Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Churchvale/Hollyoak Rooms, Sandwell Hospital **Date** 29 April 2010 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)	
Mr G Clarke	(GC)	
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)	
Mrs J Kinghorn	(JK)	
Mrs C Rickards	(CR)	
Mr J Cash	(JC)	

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 25 March 2010 as true and accurate records of discussions*	**SWBTB (3/10) 073**	**Chair**
5	**Update on actions arising from previous meetings**	**SWBTB (3/10) 073 (a)**	**Chair**
6	**Questions from members of the public**	**Verbal**	**Public**
	MATTERS FOR APPROVAL		
7	**Sustainable Development Management Plan Update**	**SWBTB (4/10) 078** **SWBTB (4/10) 078 (a)** **SWBTB (4/10) 078 (b)** **SWBTB (4/10) 078 (c)** **SWBTB (4/10) 078 (d)**	**GS**
8	**Blood transfusion policy**	**SWBTB (4/10) 087** **SWBTB (4/10) 087 (a)** **SWBTB (4/10) 087 (b)** **SWBTB (4/10) 087 (c)**	**DOD**
9	**Transport of Krypton generators – single tender action**	**SWBTB (4/10) 088**	**RK**

MATTERS FOR INFORMATION/NOTING			
10	**Quality and Governance**		
10.1	Equality and diversity update	SWBTB (4/10) 075 SWBTB (4/10) 075 (a) SWBTB (4/10) 075 (b)	RO
10.2	Progress with the safeguarding adults and children agenda	SWBTB (4/10) 085 SWBTB (4/10) 085 (a)	RO
10.3	CQC registration: ongoing monitoring of compliance	SWBTB (4/10) 093 SWBTB (4/10) 093 (a)	KD
10.4	Register of seals update for 2009/10	SWBTB (4/10) 083 SWBTB (4/10) 083 (a)	SGP
10.5	National outpatient survey results	SWBTB (4/10) 089 SWBTB (4/10) 089 (a) SWBTB (4/10) 089 (b)	JK
11	**Strategy and Development**		
11.1	'Right Care, Right Here' programme: progress report	SWBTB (4/10) 090 SWBTB (4/10) 090 (a) SWBTB (4/10) 090 (b)	RK
11.2	New acute hospital project: progress report	SWBTB (4/10) 079 SWBTB (4/10) 079 (a)	GS
11.3	Update on the Workforce strategy	SWBTB (4/10) 076 SWBTB (4/10) 076 (a) SWBTB (4/10) 076 (b)	RO
12	**Performance Management**		
12.1	Monthly finance report	SWBTB (4/10) 092 SWBTB (4/10) 092 (a)	RW
12.2	Monthly performance monitoring report	SWBTB (4/10) 091 SWBTB (4/10) 091 (a)	RW
12.3	NHS Performance Framework monitoring report	SWBTB (4/10) 094 SWBTB (4/10) 094 (a)	RW
12.4	Progress against the delivery of corporate objectives – Quarter 4	SWBTB (4/10) 077 SWBTB (4/10) 077 (a)	RW
13	**Operational Management**		
13.1	Staff engagement briefing	SWBTB (4/10) 084 SWBTB (4/10) 084 (a)	JA
14	**Update from the Board Committees**		
14.1	Finance and Performance Management Committee		
▶	Minutes from meeting held 18 March 2010	SWBFC (3/10) 037	RT
15	**Any other business**	**Verbal**	**All**
16	**Details of next meeting** *The next public Trust Board will be held on 27 May 2010 at 1430h in the Anne Gibson Boardroom, 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
NHS Trust

Trust Board (Public Session) – Version 0.2

Venue Anne Gibson Boardroom, City Hospital **Date** 25 March 2010 at 1430 hrs

Present:	Mrs Sue Davis	Dr Sarindar Sahota	Mr Richard Kirby
	Mr Roger Trotman	Prof Derek Alderson	Mr Donal O'Donoghue
	Miss Isobel Bartram	Mr John Adler	Miss Rachel Overfield
	Mrs Gianjeet Hunjan	Mr Robert White	
In Attendance:	Mrs Lesley Barnett	Miss Kam Dhami	Mr Graham Seager
	Mrs Jessamy Kinghorn	Miss Judith Whalley	Mr John Cash (Sandwell LINKs)
	Mrs Sue Wilson [Item 7]	Dr Deva Situnayake [Item 16.1]	

Secretariat: Mr Simon Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
No apologies for absence were received.	
2 Declaration of interests	**Verbal**
Mr Trotman advised that he was acting as an agent for an Independent political candidate sitting for a parliamentary seat in Erdington, Birmingham.	
3 Chair's opening comments	**Verbal**
The Chair advised that the meeting was the last which Miss Judith Whalley would be attending in her capacity as Trust Convenor. She was thanked for her work with the Trust Board over the past years and in particular for her discretion and support. Miss Whalley thanked the Trust Board for its kind wishes and remarked that she had enjoyed the work very much. On a separate matter, Mr Trotman advised that Mrs Davis had been reappointed for a further term of four years as Chair of the Trust. On behalf of the Trust Board he extended his congratulations to Mrs Davis.	
4 Minutes of the previous meeting	**SWBTB (2/10) 047**
The minutes of the previous meeting were presented for approval. Mr Cash asked that the minutes be amended to reflect the exchange that he had made with Professor Alderson, concerning the LINKs involvement in patient	

satisfaction surveys as part of the wider discussion around public health matters. He also asked that the attendance list be amended to reflect that he was representing Sandwell LINKs at the meeting. Subject to these minor amendments, the Trust Board approved the minutes as a true and accurate reflection of discussions held on 25 February 2010.	
AGREEMENT: The minutes of the previous meeting on 25 February 10 were approved as true and accurate reflections of discussions held	
5 Update on actions from previous meetings	**SWBTB (2/10) 025 (a)**
The updated actions list was reviewed. There were noted to be no outstanding actions requiring escalation.	
6 Questions from members of the public	**Verbal**
There were no members of the public in attendance at the meeting.	
7 Update on progress with the IM & T strategy	**Presentation** **SWBTB (3/10) 052** **SWBTB (3/10) 052 (a)**
Mrs Sue Wilson joined the meeting to provide the Trust Board with an update on progress with delivery of the Trust's Information Management and Technology (IM and T) strategy. The Board was advised that one the key risks associated with the strategy concerned the implementation of Lorenzo. As part of the National Programme for IT that was mandated in 2004, Lorenzo was due to be deployed across the entire health economy by 2010. Within the implementation programme however, there had been several delays meaning that interim solutions needed to be arranged. A recent announcement by the Secretary of State for Health proposed that the National Programme for IT needed to generate savings given the current economic climate, therefore the functionality to be provided from Lorenzo would need to be scaled back. As such, functionality envisaged as part of the Release 4 phase of the system, including that concerned with integrated care pathways and clinical guidelines support will not now be provided. The national clinical leads for IT have been dissatisfied with the plans for acute trusts and in terms of the impact on the Trust, the Board was advised that there is a possibly that functionality to support the new hospital may be delayed and the Electronic Patient Record solution may not be delivered. The Chair noted that a London Trust had purchased an alternative solution, which appeared to be working well. Mr Kirby advised however, that should the Trust decide to purchase a similar solution, central funds allocated for the implementation and support for Lorenzo would not be available for this alternative solution. Furthermore, there are likely to be penalties imposed, should the Trust not adopt Lorenzo. The Chair advised that liaison with PCTs is underway regarding the issues. Mrs Wilson added that six trusts across the West Midlands have decided against adopting the revised Lorenzo solution, however it is unclear as yet as to what alternative will be implemented. Mr Adler noted that the funding for Lorenzo extends to 2016 and asked what funding plans were expected afterwards. Mrs Wilson advised that it was expected that the support for the solution would have be provided locally. Mr White asked whether Lorenzo intended to replace the current set of IT interfaces	

with a more coherent system. He was advised that this was the case and different clinical models of care had been planned based on the unabridged functionality. Mr O'Donoghue supported the view that an integrated solution was needed and the additional functionality, as originally planned was essential. Mr Kirby suggested that a possibility for the Trust was to implement as much of Lorenzo functionality as possible and then purchase additional functionality. Mr O'Donoghue highlighted that there was a need to ensure that if this plan was agreed, that there was clear harmony between the additional systems purchased and Lorenzo. Mr Cash noted that the strategy included plans to move to a paperless system, but suggested that caution be given to implementing this fully. Mrs Wilson provided assurance that this would be undertaken on a phased basis and advised that paper records would be scanned into a storage system where possible. The Board was advised that a specific workstream had been added to the Quality and Efficiency Programme (QuEP), which concerned the implementation of cross organisational IT systems, including digital dictation; migration to NHSMail; electronic prescribing; and introducing more advanced technology within Ophthalmology. It is hoped that some innovations planned will reduce missed appointments. The introduction of digital pens also aims to eliminate some of the duplication associated with manually completing records. An electronic bed management system is planned to assist with providing more accurate and timely information concerning inpatients. It is envisaged that the technology will be expanded to cover staff handovers and Hospital at Night work. Progress with other IT projects was discussed, including the upgrade of the Patient Administration System (PAS); the introduction of the Evolution system into the community, which had proved to be challenging; electronic requesting of tests; and implementation of electronic discharge summaries. Support had also been provided for the work to meet the CQUIN smoking cessation referrals target and for infection control initiatives. Mr O'Donoghue asked how the IM and T strategy supported the ongoing work concerning Service Line Management and the Quality Management Framework. He was advised that an appropriate solution was currently being considered, however the refresh of the IM and T strategy due shortly will canvas areas requiring support more fully, including quality. Mrs Wilson was thanked for her useful presentation.	
8 Corporate plan 2010/11	**SWBTB (3/10) 068** **SWBTB (3/10) 068 (a)**
Mr Kirby presented the corporate plan covering 2010/11 for approval, highlighting the format and style to be consistent with that required by Monitor for Foundation Trusts. The Board reviewed the national and local context in which the plan is set, together with the high level vision. The plan was noted to incorporate 36 strategic objectives for 2010/11, a significant number of which relate to High Quality of Care and are specific to service reviews or are a continuation of work started in 2009/10. In terms of activity, Mr Kirby advised that it had been assumed that levels would be	

less that those seen in 2009/10, driven by the commissioners' view of affordability and service changes expected.

The 11 areas of CQUIN targets were summarised, together with the associated tariff set against each. The Chair asked for more detail concerning the target regarding Wharfarin prescription. She was advised that this target specifically related to the results produced when Wharfarin is administered.

A preliminary risk analysis was considered, which Mr Kirby advised would be developed further during the coming months. Overall however, the Trust Board noted that the plan carried greater risk than that for 2009/10.

Mr Trotman noted that in some instances, more than one individual was assigned to the delivery of a particular corporate objective and asked whether there had been agreement as to which of the executive directors was ultimately accountable. Mr Adler advised that there was some degree of overlap in some of the objectives, however it will be clarified which individual is responsible.

The Chair asked whether the risk ratings included in the plan took into account any mitigating actions planned. Mr Kirby advised that the ratings represented the position before any mitigating treatment had been applied.

Mr Cash observed that the level of Trust membership had dropped. Mrs Kinghorn advised that overall the level of members had risen, although the drop in numbers reported in the plan had been anticipated. Work has been undertaken to replace the individuals that had left and some targeted recruitment from under represented areas had been completed.

Mr Cash asked what additional work was planned in connection with patient experience. Miss Overfield advised that a number of workstreams were planned, including work around hygiene, High Impact Nursing Actions, nutrition and hydration. The work will be included within the overall patient experience action plan. Further progress is expected to be made regarding privacy and dignity, including the introduction of new nightware.

Mrs Kinghorn advised that in terms of the corporate objectives developed, patients had been pleased to note that the majority of objectives that had received greater than 10% support within the public consultation exercise had been included in the plan.

Miss Whalley suggested that the workforce numbers within the plan needed to be reviewed. She was advised that the numbers represented headcount, rather than whole time equivalents however.

Dr Sahota asked what happened to staff that left the Trust in respect of their Trust membership. Mrs Kinghorn advised that these individuals would no longer be a staff member, but could apply to be a public member if they met the required eligibility criteria.

Mr Adler remarked that there had been some concern over the number of corporate objectives included in the plan, however it had been clarified that these all needed to be a priority for the Trust and meet quality requirements.

The Trust Board was asked for and gave its approval to the corporate plan for

2010/11.	
AGREEMENT: The Trust Board approved the 2010/11 corporate plan	
9 Financial plan 2010/11	**SWBTB (3/10) 069** **SWBTB (3/10) 069 (a)** **SWBTB (3/10) 069 (b)**
Mr White presented the draft financial plan for 2010/11 for approval. The local health economy position was reviewed where it was noted that the Trust's two principal commissioners were anticipating a more financially stringent year, which would impact on the Trust's funding. A surplus of £2m is forecast for the year end of 2010/11. Mr White advised that a Strategic Change Reserve (SCR) had been established, whereby the PCTs had been required to contribute a proportion of its funding into a central pot, against which the Trust was required to bid for an allocation. Four best practice tariffs have been developed, including a tariff concerned with cataract procedures. The main elements of the income assessment were outlined as activity being expected to be lower than that in 2009/10; the allocation associated with the CQUIN targets is 1.5% of tariff; an adjustment has been made to the plan to take into account the elimination of the market forces factor; expenditure during the year is planned to be £375m; and income to be received is £377m. The plan takes into account key cost pressures, including the Agenda for Change increase; changes to the consultant contract and discretionary points; the increase in VAT to 17.5% from 15%; and the increase in NHS Litigation Authority premiums. The planned Cost Improvement Programme (CIP) was discussed, together with the allied Quality and Efficiency Programme. One of the plan's key risks was noted to be the potential for the Trust to be unsuccessful with its bid for an allocation from the Strategic Change Reserve. If the funds are not awarded and the plan looks to be unlikely to be met, the Board was advised that financial recovery processes would need to be invoked. Mr Trotman advised that the plan had been considered in detail by the Finance and Performance Management Committee and the risks had been reviewed. The impact of the planned reduction in workforce and associated paybill on the nursing and medical areas had been considered in particular. Mr Adler remarked that in terms of financial deliverability, 2010/11 is to be challenging, as an efficiency of a higher magnitude than in previous years is expected, driven partly due to national pressures and by local circumstances. The CIP in particular was highlighted to be higher than previous years and would be challenging to deliver. The development of the QuEP however has been devised to support the achievement of the CIP and generate a set of efficiencies which in turn may deliver long term benefits and cost savings. Mr Adler advised that the CIP had been developed through a series of discussion and challenge sessions with relevant divisional leads, which also engaged all relevant executive directors. In terms of	

