality of care
Annual priorities	
NHS LA standards	Standard 5 'Learning from Experience'
Core Standards	Core Standard C14a-c
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 and Risk Management Committee on 17 September 2009

SWBTB (9/09) 177 (a)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

2008-09 ANNUAL REPORT ON THE HANDLING OF COMPLAINTS

August 2009

1. Introduction

The Trust's aim is to comply with the requirements of the NHS Complaints Procedure and ensure that no difficulties are placed in the way of patients, carers or relatives wishing to complain about the services provided. Our objectives are:-

- To provide an easily understood, accessible system for complainants

- To ensure that information on the complaints procedure and complaint letters are available to complainants in a way that meets their individual needs e.g. a translator attending complaints meetings, sending written information on CD/tape for dyslexic patients etc

- To ensure minor complaints are handled by front line staff, responding sensitively, courteously and promptly to the complainant's needs

- To ensure that all complaints are treated seriously and sympathetically, and actioned within set timescales

- To reassure patients that their treatment will not be affected and that they will not be discriminated against in any way as a result of having made a complaint

- To ensure that all complaints are investigated in an open, non-defensive way and an honest response sent to the complainant. If the Trust has been at fault we will say so and offer an apology

- To give the complainant a full explanation of the outcome of the investigation, in terms the complainant can understand, including actions taken as a result of the complaint

- To meet national targets for timeliness in responding to complaints. Where the Trust is unable to respond within the agreed timescale we will inform the complainant of the reasons

- To ensure that trends and outcomes are monitored as part of the governance process, so that lessons are learned from the complaints received, so improving service quality

- To ensure that complaints are linked to other governance components such as incident reporting and claims investigation

- To ensure that where the Trust makes arrangements for the provision of service with an independent provider, that provider has procedures in place for the handling and consideration of complaints

2. Developments during the Year

The Trust contributed to the Department of Health "Early Adopter" programme and worked with the hospital and primary care Trusts in Birmingham and Birmingham City Council to trial changes to the complaints procedure arising from the consultation document "Making Experiences Count". All of the documentation used by the Complaints Department has been revised in preparation for the new way of working.

The Complaints Policy and documentation on how to complaint has been redrafted to take account of the introduction of the new Regulations from 1st April 2009.

An integrated risk/complaints/claims quarterly report has been developed for the Trust Board.

As part of the Annual Health Check, a self assessment has been undertaken against the Healthcare Commission's Core standards (C14a – c) and full compliance was declared.

3. Demographic Information

Details of the ages of patients at the centre of the complaints and the ethnic background of the complainants/patients are shown in Appendix A.

4. Complaints Received and Response Times

During the reporting period the Trust received 834 complaint contacts as follows:

Standard 25 days	715	Formal complaints with standard 25 working day target time for response
Can't accept	12	Concerns not addressed due to legal action or time elapsed since incident
Fast track < 7 days	25	Straightforward formal complaints dealt with within seven working days
Formal complaint meeting	7	Formal complaint where concerns are addressed firstly at a resolution meeting
General query/feedback	6	Not dealt with formally (concerns/query addressed via letter)
General service feedback	3	Not dealt with formally (concerns/query addressed via letter)
GP/intra NHS concerns	4	Concerns raised by GPs or other NHS organisations/staff members
Referred to Division for action	7	Not dealt with formally (concerns/query addressed via Division)

Resolved by local meeting	3	Not dealt with formally (concerns/query addressed via meeting)
Resolved by telephone	2	Not dealt with formally (concerns/query addressed via telephone)
Negotiated due date	45	Formal complaint with negotiated response date
Property claim referred to Division	6	Basic property loss/damage claims handled at Divisional level

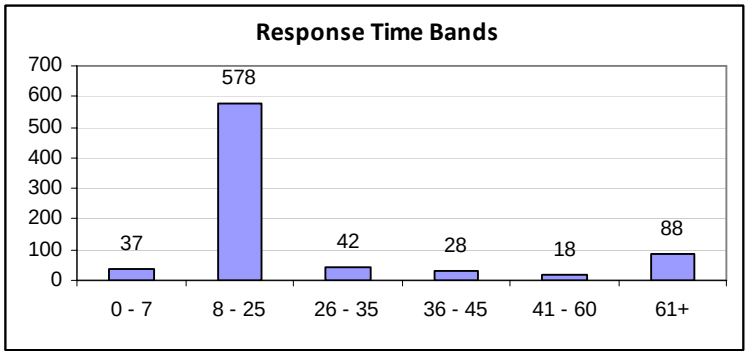
Of these, 791 contacts were considered as formal complaints, compared with 695 in 2007/08.

During the "Early Adopter" process Trusts were encouraged to provide a more flexible and personal local resolution process rather that a "one-size-fits all" approach. A key aspect of this was the option of negotiating a target response timescale with a complainant. This was an acceptance by the Department of Health following extensive consultation that the 25 working day target time was inappropriate and unachievable in the most serious cases. In view of this, direct response-time comparison with the previous years is not possible.

The negotiated target times remain an important feature of the NHS Complaints Procedure that was introduced from the 1st April 2009. The Trust's database has been updated and can now reflect whether - and how often - negotiated target times have been changed. However, that feature was not available for this reporting period.

The response time information available is as follows:

Target of 7 working days (fast track)	88% of complaints
Target of 25 working days (standard)	81% of complaints
Negotiated due dates	Not available



Divisional response times are as follows:-

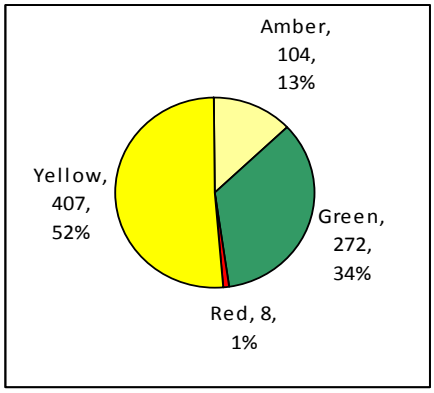
Division	Fast track (7 day target)	Standard (25 day target)	% within 25 day target	Negotiated complaint	Formal meeting
Anaesthetics/CC	1	10	70%	1	0
Development/Cancer	0	10	70%	0	0
Estates	1	9	89%	0	0
Facilities/Nursing & Therapy	3	31	94%	0	0
Finance	0	1	100%	0	0
IM & T	4	33	82%	0	0
Imaging	1	14	71%	1	1
Medicine & EC (A)	6	142	83%	14	1
Medicine & EC (B)	1	127	57%	10	1
Not Applicable	1	3	67%	0	0
Operations	0	3	100%	0	0
Pathology	2	10	80%	0	0
Surgery A	4	130	86%	10	3
Surgery B	1	92	93%	4	0
Women & Child Health	1	98	87%	5	0
Workforce	0	2	100%	0	0

Further information is shown in Appendix B.

Complaints are graded according to their severity and potential future risks to patients and/or the organisation, with red being the most serious. The 791 complaints received were graded as follows:-

Grade	2006/07*	2007/08*	2008/09*
Red	4 (1)	8 (1)	8 (1)
Amber	46 (7)	84 (12)	104 (13)
Yellow	327 (48)	234 (34)	407 (52)
Green	296 (44)	369 (53)	272 (34)

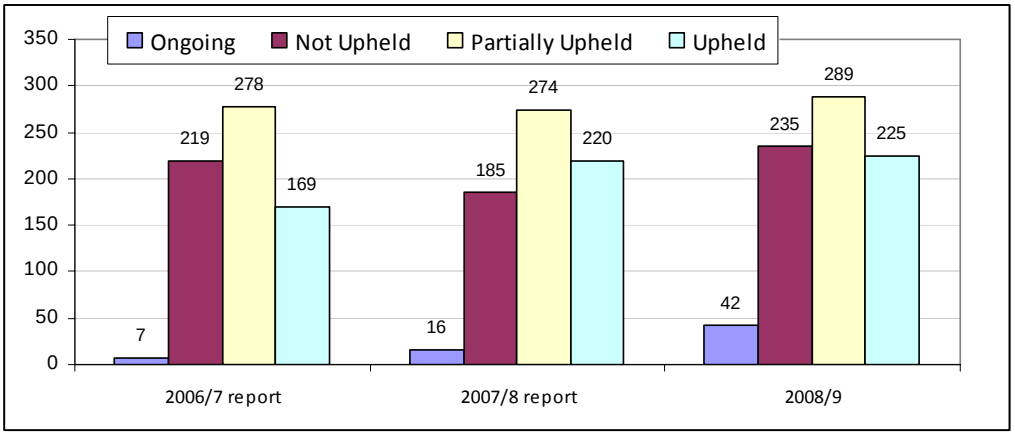
**(figure in brackets shows % of total)*



Following the completion of the complaint responses, the relevant details are sent to the appropriate Division General Managers, to ensure lessons are learned from the complaints and action plans are developed if appropriate.

The action plans for the red complaints are monitored by the Adverse Events Committee (chaired by the Chief Executive), to ensure that the identified action is undertaken. Details of the red complaints are included in Appendix C.

Complaint outcomes were as follows:-



To date, 85 complainants (10.7%) have requested further local review of their concerns following their first response. This compares with a total of 98 (14%) for the previous year. However, there can be a significant delay before complainants contact the Trust after the initial investigation and response. The 2008/9 figures are therefore subject to change.

5. Independent Review Requests

In August 2004 the independent review stage of the complaints procedure was changed, with responsibility for considering independent review requests being undertaken by the Healthcare Commission (HCC) rather than one of the Trust's Convenors. If they remain dissatisfied after the investigation of their complaint at the local resolution stage of the procedure, complainants could contact the Commission within 6 months and request an independent review. This role was taken over by the Health Service Ombudsman from 1st April 2009. Details of the complaints referred to the Commission/Ombudsman are as follows:-

Year	Number of complaints	Number referred to HCC	% referred to HCC
2004/05	689	55	8
2005/06	729	55	7.5
2006/07	673	20	3
2007/08	695	14	2
2008/09	791	5 to date*	0.6 to date

** further referrals may still be made*

Of the 149 complaints referred to the Commission, the outcomes are as follows:-

Outcome	Number	% of the total number referred to the HCC
Investigated by the Commission	2	1.3
Commission to take no further action	23	15.4
Referred back and further local action completed	108	72.5
Referred back and further local action being taken	6	4.1
Withdrawn by complainant	4	2.6
Passed to the Ombudsman as unable to consider the request prior to 31.3.09	6	4.1

The outcomes of the review requests, including the further action required, are monitored by the Adverse Events Committee.

Of the 2 complaints investigated by the Commission, 1 report was received in 2005/06 and details were included in that year's annual report. The report on the second investigation was received in 2006/07 and a detailed action plan was submitted to the Trust Board. Details of the 2008/09 complaints are shown in Appendix D.

6. Analysis of Complaints

The main categories of complaint were as follows:

Type of complaint	2005/6	2006/7	2007/8	2008/9
All aspects of clinical treatment	43.9	42.2	45.8	45.7
Delayed/cancelled appointments	15.5	16.6	15	16
Staff attitude	16.7	12.3	11.2	9.3
Communication Breakdown	6.7	8.3	5.9	5.6

Of the main four categories, complaints about staff attitude continue to decrease slightly year-on-year, whilst most areas remained largely stable. However, complaints about personal records (3% for this reporting period) and property (1.6%) were tripled and doubled respectively, albeit from relatively low starting points.

The top ten complaints areas for the Trust are:-

Area	2007/08	2008/09	% change
Accident & Emergency (S)	60	51	- 15.0
Ophthalmology (C)*	56	48	- 14.3
Accident & Emergency (C)	37	42	13.5
Trauma & Orthopaedics (S)	15	32	113.3
Trauma & Orthopaedics (C)	16	27	68.8
Contact Centre (C)	15	21	40.0
General Medicine (S)*	19	18	- 5.3
Accident & Emergency (Eye)	5	17	240.0
General Surgery (S)*	9	15	66.7
Gynaecology (C)*	18	14	-22.2

The 2 major issues complained about in the Divisions/Directorates which received more than 10 complaints are shown in Appendix E.

7. Informal Complaints and Thank You Letters

An integral part of the complaints procedure is the resolution of minor complaints at local level, without the need for the formal complaints process. In addition, thank you letters have been received praising the care and commitment of the Trust's staff. Details are as follows:-

	2006/07	2007/08	2008/09
Informal complaints	167	161	91
Thank you letters	6026	3531	2912

The apparent reduction is largely due to the arrangements for the recording of thanks you letters not being systematically followed.

8. Actions Arising from Complaints

The types of action identified can include raising awareness; improving systems or facilities; staff counselling; supervision or training; follow up arrangements for patient care; and new or revised policies and procedures. Examples of the identified actions are as follows:-

- Signage to the eye centre reviewed to ensure that clear directions given

- Staff reminded of the importance of informing patients of any delays in clinic and the reason for the delay

- Concerns regarding the location of the infertility service in the ante-natal clinic will be addressed by the relocation of the clinic. System put in place to prevent repeated cancellations of appointments

- Staff reminded to be aware of their body language and of how their actions can be perceived by patients/relatives

- Staff to ensure that allergies are documented and that the patient is given a red wrist band

- Nursing staff to be reassessed to verify their competence when triaging patients

- Plasma screen to be placed in the waiting room to explain the triage process

- Staff to undertake customer care training

- Bathrooms to be upgraded

- A supported practice programme to be introduced to address staff attitude and behaviour

- Raise awareness of the Mental Capacity Act and the relevant training

- Booking rules amended to reduce clinic numbers

- Advice card to be developed in the Fracture Clinic on the care of wounds

- Doctor made aware of missed diagnosis and scenario to be used as a learning case for junior doctors

- Senior nursing team on the ward reorganised and clear responsibilities allocated to each nurse; staff meeting held to discuss attitudes towards relatives; letter sent to staff outlining the improvements required

- Clinical Director to discuss consent issues with doctor

- Learning points discussed at risk education meetings

- Leaflets re-issued to GP practices with details of locations/times for taking blood for fasting patients

- Trial started of nurse handover sheet; customer care training booked; documentation audits arranged; discharge checklist to be introduced

- Missed fracture discussed with the junior doctor and regular review of x-rays with junior doctors

- Additional orthopaedic theatre sessions introduced

- Attitude and general approach to the management of the patient discussed with the junior doctor

- Care discussed with the junior doctor and explained that a further specialist medical opinion should have been obtained

- Failure to follow the correct procedure discussed with member of staff and work to be monitored

- Attitude discussed with receptionist and work to be monitored

- Additional sessions introduced for the reporting of x-rays

Actions are monitored within the Divisions to ensure that they are undertaken.

9. Questionnaires.

A questionnaire is sent out with most complaints (it is not sent to the relatives of deceased patients), asking for the complainants' views on how their complaint was handled. A reply paid envelope is also sent. Of the questionnaires that were sent out 162 (approximately 23%) were returned, compared with 25% in the previous year.

An analysis of the completed questionnaires is as follows.