assurance processes, the Board was advised that a large number of CIP schemes had been rejected on the basis that they would be undeliverable or would be detrimental to the service. For those schemes approved, continual monitoring will be employed to ensure that there is no compromise to the quality of service provided by the Trust. Picking out the CIP scheme associated with closure of medical beds, Mr Kirby advised that this plan had been informed by a benchmarking exercise. As a consequence however, additional acute physicians will need to be recruited and this is incorporated in the plan. Work to redesign some care pathways to deliver greater efficiency was also noted to be in progress. Miss Overfield advised that there had been a commitment not to change staff: bed ratios and there were plans in some instances to improve these ratios. Issues may occur however, should there be a need to reopen closed beds at short notice in the event of activity pressures. Miss Bartram asked where patients may notice the impact of the challenging plans. Miss Overfield advised that it was hoped that patients would not experience any deterioration in the service provided and may notice an improvement in some instances, where efficiencies are being driven out. Mr Adler reported that the continued investment in the cleaning of clinical and public areas had been built into the financial plan. Dr Sahota observed that the local authorities were also under financial pressure and asked how this would impact on delayed transfers of care. He was advised that there are plans to improve performance in this area and if difficulties are to be experienced, then this is most likely to be within Birmingham. A set of agreements are to be developed, setting out the level of delayed transfers that may be tolerated. Dr Sahota remarked that control of staff sickness absence was a key factor in delivery of the plan. The Trust Board was asked for and gave its unanimous approval to the plan.	
AGREEMENT: The Trust Board approved the financial plan for 2010/11	
10 'Leadership for the Future'	**SWBTB (3/10) 056** **SWBTB (3/10) 056 (a)**
Mr Adler reported that the importance of leadership had been shown through the 'Listening into Action' process. To review the progress for the development of leadership within the Trust, Sally Fox,, the 'Listening into Action' Facilitator, had undertaken a stocktake in conjunction with the Workforce Directorate and Executive colleagues. It was determined that there had been much work undertaken around leadership, but this had not been within an organised framework. The Board was advised that there had been an increase in input externally over recent years, covering a wide range of aspects pertaining to leadership. Individually, the Trust is strong on a number of aspects of leadership, however resourcing is presently ad hoc. One of the gaps was found to be in clinical	

leadership, therefore Mr O'Donoghue had implemented the 'Leadership in Healthcare' programme to address this area. Work on talent management has also been undertaken. In view of the findings of the stocktake, it was proposed that a leadership framework be established, which sets out the skills and behaviours that a leader within the Trust should possess. It is intended that the leadership framework be launched at the summer Leadership Conference. As there is a need to ensure that the Trust develops the most appropriate leaders, initiatives such as 360 degree feedback will be introduced and developed. The Board was advised that there is a growing interest across the health economy on this matter. Clarity around the resources required is to be gained initially and an action plan will be produced to handle the evolution of leadership development. Dr Sahota remarked that £49,000 for resourcing the work appeared to be a low estimate. Mrs Barnett advised however that this related to a central pot of funding for the work and did not reflect the total current or anticipated expenditure. Miss Bartram suggested that leaders should be expected to be able to interpret data presented to them. Mr Kirby proposed that a more useful quality may be the ability to use evidence to support decision making. Miss Bartram suggested that psychometric testing may need to be used as part of the leadership development work. It was also proposed that experience of the environments and work in other trusts may be useful for leaders as part of their development. Mr O'Donoghue asked whether there was an onus on the Trust to undertake leadership development in house or whether some elements could be outsourced. Mrs Barnett suggested that there should be a balance between in house delivery and outsourcing. The Trust Board was asked for and gave its approval to the proposals for the development of leadership within the Trust.	
AGREEMENT: The Trust board approved the proposed plans for the development of leadership within the Trust	
11 Single sex accommodation progress report and declaration	**SWBTB (3/10) 058** **SWBTB (3/10) 058 (a)**
Mr Kirby presented an update on delivery of single sex accommodation within the Trust. The number of occasions when the single sex accommodation standards had been breached was reviewed, which Mr Kirby acknowledged was significant, however was confined to a small number of units on which male and female patients could not be separated adequately. Since the single sex work had been completed however, there had been less than ten occasions when the guidelines had been breached on one of the main inpatient wards. It was noted that the areas where accommodation does not permit separation of male and female patients include Critical Care, Coronary Care, theatre recovery areas and Imaging recovery. Adherence to the guidance on the Emergency Assessment Unit and Medical Assessment Unit was noted to be variable, dependent on the activity pressures. The planned redevelopment of the Medical Assessment Unit at City Hospital was highlighted as being a measure which would assist with this	

issue. Mr Kirby presented the public declaration of status regarding adherence to single sex accommodation guidance, part of which was noted to be standard text. The Trust Board was asked to review the 'What this means for the Trust' section in particular which discussed the management of issues and the impact of them on the operation of the Trust. Acknowledging that a breach of the single sex guidance may not always result in a complaint, Mr Cash asked what type of complaints had been received in connection with the breaches. He was advised that there had been very few complaints received in this respect, largely because breaches are rare in inpatient areas. The Trust Board approved the proposed public declaration regarding adherence to single sex accommodation guidance.	
AGREEMENT: The Trust Board approved the public declaration regarding adherence to single sex accommodation guidance	
12 Information Governance toolkit	**SWBTB (3/10) 058** **SWBTB (3/10) 058 (a)**
Mr Kirby advised that this was the first time that the Trust Board had considered information governance issues in any detail. The Information Governance toolkit was noted to provide a set of standards and thresholds against a set of information governance indictors. In terms of corporate information, the Board was advised that the toolkit reveals that the storage and management of information needs to be improved. Performance against a number of the standards was noted to have deteriorated since the previous year, which Mr Kirby reported was reflective of the more detailed and challenging standards for the current year. The Board was advised that a small number of information security breaches had occurred within the year, three of which had needed to be reported to the Information Commissioner. The response form the Information Commissioner's office congratulated the Trust on the effectiveness of its management and control of the incidents, however indicated that there would be further investigation, should another incident need to be reported. Mr O'Donoghue asked how the Trust's performance against the standards compared with that of other organisations. He was advised that the Trust performed comparably, although there was further work needed to improve the overall position. The Trust Board was asked for and gave its approval to the statement of compliance against the Information Governance toolkit standards.	
AGREEMENT: The Trust Board gave its approval to the statement of compliance against the Information Governance toolkit standards	
13 Quality and Governance	

13.1 Nursing update – end of year report for 2009/10	**SWBTB (3/10) 062** **SWBTB (3/10) 062 (a) - SWBTB (3/10) 062 (f)**
Miss Overfield presented an update on nursing activities covering the second half of 2009/10. She advised that work had been undertaken to develop the nursing structure further and ward reviews had been completed. The Board was advised that the reviews were conducted twice yearly to coincide with divisional performance reviews. A shift towards better scores across many wards had been seen in the latest round of reviews, however any reduced scores may reflect a greater level of information available to be able to more accurately assess a ward's performance. It was noted that the number of wards appropriately managing vulnerable adults had increased. The ward review process was noted to now include special measures processes, where a set of processes and reviews are invoked for wards showing deterioration in accordance with a list of criteria and standards. The one ward to which special measures have been applied to date was reported to be improving. Miss Overfield reported that Essence of Care audits continue to be undertaken on a twice yearly basis, which focus specifically on basic care. It was noted that the audits are based on a set of patient records and the recent round has highlighted an improvement in standards. Of the High Impact Nursing Actions, it was noted that those concerning pressure damage and falls reduction are aligned to two of the 2010/11 CQUIN targets. Although there is a lack of national information to be able to assess the Trust's relative position regarding these indicators, it is expected that the Trust is not an outlier in this respect. In terms of nutrition, the Trust's food choice was reported to be good and patients are fed well, however patients who are nutritionally at risk are not always assessed at present. This is being addressed. The Board was advised that the Privacy and Dignity campaign had been launched in December 2009 and the outcome had since been reviewed. It was found that the Trust was performing well against overall privacy and dignity standards, however there were areas for improvement identified around privacy of conversations with patients; the use of gloves; the enforcement of the Trust's visitor policy; and the use of pet names for patients. Regarding workforce, Miss Overfield reported that an establishment review had been conducted in 2009, which highlighted wards needing additional resources. Resources on three of the wards that were highlighted to be of concern have now been increased, with a further two wards still to be addressed. Resources in the Trauma and Orthopaedics area was noted to require further review to ensure that there is a balanced staffing level between the elective and trauma wards following reconfiguration. The Board was advised that the use of bank and agency staff across the Trust had declined and was expected to continue reducing. A refinement to the bank pay rates has been delivered recently, reducing the number of rates from 26 to less than 10.	

Role development work is progressing well and assistant practitioner roles are to be introduced. The development of nursing into a graduate profession is planned, with the ultimate aim of all qualified nurses possessing a degree by 2020. Within the Trust currently only 34% of nurses are graduates, therefore there is much work to do to ensure all nurses attain a degree. It was noted that this low level of graduates within the Trust reflects the educational output of the region, however the University of Wolverhampton has been approached to assist with meeting the educational needs of the Trust. 'Top up' modules are planned and a bid to the Strategic Heath Authority has been submitted for funds to support this work.

Miss Overfield reported that a report had been issued by the Prime Minister's Commission concerning the future of nursing and midwifery in England, which sets out the actions required to inspire public confidence. All issues within the report are to be addressed locally where relevant.

Returning to the ward review process, Mr O'Donoghue asked whether the standards used were dictated nationally or applied only to local trusts. He was advised that the indicators used are derived from national standards and where additional indicators have been felt to be necessary, then these have been developed locally. It was noted that for some areas, measurement of standards is subjective. Some standards are being developed that are specific to some areas, such as paediatrics.

Mrs Hunjan asked how long a ward usually takes before the special measures are lifted. Miss Overfield advised that there was an expectation that a ward would come out of special measures after six months, although a review would be conducted every two months. Miss Whalley reported that staff on the ward currently under special measures were meeting the challenge without complaint or resentment.

Dr Sahota noted that there had been an increased level of falls at Sandwell Hospital. Miss Overfield explained that this was reflective of the improved culture of reporting as all falls are now reported; not just those resulting in injury. Furthermore, she advised that some patients may be prone to falls which can skew the results for a particular ward or area to some degree.

Miss Bartram remarked that from her experience, a 34% graduate rate in the Trust may be comparable with a number of other local trusts. Miss Overfield agreed but advised that 34% would be much lower than some trusts in more affluent areas. Miss Bartram suggested the possibility of using the Open University to assist with the education programmes where possible.

Mr Cash asked how the requirement to use hand gel was being enforced. He was advised that all measures possible are taken to promote the need to use hand gel and visitors are included within the hand hygiene audits.

Mr Cash asked whether the Trust had a full complement of volunteers to assist with basic duties. Miss Overfield advised that this was not the case and active recruitment is underway through the pool of shadow Foundation Trust membership.

The Chair noted that there had been good progress in may areas of nursing in the Trust.

13.2 Care Quality Commission report of integrated inspection of safeguarding | **SWBTB (3/10) 061**

and looked after children's services in Sandwell	**SWBTB (3/10) 061 (a)**
The Trust Board received and noted the Care Quality Commission report of integrated inspection of safeguarding and looked after children's services in Sandwell, the outcome of which had been discussed at a previous meeting of the Trust Board.	
13.3 Integrated risk, complaints and claims report	**SWBTB (3/10) 070** **SWBTB (3/10) 070 (a)**
Miss Dhami reported that there had been a reduction in the overall number of reported incidents, although there had been a notable increase in health and safety and clinical incidents. There had also been an increase in the number of red incidents compared to the same quarter in 2008/09. The Board was advised that there are plans to introduce electronic incident reporting, the guidance and proformas for which will be available from the intranet. It was noted that the number of yellow and green incidents are less than desired, suggesting room for improvement in terms of the Trust's reporting culture. In terms of the top six incidents reported by quarter, it was highlighted that the number of incidents related to patient falls had increased. Miss Dhami advised that in line with previous discussions around the nursing report, this was due to the revised classification of which falls-related incidents should be reported. The lessons learned from the incidents reported was reviewed. In terms of complaints, it was highlighted that during the reporting period there had been an increase in complainant contacts. Miss Dhami advised that a quarter of the target dates for responses to complaints made had needed to be renegotiated, as additional information was needed from clinicians or the matter had proved more complex than initially envisaged. It was noted however that the more detailed responses now provided appeared to have resulted in fewer dissatisfied complainants. Regarding the major areas of concern, Miss Dhami highlighted that delays and cancellations had prompted a significant proportion of the complaints received. The largest number of complaints however concerned dissatisfaction with medical and nursing care. The data relating to claims was reviewed. It was noted that there had been a higher level of clinical claims during the period. In terms of those claims concerning patient safety, there were observed to be a greater number of incidents that did not generate any harm, or were near misses. The incident trends for the same however show a flat trend, therefore further investigation is planned to understand the relationship between the two. Professor Alderson suggested that the way in which incident data was presented may be misleading in that a higher number of incidents aligned to a higher number of patients seen may be reported as a flat trend. Miss Dhami advised that the figures reported by the National Reporting and Learning Service (NRLS) adjusts figures to take into account activity. Mr O'Donoghue suggested that a more useful indication would be the number of incidents in relation to an agreed number of bed days. Mr Cash noted that there was a high level of claims in relation to the Women and Child Health division and asked whether it was anticipated that the trend would continue rising. Miss Dhami advised that the trend reported was consistent with the national position and there had not been a sustained increase in the number of incidents over time.	

13.4 Assurance Framework update – Quarter 4	**SWBTB (3/10) 054** **SWBTB (3/10) 054 (a)**
Mr Grainger-Payne presented the final update on progress with the actions to address the gaps in assurance and control against the risks to the delivery of the Trust's corporate objectives. The Board noted that following the application of treatment plans, two risks remain at red status: the achievement of NHS Litigation Authority Level 2 standards, which concerned the agreed postponement of the assessment; and the delivery of Mandatory Training. Mr Grainger-Payne highlighted that following a recent interim internal audit of the Assurance Framework, additional detail had been added to the elements of the Assurance Framework concerned with sources of external assurance and key controls in place.	
14 Strategy and Development	
14.1 'Right Care, Right Here' programme: progress report	**SWBTB (3/10) 071** **SWBTB (3/10) 071 (a)** **SWBTB (3/10) 071 (b)**
Mr Kirby presented the latest update on progress with the 'Right Care, Right Here' programme, which was received and noted by the Board. Mr Cash asked whether the planned ward closure of inpatient beds at Rowley Regis Hospital were linked to the 'step up' plans. He was advised that the pilot 'step-up/step-down' ward had been closed but Sandwell PCT was developing plans for additional intermediate care beds at Rowley Regis Hospital.	
14.2 New Acute Hospital project: progress report	**SWBTB (3/10) 063** **SWBTB (3/10) 063 (a)**
Mr Seager presented the new acute hospital project progress report, which the Board received and noted.	
15 Performance Management	
15.1 Monthly finance report	**SWBTB (3/10) 051** **SWBTB (3/10) 051 (a)**
Mr White reported that the in-month surplus achieved was £96k against a target of £70k; £26k above plan. The year to date surplus was reported to be £2,202k against a plan of £2,232k. In month WTEs are 127 below plan and the cash balance is approximately £5m above plan as at 28 February 2010. The Board was advised that following a recent revaluation the Trust's estate by the District Valuer, it is likely that a large technical write off will need to be included in the annual accounts to reflect the outcome of the exercise. Mrs Davis asked whether there was confidence that the forecast financial outturn could be achieved. She was advised that this was the case.	