Question	**Categorisation**				
	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
Satisfied with speed of response	11% (15%)	53% (53%)	9% (6%)	16% (10%)	11% (16%)
Felt that there was too long without contact from the Trust	10% (14%)	26% (17%)	10% (11%)	43% (47%)	11% (11%)
Thought that the response answered the concerns raised	15% (13%)	34% (42%)	13% (9%)	17% (20%)	21% (16%)
Did not understand the letter because it contained medical terms that were not explained	3% (1%)	5% (6%)	12% (8%)	49% (49%)	31% (36%)
Feel that my concerns have been listened to	17% (16%)	31% (36%)	15% (15%)	20% (15%)	17% (18%)
Feel that the findings of the investigation were fair	`10% (12%)	37% (34%)	19% (20%)	19% (15%)	15% (19%)

Figures in brackets are for 2007/08

Whilst it is difficult to draw conclusions from such a small sample, it appears that the majority of the complainants who completed the questionnaire were satisfied with the complaint handling process.

10. National and Local Comparison

Figures for 2008/09 have not yet been published by the Department of Health and 2007/08 figures have been used. Comparisons with local Trusts for 2007/08 are as follows:-

Trust	Number of complaints	% completed within target
Sandwell and West Birmingham	695	81
Heart of England Foundation Trust	Not available	
Dudley Group	415	77
Royal Wolverhampton Hospitals	449	93
University Hospitals Birmingham	572	92
Walsall Hospitals	262	97
Total for England	87,080	75

Comparisons with other Trusts receiving over 650 complaints are shown in Appendix F.

Nationally, 40% of complaints were about clinical treatment, 13% were about appointment delays/cancellations, 9% were about communication, 12% were about staff attitudes and 5% were about admissions/discharges.

11. Developments during 2009/10

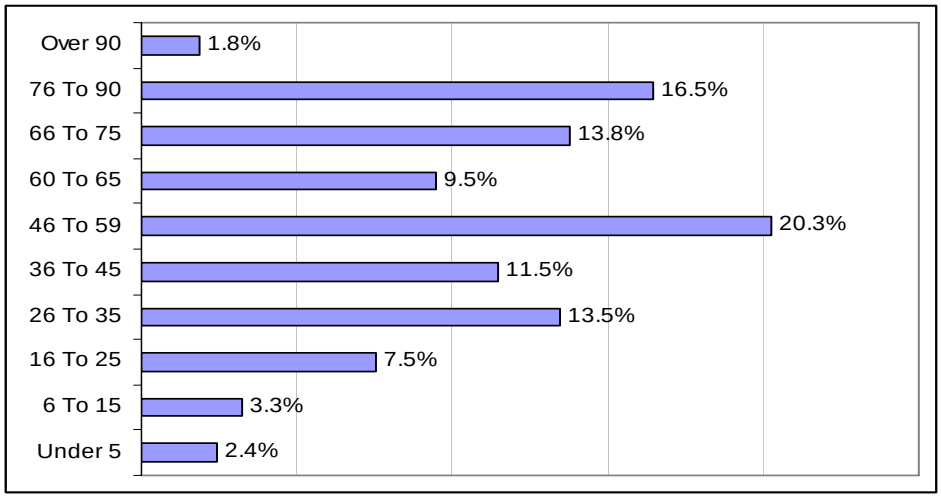
Key developments for 2009/10 are as follows:-

- Maintain compliance with the Care Quality Commission's core standards for complaints
- Ensure compliance with the NHSLA Risk Management Standards on complaint handling
- Review the changes made to implement the revised Regulations and make any required amendments
- Remind Divisions/Departments of the reporting arrangements for informal complaints and thank you letters, to ensure that they are adequately recorded

Appendix A:

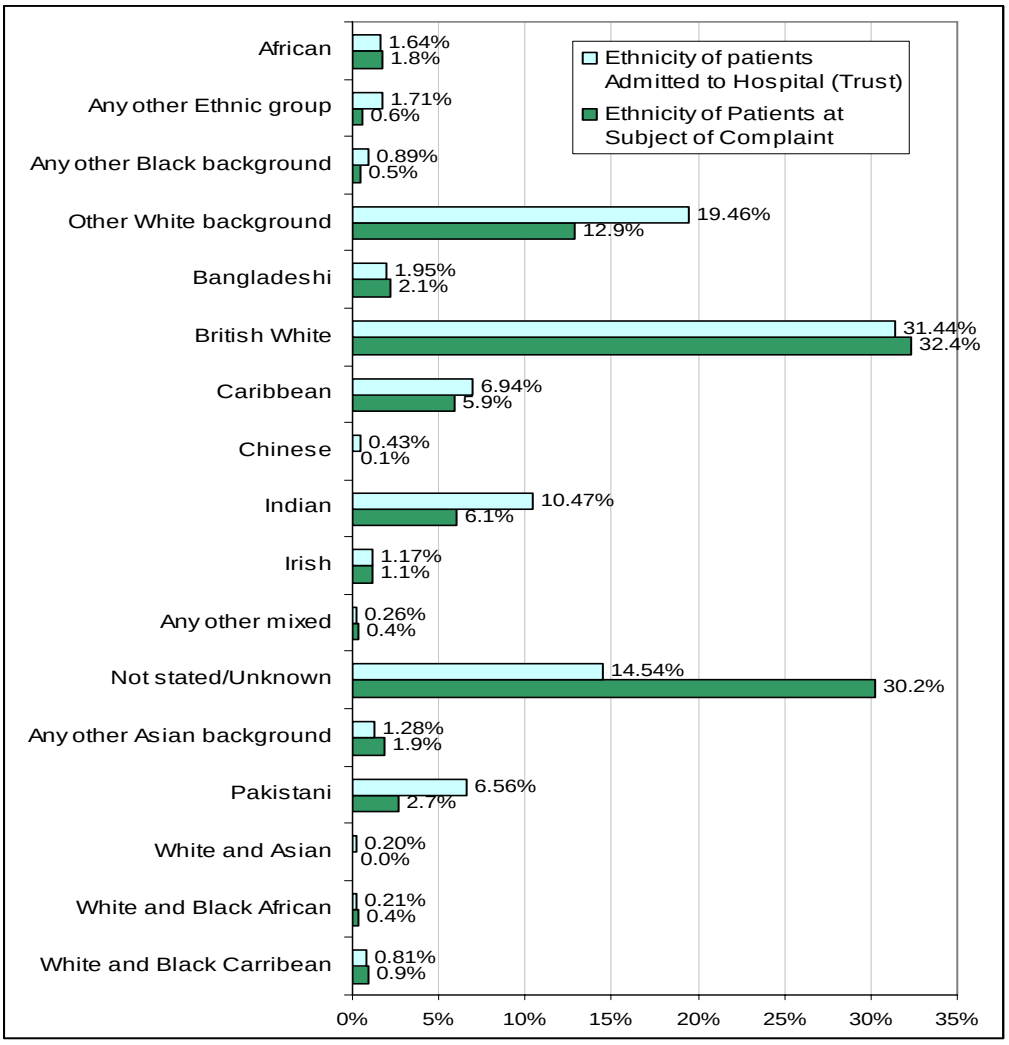
Demographic Information

(1) Age profile of patients at subject of complaint



The age profile is broadly consistent with previous reporting periods.

(2) Ethnic profile of complainants



This graph illustrates, broadly speaking, the ethnic profile of patients at the subject of complaint compared to the ethnicity of all patients. However, the graph should be treated with caution. In particular, not all complaints relate to patients and thus the higher “not stated” figure may disguise the overall ethnicity findings.

The graph suggests that the complaints process is accessible by all groups. Notably, though, patients with an Indian and Pakistani background appear to be slightly under-represented. This is consistent with the 2007/8 data. It is extremely difficult to assess the significance of this. For assurances purposes it may be worth taking further advice from the Trust’s Equality and Diversity team.

Appendix B:

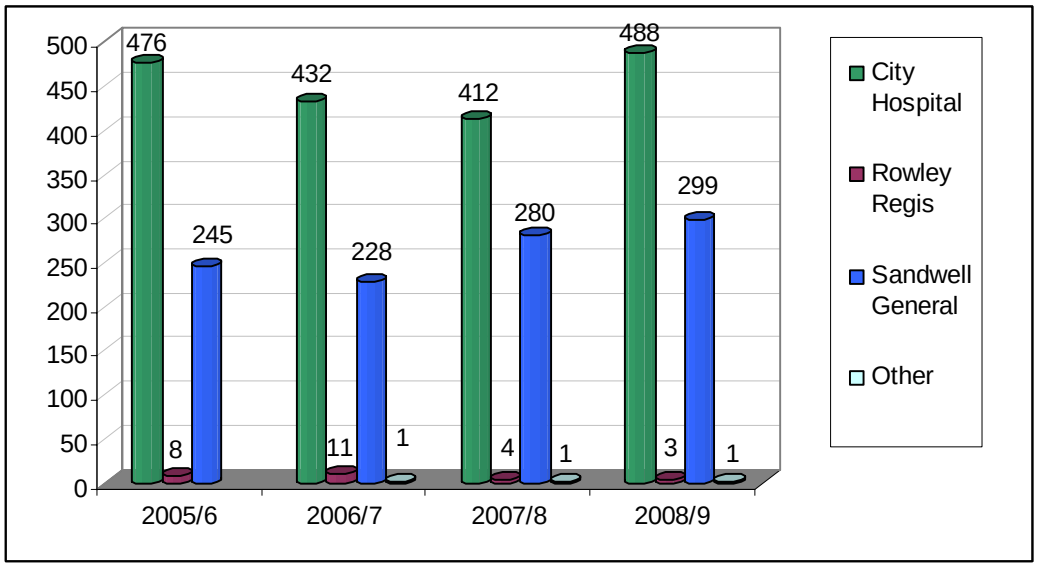
More Detailed Analysis of Complaints

Number of complaints received by quarter

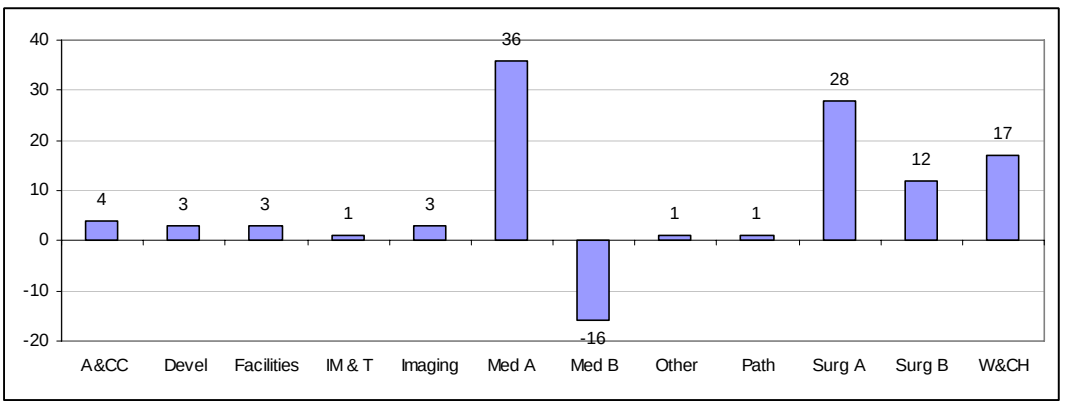
Period	2005/6	2006/7	2007/8	2008/9
April to June	175	155	168	173
July to September	170	175	164	226
October to December	184	166	166	185
January to March	200	176	200	207
Total	729	672	698	791

Complaint volumes across all quarters were higher than previous experienced. However, July to September was particularly acute (with 57 complaints relating to concerns about medical treatment).

Breakdown by Hospital Site



Details of the Key Changes in Complaints by Division/Directorate



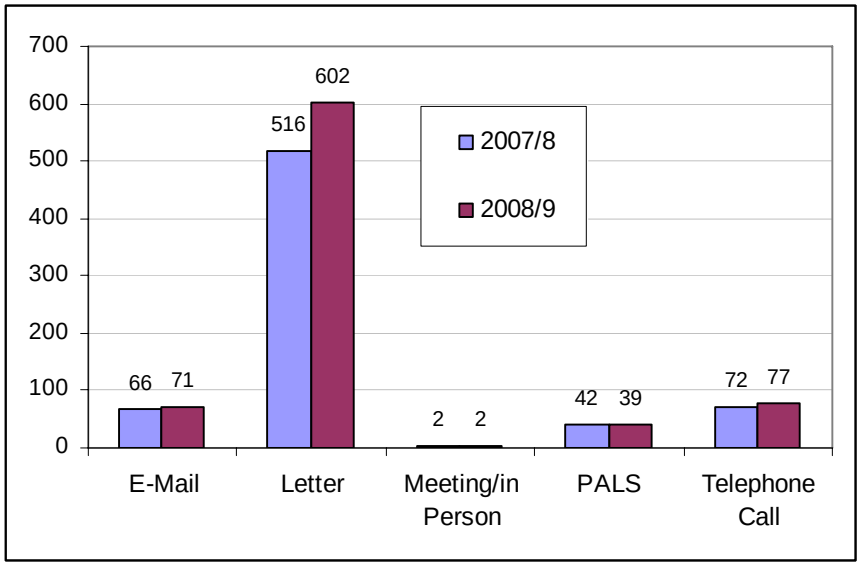
1 The Medicine A divisional figures reveal a general across-the-board increase in complaints without any notable trends.

2 For Surgery A, much of the increase can be accounted for by concerns relating to Trauma and Orthopaedics (30 for 2007/8 compared to 59 in this reporting period).

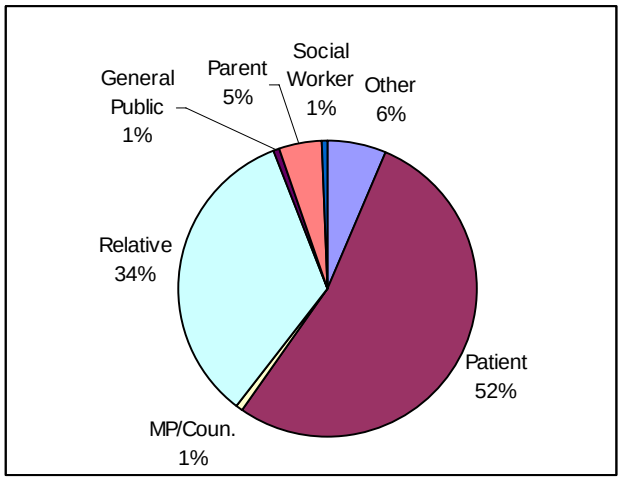
3 For Surgery B, the primary source of the increase was due to an increased number of issues relating to the A&E Department in the Birmingham and Midland Eye Centre (5 for 2007/8, compared to 16 in this reporting period).

4 For Women and Child Health, the increases appear to have been primarily seen in the Labour Wards on both sites (6 for 2007/8 compared to 23 in this period).

Information on how people have complained



Information on who has complained



APPENDIX C

ACTIONS ARISING FROM RED COMPLAINTS

Complaint ref	Complaint issues	Actions arising
FC7/769	Lack of follow up following DVT; lack of nursing care; poor communication	Action plan being developed
FC8/105* Also a red clinical incident and a Coroner's Inquest	Failure to diagnose fractured skull on first attendance. Returned the following day and fracture diagnosed. Patient died the following day	• Audit compliance in A&E with NICE head injury guidance • Review practice for managing patients presenting with a head injury • Re-circulate head injury guidance to junior doctors and nursing staff • Provide training sessions to A&E clinical staff on the appropriate management of head injuries • Consider the use of a head injury stamp to ensure that the relevant documentation is completed • Inform nursing staff that it is not appropriate for untrained HCAs to be taking observations for patients with head injuries
FC8/178* Also a red clinical incident and is now the subject of litigation	Baby in poor state at birth and subsequently died on NNU	• Cross-site arrangements made for bleeping emergency teams using 2222 • Place posters of the bleeping system in all clinical areas and discuss at team meeting to ensure that staff are aware • Include details of the bleeping system in the communication guideline and doctors' handbook • Update fetal monitoring guideline • Supervisory investigation and supervisory review of staff to take place • Discuss lessons learnt at internal meetings
FC8/243* Also a red clinical incident	Several admissions for reduced fetal movements. Concerned that not induced at 40 weeks. Concerns not listened to. Baby died	• Care pathway to be developed for patients with symphysis pubis dysfunction • Day assessment unit guidelines to be updated • Diabetic guideline to be updated • All patients who present repeatedly to

		triage should be referred to the consultant midwife for a counselling session
FC8/442* Also a red clinical incident	Developed C.Diff colitis and subsequently died	• Discuss primary care antibiotic prescribing policies with the prescribing lead for the PCT • Review the C.Diff policy to provide a more robust multidisciplinary approach in response to the new draft national guidelines
FC8/848 Also a red clinical incident	Hoist injury to patient. Relatives not informed of this	• Remind staff of the importance of recording the location of a patient as well as date/time of entry • Discuss issue of lack of medical ownership of D18/D12 and lack of access to junior medical staff on D18. discuss options for medical cover of D29 patients • Remind staff of the importance of carrying out moving and handling assessments • Targeted training in the use of hoists for wards D12, 18 28 and 29 to ensure the correct use of equipment • Ensure process in place for the supply of all sizes of slings • Discuss frequency of swabbing of wounds to check for infection
FC8/772	Lack of follow up following chest x-ray showing localised pleural thickening	Action plan being developed
FC8/892* Also a red clinical incident	Management of labour and delay in delivering the baby. Mother suffered a ruptured uterus and the baby subsequently died on NNU	• Review system for ensuring that all locum medical staff have an appropriate induction and access to appropriate senior support • Review middle grade labour ward cover • Review role of shift co-ordinator • Supervisory follow-up meeting with midwife • Present case internally to ensure awareness of learning points • Review dissemination of guidelines and provide further training as appropriate

*these complaints were also investigated as red clinical incidents. There were no issues arising solely as a result of the complaint investigation and the actions arising are the main issues identified following the red incident investigation.

Appendix D

INFORMATION ABOUT THE 2008/09 COMPLAINTS REFERRED TO THE HEALTHCARE COMMISSION

Division/complaint ref	HCC recommendation	Trust response
Medicine and Emergency Care B FC8/127	HCC unable to consider prior to 31.3.09 and papers passed to the Ombudsman	N/A
Medicine and Emergency Care A FC8/191	Complainant should be reimbursed in full for the lost hearing aid rather than the 50% offered by the Trust	Cheque sent to the complainant
Medicine and Emergency Care B FC8/252	CCTV footage of the relevant V&A incident to be reviewed to determine if the previous interpretation was reasonable	Letter sent to the complainant to confirm that the CCTV footage had already been reviewed as part of his complaint, when it had been concluded that the earlier interpretation was reasonable
Women and Child Health FC8/284 and 504	HCC unable to consider prior to 31.3.09 and papers passed to the Ombudsman	N/A
Surgery A FC8/327	HCC unable to consider prior to 31.3.09 and papers passed to the Ombudsman	N/A

APPENDIX E

THE 2 MAJOR AREAS COMPLAINED ABOUT –
BY DIVISION/DIRECTORATE

Division/ Directorate	**Major issues complained about**	**Percentage of the total number of complaints received in the Division or Directorate**
Anaesthetics/ Critical Care	Dissatisfied with medical treatment Communication breakdown	27 18
Facilities/ Nursing & Therapies	Car park Transport service	24 26
IM&T	Cancelled appointments Attitude of staff	27 14
Imaging	Communication breakdown Cancelled treatment Failure/delay in diagnosis	12 12 12
Medicine and Emergency Care A	Dissatisfied with nursing care Dissatisfied with medical treatment	19 21
Medicine and Emergency Care B	Dissatisfied with medical treatment Dissatisfied with nursing care	32 14
Pathology	Long wait Communication breakdown	17 17
Surgery A	Dissatisfied with medical treatment Dissatisfied with nursing care	41 15
Surgery B	Long wait in clinic Dissatisfied with medical treatment	19 16
Woman and Child Health	Dissatisfied with medical treatment Dissatisfied with nursing care	16 31

APPENDIX F

COMPARISON WITH OTHER TRUSTS RECEIVING OVER 650 COMPLAINTS IN 2007/08

Trust	Number of complaints	% completed within target
Sandwell and West Birmingham	695	81
Sheffield Teaching Hospitals	652	67
Leeds Teaching Hospitals	1084	75
Mid Yorkshire Hospitals	880	83
United Lincolnshire Hospitals	733	35
University Hospitals of Leicester	1276	84
Nottingham University Hospitals	1151	63
Burton Hospitals	669	74
Mid Essex Hospital Services	710	79
East and North Hertfordshire	837	64
Royal Free Hampstead	722	71
Barking, Havering and Redbridge	1068	80
Guys and St Thomas'	943	72
St George's Healthcare	702	71
Barts and the London	707	78
University College London	648	91
North West London Hospitals	754	67
Imperial College Health	1003	73
East Kent Hospitals	940	69
Maidstone and Tunbridge Wells	745	45
Brighton and Sussex University Hospitals	821	68
Southampton University Hospitals	836	61
Portsmouth Hospitals	875	81
Plymouth Hospitals	938	35
Gloucestershire Hospitals	698	78
North Bristol	690	80

Source – The Information Centre for Health and Social Care

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Annual Risk Report – 2008/9
SPONSORING DIRECTOR:	Kam Dhami – Director of Governance
AUTHOR:	Ruth Gibson, Head of Risk Management Dally Masaun, Head of Health and Safety
DATE OF MEETING:	24 September 2009

SUMMARY OF KEY POINTS:

This report highlights key risk activity undertaken during 2008/9:

- risk register process
- Patient Safety Development Plan
- NHSLA assessment progress
- policy review
- Analysis of 2008/9 incident data

Key incident data points:
- Total incidents: 8038 (6743 in 2007/8), an increase of 19% (Graph 1)
- Clinical incidents: 4823 (4067 in 2007/8), an increase of 19%
- Health and safety incidents: 3215 (2676 in 2007/8), an increase of 20%
- Red incidents: 155 (197 in 2007/8) a decrease of 21%
- Top incident type: patient accident (1312)

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	
NHS LA standards	Standard 5 'Learning from Experience'
Core Standards	SfBH Core Standard C1a
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 and Risk Management Committee on 17 September 2009

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Risk report – annual

2008/9

1 Introduction

This report highlights key risk activity undertaken during 2008/9:

- risk register process
- Patient Safety Development Plan
- NHSLA assessment progress
- policy review
- Analysis of 2008/9 incident data

2. Risk register process

Work started during 2007/8 to revitalise the risk register process was continued in 2008/9, resulting in achievement of level 3 in ALE KLOE scores. Throughout the year there was good divisional compliance with the requirement to produce quarterly divisional risk registers.

The risk register process was refined to build in a stage of "testing" proposed new red risks at the Risk Management Group, prior to presentation at the Governance Board. Red risks were reported and discussed on a quarterly basis at Governance Board and Trust Board, along with the Assurance Framework.

The Health and Safety Department piloted and launched a "starter pack" of generic health and safety risk assessments for wards to use when reviewing key health and safety risks such as violence and aggression, stress, manual handling and lone working.

3. Patient Safety Development Plan

In line with 2008/9 corporate objectives around patient safety, a development plan covering key areas such as policies, training and implementing national standards was presented on a quarterly basis at key corporate committees. There was good progress against identified objectives and this is reported separately.

4. NHSLA assessment progress

The Trust was due to undertake an assessment against level 2 NHSLA risk management standards in December 2008. Due to identified shortcomings in systems to identify training needs for staff against the mandatory training needs analysis and in ALE KLOE scores the assessment was deferred to 2009/10.

No assessment was undertaken against the maternity CNST standards as new standards were being piloted. Whilst the Trust applied to take part in the pilot, this was heavily

oversubscribed and the Trust was not able to participate. A level 1 assessment against the significantly expanded standards is planned for Quarter 4 2009/10.

5 Policy review

The Risk Management Strategy and Risk Assessment and Risk Register Policy were both reviewed and reapproved with relatively minor amendments. The Incident Reporting Policy was revised and discussions ie around planned changes to incorporate earlier reviews of incidents to target investigations were held within year. The policy was reapproved during 2009/10.

6. Analysis of 2008/9 Incident data

6.1 Incident data analysis
Incident data and comment on issues raised/steps taken is attached (appendix 1).

6.2 Key issues highlighted within appendix 1
Total incidents: 8038 (6743 in 2007/8), an increase of 19% (Graph 1)
Clinical incidents: 4823 (4067 in 2007/8), an increase of 19%
Health and safety incidents: 3215 (2676 in 2007/8), an increase of 20%
Red incidents: 155 (197 in 2007/8) a decrease of 21%
Top incident type: patient accident (1312)

7. Next steps
Key objectives during 2009/10 are achievement of level 2 NHSLA standards and maintaining compliance with ALE KLOE requirements and Standards for Better Health.

8. Recommendations
The Trust Board is recommended to NOTE this report.

Appendix 1

Incident Data Analysis

2008/9

The Trust has established an organisation-wide culture of incident reporting. On receipt of a completed incident form, information is centrally inputted onto Safeguard, an electronic database, against 1 of 28 categories (cause groups).

This report is based on data from Safeguard and looks at incident trends from key cause groups and associated sub-cause groups over 4 years since 2005/6.

Key indicators are shown below and more detailed information is provided on a regular basis (generally quarterly) to divisional meetings and to key corporate committees.

All incidents are investigated in accordance with the grade of severity assigned to each incident. Green/yellow incidents are followed up locally. Amber incidents are investigated and the resulting action plans monitored at divisional level. Red incidents are investigated and monitored centrally, with action plans being approved monitored and closed at the Adverse Events Committee, chaired by the Chief Executive.

Cause groups for clinical incidents are aligned with cause groups used in the National Reporting and Learning System (NRLS), run by the National Patient Safety Agency (NPSA) as far as is possible. As the NRLS develops benchmarking is undertaken against national data. This is included in the regular quarterly reports and will be incorporated into future annual reports as indicators become more developed.

Sections 1-3 set out comment on incident data. Graphs/tables detailing the data appear in section 4.

1 Overview of incident data (Graphs 1 and 2 and Table 2)

The total number of incidents recorded for 2008/9 is 8083 (6743 in 2007/8), a 19% increase (Graph 1). Numbers of reported clinical incidents increased from 4067 in 2007/8 to 4823 in 2008/9, an increase of 19%. Numbers of reported health and safety incidents increased from 2676 in 2007/8 to 3215 in 2008/9, an increase of 20%.

2 Risk ratings and red incidents (Graphs 3 and 3a and Table 2)

Whilst overall levels of numbers of incidents gives information about patient safety activity, a breakdown by grade (graphs 3 and 3a) indicates whether staff are managing risks proactively. The most desirable trend is for high numbers of green/yellow incidents, with lower numbers of amber incidents and relatively few red incidents.

The overall number of reported red incidents in 2008/9 was 155 (Graph 3a). This is a decrease of 21% from 197 in 2007/8. This decrease reflects a significant decrease in numbers of incidents around post partum haemorrhage within maternity. The number of red incidents as a proportion of total incidents is 1.9%, compared with 4% in 2007/8.

Not all red incidents result in generation of an incident form, although areas are reminded to provide forms. Reviews are still held and action plans developed irrespective of whether a form is received or not.

3 Analysis of specific cause groups

Patient accidents (graph 4) are one of the most frequently reported incident types within the NRLS, due to the large number of in-patient falls. It is noted that the number of patient falls reported during 2008/9 increased by 60%, compared with 2007/8. This results from a change in policy at the end of 2007/8 to ensure all patient falls were captured, whereas previously only falls resulting in harm were captured. Patient accidents now make up 16% of all reported incidents, compared with 12% in 2007/8.

Graph 5 shows a fall in the number of **missing patients**, although numbers of reported **communication failures** and **inappropriate transfers** increased. The increase in "other-admission" relates to focused reporting around in utero transfer incidents between Sandwell/City maternity and neonatal units and this is monitored via the In Utero Transfer group.

Aspect of care incidents (graph 6) showed an increase in reported instances of failures to provide planned care. These have been followed up in year where particular increases were noted (ie Sandwell EAU, maternity). New categories around pressure sores have been introduced and are being reported against.

Graph 7 shows reported **medication errors**. There have been increases in incidents around wrong medication and omitted/missed medication. This trend has been noted at the Medicine Safety Committee and reviews of missed medication introduced.

Medical Equipment (Graph 8). There was a fall in incidents around defective/unavailable medical equipment, resulting from an improved service by the new external sterile services provided by BBraun.

Maternity incidents by area reporting and by trigger list category (graph 9 and table 1) are included to acknowledge the high risk nature of obstetrics. Although maternity report high numbers of incidents compared with other specialities there are still trigger list categories that appear underused and areas of the service that are not reporting regularly. This data is presented at the Perinatal Risk Group where representatives are expected to feed back these issues locally. In line with the comments around reduced red incidents around post partum haemorrhage, the data shows a fall in overall reports around post partum haemorrhage.

Moving & Handling (Graph 10) 99 incidents were reported under this Health & Safety category (*previous year: 113; 12%* ***decrease***).

Slip, Trip, Fall (Graph 11) 158 incidents were reported under this Health & Safety category (*previous year: 92; 72%* ***increase***).

Sharps (Graph 12) 174 sharp injuries were reported under this Health & Safety category (*previous year: 211; 18%* ***decrease***).

Verbal/Aggression (Graph 13) 443 incidents were reported under this Health & Safety category (*previous year: 572; 23%* ***decrease***).

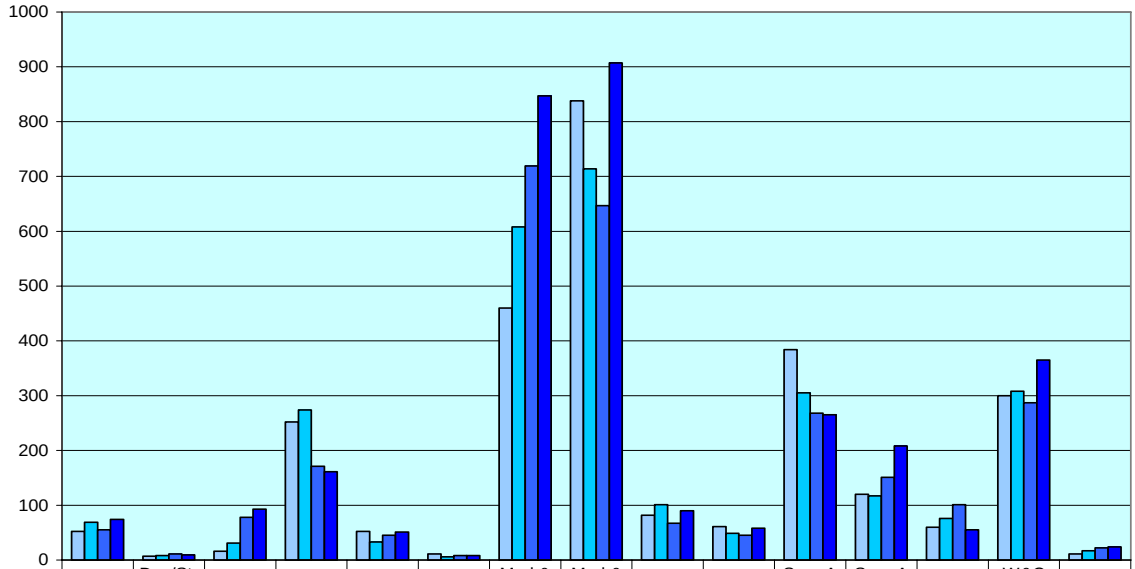
Violence (Graph 14) 148 incidents were reported under this Health & Safety category (*previous year: 142; 4%* ***increase***).