15.2 Monthly performance monitoring report	**SWBTB (3/10) 049** **SWBTB (3/10) 049 (a)**
Mr White reported that there had been a change to the way in which cancer waiting times are being monitored. Cancelled operations were reported to have reduced, although the number of delayed transfers of care has increased. There had been an improved performance against the stroke care target. The percentage of patients waiting four hours or less to be seen in Accident and Emergency was reported to be 98.4% year to date. Performance against infection control targets was noted to be good. Referral to treatment time performance is predicted to be in excess of 95% for admitted patients and 90% for non-admitted patients in all specialities apart from in orthopaedics. The Chair suggested that exception reports for referral to treatment time should be received by the Trust Board, with further detail to be considered by the Finance and Performance Management Committee where required. In terms of performance against CQUIN targets, the target was reported to have been met for smoking cessation referrals, with over 1000 having now been made. Further work is required to meet the hip fracture target, with performance currently standing at 83.4%. A drop in the use of bank and agency staff was noted. Returning to the accident and emergency waiting time performance, Mr Adler highlighted that this was particularly pleasing, given the difficult winter pressures. He advised however, that the West Midlands area was the worst performing in the country overall.	
15.3 NHS performance framework monitoring report	**SWBTB (3/10) 050** **SWBTB (3/10) 050 (a)**
Mr White presented the NHS Performance Framework monitoring report. The Board was pleased to note that the Trust remains classified as a 'performing' organisation and that performance against all targets was rated as being 'green'.	
16 Operational Management	
16.1 Medical Education plans	**SWBTB (3/10) 059** **SWBTB (3/10) 059 (a)**
Dr Deva Situnayake joined the meeting to present the plans for the medical education area. He advised that the plans concerned the introduction of proactive quality assurance for undergraduate and postgraduate training. The programme will identify the training work underway and rectify any issues that occur ahead of the Deanery. It was reported that the training plans will feed into the new clinical directorate structures. The postgraduate tutors have reviewed training for their particular remit and arrangements have been made for pairs of college tutors to meet to share experience. The arrangements paired better performers with weaker individuals to ensure transfer of appropriate skills and knowledge. The need to develop teaching and training is now reflected within the job	

descriptions of relevant members of staff and a link to the Clinician Resource Management System has been created to ensure that the work is captured centrally. The Chair observed that the recent surgical reconfiguration had presented a number of issues for medical education and asked for further detail. Dr Situnayake advised that medical training needed to catch up with the revised structures, therefore there was a discrepancy between what training was being delivered and the requirements of the surgical area. This is currently being resolved however. In general, if large groups of patient care are changed, then medical education will also need to be revised. Likewise, training will also need to be updated in line with the 'Right Care, Right Here' plans as treatment moves to being more community based. Miss Overfield advised that multi-professional training is being arranged for the nursing area. Mr Adler summarised that the plans were a welcome development, which strengthen the current arrangements. It was agreed that an annual update to the Trust Board is required, although exception reports may be presented as necessary.	
17 Update from the Committees	
17.1 Finance and Performance Management	**SWBFC (2/10) 023**
The Board received and noted the minutes of the Finance and Performance Management Committee meeting held on 18 February 2010.	
17.2 Audit Committee	**SWBAC (2/10) 016**
The Board received and noted the minutes of the Audit Committee meeting held on 4 February 2010.	
17.3 Governance and Risk Management	**SWBAC (1/10) 009**
The Board received and noted the minutes of the Governance and Risk Management Committee meeting held on 21 January 2010.	
18 Any other business	**Verbal**
There was none.	
19 Details of the next meeting	**Verbal**
The next meeting is scheduled for Thursday 29 April 2010 at 14.30pm in the Churchvale/Hollyoak Rooms at Sandwell Hospital.	
20 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: 29 April 2010, Churchvale/Hollyoak Rooms @ Sandwell Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

25 March 2010 - City Hospital

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

In Attendance: Mrs L Barnett (LB), Miss K Dhami (KD), Mr G Seager (GS), Mrs J Kinghorn (JK), Miss J Whalley (JW)

Apologies: None

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 23 April 2010

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status	Review Date
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	Deferred to the May meeting.	In hand - review next meeting	
SWBTBACT. 118	Patient satisfaction survey	SWBTB (1/10) 010 SWBTB (1/10) 010 (a)	28-Jan-10	Circulate the revised version of the patient satisfaction survey	RO	25-Mar-10	Due to be considered by the Executive Team on 27 April, after which time it will be circulated to the Trust Board	In hand - review next meeting	
SWBTBACT. 114	Communication and engagement strategy update	SWBTB (12/09) 251 SWBTB (12/09) 251 (a)	17-Dec-09	Present an update on the communications and engagement strategy at the meeting of the Trust Board in May 2010	JK	27-May-10		In hand - review next meeting	
SWBTBACT. 117	Maternity services reconfiguration business case	SWBTB (2/10) 045 SWBTB (2/10) 045 (a) SWBTB (2/10) 045 (b) SWBTB (2/10) 045 (c)	25-Feb-10	Present the implementation plan for the reconfiguration of maternity services at the May meeting of the Trust Board	JD	27-May-10		In hand - review next meeting	
SWBTBACT. 118	Maternity services reconfiguration business case	SWBTB (2/10) 045 SWBTB (2/10) 045 (a) SWBTB (2/10) 045 (b) SWBTB (2/10) 045 (c)	25-Feb-10	Present the timetable for the identification of a location for a new stand alone midwifery-led unit at a future Trust Board meeting	JD	27-May-10		In hand - review next meeting	
SWBTBACT. 117	Single Equality Scheme update	SWBTB (1/10) 009 SWBTB (1/10) 009 (a) SWBTB (1/10) 009 (b)	28-Jan-10	Include greater level of supportive data into future versions of the equality and diversity updates and amend the list of languages using translation services to include Spanish	RO	29-Apr-10	Further supporting information includes as an appendix to the Equality and Diversity report.	Completed Since Last Meeting	

Next Meeting: 29 April 2010, Churchvale/Hollyoak Rooms @ Sandwell Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

25 March 2010 - City Hospital

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

In Attendance: Mrs L Barnett (LB), Miss K Dhami (KD), Mr G Seager (GS), Mrs J Kinghorn (JK), Miss J Whalley (JW)

Apologies: None

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 23 April 2010

Reference No	Item	Paper Ref	Date	Agreement
SWBTBAGR.158	Minutes of the previous meeting	SWBTB (2/10) 047	25-Mar-10	Subject to minor amendment, the Trust Board approved the minutes of the previous meeting as a true and accurate receords of discussions held.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Sustainable Development Management Plan Update
SPONSORING DIRECTOR:	Graham Seager, Director of Estates/New Hospital Project
AUTHOR:	Rob Banks, Head of Estates
DATE OF MEETING:	29 April 2010

SUMMARY OF KEY POINTS:

The purpose of this paper is to update the Trust Board on the progress to date with the sustainability agenda following the previous sustainability management action plan presented to the Board in November 2009 and follow up report in January 2010.

KEY POINTS:

- Sustainable Development Group action plan updated (Appendix 1)
- Sustainability Champions (Appendix 2)
- Carbon Trust Management Plan (Appendix 3 - Partnership Agreement).

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

Approval	Receipt and Noting	Discussion
✓		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is recommended to:

- Approve the Trusts participation in the NHS Carbon Management Programme with the nomination of Graham Seager, Director of Estates & New Hospital Project Director as the Trusts Project Sponsor and Robert Banks, Head of Estates as the Project Lead.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Improve the environmental sustainability of the Trust's operations by responding to the national carbon reduction strategy.
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	Standard 2.3.4 – Trust can demonstrate commitment to sustainability

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

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

PREVIOUS CONSIDERATION:

The Sustainability Development Group has approved:

- The Sustainability Action Plan
- The GCC Assessment
- The Sustainability Champion
- The Sustainability Policy

Sustainability Update

Introduction

The purpose of this report is to update the Trust Board on progress to date with sustainability and seek approval to join the NHS Carbon Management Programme.

Sustainable Development Management Plan

The Sustainable Development Management Plan which was presented to the Trust Board at the November meeting has now been updated with current status. Assigned leads have been asked to present at Sustainability Working Group (SWG) an update on their progress with the following:

- IT Plan
- Travel Plan
- Waste Management.

A shared folder has been created on the server for members of SWG to access a single action plan and amend.

The action plan is shown as Appendix 1. Success in achieving these actions will improve the Trusts contribution to the sustainability agenda.

Sustainability Champions

The first training session has been held for sustainability champions in March and further sessions have been scheduled for May and June. Ten Champions attended the first training session and a similar number are expected to attend subsequent sessions.

Attendance at Senior Nurse Forum and Facilities LiA meeting has provided the opportunity to gather more support.

The SWG and sustainability champions visited all areas of the Trust on 22nd April 2010as part of Earth Day 2010 to promote sustainability work currently underway across the Trust

Carbon Trust Management Plan

SWBH has been accepted onto Phase 5 of NHS Carbon Management Programme in conjunction with the Carbon Trust which covers all areas of sustainability.

The programme is designed to assist SWBH in developing our Carbon Management Plan and provides support from the Carbon Trust and its consultants in the following areas:

- Identifying and tracking cost effective carbon saving opportunities
- Best practice information and advice on technologies and energy management processes
- Data gathering and analysis software

- Experience sharing mechanisms and networks
- Consultancy support to develop an emissions reduction implementation plan
- Consultancy resources to help manage significant organisational change.

In order for this programme to commence we have identified the following leads who will be working to deliver the programme.

Role	**Representative**
Project Sponsor	Graham Seager- Director of Estates and New Hospital Project Director
Project Leader	Robert Banks-Head of Estates

The Carbon Trust will be holding a briefing session on May 22nd 2010 in London before the programme starts and SWBH will have representation at the event.

As the programme proceeds the team will provide updates to the SWG and Trust board on progress against key milestones.

SWBH success will be through the support provided from areas of the business such as Finance, Communications, HR, Procurement and IT and your assistance in achieving is required.

In order to confirm the Trust's participation in the programme the following actions need to be completed:

- An authorised signatory must sign and return the Partnership Agreement (appendix 3 attached)
- Top level commitment must be illustrated by the submission of a written statement of support from the Trust Board nominating the Project Sponsor and Project Leads. Trust Board minutes will be used for this purpose.

<u>Recommendations</u>

The Trust Board is recommended to:

- Note progress made with the sustainability agenda
- Approve the Trusts participation in the NHS Carbon Management Programme and nomination of Graham Seager, Estates Director and New Hospital Project Directors as the Trust's Project Sponsor and Robert Banks, Head of Estates as the Project Lead.

APPENDIX 1

Sustainability Development Group

ACTION PLAN

ITEM	DESCRIPTION	DISCUSSION	PRIORITY			ACTION	CURRENT STATUS	GROUP INVOLVED	DATE
1.00	**TRAVEL ARRANGEMENTS (patients, visitors, staff)**								
1.01			S	M	L				
a)	More clinical activity in the community – less patients travel				✓			RIGHT CARE RIGHT HERE GS	
b)	Patients – travel details supplied with appointments and suggestions of how to get to the hospital				✓			RIGHT CARE RIGHT HERE GS	
c)	If patient have several appointments at hospital manage time so they only have to come once				✓			RIGHT CARE RIGHT HERE GS	
d)	Reduction in patients' visits – more towards RCRH modes of care				✓			RIGHT CARE RIGHT HERE GS	
1.02	Staff travel/general travel arrangements		S	M	L				
a)	Travel – single permit for car parking rather than two, transport links improved, car sharing, free bicycle for staff who live near the Trust – car parking only for staff who lives further than 3 miles			✓			• Cycle scheme being investigated • Car Park policy being revisited in 2010, car sharing scheme and restriction of permit issue based on distance to work (and other factors) to be investigated as part of revision	DA/SC/JB/DH FACILITIES	July 2010
b)	One day a month no vehicles on site			✓				DA/SL/RB/SC	
c)	Regular competitions to promote sustainable travel			✓			Promotion of sustainable travel to work by issue of single day use travel passes to be organised	DA/SL/RB/SC	
d)	Smarter driving – all Trust's vehicles on bio fuel, smart driving lessons			✓				DH/SC/SS FACILITIES	

ITEM	DESCRIPTION	DISCUSSION	PRIORITY			ACTION	CURRENT STATUS	GROUP INVOLVED	DATE
e)	Fully integrated transport systems – bus services, direct onto hospital site, re open local railway station				✓			RIGHT CARE RIGHT HERE GS	
f)	Replace shuttle bus with more sustainable vehicle			✓				DN/SS/SC FACILITIES	
g)	Shuttle bus could pick up from central point to get to work			✓				DH/SS/SL FACILITIES	
h)	Review car parking charges for low emission of carbon vehicles			✓				DA/DH/SS/SL FACILITIES	
i)	Green travel plan	The creation of travel plan will include items A-H & J	✓				In process of writing more concise travel plan	DA/SC/RB/SL	May 2010
j)	Link up with Toyota who make Hybrids to get some deal on corporate sponsorship for negotiated rates			✓				DH/SC FACILITIES	
k)	Do not pay travel expenses to staff that choose to drive between Sandwell and City, rather than using the shuttle bus?		✓					SL/FINANCE/TMB	
2.00			**S**	**M**	**L**				
a)	Essential to measure all critical areas to ensure progress can be measured and reported against – smart meters, energy monitoring, put in more controls on heaters, energy efficient electrical equipment			✓				RB/SL/KR	
b)	Change all light bulbs to eco friendly	Lighting schemes to incorporate design for energy saving on future projects	✓			• Estates and Capital to ensure that energy saving lighting is considered for future projects • Estates to ensure that all lighting when replacement as a reactive or proactive task utilise energy saving technology	• Estates have replaced a large number of lights across the Trust with energy saving fittings	RB/IH/ESTATES	Dec 09
c)	Double doors that shut automatically			✓				PF/ESTATES	