Security (Graph 15) 214 incidents were reported under this Health & Safety category (*previous year: 118; 81%* ***increase***).

Fire (Graph 16) 177 incidents were reported under this Health & Safety category (*previous year: 192; 8%* ***decrease***).

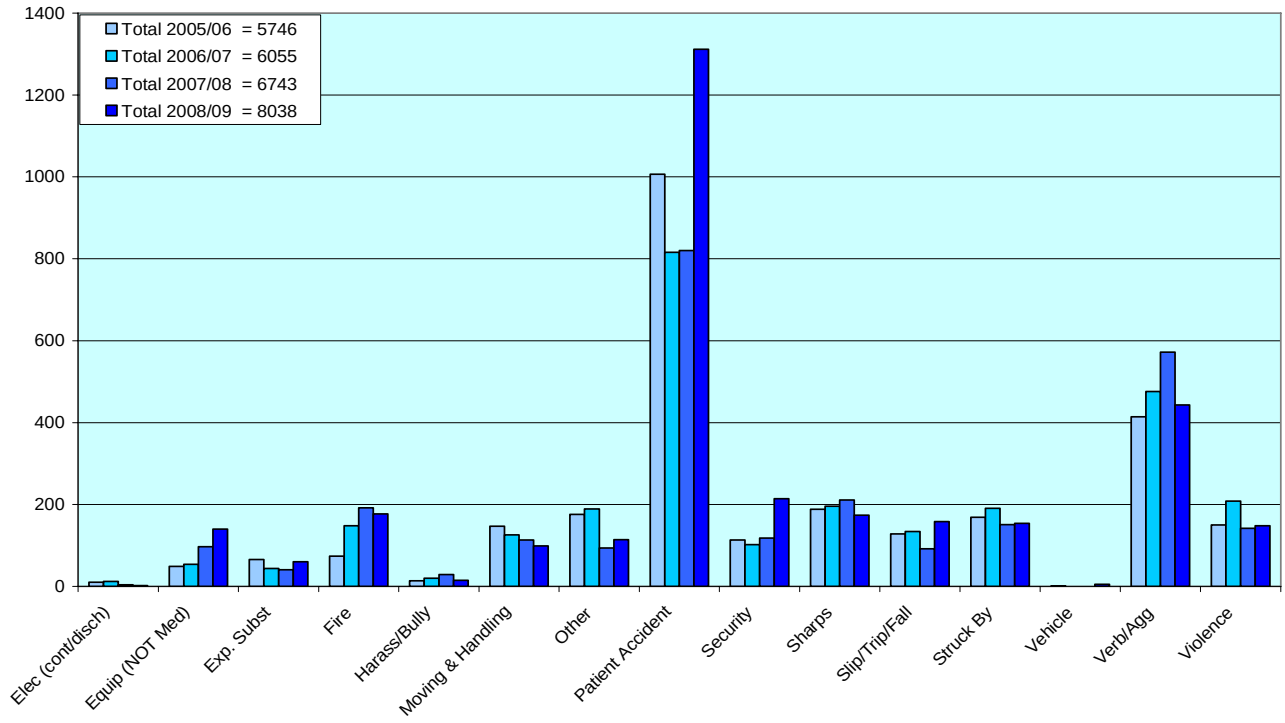
4. Performance Monitoring Data

Graph 1: **Incident Trends (Trust) 2005/6 – 2008/9**

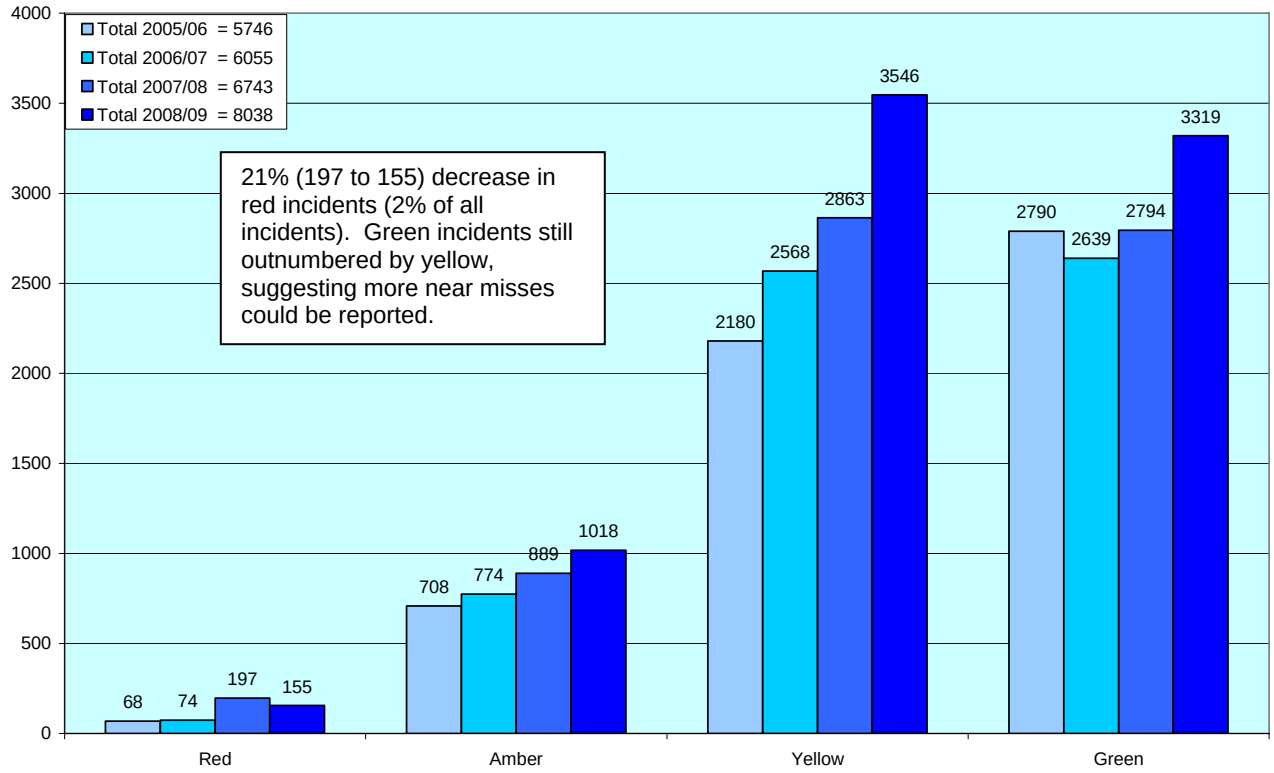


	A&CC	Dev/Str a	Est	FN&T	Imag	IM&T	Med & EC (A)	Med & EC (B)	Ops	Path	Surg A (C)	Surg A (S)	Surg B	W&C Hlth	WF/Fin
2005/06 = 2706	52	7	16	252	52	11	460	838	82	61	384	120	60	300	11
2006/07 = 2716	69	8	31	274	33	6	608	714	101	49	305	117	76	308	17
2007/08 = 2675	55	11	78	171	45	8	719	647	67	45	268	151	101	287	22
2008/09 = 3215	74	9	93	161	51	8	847	907	90	58	265	208	55	365	24

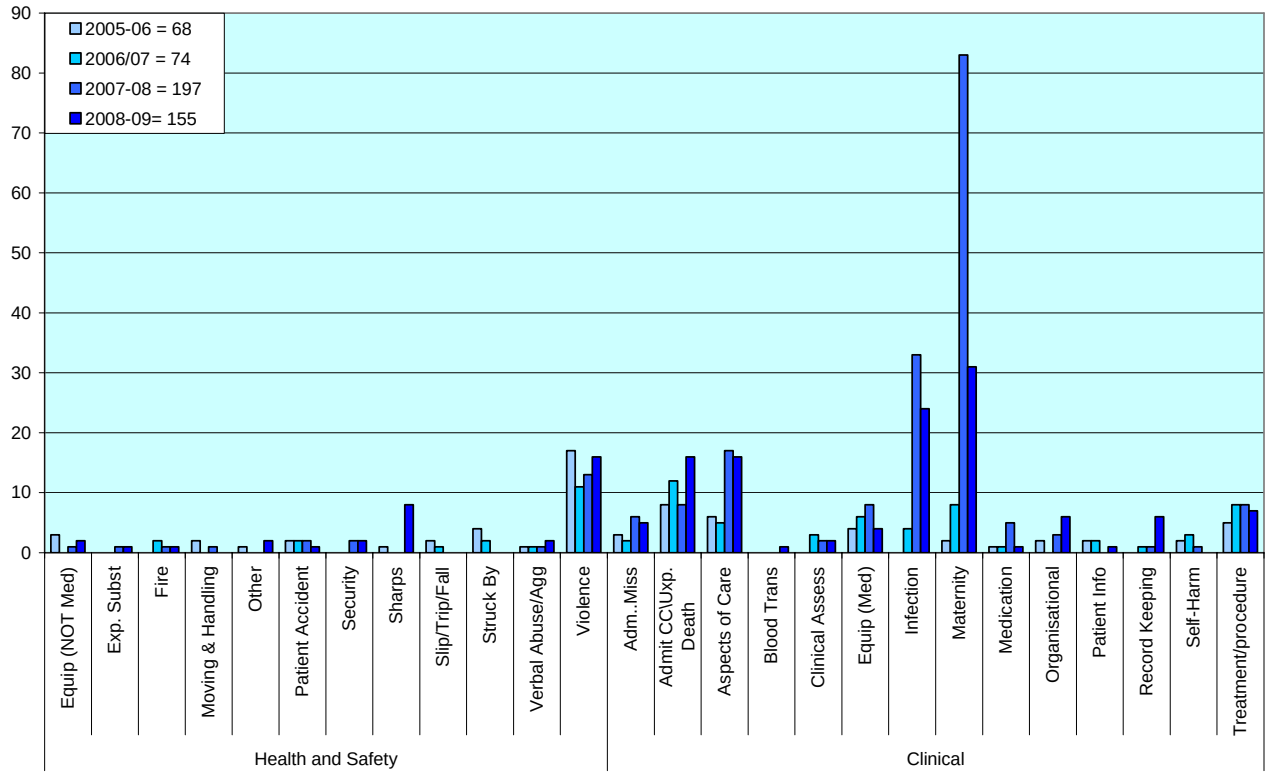
Graph 2: **Incidents by Division 2005/6- 2008/9**



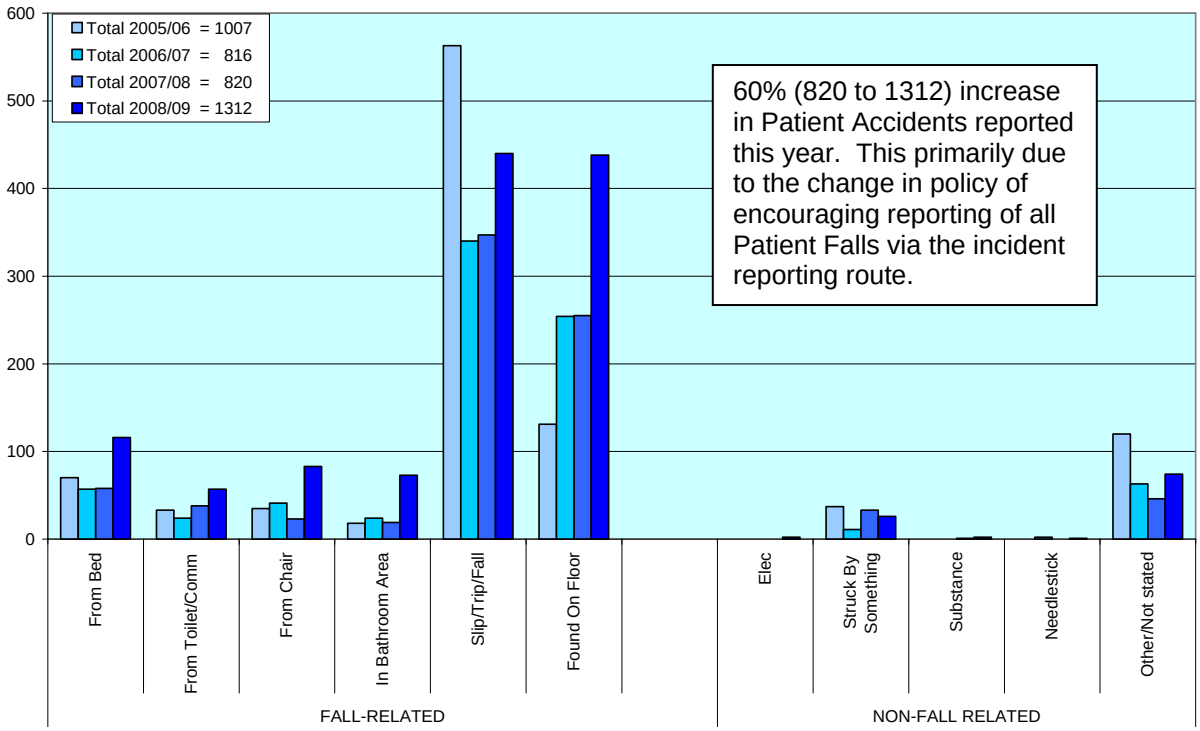
Graph 3: **Risk Rating Trends 2005/6 – 2008/9**