ITEM	DESCRIPTION	DISCUSSION	PRIORITY			ACTION	CURRENT STATUS	GROUP INVOLVED	DATE
d)	Heating on/off appropriate time of the year/day	Utilise Building Management System to control heating and review / update schedules	✓			• Collect data for Sandwell and City space utilisation including times of use	• Ongoing modification to heating controls under statutory standards funding	SK/ESTATES	Dec 09
e)	Energy performance	Energy usage to be publicised across the Trust to show status	✓			• Use Trust Media to pass information	• Display Energy Certificates displayed to all Buildings over 1000m2	RB/PF/ESTATES	
f)	Energy hotline, sustainability well publicised on website	To promote work of SWG and how staff can assist to achieve corporate goal	✓			• Update webpage regularly • Hold awareness sessions • Utilise all user emails • Use Estates Helpline answer phone for energy tips • Energy Tips to be put on intranet • Energy Champion request • Staff Comms used to request champions • Attendance of Senior Nurse Forum Feb 10 to promote subject	• Two Energy Awareness days held in Dec 09 in conjunction with Energy Saving Trust • Sustainability email address established • Links on Estates webpage to external bodies for advice • Names received through Sustainability email address	SL/KR/PM	Dec 09 Feb 10
g)	Fit low energy measurers to buildings (sensor lighting, sensor laps)	To incorporate in design of new areas or upgrades		✓		• To be made standard in design brief • New Technology to be reviewed and evaluated for potential use	• Sensor Taps fitted to all upgrades	RB/KR/ESTATES	Dec 09
h)	Servers powering down when not in use, energy efficient computer rooms				✓			SP/JB	
i)	Turning temperature down 2C and cut down external lighting		✓					SL/RB	
j)	Being able to turn off patient line monitors when not in use		✓					SC/SL/IT/ML	
k)	Windows that open easily?			✓				PF/ESTATES	
l)	Experimenting with Biomass Fuels, schemes and production plants are now being developed as part of the sustainable fuels initiative, such operations could claim support under the Renewable Obligation and Climate Change Levy. .				✓			RIGHT CARE RIGHT HERE GS	
m)	Turn off plugs/lights out of hours at plug point		✓					RB/IH/ESTATES	
	Heating on and windows open, close							RB/SL/ESTATES	

ITEM	DESCRIPTION	DISCUSSION	PRIORITY			ACTION	CURRENT STATUS	GROUP INVOLVED	DATE
n)	doors		✓						
o)	Turn heating off in some areas for the weekend Non touch light switches motion sensors	See comments for 2d as duplicate	✓					RB/SK/ESTATES	
p)	Buy stand by savers for computers		✓					SP/IT/ESTATES	
q)	More reminders to switch off the light – stickers to put up in all areas	To promote switch off campaign	✓			• Supply SWBH labels to Energy Champions to fit • To provide posters with examples of how much can be saved and what it relates to in patient care • Develop Energy Champion packs • Provide Energy Champion sessions • Training developed with L&D	• Energy Awareness days have provided a number of potential energy champions • Training booked for March 18th 2010 • Stickers available to be given out at training day • Currently have 10 names and emailed to chase attendance	ENERGY CHAMPIONS ESTATES SL	Dec 09 Feb 10
r)	Green gas, electricity, burning recycled waste				✓			RIGHT CARE RIGHT HERE GS	
s)	Switch it “off” campaign	See comments for 2q	✓					ENERGY CHAMPIONS ESTATES SL	
t)	Funds from Salix Finance for refurbishment of buildings			✓				RB/GS/SWG	
u)	Make staff cost aware of what is spent on energy – monthly energy spend advised to staff in “Heartbeat	See comments for 2e	✓					SL/SWG	
v)	Practical implementation – double glazing, modernising buildings to preserve energy, A-rated appliances		✓					RB/KR	
w)	Wherever possible use our own waste to generate fuel, use solar panels for water heating and energy				✓			RIGHT CARE RIGHT HERE GS	
x)	Energy smart equipment, ground				✓	•		RIGHT CARE GS	

ITEM	DESCRIPTION	DISCUSSION	PRIORITY			ACTION	CURRENT STATUS	GROUP INVOLVED	DATE
	source heat pumps, solar films								
y)	Competition between wards/departments for the most energy efficient department	To provide enthusiasm to continue involvement of departments through local reward	✓			• Establish a quarterly award and determine prize and funding • Establish a yearly Trust Award • Establish submission document • Investigate possible local metering to allow competition	• Support for annual award given by John Adler at LiA review in Dec 09 • IH to investigate what can be done and feedback to group in March 10	SL/SWG/ ENERGY CHAMPIONS	Dec 09 Feb 10
3.00	**GOVERNANCE**								
a)	Sustainability development budget plans for all prospects			✓				GS/SL/TMB	
b)	Carbon officers for departments (similar to H&S)	To promote locally work of SWG and Trust to reduce carbon footprint	✓			• Develop Energy Champion packs • Provide Energy Champion sessions • Hold regular updates and utilise Trust media to promote role • Contact all interested parties • Present to Senior Nurse Forum • Subject on induction	• Energy Awareness days have provided a number of potential energy champions • Presented to senior nurse forum in Feb 10 • Agreed with Nora Parsons L&D for subject to be included on future inductions • Andrew Adam developing slides for use based upon champions session	RB/SL/SWG	Dec 09 Feb 10
c)	Pilot some ideas before moving to the new hospital to see what works and what not		✓					ESTATES/ SWG RB	
d)	Employ energy manager (Sustainability)		✓			• Funding approval sought • JD/PS to be developed	• Job out to advert Feb 10 • Interview date 11/3/10 • Short listed 6 for interviews	GS/RB/SL	Feb 10
e)	Introduce sustainability award	See comments 2y	✓					SL/RB	
f)	Introduce budget holder responsibility			✓				GS/RB/SL/TMB	
g)	Energy reduction schemes implemented	To implement major schemes to Trust Infrastructure through capital funding or externally sourced fund		✓		• To complete schemes as identified in 2009/10 Statutory Standards funding • Risk Assessment to be updated to identify future actions and savings that can be produced	• Works identified and works ongoing • Energy Risk Assessment updated Feb 10	KR/SL/ESTATES	Dec 09 Feb 10
		To provide a framework for the Trust to work too and				• Policy to be approved by	• Policy in draft format	KR/SL/ESTATES	Dec 09

ITEM	DESCRIPTION	DISCUSSION	PRIORITY			ACTION	CURRENT STATUS	GROUP INVOLVED	DATE
h)	Trust needs an environment policy	identify roles and responsibilities				TMB • Policy to be promoted across organisation			
i)	Mandatory environmental training as part of the induction		✓					AA/RB/L & D	
j)	Study days or workshops for greener Trust	See comments as 3b	✓					AA/RB/SL/SWG	
k)	Choose one champion for each department to monitor energy saving/recycling/making the ward greener and money saving team	See comments 3b	✓					SL/JK/SWG	
l)	Sanction for breaking the roles should be implemented with regards to greener environment in a workplace			✓				SWG/GS	
m)	Introduce rewards for lowering carbon footprint	See comments 2y		✓				GS/RB/SL/SWG/TMB	
n)	Cascade information – set targets for environmental training			✓				AA/SL/L & D	
o)	Local budgeting				✓			GS/RB/TMB/ ESTATES	
p)	Introduce reporting of sustainability programmes at Trust level – pass on shared experience	To promote news from group	✓			• Trust Board updates • Media	• Green Heartbeat in Nov 09 • Links via estates web page • Members/Champions to feedback through team meetings	GS/SL/JC/SWG	Feb 10
q)	Carbon management programme		✓					PF/SL/RB	
r)	Carbon survey from Carbon Trust			✓				SL/PF/RB	
s)	Responsibility for every employee – targets, aims, objectives		✓					KR/GS/SWG	

ITEM	DESCRIPTION	DISCUSSION	PRIORITY			ACTION	CURRENT STATUS	GROUP INVOLVED	DATE
t)	Steering Group	To promote sustainability across the Trust	✓			• Members to take lead for actions as shown in this action plan • Provide point of contact • To monitor and review organisation with regard to sustainability • Additional interest	• Meeting developed with terms of reference • Meetings scheduled for 2010 • Action plan developed • IT and library services now members	GS/RB/SL	Dec 09 Feb 10
u)	Focus groups to reach high energy users		✓					RB/PF/SL/SWG	
v)	Include in PDR's	To make as a corporate objective and on all individuals PDR		✓		• Create Trust policy for Sustainability and identify individuals actions • Speak with Unions for involvement	• Spoke to HR advised policy is best route to avoid revisiting all JDs	GS/RB/SL/SWG/TMB	Dec 09
w)	Liaise with other hospitals, City Council	To share best practice with others and learn from others	✓			• Gather ideas and formats used to avoid time wasting • Look for good ideas	• External agencies now members of SWG from PCT and Birmingham Council • Contacted other Trusts and Universities and have been given names and address to speak with. • Attended conferences and networked with others	SL/SWG	Dec 09 Feb 10
x)	Devolution of responsibilities to each department	To provide guidance on roles and responsibilities through Trust Policy		✓		• Policy to be approved by TMB • Policy to be promoted across organisation	• Policy in draft format	GS/RB/SWG/TMB	
y)	Awareness of carbon impact of decisions			✓				SL/JK/SWG/ TMB	
z)	Give financial rewards for green departments	See comments 2y		✓				GS/JK/SWG/TMB	
a1)	Consult with staff non compliance		✓					GS/SL/JK/SWG	
a2)	Strategy needed for equipment replacement – to environmentally friendly			✓				RB/LB/SWG	
4.00	**PROCUREMENT**								
a)	Re use of envelopes for internal letters		✓					SL/JK/TMB/SWG	
	Encourage to bring their own food to							JO/SC	

ITEM	DESCRIPTION	DISCUSSION	PRIORITY			ACTION	CURRENT STATUS	GROUP INVOLVED	DATE
b)	work			✓					
c)	Use email to communicate information on sustainability	To communicate to a Trust wide audience	✓			• Send regular all user emails • Communicate to champions on regular basis	• Sustainability email address set up Oct 09 • Articles in Green Heartbeat Nov 09 • Staff comms Jan /Feb 10	SL/KR/RB	Nov 09 Feb 10
d)	Holding staff events and suggestion schemes	To communicate to a Trust wide audience	✓			• Energy Champion events • Attend departmental LiA events on sustainability • Training for champions • Attend SNF in Feb 10	• LiA Event held Oct 09 • LiA Estates events in Oct 09 • Energy Awareness days in Dec 09 • Attended SNF in Feb	SL/KR/RB	Nov 09 Feb 10
e)	Pharmaceutical procurement – educating staff about the life cycle of the product, this could encourage appropriate level of purchase rather than		✓					BH/JM	
f)	Shop around for best eco friendly option		✓					JM	
g)	Nitrous free anaesthesia		✓					BH	
h)	Material reclamation facilities		✓					DH/SS/SWG	
i)	Paper, food, waste recycling/anaerobic digestion (offices and other areas)		✓					SC/SS/SWG	
j)	Reduced computer print outs		✓					SP/IT/SWG	
k)	Reduction and correct segregation of clinical waste		✓					SS/SWG	
l)	Stock control audits, internal stock supply, fewer deliveries		✓					JM/SWG	
m)	Have on site shredding facility, use recyclable products		✓					SS/JM/SWG	

ITEM	DESCRIPTION	DISCUSSION	PRIORITY			ACTION	CURRENT STATUS	GROUP INVOLVED	DATE
n)	Repair rather than throw		✓					SL/BH/JM/JC/SS/SWG	
o)	Buying of pharmaceuticals from companies which concentrate on lowering their carbon footprint			✓				BH/JM/JK	
p)	Buying medical devices from carbon footprint aware manufacturers			✓				LB/JM	
q)	Don't waste resources by sending questionnaires etc to home addresses, use email, internal mail		✓					JK	
r)	Stop sending staff payslips home		✓					SL/FINANCE/SWG	
s)	Issuing electronic payslips where possible would increase efficiency and reduce costs long term.		✓					SL/FINANCE/SWG	
t)	The Trust should not send mail to the home addresses of employees where they can use the internal mail.		✓					SL/KR/TMB SWG	
u)	Learn how to rotate stock efficiently		✓					JM/SWG	
v)	Recycling bins and systems to be put in place, on site biomass/waste energy		✓					SS/SWG	
w)	Stock rationalisation group to include ethical			✓				JM/SWG	
x)	Avoid sterilization of unneeded item			✓				MC/SWG	
y)	Measure carbon output – for individual departments			✓				RB/SL/SWG	
z)	Documents to be viewed on line, double sided printing		✓					SP/IT/TMB/SWG	

ITEM	DESCRIPTION	DISCUSSION	PRIORITY			ACTION	CURRENT STATUS	GROUP INVOLVED	DATE
aa)	Food – local, seasonal, anaerobic digestion Food – less meat		✓					SC/JO/SWG	
bb)	Electronic payslips, e-invoicing, twitter, e-procurement		✓					GS/FINANCE/SWG	
cc)	Use of own mugs, caps no plastic ones, stop deliveries of bottled water		✓					JM/SWG	
dd)	Share photocopiers		✓					SP/IT/SWG	
ee)	Open 2014 hotline	To promote sustainability in Trust		✓		• Promote use of email address by staff and champions to request information • To send information via email address	Sustainability email address set up Staff Comms used as reply	SL	Feb 10
ff)	Cut down on instructions in pocket drugs			✓				BH/RB/SWG	
gg)	Make better use of video conferencing		✓					ML/BH/SWG	
hh)	Regular email remainders about environmental issues	See comments ll	✓					SL/IT/SWG	
ii)	Could NHS mail be used more reducing resource required for Trust email, archive and Blackberry servers?		✓					SL/RB/SWG	
jj)	Installing laser jet printers for secretaries as these are more cost effective than desk jets in the long run		✓					SP/IT/ML/SWG	
kk)	Standardise equipment, such as printers, so cartridges could be bought in bulk, rather than piecemeal.		✓					SP/IT/SWG	
ll)	IT to look at printers, every printer is different and requires different ink cartridges. Be aware of how much cartridges cost, some printers may be cheap but the ink is expensive.		✓					SP/IT/JM/SWG	
	Are there areas where a large, shared,							SP/IT/JM/SWG	