Graph 3a: **Red Incidents (Trust) 2005/6 – 2008/9**



Graph 4: **Patient Accident (Trust) 2005/6 – 2008/9**



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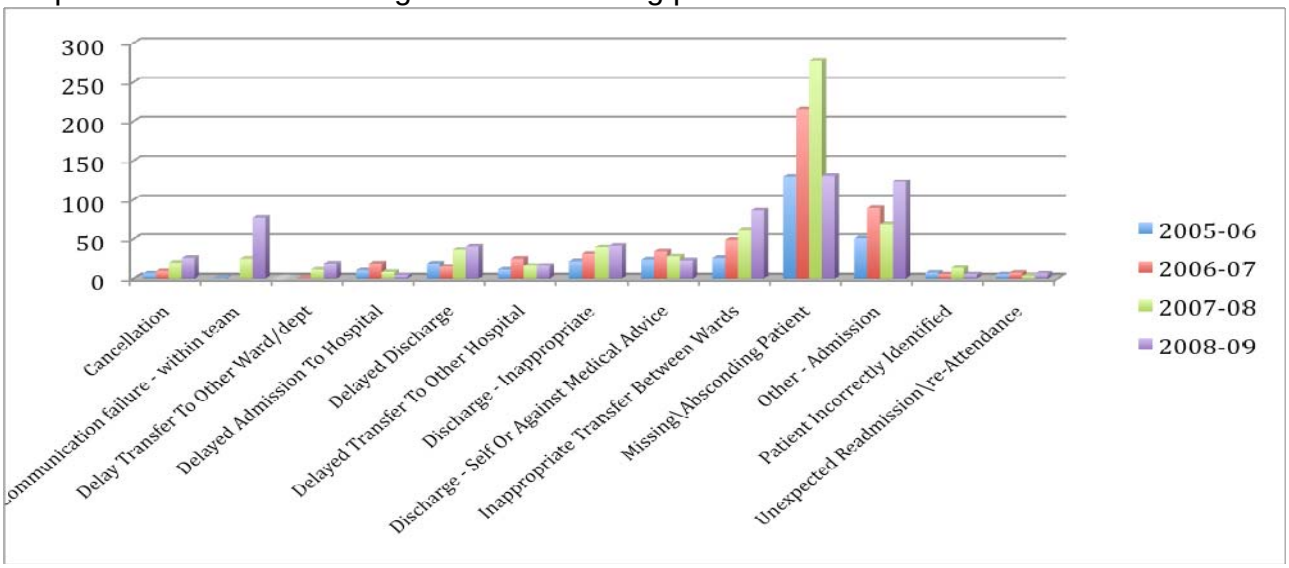
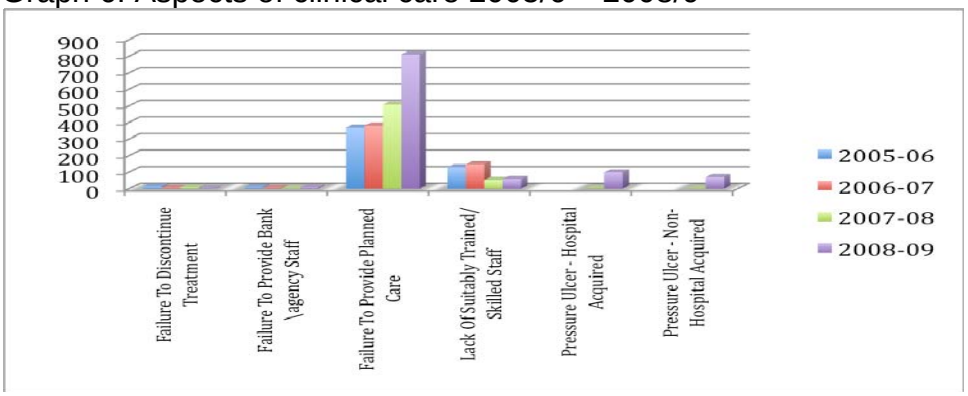
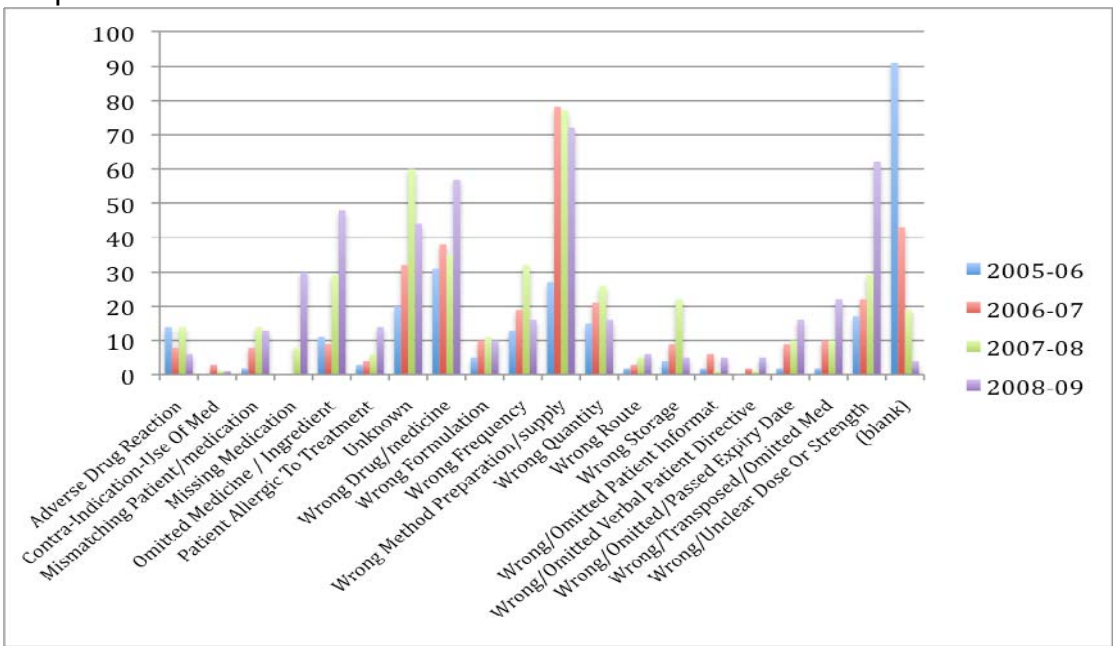
Graph 5: Admission/discharge/transfer/missing patients 2005/6 – 2008/9



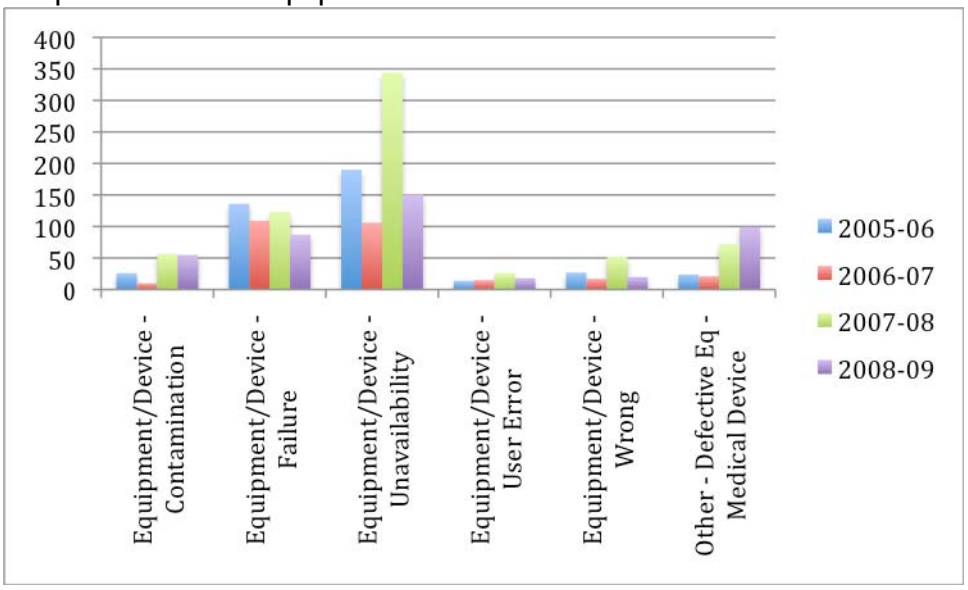
Graph 6: Aspects of clinical care 2005/6 – 2008/9



Graph 7: Medication Errors 2005/6 – 2008/9



Graph 8: Medical Equipment



Graph 9 Maternity incidents by trigger list category 2005/6 – 2008/9

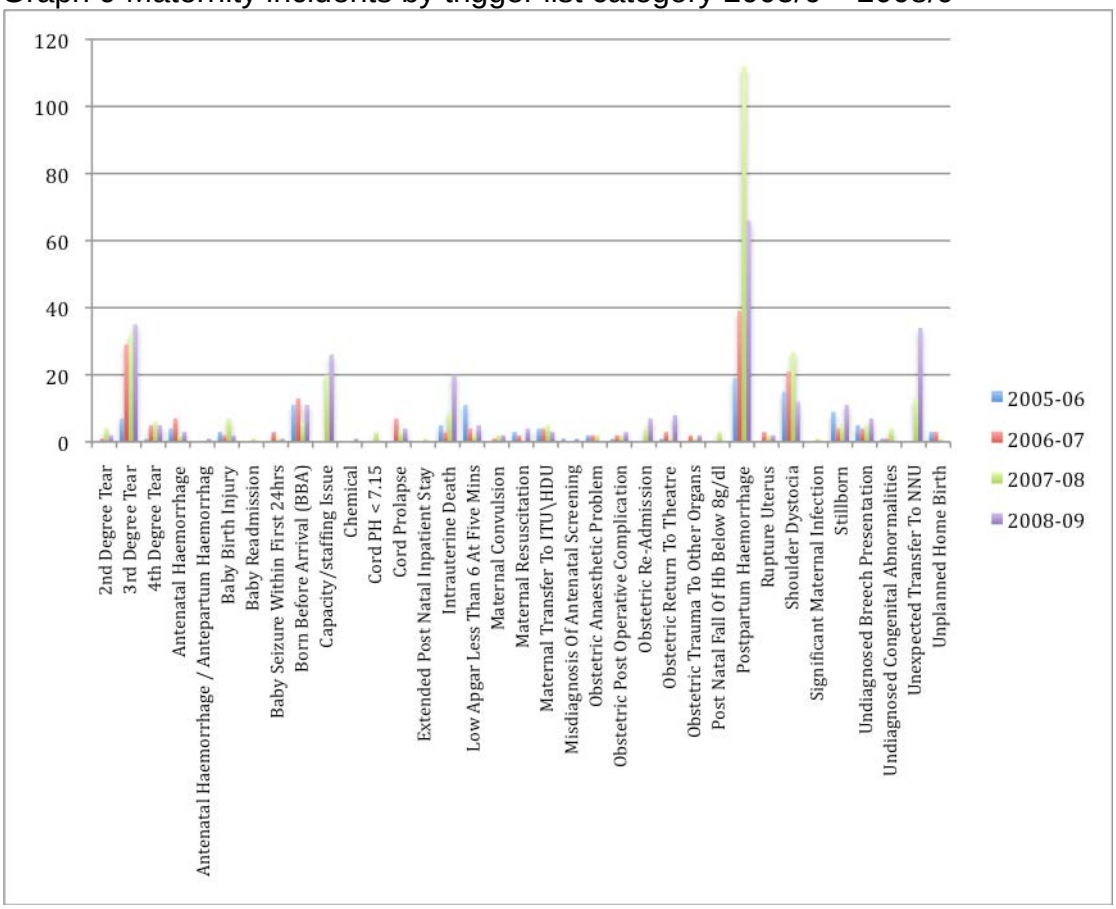
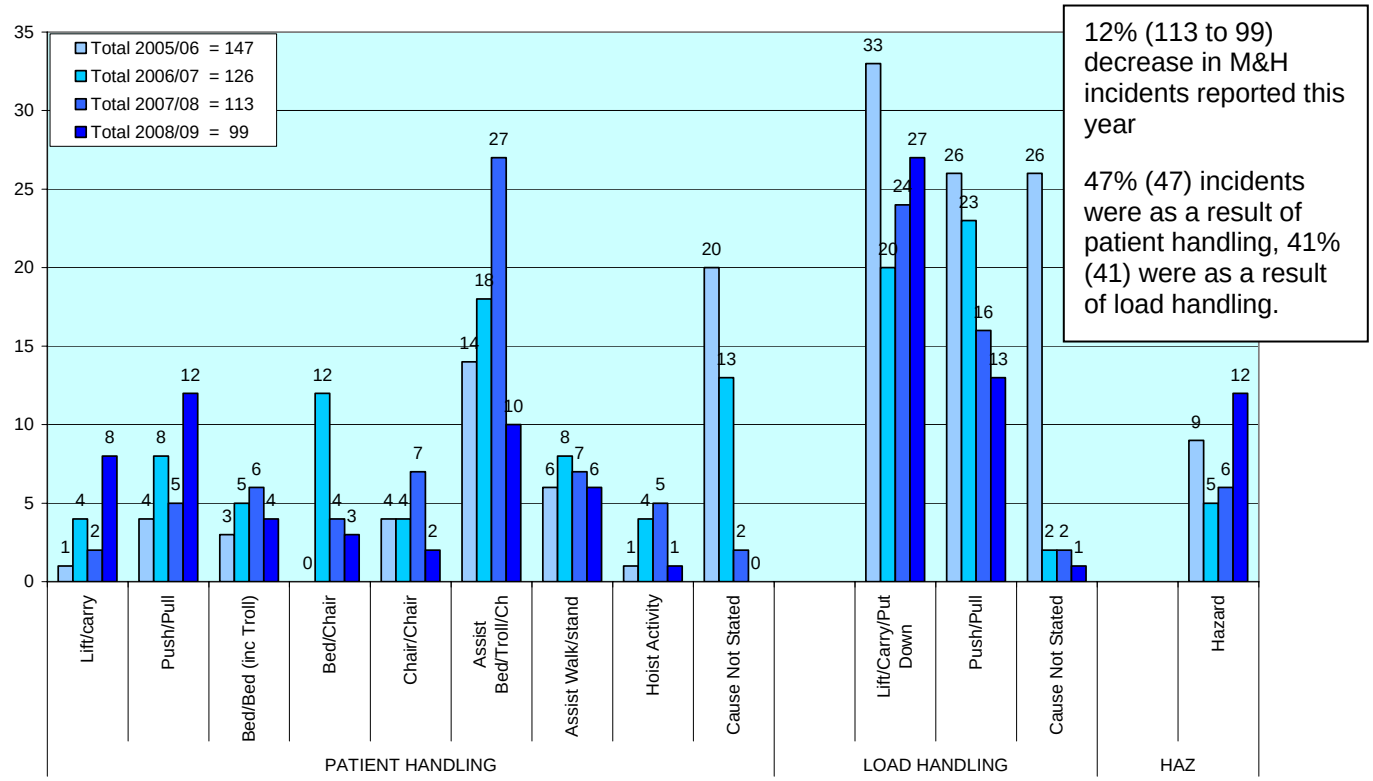


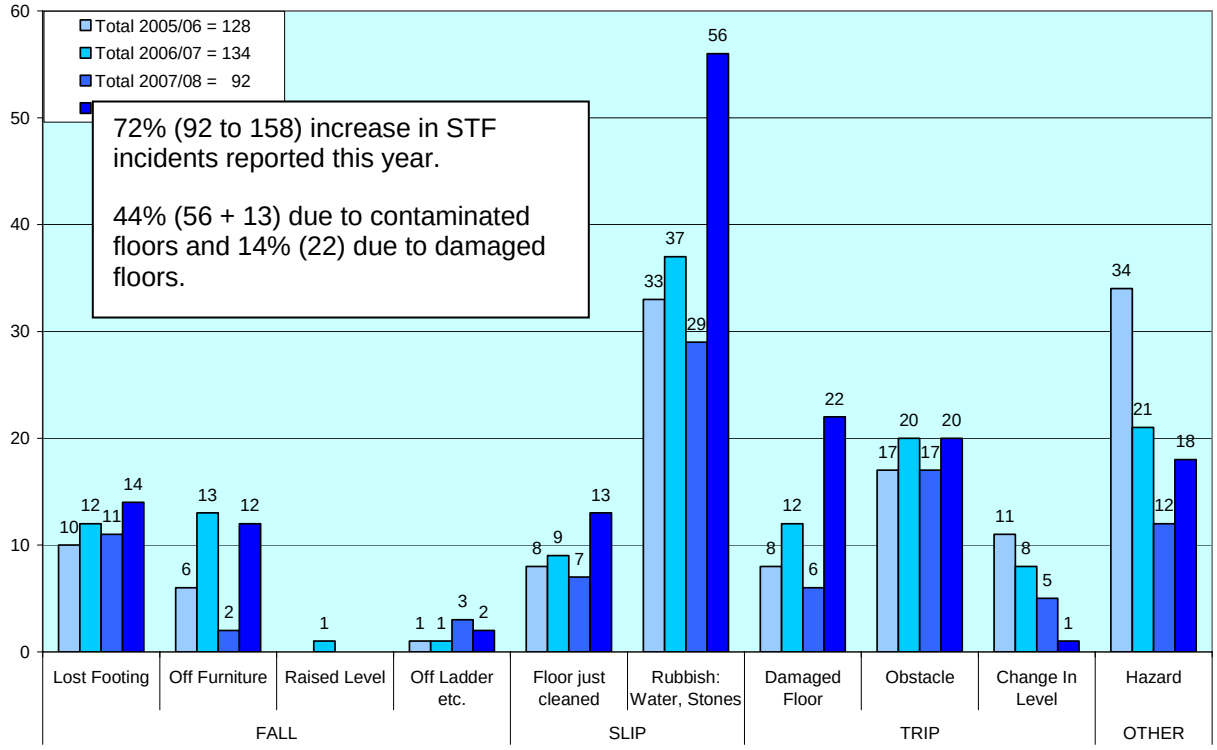
Table 1: Maternity incidents by location 2005/6 – 2008/9