ITEM	DESCRIPTION	DISCUSSION	PRIORITY			ACTION	CURRENT STATUS	GROUP INVOLVED	DATE
mm)	leased printer/photocopier /scanner is available and staff still have individual printers on desk?		✓						
nn)	Why so many staff have costly colour laser printers? Could Medical Illustration print high quality colour when required?		✓					SP/IT/JM	
oo)	Monitoring the use of the photocopier – assigning a cost code whereby an invoice gets sent to each department instead of the Nursing division or for all of Arden House. Need to maintain a record/ know of who is spending what.		✓					JM/SWG	
pp)	There is no need for photocopying reams of notes/reports, Maintain electronic files which could save cost of not also printing out every email for the paper file- double entry and waste of paper/ink			✓				JH	
rr)	Heartbeat could be printed for each group of staff rather than individuals, or could there be an e-version to save even more money (and trees).		✓					JK/KE/JM/SWG	
ss)	Don't duplicate information leaflets i.e. if already given out ante-natal, do not then give them out again post-natal.		✓					JK/JM/SWG	
tt)	Unnecessary dispensing of medication. Make sure medication is actually required. Inappropriate prescribing does the patient need analgesia on discharge. Large amounts of analgesia are dispensed and then returned to Pharmacy unused.		✓					BH/SWG	
uu)	Use patients' medication more efficiently on admission. Improve advertising, via appointment letters encouraging that they always bring in their medication to hospital. This also helps with drug reconciliation and drug history taking, but also means that drugs already dispensed from outside the hospital are utilised correctly and assessed for suitability. Advertise in GP surgeries, out-patient			✓				BHSWG	

ITEM	DESCRIPTION	DISCUSSION	PRIORITY			ACTION	CURRENT STATUS	GROUP INVOLVED	DATE
	departments and the BTC with posters and leaflets.								
ww)	Should we review the quantity of drugs supplied for short stay surgery patients. Patients are discharged on up to 28 days supply. Drugs are re-supplied when there is less than 14 days supply remaining. Surgery patients may not require such a large quantity			✓		•		BH/SWG	
xx)	Education at all levels – do not use/open thing you do not need			✓		•		SL/RB/SWG	
yy)	Implement team working at all times with regards to greener environment			✓		•		SL/RB/SWG	
zz)	Self discipline for each and everyone			✓		•		GS/TMB	
aaa)	Staff involvement and participation – knowledge and understanding, training, visibility and cooperation			✓		•		GS/KB/RB/SL/SWG	

Members of Sustainability Steering Group

Graham Seager (GS)	Jilly Croasdale (JC)	Brian Hebron (BH)	Adam Andrews (AA)	Rob Ashley (RA)
Rob Banks (RB)	Diane Alford (DA)	Sally Fox (SF)	Steve Lawley (SL)	Jessamy Kinghorn (JK)
David Newbould (DN)	Jenny Marshall (JM)	Simon Sims (SS)	Paul Russell (PR)	Hamish Brown(HB)
Ali Shaukat (AS)	Keith Budden (KB)			

Others

IT - Information Technology
L & D - Learning and Development
DT - Debbie Talbot
MC - Mike Caufield
LB – Lawrence Barker
SC - Steve Clarke
JO - Jane Owen
ML - Martin Lynch
RCRH - Right Care Right Here (RB/GS)

Timescales

Targets	Time Scale
Short term	Dec 2010
Medium term	Dec 2013
Long term	Dec 2016 (New Acute Hospital)

Group Involved – lead of the group highlighted in yellow

SUSTAINABILITY CHAMPIONS - CITY SITE

AREA	REPRESENTATIVE NAME	JOB TITLE	CONTACT DETAILS
BLOCK 1			
A/E Casualty (Ground Floor)			
A/E X-Ray (Ground Floor)	Paul Queen	Radiographer	email
Diabetes Clinic (Corridor C) 1st Floor)			
Neuophysiology (2nd Floor)			
Medical Records (2nd Floor)			
BLOCK 2			
Radiopharmacy (Basement)			
Fracture Clinic (Ground Floor) / Chiropdy			
Neurophysiology Annexe (Ground Floor)			
Contact Centre (Ground Floor)			
Physiotherapy (1st Floor)			
BLOCK 3			
M.A.U. (Ground Floor)			
D41 (1st Floor)			
Surgical Sec's (2nd Floor) & Nursing Admin	Alison Hughes	Matron	email
BLOCK 4			
X-Ray (Out Patients) Ground Floor			
Speech Therapy (Ground Floor)			
D42 (SAU)			
BLOCK 5			
Physics & Nuclear Medicine (Ground Floor)			
BLOCK 6			
Hilda Lloyd Building			
BLOCK 7			
Police Bungalow & Security	Gary Woodhouse		email
BLOCK 8			
Ellis House Residence			
BLOCK 9			
Ellis Lodge			
BLOCK 10			
Pharmacy			
BLOCK 11			
Endoscopy			
BLOCK 12			
ITU (Critical Care) Ground Floor			
D11			
D21			
BLOCK 13			
MRI & CT Scanning)			
BLOCK 15			
Windmill Theatres 1,2,3, & Recovery			
Windmill Theatres Staff Changing & rest area			
BLOCK 16			
Theatres 9 & 10 (inc Staff Changing & rest areas)			
BLOCK 17			
Theatre 4 (Ground Floor)			
Discharge Lounge (1st Floor)			
Infection Control (2nd Floor)			
BLOCK 18			
D5	Vanessa Timmins	Ward Clerk	
D15			
D25			
BLOCK 19			
Clinical Investigation Unit			
	Sibo Kaur	Ward Services Officer	
Changing Rooms & Hotel Services	Kuldip Dhesi	Ward Services Officer	
BLOCK 20			
D6			
D16			
D26			
BLOCK 22			
Oral Sugery (Dental)			
BLOCK 23			
D7			
D17			
D27			
BLOCK 24			
IT Dept / Offices			
BLOCK 25			
D7B			

D8			
D18			
D28			
BLOCK 26			
Linen Services / Decontamination RDC			
BLOCK 27			
D9			
D19			
D29			
BLOCK 28			
D10			
D20			
D30			
BLOCK 29			
Medical Engineering			
BLOCK 30			
Post Graduation Centre			
BLOCK 31			
Millers (Staff Dining)			
BLOCK 32			
Nurses Home (Boardroom) Ann Gibson			
BLOCK 33			
Arden House (Physio Gym & Occ Thearpy)			
BLOCK 34			
Mill Court			
BLOCK 35			
WMAS PTS Office / Patient Transport/Transport dept	Dennis Wood		
BLOCK 38			
	Stephen Shilvock, Colin Andrews	Craftsperson	
Estates Workshop & Supplies & Boilerhouse	Colin Andrews	Electrician	
BLOCK 41			
Telephone Exchange			
BLOCK 44			
Regional Toxicology			
BLOCK 45			
Social Workers			
BLOCK 46			
Old Pathology (Microbiology upstairs)	Ricky Salomon	Microbiology	4262
BLOCK 47			
New Pathology / Post Mortem (Haematology)	Dean Edgington	Medical Lab Assistant	email
	Samantha Bailey	PA to DGM	email
BLOCK 48			
Immunology			
BLOCK 51			
Ante-Natal (Ultrasound)			
Maternity M1 (Ground Floor)			
Maternity M2 (1st Floor)			
Old Neo-Natal (Ground Floor)			
M8/Rheumatology OPD & Urodymanics			
Maternity Admin			
Maternity (Incubator Room)			
BLOCK 52			
Labour Suite			
BLOCK 56			
Gynae Oncology (CCA)			
BLOCK 64			
Sickle Cell			
BLOCK 65			
Day Hospital (Ground Floor)			
Eye Ward & Eye Management Offices			
Eye Cataract (Day Surgery)			
Skin OPD/ Minor OPS Theatre)			
Skin Ward			
D43 (Ground Floor)			
D46 (Training Room) 2nd Floor			
D47 (Rehab)			
BLOCK 66			
Stephen's House/ Facilities			
BLOCK 68			
Brookfield House/Union			
BLOCK 69			
Summerfield House			
BLOCK 71			
Hearing Services Centre	Jagpal Jagd		email
BLOCK 80			

Hardressing Salon			
BLOCK 102			
Gardeners' Department			
BLOCK 111			
Little Saints Nursery			
BLOCK 115			
Estates Dept	Steve Lawley	Compliance Manager	3504
BLOCK 118			
Cardiology Theatre/D2			
D12			
D22			
BLOCK 119			
D14 Renal Dialysis			
D24			
BLOCK 129			
Ascot Clinic			
BLOCK 134			
Geriatric Office Block (Unit Admin)			
BLOCK 135			
Neo-Natal			
Management Block			
BLOCK 136			
Catering Storage (Catering to complete)			
BLOCK 143			
Bham & Midland Eye Hospital (Eye A & E)	Siddiqi Rizwana	Birmingham Eye Centre	email
Outpatients Clinics 1 - 4 (Ground Floor)	Michaela Martin	Staff Nurse - ophthalmol	email
Eye Area Foyer			
Eye theatres			
Orthotics/University (1st Floor)			
BLOCK 147			
Theatres 11 & 12			
BTC			
Ground Floor			
Blood Unit			
Ent			
Paediatric OPD			
Oncology			
Breast Unit			
First Floor			
X-ray & Ultrasound			
Clinical Neurophysiology			
OPD 1			
OPD 2 & minor ops			
OPD 3 + Cardiology			
OPD 4 and Clinical Investigation, Respiratory			
Second Floor			
Endoscopy			
OPD5 and 1st floor DRUM			
POD ABC and Day Surgery Unit			
Theatres ASU (A-F)			
Phlebotomy	Pauline King	Senior Phlebotomist	

Appendix 2

SUSTAINABILITY CHAMPIONS - SANDWELL SITE

AREA	REPRESENTATIVE NAME	JOB TITLE	CONTACT DETAILS
1st Floor Theatres			
3rd Floor Theaters			
A & E Clincal			
Antenatal Clinic			
Basement			
Breast Clinic			
Bryan Knight			
Chest Clinic			
Dartmouth Clinic (GUM)			
Day Unit Theaters			
Day Unit Ward			
Dental/Eye			
DHQ			
DHQ Physio			
Diabetes Cent			
Elizabeth Suite			
Endoscopy			
ENT			
ESC Cath Lab			
ESC CCU			
ESC EAU			
ESC X-RAY			
ESC Ground			
Estates/ EBME			
ITU			
Lower GRND CHANG/MOP SIT ROOM			
Labour Ward			
Lyndon Ground			
Lyndon 1			
Lyndon 2			
Lyndon 3			
Lyndon 4			
Lyndon 5			
Main Reception			
Management Block			
MAT 1			
MAT ADMIN			
MAT Reception			
Medical EDUCAT			
Medical Legal (PORTACABIN)			
Medical Records			
MRI Scanner			
Neo Natal			
Newton 1			
Newton 2			
Newton 3			
Newton 4			
Newton 5			
Nursery			
Occupational Therapy			
OPD 1st FLOOR D 1.1 / 1.48			
OPD 1st FLOOR 1.2 / 1.14			
OPD GROUND			
ORTHOPAEDIC			
GRND FLR LINK PAED CLIN			
PATH LAB 1st FLOOR			
PATH LAB GROUND			
Pharmacy			
Physio Hydrotherapy			
PRE OP ASSESSMENT			
Priory Gound			
Priory 2			
Priory 3			
Priory 4			
Priory 5			
Scanner			
Social Club			
Speech Therapy			
Training and Development			
TSSU			
X-RAY			

X-RAY Recovery			
Hallam Building	Melanie Allison	Senior Implementation Analyst	
Library Service and Education Centre	Cheryl Powley	Library and Information Officer	
Phlebotomy	Tina Turner	Senior Phlebotomist	3650
Hotel Services	Diane Moore	Ward Services Officer	
	Sue Atkins	Ward Services Officer	

SUSTAINABILITY CHAMPIONS - ROWLEY REGIS

AREA	REPRESENTATIVE NAME	JOB TITLE	CONTACT DETAILS
Day Hospital			
Eliza Tinsley - closed			
Laundry/Shower Rooms			
Main Reception/Toilets/1ST Floor Admin			
MCCARTHY			
OPD			
PCRT Day Hospital			

Appendix 3

Mr Graham Seager,
Sandwell and West Birmingham Hospitals NHS Trust

22 April 2010

Dear Graham,

Thank you for your interest in the **NHS Carbon Management Programme**. We are delighted to be able to offer you a place in the next phase of this programme. The programme is designed to assist you in developing your Carbon Management Plan and will include support from the Carbon Trust and its consultants in the following areas:

- Identifying and tracking cost effective carbon saving opportunities
- Best practice information and advice on technologies and energy management processes
- Data gathering and analysis software
- Experience sharing mechanisms and networks
- Consultancy support to develop an emissions reduction implementation plan
- Consultancy resources to help manage significant organisational change

In order to confirm your participation we need you to complete the following actions:

- An authorised signatory must sign and return the Partnership Agreement on the reverse of this letter.
- Top level commitment must be illustrated by the submission of a written statement of support from a member of the Trust Board nominating:
  - **Project Leader** and committing two days a week for the duration of the programme;
  - **Project Sponsor**. Director level representation for the project. If the Project Sponsor for this work is from the Estates team we would ask that a second Operational Sponsor is also nominated to ensure a wider organisational participation from departments across the NHS Trust.

  As the programme proceeds, we will ask that individuals are identified to represent their respective departments at key milestones over the 5-step process. The successful Trusts that are embedding Carbon Management have established teams with representation from Finance, Communications, HR, Procurement and IT. This engagement will ensure the best chance of buy-in for their respective teams.

Please return your Partnership Agreements and all supporting material to me by **1 May**. You are welcome to e-mail enquiries to me, tim.pryce@carbontrust.co.uk, or ring on 020 7832 4662.

Subject to receipt of the above, we will commence the programme in partnership with your organisation at the NHS Carbon Management launch event at The Grange St Paul's in London on the **20 May**. It is essential that both the Project Leader and Sponsor be available to attend this event as it will provide the foundation of the programme. Members of the wider team are also encouraged to attend.

Thank you again for your commitment to date and we very much look forward to working with you on this ambitious and exciting programme.

The Carbon Trust
6th Floor, 5 New Street Square, London EC4A 3BF
T: +44 (0)20 7170 7000 F: +44 (0)20 7170 7020 www.carbontrust.co.uk

The Carbon Trust – Partnership Agreement, NHS Carbon Management Programme

The Carbon Trust ("CT") is an independent company funded by Government. Its aim is to spearhead the transition to a low carbon economy by helping businesses and public sector organisations cut carbon emissions through improving their energy efficiency and implementing low carbon technologies. The benefits of participating in the partnership arrangement are expected to be:

- reduced energy bills;
- reduced $C0_2$ emissions;
- the implementation of a robust strategy regarding the management of $C0_2$ emissions; and
- enhanced reputation with constituents, the local community and other key stakeholders.

Aim and Scope of Partnership Arrangements
We agree, relying upon your commitment under the Framework Agreement, to provide you with assistance to:

- understand and quantify your energy consumption and carbon emissions;
- develop a carbon management plan containing achievable projects and actions to realise carbon and energy cost savings for your organisation;
- understand your exposure to, and risks from, an increasingly carbon-constrained economy.

This assistance may consist of any (or a combination) of:

- the provision of a carbon management process and Toolkit;
- help in the development of a carbon baseline and carbon management strategy for your organisation;
- direction relating to identifying abatement opportunities and implementing a plan to capture these
- facilitation of knowledge sharing with similar organisations;
- other advice on energy efficiency best practice and other low carbon technologies.

Following on from the work that we do together, you may also be eligible to participate in marketing activities with CT which will raise the profile of the work that you do to reduce your organisation's $C0_2$.

NEXT STEPS - Please read the Terms and Conditions of the Framework Agreement for the partnership arrangement. If you wish to take part in the Carbon Management programme then please sign and date this Partnership Agreement letter and send it to CT addressed for the attention of Tim Pryce, along with the statement of Board level support described above.

Yours sincerely

Tim Pryce
Public Sector Manager
for and on behalf of
THE CARBON TRUST

We acknowledge and accept the terms of the Framework Agreement.

…….. for and on behalf of Sandwell and West Birmingham Hospitals NHS Trust	…… Print Name	…….. Position	……..2010 Date

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

POLICY TITLE:	Blood Transfusion Policy
ACCOUNTABLE DIRECTOR:	Donal O'Donoghue, Medical Director
POLICY AUTHOR:	Trust Transfusion Committee
DATE OF MEETING:	29 April 2010

SUMMARY OF KEY POINTS:

The blood transfusion policy describes the processes for all stages of the transfusion policy from sample collection, collection of blood, administration of blood and monitoring of patients who are receiving a blood transfusion.

The Trust is implementing an electronic transfusion system BloodTrack which will improve transfusion safety.

The policy has been revised to incorporate the procedures for transfusion using BloodTrack as well the present traditional manual system.

It is a stipulation of the Policy for the Development, Approval and Management of Policies, that the Blood Transfusion Policy requires Trust Board approval.

PURPOSE OF THE REPORT:

To seek approval for the implementation of the policy attached and request that the policy is added to the Trust's intranet for access by all staff.

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Board is requested to approve the policy, together with the proposed implementation plan and Equality Impact Assessment.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	None specifically
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

Financial		
Business and market share		
Clinical	**x**	Change from existing practice; all staff involved in transfusion will need to be trained in the electronic system
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		The traditional non electronic system of blood transfusion remains applicable until the electronic system has been fully implemented.

PREVIOUS CONSIDERATION:

Policy circulated to the Trust Transfusion Committee and to Drug and Therapeutics Committee.

The revised policy was approved by the Governance Board at its meeting on 9 April 2010.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

BLOOD TRANSFUSION POLICY

Reference	SWBH/Pt Care/09
Category	Patient Care
Date Approved	
Date of Next Review	

PROFILE	
Overview	
Key overall purpose of policy	*Single sentence description of the policy purpose*
Principal target audience	*State to which groups of staff the policy applies*
Application	*State whether the policy applies to child patients, adult patients, both or staff only*
Accountable Executive Director	Medical Director
Author(s)	Consultant Haematologist
Impact Assessment	
Resource implications	*State financial, personnel or any other resources required to implement and support the policy*
Training implications	
Communications implications	
Date of initial equality impact assessment	
Date of full equality impact assessment (if appropriate)	
NHSLA risk management standards/ CQC core standards	*List any standards which the policy supports – details available from Trust Secretary if needed*
Consultation and referencing	
Key stakeholders consulted/involved in the development of the policy	
Complementary Trust documents for cross reference	Blood Transfusion Refusal; Jehovah's Witnesses and Others (Pt Care/041) Consent Policy Blood Transfusion; Fresh Frozen Plasma (FFP); indications for use (ClinHaem/014) (SWBH) Blood transfusion: Guidelines for the clinical use of Red Cell Transfusions in Adults (ClinHaem/09)
Approvals and monitoring	
Approving body	Governance Board Drugs and Therapeutic Committee
Date of implementation	
Monitoring and audit	*State which bodies will be responsible for monitoring the progress against the implementation plan*

DOCUMENT CONTROL AND HISTORY				
Version No	**Date Approved**	**Date of Implementation**	**Next Review Date**	**Reason for Change e.g. full rewrite, amendment to reflect new legislation, updated flowchart, etc.**

5	October 2008	October 2008	October 2010	
6				

Blood Transfusion Policy
Contents

1.0 Introduction

1.1 It is well documented that simple errors, not related to laboratory compatibility testing, are often the cause of the great majority of serious, life threatening adverse transfusion reactions.

1.2 Serious Hazards of Transfusion (SHOT) reports have highlighted that the main reason for an incompatible blood transfusion is due to the failure of some aspect of the checking procedure.

1.3 As part of the risk management process for blood transfusion it is imperative that all staff collecting blood samples for compatibility testing, collecting, storing and administering blood, follow a protocol which details the checking procedures which must be followed.

1.4 The decision to transfuse is a strictly clinical one. National and local guidelines (see References section) are available for a variety of conditions and it is important that medical staff are aware of these and apply them in practice. The blood transfusion department staff and consultant haematologists are available if advice is required at any time.

ALL STAFF THAT ARE INVOLVED IN BLOOD TRANSFUSION SHOULD ENSURE THAT THEY HAVE BEEN TRAINED AND THAT THEY HAVE BEEN ASSESSED AS COMPETENT IN THE RELEVENT AREA OF THE TRANSFUSION PROCESS.

Major changes to the blood transfusion policy

The policy describes the processes for all stages of the transfusion policy using the traditional manual system as well the procedure to be followed using BloodTrack ® which is an electronic system. The policy also outlines the training requirements for blood transfusion.

2.0 Objectives

2.1 To ensure the highest standards and a consistent approach for:
- a) The safe collection of samples for blood grouping and cross-matching,
- b) The safe collection, storage and administration of blood and blood components

2.2 To ensure that only those staff who have been formally trained in each aspect of the protocol carry out those duties.

2.3 To ensure the sampling of patients for blood grouping and compatibility testing is performed correctly to avoid mis-identification of patients and mislabelling, which may lead to potentially fatal errors.

2.4 To ensure that blood and blood components are handled, stored, checked and administered in a safe and consistent manner to reduce the risk of an adverse event.

2.5 To standardise the observations made of the patient during blood transfusion and to enable staff to identify signs and symptoms of an adverse reaction.

2.6 To ensure that all staff are aware of the procedure to follow in the event of an adverse reaction to a blood transfusion.

2.7 To ensure that all suspected transfusion-related adverse events are recognised, investigated, managed and reported appropriately.

3.0 Scope

The policy sets out the processes to be followed by staff when collecting blood samples and before, during and after a blood transfusion to ensure this is done as safely as possible.

4.0 Definitions

4.1 Blood
Any blood component e.g. red cells, platelets, fresh frozen plasma and cryoprecipitate.

4.2 Blood Bank Register
The book in which all blood withdrawals must be recorded. This is located in or adjacent to each Blood Issue Refrigerator.

4.3 Blood Issue Refrigerator
Blood issue refrigerator outside the Pathology Department at Sandwell Hospital.
Blood issue refrigerator in the Blood Bank Lobby, Pathology, and City Hospital

4.4 Blood product collection form
The form with which blood is collected from the Blood Issue Refrigerator

4.5 Blood Track abbreviations

4.5.1 SafeTx: Handheld PDA (personal digital assistant) which are used at the bedside to check the unit of blood against the patient's wristband.

4.5.2 BloodTrack Courier
Electronically controls and tracks the movement of blood products in and out of hospital blood issue refrigerators.

4.5.3. BloodTrack HemoSafe
The 'Blood bank issue fridge': HemoSafe dispenses individual blood units

4.5.4 BloodTrack Enquiry
Enables caregivers to query the location of blood units and check the status of transfusions from the nursing station. This program will be on ward PCs

4.5.5 BloodTrack Manager
This is based in the blood bank and maintains a central repository of transfusion and blood movement events to enable a full audit trail.

4.6 Blood Transfusion Report Form
The form which details the Blood Transfusion Department's report and the blood issued for a patient

4.7 BMS
Biomedical Scientist

4.8 Compatibility Label
Label applied to the donor unit by the Blood Transfusion Department, which lists the patient's details

4.9 Compatibility Testing
Cross-matching units of blood against patient's sample

4.10 CMV
Cytomegalovirus

4.11 Donor Unit Number
The unique identification donor number on the unit of blood

4.12 Irradiated
Cellular product that has been treated with gamma-rays to prevent DNA replication

4.13 NBS
National Blood Service

4.14 Qualified Person
Registered Nurse, Registered Midwife, Doctor, Operating Department Practitioner

4.15 SHOT
Serious Hazards of Transfusion

4.16 Theatre Refrigerator

Blood issue refrigerator located within theatres at SWBH Trust.

5.0 Roles and Responsibilities

5.1 Managers and Consultants

- Implementation of the blood transfusion policy
- Monitoring standards of care

5.2 Consultant staff

- Maintaining an up to date Maximum Surgical Blood Order Schedule
- Promoting appropriate use of blood and alternatives to transfusion.

5.3 Medical Officers, (doctors registered with the General Medical Council).

- Assessing the patient's blood product requirement.
- Prescribing and ordering blood products stating, component, quantity, duration of transfusion and any special requirements (e.g. irradiated products, CMV negative).
- Communicating and discussing decisions with nurses.
- Explaining risks and benefits of transfusion to patients.
- Obtaining patient consent for transfusion.
- Documenting the reason for transfusion and the clinical outcome in the medical notes.
- Knowing how to investigate and manage transfusion reactions.

5.4 Medical staff

Share responsibility for:

- Requesting blood products including special requirements i.e.: CMV Negative or Irradiated.
- Taking and submitting samples for compatibility testing.
- Dealing with and reporting transfusion reactions and transfusion incidents.
- Prompt return of unused components within agreed time frame.
- Cannulating patients.
- Intravenous drug management and use of specialist lines.
- Requesting blood for cross match.
- Prescribing blood for transfusion.
- Accurate documentation.
- Collection and removal of blood from blood fridge.
- Returning of blood to blood bank fridge.
- Obtaining emergency blood supply.
- Correct patient identification.
- Providing patient information.
- Administering blood.
- Checking blood and blood product
- Managing adverse events

5.5 Senior Nurses and midwives

Blood, including red cells and platelets, is considered to be a medicinal product and cannot be prescribed by nurses.

Haematology Specialist Nurses may request blood products, including special requirements i.e. CMV Negative or Irradiated.

Those approved would be able to:

- Take samples of blood for cross match
- Cannulate patients
- Be responsible for Intravenous drug management and use of specialist lines
- Monitor and observe patient observations
- Provide documentation, ensuring accuracy.
- Collect and remove blood from blood fridge
- Return blood to Blood Bank/fridge
- Identify patient correctly
- Gain patient's consent
- Provide patient information
- Administer blood
- Check blood/blood product
- Manage adverse events

5.6 Registered nurses and midwives:

- The positive identification of the patient when taking samples and administering blood products.
- Confirmation that consent has been obtained.
- Explaining the risks and benefits of blood transfusion to patients.
- Accurate checking, administering and discard of blood components.
- Accurate observation of patient during transfusion.
- Monitoring patient transfusions and management of adverse incidents.
- Reporting incidents relating to the transfusion (including transfusion reactions).
- Prompt return of unused components within agreed time frame.

5.7 Phlebotomists and Others Taking Blood Samples

- To check the identity of a patient before taking any blood samples
- To check information written on the request form is complete
- To use safe techniques for obtaining blood
- To label sample tubes correctly
- To report incidents

5.8 Healthcare Assistants

- To collect blood and blood components
- To monitor and document patient transfusions

- To report incidents relating to the transfusion (including transfusion reactions)

5.9 Porters, Theatre Support Workers
Collection and delivery of blood and components

5.10 Operating Department Practitioners:
May be responsible for:
- Correct identification of patient and blood products.
- Collection, Identification of blood products for a named patient.
- Transport and delivery of blood products to appropriate clinical areas.
- Prompt return of unused components within agreed time frame.
- Accurate documentation
- Obtaining emergency blood supply

5.11 State Registered Biomedical Scientists (BMS) and supervised trainees in Blood Banks

- Blood group and antibody determination and compatibility testing
- Ordering and storage of blood products.
- Correct identification of samples against requests.
- Checking patients for special blood requirements.
- Accurate and timely testing.
- Ensuring compatibility of issued components.
- Ensuring integrity of the blood products.
- Providing correctly labelled blood products which correlate with the details on the sample that was used for the testing purposes.
- Maintaining records of blood product usage to facilitate audit trails, patient transfusion records and provide statistical information.
- Investigation and reporting of transfusion incidents including transfusion reactions; and reporting them to SHOT (Serious Hazards of Transfusion scheme) and the Medicines and Healthcare products Regulatory Authority.
- Receipt of samples and arrangement of appropriate laboratory tests
- Issuing blood products
- Offering advice and support to clinical staff
- Managing blood stocks and liaison with the National Blood Service

All procedures will be in compliance with approved laboratory Standard Operating Procedures

5.12 Trust Transfusion Committee:
- Review of Blood Transfusion Policies and Procedures.
- Review of adverse transfusion events including "near misses".
- Manage the Blood Transfusion Risk register
- Recommendation of corrective action in transfusion practice where indicated and feedback to clinical areas.
- Monitoring staff training in relation to transfusion.

- Review of the appropriate use of blood products.
- Review maximum surgical blood order schedules (MSBOS)
- Promotion of continuing education for all relevant members of staff.
- Review of transfusion documentation/policies
- Ensuring participation in audit

5.13 The Trust Transfusion Team

a) assists in the implementation of the Blood Transfusion Committee's objectives of promoting safe and appropriate transfusion practise
b) Provides training to all staff involved in the process of blood transfusion.

5.14 Ward Managers/ Matrons

a) ensuring that staff who are involved in the blood transfusion process are Competent through training to follow procedures which ensure that the correct Blood is given at the right time
b) ensuring that written information is made available to patients about blood Transfusion and potential alternatives
c) ensuring that the patient is positively identified through verbal interrogation and by looking at the patient identity wristband prior to taking a blood sample for crossmatch or administering a blood or component transfusion
d) incidents are reported through the Trust Adverse Incident Reporting procedure

5.15 The Trust Executive Team working with the Transfusion Committee

Are responsible for ensuring that health care professionals are informed of and follow the Trust policy.

5.16 Transfusion practitioner(s)
a) Provide blood transfusion training and advice
b) Work with clinical teams to improve transfusion practice across the Trust
c) Facilitate participation in regional and national audit

All staff involved in transfusion are responsible for maintaining and updating their knowledge, competence and practice.

6.0 Infection Control Procedures

Infection control procedures must be followed at every stage in the policy;

- Aprons and gloves must be worn when in contact with blood or bodily fluids.
- Hands must be decontaminated before and after patient contact.

- An aseptic technique must be used for all line (peripheral and central) insertion.
- An appropriate secondary dressing must be used to secure the cannula, in line with Epic Guidelines.
- Insertion site must be observed for signs of infection/phlebitis
- Documentation for line insertion must be completed in line with Trust Guidelines.
- Giving sets must be removed within 12 hours, or sooner if contamination of the line is suspected.