Department	2005-06	2006-07	2007-08	2008-09
*Community	1	14	2	
Admin Suite - Maternity Bk (C				4
Ante-Natal (C)	12	139	67	143
Ante-Natal (S)	2	17	30	41
Community - Womens (C)			10	49
Community - Womens (S)				26
Labour Ward (C)	65	288	389	558
Labour Ward (S)	48	205	195	352
Lyndon 1	3			
Lyndon Ground	3			
Maternity 1 (C)	25	97	82	39
Maternity 1 (S)	14	35	65	66
Maternity 2 (C)	8	54	80	75
Maternity 2 (S)		1		2
Maternity Theatres (C)	2	4	57	27
Maternity Theatres (S)		5	35	10
Midwifery (C)*	2	1	2	3
Midwifery (S)*			2	
Neonatal Unit (C)	2			
Neonatal Unit (S)	1			
Obstetrics (C)*	3	27	12	2
Obstetrics (S)*	15	25	16	
Paediatric Medicine (C)*	1			
Paediatric Medicine (S)*		1		
Paediatric OPD City			2	

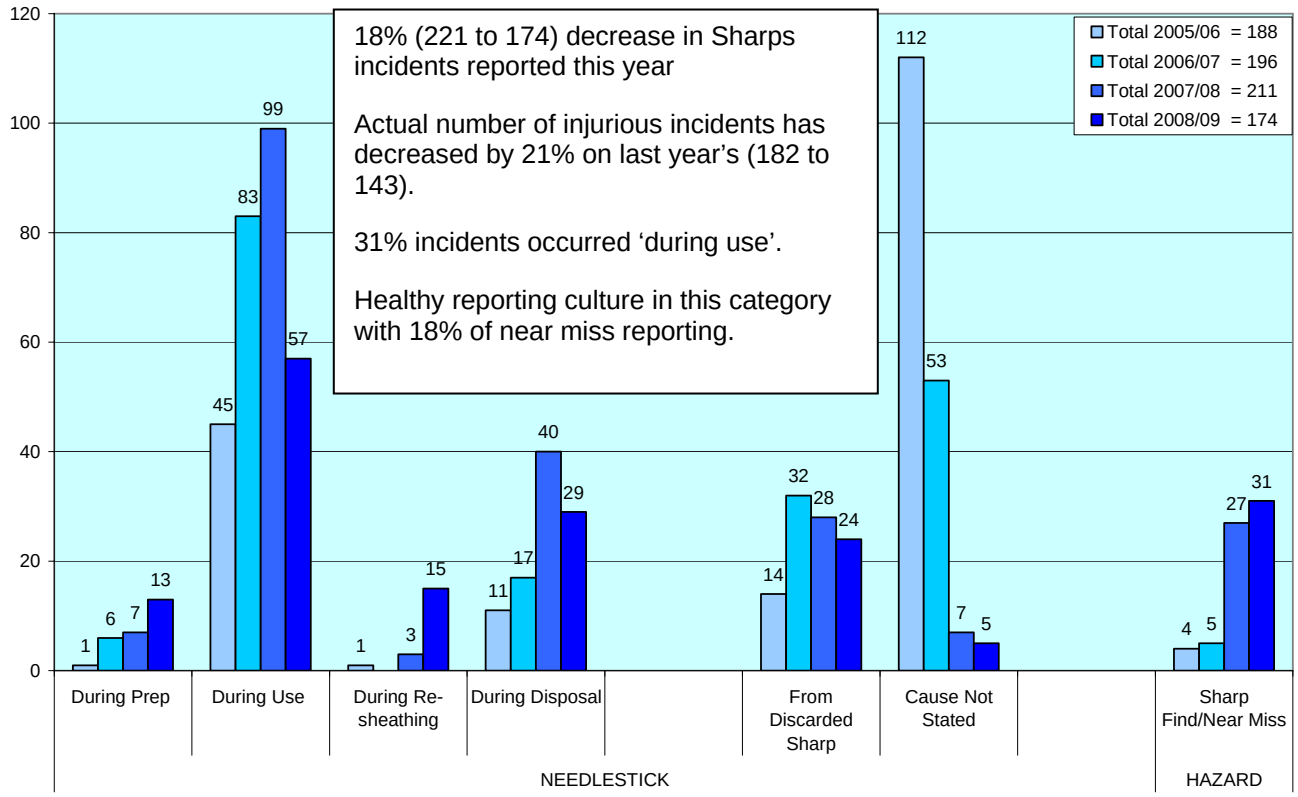
Graph 10: **Moving & Handling (Trust) 2005/06 – 2008/09**.



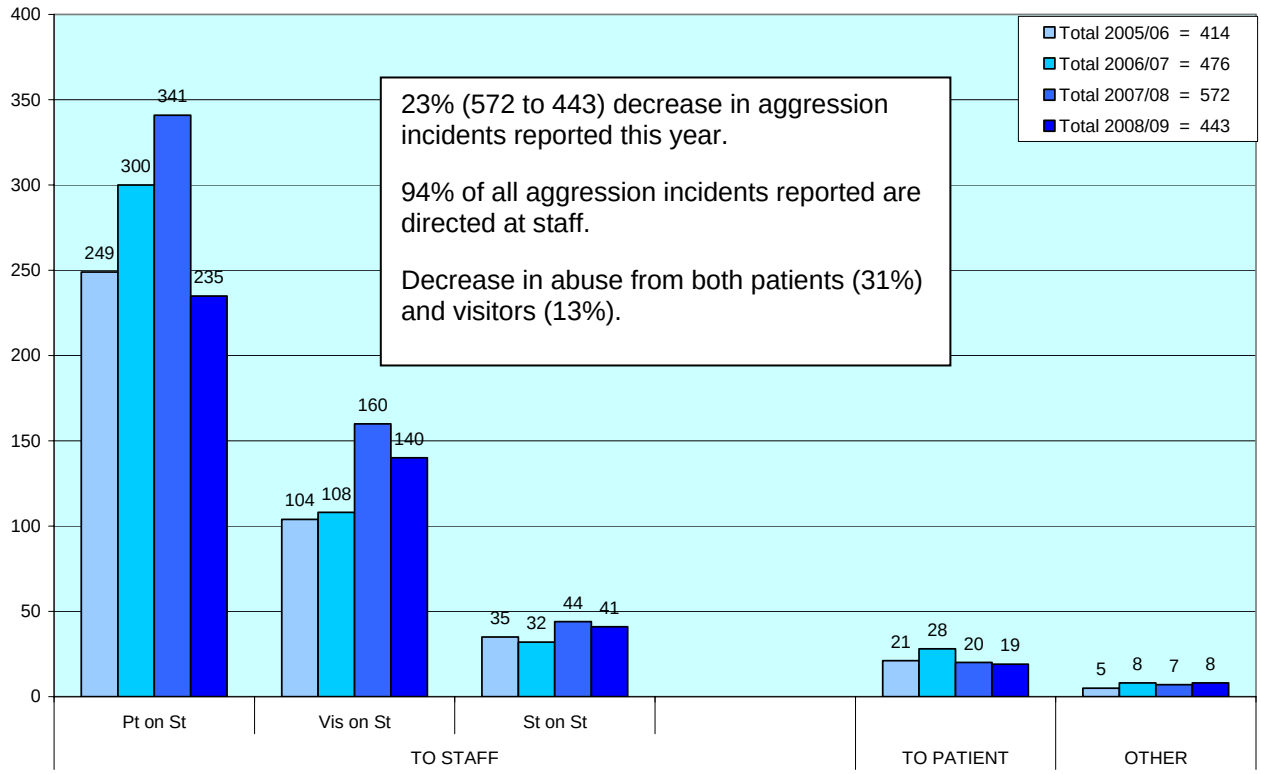
Graph 11: **Slip, Trip, Fall (Trust) 2005/06 - 2008/09**.



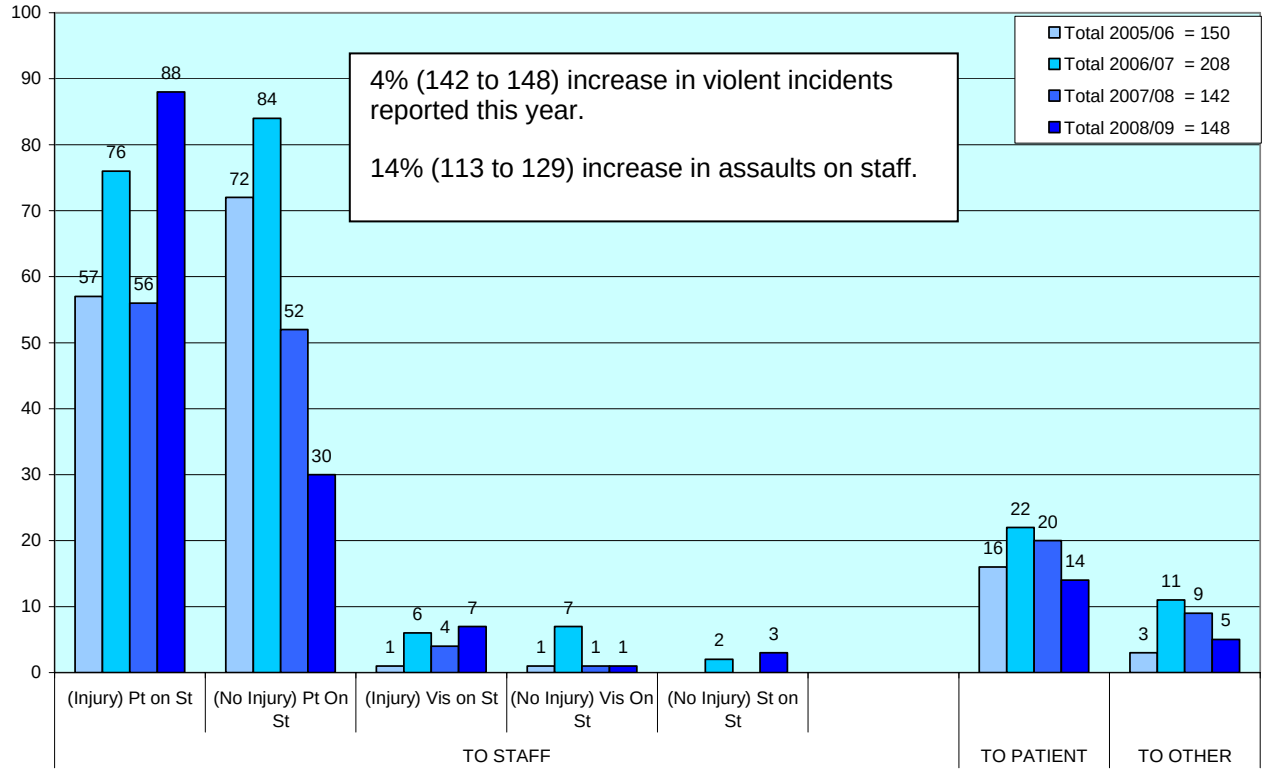
Graph 12: **Sharps (Trust) 2005/06 - 2008/09**.



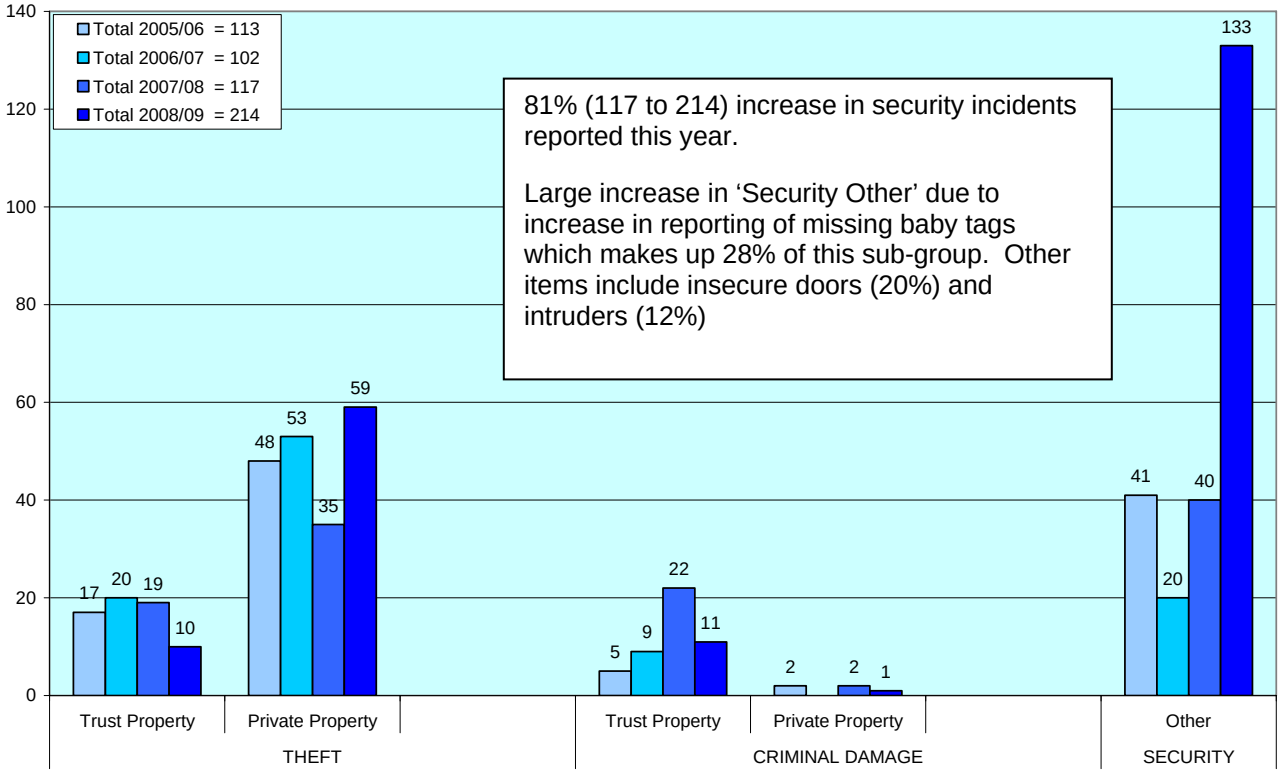
Graph 13: **Verbal/Aggression (Trust) 2005/06 - 2008/09**.



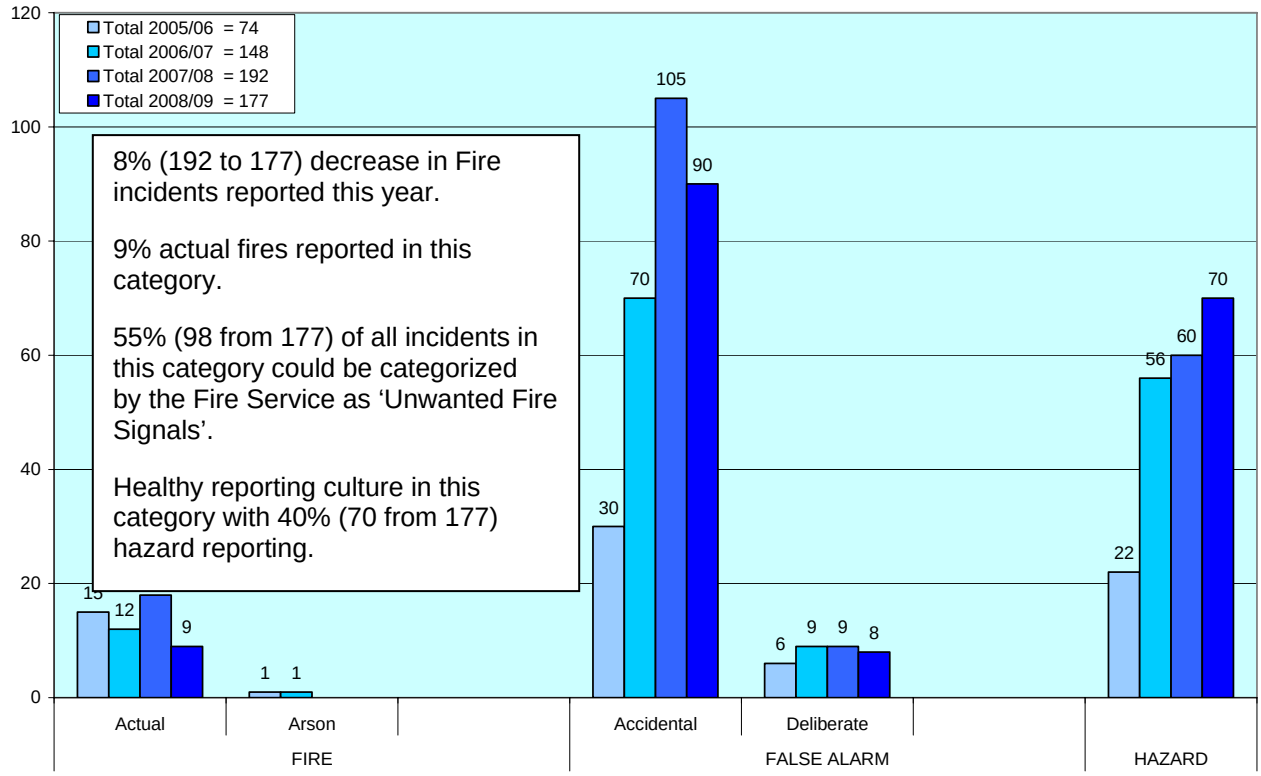
Graph 14: **Violence (Trust) 2005/06 -2008/09**



Graph 15: **Security (Trust) 2005/06 -2008/09**.



Graph 16: **Fire (Trust) 2005/06 -2008/09**.



Graph 17: **RIDDOR (Trust) 2005/06 -2008/09**.

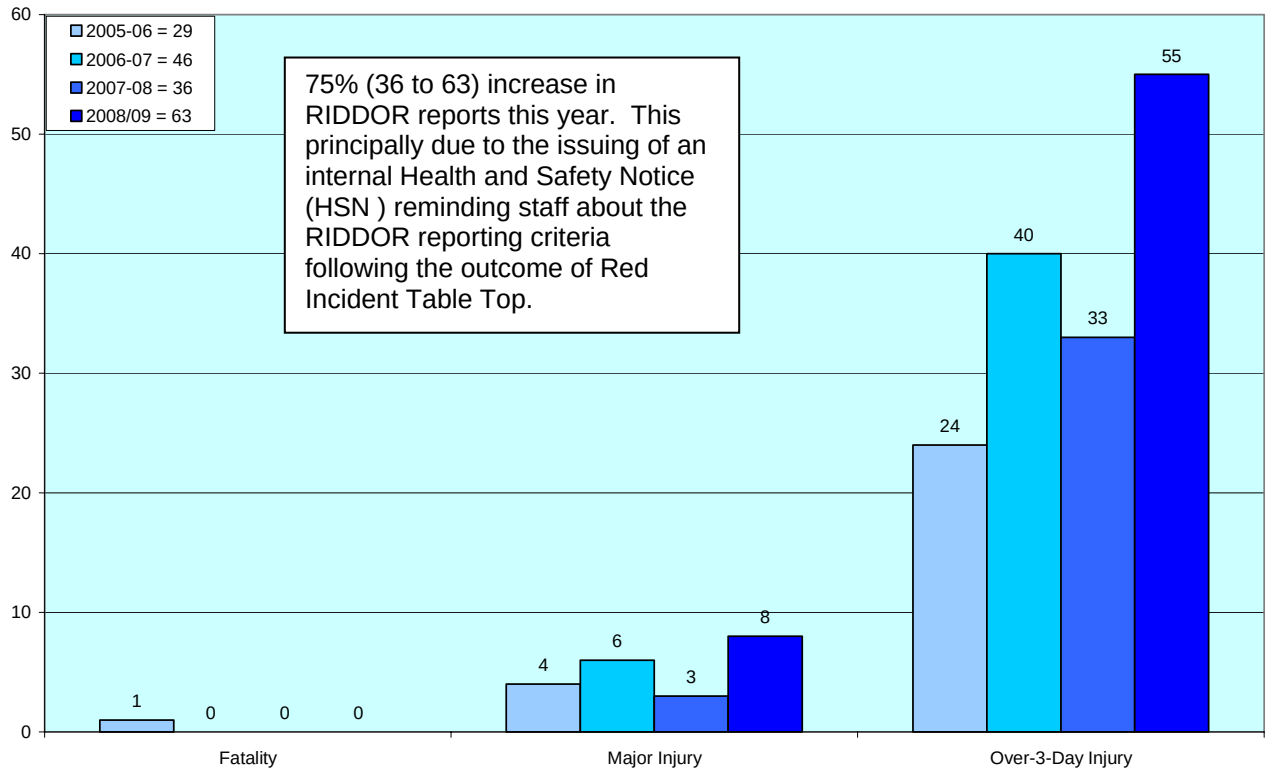


Table 2: **Reported Incidents (Cause Group & Risk Rating by Division) 2008/09**

	A&CC	D/S	Est	FN&T	Imag	IM&T	Med A-EC	Med B-EC	Ops	Path	Surg A C	Surg A S	Surg B	W&CH	WF/F	Total
Electricity (Contact)											1				1	2
Equipment (Other)	1	1	9	16	4		18	9	11	7	7	9	3	45		140
Exposure Substance	8		1	2	1		6	6	6	11	7	5	2	5		60
Fire	6	3	13	26	8	3	36	11	10	3	15	7	6	28	2	177
Harassment/Bullying	2				1		7	4				1				15
Moving & Handling	4		3	18	4	1	15	18	6	1	14	5	1	8	1	99
Needlestick (Sharps)	10		5	4	2		35	29	5	9	19	20	4	32		174
Other Incident/Haz	10	1	7	12	1	2	16	11	5	2	12	11	2	21	1	114
Security	1		7	19	2		36	34	9	10	10	8		74	4	214
Slip, Trip, Fall	5	2	18	22	3		24	17	11	6	7	10	7	20	6	158
Struck By Something	5	1	22	26	5	1	16	20	5	2	8	9	5	22	7	154
Vehicle				2								1		1	1	5
Verbal Abuse	6		6	9	7		173	97	6	6	37	30	5	60	1	443
Violence - Assault	8		1	1			66	49	1		8	9		5		148
Admission	22		2	1	4		110	104	9	2	92	37	5	210		598
Admit CC/Uxp Death	2						10	10			1	1		22		46
Aspect of Care	42	1			17		195	288	11	11	105	91	11	266		1038
Blood Transfusion	3						8	5	1	3		3		16		39
Clinical Assessment	4	1			5		45	25	5	71	18	11	3	44		232
Equipment (Medical)	13				7		23	33	1		84	136	48	85		430
Infection Control	10				2		22	25	1	2	28	16		8		114
Maternity							1	1						277		279
Medication	23			1	5		121	93	75	5	46	16	4	62		451
Organisational	12		1	3	7	1	110	98	33	8	60	40	9	257		639
Patient Accident	8	1	1	4	13		399	603	15	1	120	83	20	44		1312
Patient Information	2		1	1	1	2	6	6	7	2	19	10	5	21		83
Record Keeping	9			2	14	3	52	64	47	32	53	43	18	231		568
Self-Harming							8	6		1		1		1		17
Treatment/procedure	7	3		1	65		42	52	7	4	31	19	12	46		289
TOTAL	223	14	97	170	178	13	1600	1718	287	199	802	632	170	1911	24	8038
	Risk Rating															
Red	4	0	0	0	1	0	36	29	4	1	14	7	2	57	0	155
Amber	20	1	12	14	9	0	209	171	27	36	114	99	22	283	1	1018
Yellow	69	5	34	49	42	7	564	676	117	72	328	307	68	1198	9	3545
Green	130	8	51	107	126	6	791	842	139	90	346	219	78	373	14	3320
TOTAL	223	14	97	170	178	13	1600	1718	287	199	802	632	170	1911	24	8038

ABBREVIATIONS

Directorates

A&CC	Anaesthetics & Critical Care
D/S	Development/Strategy
Est	Estates & Capital Projects
WF/F	Workforce/ Finance
IM&T	Information Management & Technology
Imag	Imaging
Med A-EC	Medicine A & Emergency Care
Med B-EC	Medicine B & Emergency Care
FN&T	Facilities & Nursing, Therapies
Ops	Operations
Path	Pathology
Surg A C	Surgery A (City)
Surg A S	Surgery A (Sandwell)
Surg B	Surgery B
W&CH	Women & Child Health

Cause Groups

Admission	Admission, Discharge, Transfer, Miss Patient	**Organisational**	Organisational Issues
Clinical Care	Aspects of Clinical Care	**Other Incident/Haz**	Other Accident\incident
Blood Transfusion	Blood Transfusion	**Patient Accident**	Patient Accident
Clinical Assessment	Clinical Assessments (Diag, Scans, tests)	**Patient Information**	Patient Information Incident
Contract Electricity	Electricity – contact with	**Record Keeping**	Record Keeping\filing\missing notes
Equipment (Medical)	Equipment – Medical	**Security**	Security
Equipment (Other)	Equipment – Non Medical	**Self-Harming**	Self harming behaviour
Exposure Substance	Exposure\contact with harmful substance	**Slips, Trips & Falls**	Slips, trips and falls
Fire	Fire	**Struck by Something**	Struck by something
Harassment/bullying	Harassment\bullying	**Treatment/procedure**	Treatment procedure
Infection Control	Infection Control Incident	**Unexpect Death\CC**	Unexpected Death\ admit to Critical\Neonatal
Maternity	Maternity	**Vehicle**	Vehicle\Driving Offence\Accident
Medication	Medication	**Verbal Abuse**	Verbal Abuse\Aggression
Moving & Handling	Moving and Handling	**Violence (Assault)**	Violent assault
Needlestick	Needlestick		

RIDDOR Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Integrated Incident, Complaint and Claims Report – Q1 2009/10
SPONSORING DIRECTOR:	Kam Dhami – Director of Governance
AUTHOR:	Ruth Gibson, Head of Risk Management Dally Masaun, Head of Health and Safety Debbie Dunn, Head of Complaints and Litigation
DATE OF MEETING:	24 September 2009

SUMMARY OF KEY POINTS:

Key incident data points:

- There were 2114 reported incidents (1901 in Q1 2008/9).
- Reported clinical incidents rose from 1437 in Q1 2008/9 to 1626 in Q1 2009/10.
- Reported health & safety incidents rose from 454 in Q1 2008/9 to 488 in Q1 2009/10.
- There were 31 incident forms received relating to red incidents (1.0% of the total), compared with 38 in Q1 2008/9 (2.0% of the total).

Key complaint data points:

The Trust received 228 complaints, compared with 172 in the same quarter in 2008/09, an increase of 32%. Of these 2 (1%) were graded as red, compared with 3 (2%) in Q1 2008/09. The most frequently occurring area of concern was clinical treatment, affecting 42% of complaints, compared with 37% in Q4.

Key claims data points:

22 clinical negligence and 14 personal injury claims were received in Q1 (compared to 20 clinical negligence claims and 9 personal injury claims in Q4)

Aggregated analysis:

The second most reported incident category (aspects of clinical care) correlates with the most frequently recorded complaint category (dissatisfaction with clinical treatment). There is no clear correlation between incidents/complaints and claims.