7.0 Consent

Informed consent for blood transfusion should be obtained in a timely manner wherever possible.

7.1 A trained and knowledgeable practitioner should inform the patient (and/or for paediatric patients those with parental responsibility) of the reason for and the risks, benefits and alternatives to transfusion. This should be done in a timely manner and in a way that they can understand.

7.2 Signed consent is presently not required, verbal consent is sufficient. Consent should be documented in the patient's notes.

7.3 Information leaflets (translated into several languages) are available on the intranet and from the Trust transfusion practitioners. All information given, written and verbal, should be clearly documented in the patient's clinical records.

7.4 The rationale for blood transfusion should be recorded in the patient's notes.

7.5 Blood transfusion should be discussed if it is an extra procedure that may become necessary during certain investigations, interventions or treatment.

7.6 Where consent is not possible, e.g. in emergency situations, where the patient has no capacity to consent, it is a matter of clinical judgement of what is in the patient's best interests.

7.7 For patients who receive regular blood transfusions; it is not necessary to document consent prior to each transfusion

7.8 Patients who refuse blood products: please refer to **Blood Transfusion Refusal; Jehovah's Witnesses and Others (Pt Care/041) (SWBH)**

8.0 Identification of the patient

1. The accurate identification of patients at all stages of the blood transfusion process is essential.

2. All patients having a blood transfusion must have a wristband. Wristbands must comply with the Trust policy: Patient Identification; Wristband Policy (Pt Care/014) (SWBH).
3. Positive patient identification must be used to ensure the correct wristband is attached to the patient prior to blood sampling (inpatients) or blood administration.
   - All patients should, whenever possible, be asked to **state** their full name (first and last name) and date of birth. This must match exactly the information on the patient's identification band (or equivalent)
   - For paediatric transfusions, it is acceptable to ask the child to positively identify themselves if the child is deemed able to respond competently.
   - For patients who are unable to identify themselves, for example children who are unable to respond competently, unconscious or confused patients or where there is a language barrier, verification of the patient's identification should be obtained from a parent or carer (if present at the patient's bedside) and checked against the patient's identification band.

4. If the patient is unconscious and unknown they must be registered with the hospital and a new, unique RXK number assigned,
   - the RXK number must be assigned before the blood transfusion process can begin (this includes collecting the sample). This RXK number must be recorded in the notes
   - unless the patient requires O neg blood in an emergency and before registration can be completed, then an RXK number can be allocated retrospectively after transfusion has begun

   The wristband will be the primary source for identifying an unconscious, unknown patient. However, the notes may provide an auxiliary source if needed.

9.0 Requesting Blood for Transfusion

9.1 Staff responsible: medical staff and specified nursing staff who have received training

9.2 For routine requests, the inpatient or outpatient phlebotomy service should be used whenever possible.

9.3 Complete a transfusion request form with all patient's details. The key information required on the request form:

9.3.1 **Mandatory** Patient's first name and surname
Date of birth
Hospital number
Date and time of sample
Gender

9.3.2 Pre-printed patients identification ('Addressograph') labels can be used on the request form but **not on the sample**. However, these must be clearly printed and the name of the Consultant and location/ward added to the label.

9.3.3 Clinical information needed

- State the diagnosis and the reason for giving blood component.
- Type of blood component and the number of units (exact volume in ml for paediatric transfusions)
- Any special requirements e.g. gamma irradiated product, must be clearly indicated.
- Any known antibodies must be clearly indicated on the request form.
- Any previous transfusion reactions
- Date of last blood transfusion especially if this transfusion occurred at another hospital

9.3.4 The member of staff making the request must sign and clearly print their name and bleep number on the request form. Likewise, the member of staff who takes the blood sample must print their name on the sample and sign the request form.

9.3.5 The location of the patient at the time of the request and at the time of the anticipated transfusion (if different) must be stated.

9.4 Requests out of hours (8pm to 8am) should be able to demonstrate sufficient clinical urgency, as risks associated with out of hours transfusion are known to be greater, as reported in the SHOT reports.

9.5 Procedure for urgent requests for blood including all requests out-of-hours

9.5.1 Request forms must be completed and samples labelled in the same way as for non–urgent samples.

9.5.2. Inform the Blood Transfusion laboratory or on-call BMS if there is a possibility that the laboratory might already have a blood sample. Use of a sample which is already in the laboratory will obviously save time.

9.5.3 Contact the Blood Transfusion laboratory (x 4251/4252 at City Hospital, 3110 at Sandwell Hospital or the red phone in an emergency) or if it is 'out-of-hours' (any time other than 8.00 am–5.00 pm Monday to Friday) contact the on–call BMS using bleep 5251 at City and 6226 at Sandwell

9.5.4 State the following:

- The identity of the person making the request
- The patient's surname, first name, gender and hospital number
- Current location of patient (If the patient is about to be transferred to a different location, provide the location of where the blood will be needed)
- The point of contact (bleep or telephone extension number) for the laboratory for queries and to inform when the blood is ready for collection
- The number and type of blood or blood components required, including any special requirements e.g. gamma-irradiated, CMV-seronegative
- The reason for the request

- The urgency of the requirement, which should be one of the following options:-

a) Blood required immediately
Emergency 'flying squad' O RhD negative blood is available when blood is required immediately. Units of O RhD negative blood are kept in the blood issue refrigerators at both hospitals and in A & E (City). It is acceptable to give O RhD positive blood to males and to females with an unknown blood group over the age of 60 years. It is imperative that a Group and cross match is taken before the patient receives O neg blood and that the sample is sent to blood bank urgently.

b) Group specific blood: ready in 10 minutes from receipt of sample in the laboratory
The Blood Transfusion laboratory will provide Group Specific uncrossmatched blood of the same ABO and RhD group as the patient.

c) For blood required in 60 minutes or longer from receipt of sample in the laboratory
The Blood Transfusion laboratory will provide fully crossmatched blood.
The laboratory must be informed clearly of the urgency with which blood is required. The Blood Transfusion laboratory will phone the clinical area to confirm the receipt of the sample and will inform the relevant clinical area when the blood is ready for collection for all urgent requests.

10.0 Collection of Sample for Blood Grouping, Antibody Screening and Compatibility Testing

10.1 The strict procedure for taking blood samples for blood grouping, antibody screening and compatibility testing (cross-matching) from patients must be followed. This is to avoid misidentification of the patient and the labelling of samples with incorrect patient information which can lead to incompatible blood being cross-matched, and wrong blood given to a patient. Once a significant error is made at the sampling stage it may not be detected further on in the transfusion process. Such errors and fatalities have been reported in the Serious Hazards of Transfusion Report each year

10.2 Staff responsible: phlebotomists, biomedical scientists, doctors, nurses and midwives **who have received blood transfusion training.**

10.3 Only one patient should be bled at a time and the patient identification, labelling and packaging of samples process must be completed before proceeding to another patient.

10.4 Ensure that the request form is completed and available when patient is being bled.

10.5 Confirm the identity of the patient: Do not prompt the patient at any time. Ask the patient to the state the following details:

- First name
- Surname
- Date of Birth
- Address

10.6 Check the details on the patient's identification wristband. This MUST fully match ALL the details on the transfusion request form and the verbal answers by the patient.

With **unconscious or confused patients**, their identity must be confirmed from the wristband and fully checked against the details on the transfusion request form.

10.7 Label the sample bottle AT THE BEDSIDE/ next to the patient. The following minimum details are required on the sample tube:

- First name
- Surname
- Date of Birth
- Hospital Registration number
- Gender
- Date
- Signature of person taking the blood

Printed labels using SafeTx should be used when possible.

10.8 For inpatients/ day case patients, the patient identification number must be identified and obtained from the patient identification wristband AND this must match the number on the request form.

10.9 When not using SafeTx, handwrite in ballpoint pen and sign both the bottle and request form.

10.10 DO NOT PRE LABEL SAMPLE TUBES PRIOR TO PHLEBOTOMY UNDER ANY CIRCUMSTANCES

10.11 Pre-printed labels **other than SafeTx** are NOT acceptable on samples for blood grouping and cross-matching

10.12 Errors or discrepancies in the patient's name, DOB or hospital number will mean that the patient will need to have a repeat sample taken. Clinical staff should take extreme care to ensure all required details are correctly completed to avoid delays in obtaining blood products.

10.13 With children who cannot be relied upon to confirm their identity, this must be confirmed from both the wristband and with the parent/guardian and fully checked against the details on the transfusion request form.

11.0 Preparation of patient prior to transfusion

11.1 The rationale for the decision to transfuse and the specific components to be transfused should be documented in the patient's clinical records.

11.2 ensure that informed consent is obtained (see section 7)

11.3 ensure that the patient is wearing a wristband

11.4 An appropriate-sized cannula should be inserted aseptically. The connection of the cannula should be visible and secured. The procedure for setting up an intravenous infusion should be followed and the usual care for intravenous lines should be applied.

11.5 Infusion pumps may be required for transfusions. Only infusion pumps that have been deemed fit by the manufacturer for blood transfusion should be used.

11.6. Prepare to take and record baseline observations of temperature, pulse, and blood pressure prior to the transfusion.

11.7 Ensure that drugs needed for the treatment of anaphylactic shock are available on all resuscitation trolleys.

11.8 **Prescription of blood**

- The prescription of blood components is the written authorisation to administer a blood component and is different to the request
- Blood must be prescribed by a doctor.
- The prescription should include the following information:
    a. patient core identifiers
    b. date (and time if appropriate) the blood component transfusion is required
    c. type of blood component to be administered
    d. any clinical special transfusion requirements e.g. irradiated, CMV seronegative,
    e. volume or number of units to be transfused (exact number in mls for
    f. paediatric transfusions)
    g. time over which each unit is to be transfused (rate or exact length of time
    h. over which the specified volume is to be transfused for paediatric transfusions)
    i. any special instructions e.g. concomitant drugs required
    j. signature of the prescriber

12.0 Collection of blood components from the Blood Issue Refrigerator

Removal of blood components from their storage location continues to be a major source of error in the transfusion process. **All staff involved in the collection of blood components must be competency assessed.**

Clinical staff:

12.1 Complete blood product collection form. The blood transfusion prescription (drug chart) can alternatively be used to collect blood products. Ensure that the blood is prescribed and that the patient has a working cannula prior to arranging collection.

12.2 The blood product collection form must state the following:

- Patient's first name and surname
- DOB
- Hospital number
- Clinical area
- Blood product that is to be collected
- The form must be signed, and dated by the person making the request to allow the person collecting the blood product to deliver it to the requestor.
- The name and contact details of the person collecting the blood product must also be recorded on the collection form.

12.3 The patient details on the blood product collection form or blood transfusion prescription should be checked with the patient by asking them to state their name and DOB **and** against the patient's wristband. The details MUST match. If there is any discrepancy then check that the blood product collection form has been completed correctly and that the patient has the correct wristband.

12.4 For unconscious patients, the information on the blood product collection form or blood transfusion prescription should be checked against the patient's wristband.

12.5 Where porters are being used to collect blood product(s) from the blood issue refrigerator, the blood product collection form should be either collected from the ward or faxed to the portering department prior to collection of blood.

Porters

12.6 The blood product collection form or blood transfusion prescription must be collected from the ward prior to collecting the blood product from the blood issue refrigerator. Collection forms may be faxed to the portering department for expediency.

12.7 Telephone requests for porters to go directly to the blood bank are only acceptable in life threatening situations.

Removing Blood Components from the Blood Bank Refrigerator

The Blood Transfusion prescription or blood product collection form must be taken to the blood issue refrigerator. The details on the document used for collection must be checked against the compatibility label on the unit of blood.

12.8 **Remove unit of blood from blood issue refrigerator**

a) CHECK the patient's details (First name, surname, Hospital Number and DOB) on the Blood Transfusion prescription/blood product collection form match the patient's details on the Compatibility Label on the unit of blood.
a) If there are any discrepancies, contact the Blood Transfusion Department staff.
c) The Blood issue register has lab copies of the Blood Transfusion Report Form filed in alphabetical order by patient's surname.
The person collecting the blood MUST sign, date and time (using the 24 hour clock) the patient specific form in the register against the unit taken. This form must not be removed from the blood issue register.
d) Units should be taken in order that they are listed on the lab copy of the Blood Compatibility Report Form.
e) Under normal circumstances only ONE UNIT OF BLOOD for the patient should be collected at any one time, using individual Blood product collection forms. More than one unit can be taken in cases of massive blood loss, or when blood is transferred to the satellite refrigerators. In such cases a single blood product collection form can be used for this episode.
f) Blood must be taken directly to the clinical area.

12.9 **Collecting blood using BloodTrack Courier**

Blood/Component collection can only be undertaken by trained, competent staff that have been issued with a barcode to access the new electronic blood system.

Collection Locations
Red cells and Fresh Frozen Plasma can be collected from the HemoSafe Issue fridges
Platelets from the platelet shaker at City and the Blood Bank at Sandwell
Cryoprecipitate can be collected from the Blood Banks
Albumin and Anti-D can be collected from the Blood Banks

12.9.1 To collect a unit of blood for a specific patient

a) Scan user ID barcode under the barcode reader.

b) Select the ‘taking out’ option on the touch screen
c) Select transport method. This is a choice of room temperature or cooler box. (If the cooler box option is selected, the blood must be packed by the Blood Bank staff). The small red transport boxes used at Sandwell are classed as room temp transport)
d) Enter the patient’s hospital number. The patient’s full RXK number must be entered on the screen using the keyboard displayed on the touch screen.
e) The patient’s details will be displayed on the screen. Select the ‘yes’ option only if these identifiers match those on the Prescription chart or blood collection form. If they do not match exactly select ‘no’ and return to the clinical area to check the patient information.
f) If ‘yes’ is selected, the HemoSafe will select the appropriate unit and unlock the door.
g) Using your left hand push the glass door open (This will not require any force if unlocked) and remove the unit using your left hand. The door will automatically lock.
h) The unit number on the blood must be scanned under the barcode reader before leaving the fridge.

12.9.2 Emergency Blood

Scan user ID barcode under the barcode reader.

a) Select the ‘Emergency Blood’ button on the touch screen
b) The fridge will automatically select a suitable O negative unit and open at the appropriate compartment.
c) Push the glass door open (This will not require any force if unlocked) and remove the unit using your left hand. The door will automatically lock.
d) The unit number on the blood must be scanned under the barcode reader.
e) There is now an option to select more Emergency blood if required.
f) If yes repeat from step 2 above.
g) If no, the screen will log out.