PURPOSE OF THE REPORT:

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	
NHS LA standards	Standard 5 'Learning from Experience'
Core Standards	SfBH Core Standard C1a and C14 a - c
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 and Risk Management Committee on 17 September 2009

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

Integrated Risk, Complaints and Claims Report: Quarter 1 2009/10

1. Overview

This report highlights key risk activity including:

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

2. Introduction

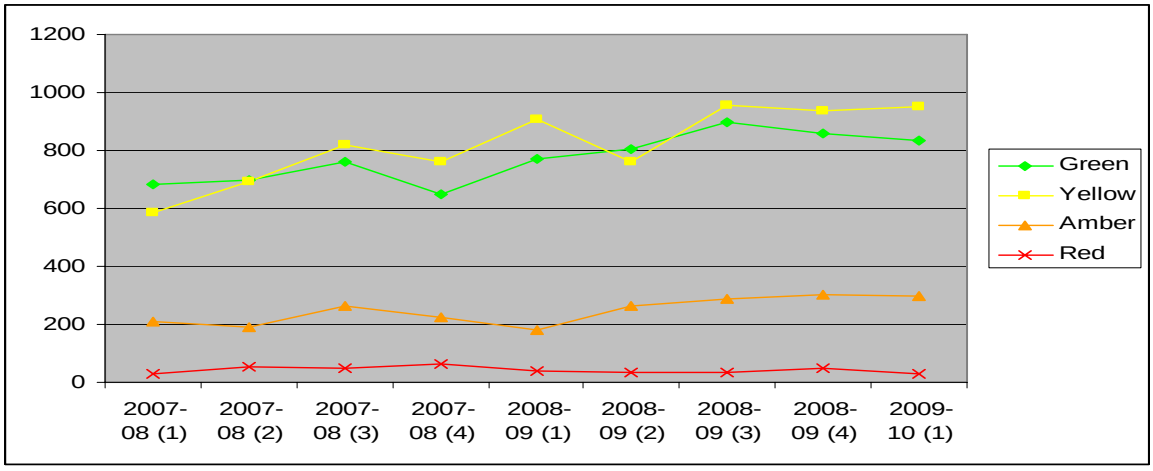
This report combines previous quarterly reports on incident/risk and complaints to implement the Policy for the Investigation, Analysis and Learning of Lessons from Adverse Events and meet NHS Litigation Authority assessment requirements. Where possible, comparisons across these areas of activity will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

3. Key Issues

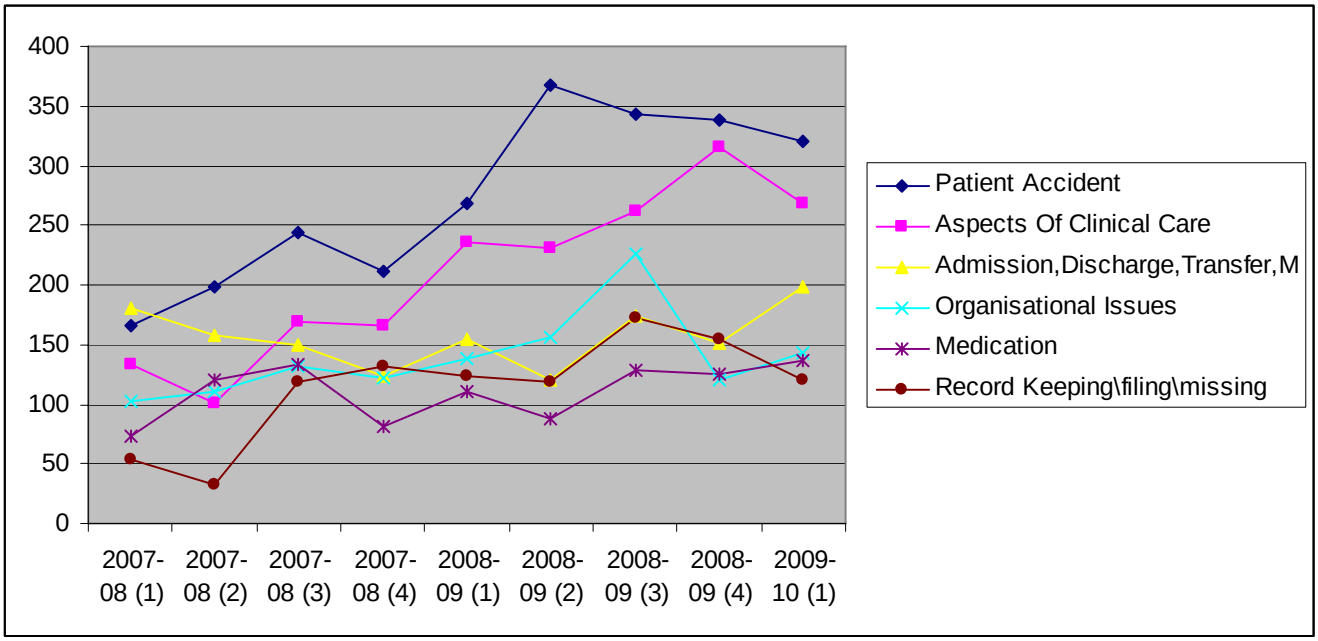
3.1 Review of Quarter 1 Incident Data

- There were 2114 reported incidents (1901 in Q1 2008/9).
- Reported clinical incidents rose from 1437 in Q1 2008/9 to 1626 in Q1 2009/10.
- Reported health & safety incidents rose from 454 in Q1 2008/9 to 488 in Q1 2009/10.
- There were 31 incident forms received relating to red incidents (1.0% of the total), compared with 38 in Q1 2008/9 (2.0% of the total).

Graph 1 - Incident Trends by risk score 1/4/07 – 30/6/09

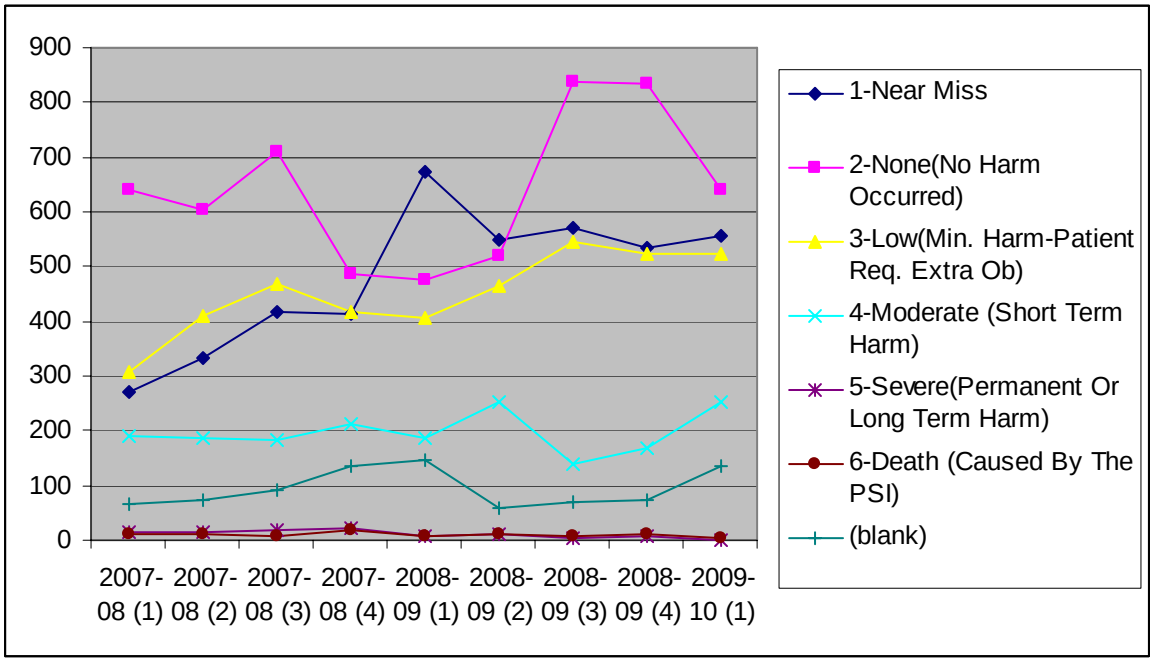


Graph 2 – Top 6 reported incidents by quarter (1/4/07 – 30/6/09)



The top 4 most frequently reported categories appear in the same order for this quarter and for the same quarter last year. The 5th most frequently reported category in Q1 2008-9 was violence and aggression, which was the 10th most frequently reported category last quarter. This may be as a result of Listening into Action work following the Staff Survey. The 6th most frequently reported category in Q1 2008-9 was medical equipment, which was 7th most frequent last quarter. Medication and record keeping were 7th and 8th most frequently reported in Q1 2008-9 respectively. In real terms numbers of medication incidents have increased from 110 to 136, whilst record keeping incidents have dropped from 123 to 120.

Graph 3 Patient Safety incidents by actual impact by quarter (1/4/07 – 30/6/09)



Graph 3 looks at reported actual harm suffered by the patient and allows benchmarking against the six monthly feedback reports provided by the National Patient Safety Agency (NPSA) from its National Reporting and Learning System (NRLS). The NRLS is a national database to which SWBH, along with almost all Trusts, reports patient safety incidents on a regular basis.

When the last report, covering April – September 2008, was published in February 2009 it was identified that SWBH staff were overstating the consequences of incidents, resulting in apparently high reporting against the severe harm/death categories. As a result staff have been reminded of the specific NPSA categories of harm. A piece of work has been undertaken with the NPSA to review incident inputting to identify any anomalies and concerns. This concluded that the Trust did not have inappropriately high levels of incidents in these categories and that systems put in place to check incidents prior to submission to the NPSA were now more robust.

The next report is expected during September 2009 (and will be reported in the Q2 report). This should show the Trust's profile is more closely aligned to national profiles. However as some of the data collection periods had already passed at the time this issue was first identified it is likely to take a further quarter before the full correct picture is available.

Examples of lessons learned from root cause analysis and incident reviews are attached at **Appendix 1.**

3.2 Complaints

The Trust received 228 complaints, compared with 172 in the same quarter in 2008/09, an increase of 32%.

Negotiated target times are an important feature of the new NHS Complaints Procedure that was introduced from the 1st April 2009. The Trust's database has been updated and can now reflect whether - and how often - negotiated target times have been changed. Details of this are shown below. However, this feature was not available for previous reporting periods and therefore direct comparison cannot be made.

The deadlines for 24% (55) of complaints were re-negotiated. Some of these timescales had to be extended more than once. In total there were 82 date changes for the following reasons.

Date Change Agreed with Complainant	9%
Clarification/Additional Info Required	37%
Clinical Risk Investigation Ongoing	2%
Draft Requiring Amendment	6%
Medical Records Delayed/Missing	2%
Awaiting consultant comments	11%
Awaiting nursing comments	10%
Awaiting other comments	6%
Case Referred To Senior Clinical Advisor	5%
Other Reason	12%

The complaints were graded as follows:-

Grade	April – June 2008	April - June 2009
Red	3 (2%)	2 (1%)
Amber	28 (16%)	33 (14%)
Yellow	61 (35%)	89 (39%)
Green	80 (47%)	104 (46%)

To date, 4% of the complaints have been re-opened as the complainant raised queries or concerns with the original response. This is presently below the same quarter last year (April to June 2008 was 9% based on current reports).

The main areas of concern were:-

Category	April – June 08	Apr – June 09
Clinical treatment	37%	42%
Delays/cancellations	20%	26%
Communication	9%	5%
Staff attitude	11%	12%
Hotel services/food*	4%	1%

Key lessons learned for complaints during Q1 are attached at **Appendix 1**.

3.3 Claims

22 clinical negligence and 14 personal injury claims were received in Q1 (compared to 20 clinical negligence claims and 9 personal injury claims in Q4)

The allegations for the claims received in Q1 fall into the following categories:

Category	Clinical Negligence	Personal Injury
Delay In Treatment	1	0
Defective Equipment	0	1
Dissatisfied With Treatment	5	0
Failure Or Delay In Diagnosis	6	0
Failure To Recognise Complications	1	0
Fall/slip	0	5
Late Diagnosis And Treatment	2	0
Lifting/moving/handling	0	2
Moving/falling Objects	0	1
Needlestick	0	5
Operation Carried Out Negligently	6	0
Treatment Carried Out Negligently	1	0

At present the Trust has 243 clinical negligence claims and 89 personal injury claims at various stages of the legal process:

Status Type	Clinical Negligence	Personal Injury
Disclosure Of Records	152	0
File In Abeyance	1	0
Interim Payment	1	0
Letter Of Claim	35	53
Letter Of Response	8	1
Liability Admitted	5	13
Liability Being Assessed	5	3
Liability Denied	4	6
Negotiate Settlement	6	0
Part 36 Offer	3	1
Proceedings Issued/served	6	2
Settlement Made	17	10

The ongoing claims fall into the following categories:

Category	Clinical Negligence	Personal Injury
Burns/scalds/reactions	2	4
Defective Equipment	1	3
Delay In Treatment	15	0
Dissatisfied With Treatment	57	0
Drug Error	2	0
Electric Shock	0	0
Failure Or Delay In Diagnosis	70	0
Failure To Ob Informed Consent	2	0
Failure To Obtain Consent	2	0
Failure To Recognise Complications	18	0
Failure To Warn Of Risk	1	1
Fall/slip	3	40
Head Injury	0	2
Infection - MRSA	1	0
Infection - Other	2	0
Lacerations/sores	2	0
Lack Of Care	3	1
Late Diagnosis And Treatment	4	0
Lifting/moving/handling	2	8

Moving/falling Objects	0	7
Needlestick	1	15
Operation Carried Out Negligently	36	0
Other	1	1
Stress	0	1
Toxic Fumes	0	1
Treatment Carried Out Negligently	18	0
Violence & Aggression	0	5

Comparisons with other Trusts of a similar size for claims reported to the NHS Litigation Authority in 2007/8 are shown in **Appendix 2**.

3.3 Aggregated analysis

As with previous quarters, the second most reported incident category (aspects of clinical care) correlates with the most frequently recorded complaint category (dissatisfaction with clinical treatment). In Q1 42% of all complaints related to clinical treatment, however this made up only 14% of reported incidents.

There is no clear correlation between claims received during Q1 2008/9 and incidents/complaints. The new claims in general relate to medical management (ie diagnosis, complications, operations, treatment). It may, however, be possible to focus on any incidents/complaints received in these areas in future as these may be more likely to be potential claims.

Incidents and complaints are categorized using the same grading system. 2.6% of incidents and 1% of complaints received during Q1 were red.

4. Recommendations

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

Appendix 1

Lessons Learned Q1 2009/10

1. Incidents

31 red incidents were reported via incident forms during this period. Table top reviews are held for each and action plans developed, which are monitored through the Adverse Events Committee, chaired by the Chief Executive.

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

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

Incident type	**Lessons Learned/ Improvements/Actions taken**
Wrong site surgery (right Bartolin gland marsupialised instead of left)	**Root cause** – failure to confirm site with documentation prior to operation **Good practice** – use of WHO surgical site checklist **Action taken / lessons learned:** Site to be included on ORMIS/theatre lists for this procedure Lessons incorporated into junior doctor specialty induction Review to be undertaken with a view to improving ORMIS accuracy and simplifying gynae categories
Intoxicated patient found dead after taking his own discharge (suspected Sudden Unexpected Death in Epilepsy)	**Root cause** – no causal link with death established. Poor documentation in A&E and failure to identify previous attendances for epilepsy identified **Good practice** – Patient had been warned of dangers of drinking in clinic the previous day **Action taken/lessons learned :** Develop pathway for management of intoxicated patients Review computer systems to ensure full clinical picture is known Feedback to staff around use of documentation
Cluster of fractured neck of femur incidents following in-patient falls	**Root cause** – higher number of mobile patients with social needs on ward **Action taken/lessons learned:** Use of volunteers to help feed patients introduced to free up nurses for clinical care Targeted record keeping training for staff to ensure accurate documentation following falls Amendment to care plan to include referral to NSF Older People Lead
Focus on Needlestick incidents	**Root cause –** Differing practices wrt to bedside needle management leading to inappropriate used needle management/disposal **Action taken/lessons learned:** Work with Division to get consistency wrt to availability and storage locations of portable sharp boxes and trays. Work is still progressing (lead by Occupational Health Consultant) to identity and implement more proactive controls.

2. Complaints

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

- Remind consultants to use the electronic system for requesting scans
- Procedure for booking patients with the clinical nurse specialist amended to overcome problems highlighted by the complainant
- Phlebotomists reminded to ensure that gloves are available in the correct size before the start of the clinic
- Awareness raised at team meeting of the issues highlighted by the complainant
- Consultant discussed complaint/different approach with the junior doctor

COMPARISON WITH OTHER TRUSTS OF CLAIMS REPORTED TO THE NHS LITIGATION AUTHORITY IN 2007/8

Name of Trust	No. of medical negligence claims reported	No. of personal injury claims reported
Sandwell and West Birmingham Hospitals	43	48
Barking, Havering & Redbridge Hospitals	67	22
Barts and the London NHS Trust	41	12
Central Manchester & Manchester Children's	54	46
Guys & St Thomas	51	24
Hull & East Yorkshire Hospitals	60	44
Imperial College Healthcare	78	15
Mid Yorkshire Hospitals	45	32
Newcastle Upon Tyne Hospitals	41	32
Nottingham University Hospitals	53	36
Pennine Acute Hospitals	82	40
Sheffield Teaching Hospitals	56	69
Southampton University Hospitals	39	19
The Leeds Teaching Hospitals	67	32
The Oxford Radcliffe Hospitals	54	12
University Hospitals of Leicester	94	27

Source – NHS Litigation Authority website