12.10 When blood is to be transported to a remote site e.g. Rowley Regis Hospital and John Taylor Hospice, it must be transported in an approved blood box supplied and packed by the Blood Transfusion Department staff and taken directly to the destination. The box must be returned to the Blood Transfusion Department as soon as possible. These units of blood will be booked out in the Blood Issue Register by the laboratory staff.

Receipt of Blood in the Clinical Area

12.11 In the clinical area the person taking the unit to the ward must notify a registered nurse or midwife that the blood is now on the ward. The first trained member of staff receiving the blood must commence the transfusion.

Clinical staff receiving the blood product(s) must check that the patient's details on the compatibility label match the patient's details on the blood product collection form or blood transfusion prescription. Receipt of the blood product(s) should be confirmed by signing the collection form, and by recording the date and time of delivery.

12.12 Scanning the arrival of the blood onto the ward using SafeTx.

a) Turn on PDA
b) Select transfusion and choose arrival
c) Scan your ID
d) Scan porter ID
e) Scan Blood Unit ID
f) Scan Blood Product Code
g) PDA gives message of recent arrivals i.e. Unit number and the hang by time.

Blood stored in satellite transfusion fridges

Sandwell Hospital

12.12 Blood for planned operations is stored in a rack in the blood issue refrigerator in the tray appropriate for the patient's location. If blood is required in theatre, it is transferred to the theatre blood issue refrigerator. A theatre blood bank register is located beside this refrigerator and should be completed by the person collecting blood for administration to a patient.

12.13 At 17.15 hours, a member of the laboratory staff will remove all blood in the theatre refrigerator after checking with theatre staff that no blood is required. The blood will then be transferred to the main Issue Blood Bank Refrigerator. Blood for each patient will be placed in the tray appropriate to the patient's ward. If theatre staff require blood to be left in the theatre refrigerator then the theatre staff must ensure that any remaining blood is returned to the Blood Issue Refrigerator and is not left overnight in the theatre refrigerator.

City Hospital

12.14 All blood units cross-matched for routine operations are collected by the theatre staff and signed out through the blood issue register. A member of appropriately trained staff, a theatre practitioner, must receive the blood or blood component from the nurse or orderly. To avoid later problems, components are identified and immediately returned to the transport box with the cool packs. Blood must not, generally, be stored for longer than 4 hours in these containers. Blood that is not used must be returned as soon as possible to blood bank. .

Platelets, FFP and cryoprecipitate are not stored in the Blood issue refrigerator or in any of the satellite blood refrigerators. FFP should be transfused as soon it is received in the clinical area to optimise its efficacy.

13.0 Bedside Checking and Administration of Blood

13.1 Staff Responsible: Registered Nursing Staff, Registered Midwives, Doctors and Operating Department Practitioners

13.2 The following personnel may perform the blood transfusion final check either:

- Registered Nurses/Midwife, one of whom would normally be the nurse currently responsible for the patient
- One Registered Nurse and a Doctor or one Operating Department Practitioner and a Doctor/Nurse.
- Staff involved in administration of blood must be competency assessed

13.3 THESE CHECKS MUST TAKE PLACE AT THE BEDSIDE IMMEDIATELY PRIOR TO THE COMMENCEMENT OF THE TRANSFUSION:

- Check that the unit of blood is prescribed and signed for by the medical officer on the patient's current intravenous infusion chart. The Nurse signs the chart.

- Check the following:

    - The expiry date on the unit and that this is still in date.
    - The donor unit number on the blood component must match the donation number on the Compatibility Label and Blood Transfusion Report Form
    - Check that the unit complies with any special requirements stated on the blood transfusion prescription e.g. CMV negative blood or irradiated blood
    - The unit of blood should be examined for the following: discolouration, turbidity, evidence of haemolysis, clots or air in the bag, and leaks (check by applying firm pressure to the bag.

- All patients receiving a blood transfusion **must** be wearing an identification wristband prior to the commencement of the checking and transfusion procedure.
- If the patient is not wearing an identification wristband, then a second nurse/midwife must check the patient's identity and apply the wristband prior to the checking and transfusion. The checks must be independent of each other.

- Check that the following patient's details match on the Blood transfusion prescription, identification wristband, the compatibility label on the unit of blood and the patient's verbal response:

    First name, surname, date of birth and registration number

- Ask the patient to state his/her first name, surname, date of birth;

  Do not prompt the patient i.e. DO NOT ASK “are you Mr. Jones ...” etc.
  Ask ‘What is your full name, date of birth etc.
  These should correspond on all forms, labels and wristband
  If there are ANY discrepancies, do not transfuse the blood and contact the blood transfusion department staff.

  The final check MUST be the patient’s wristband against the compatibility label.

13.4 For unconscious and confused patients, the patient’s identity must be confirmed by the wristband. The administering Nurses should include the Nurse in charge of the patient and who knows the identity of the patient.

13.5 The identity of young children who cannot reliably identify themselves must be confirmed by the wristband.

13.6 The unit should be connected to a suitable intravenous giving set by firm insertion into the blood bag port taking care to avoid puncture of the blood bag. Suitable giving sets have an integral screen filter.

13.7 IV giving sets will normally be primed with sodium chloride 0.9% solution (‘Normal saline’)

13.8 The drip rate should be adjusted after the blood has filled the giving set and is passing through the cannula.

13.9 For neonates and children, blood must be administered by an I.V. pump.

13.10 The start and finish times for each unit of blood must be recorded on the compatibility form.

13.11 Once a unit has been commenced, it cannot be used for another patient

Blood administration using SafeTx

Blood component administration by SafeTx requires one trained health care professional. Step by step guide:

- Turn on the PDA and select ‘Transfusion’
- Choose ‘Begin Transfusion’
- Scan your ID
- Scan patient identification (wristband)
- Ask patient to state name and date of birth. Ensure that the patient’s response matches the details on the wristband /PDA. Press the next button.

- Scan compatibility label barcode
- The PDA will now display the compatibility label details and the patients details. Ensure that these details match.
- Scan blood unit number
- Scan blood product code
- Compare details on screen. Press the next button
- Complete all reminders (tick the boxes)
- Enter the patient's observations as prompted by the PDA. If the printer is attached and turned on you will then get the option to print. Press the print button and stick into the patient's medical notes.

Vital Signs / Reactions

- Scan your ID
- Scan patient identification (wristband)
- Scan blood unit number
- Scan blood product code
- Enter the patient's observations as prompted by the PDA
- Assess patient for signs of a transfusion reaction. Tick the appropriate boxes on the PDA.
- If the printer is attached to the PDA, and turned on, you will get the option to print. Press the print button and stick into the medical notes.

End Transfusion

- Scan you ID
- Scan patient's ID (wristband)
- Scan blood unit number
- Ensure that the details on the PDA match the blood unit number on the blood bag
- Enter the volume of blood that was transfused
- Enter patient's observations as prompted by the PDA.
- Note transfusion reactions by ticking the appropriate boxes on the PDA.
- Was the transfusion completed? Tick the appropriate box.
- If printer is connected to PDA, and turned on, you will now get the option to print. This should be printed out and stuck into the patient's medical notes.

Emergency Transfusion

- Scan your ID
- Scan patient's ID (wristband)
- Ask patient to state their name and date of birth. Ensure that the patient's response matches the details on their wristband/PDA.
- Scan blood unit number
- Scan product code
- Check the unit number on the bag matches the unit number displayed on the PDA.
- If printer is attached and turned on, you can now print details of this transfusion. This should be stuck into the patient's medical notes.

Crossmatched Blood

- Scan your ID
- Scan patient's ID (wristband)
- If possible, ask the patient to state their name and date of birth. Ensure that these details match.
- Scan compatibility label, and ensure that these details match.
- Scan blood unit number
- Scan product code
- If the printer is attached and turned on, you can now print details of this transfusion. This should be printed out and stuck into the medical notes.

14.0 Observations

14.1 Staff responsible: The patient's current nursing and/or medical staff, HCA's

14.2 It is vitally important that all observations are done at the correct times and recorded in the patient's notes to provide a clear audit trail.

14.3 Baseline observations i.e. Blood Pressure, pulse, temperature and respiration rate must be taken before the start (within 60 minutes) of the transfusion and at the start of each subsequent unit of blood. This must be recorded in the patient's notes.

14.4 At 15 minutes after the start of each unit of blood take temperature, Blood pressure, Pulse and Respiration and record in the patient's notes. An adverse reaction should be considered when assessing a deterioration or change in

the patient's condition, particularly in the first 15 minutes following the start of a unit of blood. Once only is sufficient unless the patient has had any previous adverse reactions or is already having more frequent observations for other reasons or if there are any signs of a transfusion reaction. This protocol should not detract from the necessity to maintain general observations throughout the transfusion period.

14.5 Observations should be done on completion (within 60 minutes) of each unit of blood and prior to the start of any subsequent units of blood.

14.6 If the patient develops symptoms or signs of an adverse reaction, more frequent observations will be required (see section on Adverse reactions),

14.7 Unconscious patients are more difficult to monitor for signs of an adverse reaction. Routine observations should continue at least hourly.

15.0 Documentation of Transfusions

15.1 Patient clinical records should be available within the clinical area at the time of the transfusion. Minimum documentation of transfusion episodes in the patient clinical records should include:

Pre transfusion

- the clinical indication for transfusion
- relevant pre transfusion indices
- the date the decision for the transfusion was made and the date transfusion should be administered (if different)
- blood components to be transfused and their volume/dose
- the risks, benefits and possible alternatives of transfusion as explained to the patient (or those with parental responsibility) and consent to proceed

15.2 Blood and blood components must be prescribed as for other medications by a qualified doctor on a prescription chart.
The prescription should include the following information:

- patient core identifiers
- date (and time if appropriate) the blood component transfusion is required
- type of blood component to be administered
- any clinical special transfusion requirements e.g. irradiated, CMV seronegative, blood warmer required
- volume or number of units to be transfused (exact number in mls for paediatric transfusions)
- time over which each unit is to be transfused (rate or exact length of time over which the specified volume is to be transfused for paediatric transfusions)
- any special instructions e.g. concomitant drugs required
- signature of the prescriber

15.3 Medical staff must record in the medical section of the notes the reason for transfusion and that information regarding the risks and benefits of transfusion has been given to the patient.

15.4 The two registered nurses/midwives checking the unit prior to transfusion must both sign both the Blood Transfusion Report Form and the Blood Transfusion prescription.

15.5 The Blood Transfusion Report Form must be filed in the patient's notes in the haematology results section when the transfusion episode is completed.

15.6 The observation chart for the period of transfusion must be retained and filed in the patient's notes. The observations taken before, during and after the transfusion should be recorded; the time that the transfusion is completed must be documented on the blood transfusion report form.

15.7 The nurse completing the transfusion must complete the traceability tag on the reverse of the compatibility label by stating the clinical area, date and a signature and return the tag and bag to the blood bank.

15.8 Used Blood Bags

The used blood pack units along with the traceability label must be kept and RETURNED TO THE BLOOD TRANSFUSION DEPARTMENT within 24 hours as soon as possible in a sealed plastic bag. This enables investigation of the bag if any reaction occurs at some time after the completion of the transfusion. The blue plastic plug MUST be inserted into the bag to avoid leakage of the contents. Do not return used bags through the air tube system as this poses a considerable risk of contamination of the air tube with blood from the bag and do not store used packs on the ward.

15.9 Traceability tags from albumin and anti-D can be removed from the vials and then returned to blood bank.

15.10 **Documentation of transfusions using SafeTx**

- Scan your ID
- Scan patient identification (wristband)
- Scan blood unit number
- Scan blood product code
- Enter the patient's observations as prompted by the PDA
- Assess patient for signs of a transfusion reaction. Tick the appropriate boxes on the PDA.

- If the printer is attached to the PDA, and turned on, you will get the option to print. Press the print button and stick into the medical notes.

16.0 Transfusion time limits

Generally blood should be transfused as soon as it is received into the clinical area.

16.1 Blood that has been out of the Blood issue refrigerator for less than 30 minutes that is not required imminently should be returned to the blood issue refrigerator for further storage.

Returning blood

a) Scan user ID barcode under the barcode reader.
b) Select the 'putting in' option on the touch screen
c) Scan the unit number
d) Using your left hand push the glass door open (This will not require any force if unlocked) and place the unit in the open compartment using your left hand. The door will automatically lock.
e) Touch logout.

16.2 Blood that has been out of the blood issue refrigerator for more than 30 minutes must not be returned to the blood issue refrigerator BUT may be transfused to the intended patient as long as the blood infusion is completed within 4 hours of removal of the blood from the blood issue refrigerator.

16.3 If the blood is returned after 30 minutes of its removal then DO NOT RETURN THE BLOOD TO THE BLOOD ISSUE REFRIGERATOR but inform the Blood Transfusion Department or the BMS on call if this occurs out of hours.

16.4 Platelet transfusions should be completed within 30-60 minutes.

16.5 The transfusion of FFP and cryoprecipitate should be completed within 4 hours of removal from blood bank.

17.0 Adverse Reactions

17.1 All transfusion reactions must be reported immediately to the Blood Bank who will issue the required documentation and have the implicated pack(s) returned to the Blood Bank.

17.2 If the patient develops any of the following symptoms;

- Pyrexia
- Rigor (chills)
- Lumbar Pain
- Rash or itching
- Hypotension/Tachycardia
- Jaundice
- Oliguria/Anuria
- Chest Pain or discomfort
- Dyspnoea
- Dark Urine
- Loin Pain

Then the following documented action MUST be taken by the nurse in charge;

a) Stop the transfusion and inform the doctor
b) Repeat the observations every 30 minutes, for at least 2 hours and document them
c) The doctor must decide
   - Whether the transfusion should be continued
   - If any medication is to be administered
   - If discussion with a Consultant Haematologist is required
   - If further laboratory investigation is required

17.3 If an investigation is required, an 'Investigation of an Apparent Transfusion Reaction' form (Appendix 3) must be completed by the Medical Officer and then if necessary, a 'Laboratory Investigation of a Transfusion Reaction' form (Appendix 4) by the Blood Transfusion Department .The forms are kept in the Blood Transfusion Department and can be obtained by telephoning the department on ext. 3110 at Sandwell and 4252 at City Hospital, or via the bleep during out of hours to contact the on-call BMS; bleep 6226 at Sandwell Hospital and 5251 at City Hospital.

18.0 Night time Transfusions

18.1 Where the clinical condition permits, then transfusion at night must be avoided wherever possible as;

- There is difficulty in visually detecting reactions
- Lower staffing levels make it difficult to carry out the observations in a timely fashion.

Therefore:

18.2 If the transfusion must occur at night then the night light above the patient must remain on while the patient is being transfused.

18.3 It should be ensured that sufficient numbers of suitably qualified staff are available to monitor the patient. (See Observations section)

19.0 Technical Notes

19.1 Blood must NEVER be stored in a ward or drugs refrigerator under any circumstances.

19.2 Blood for patients during surgery and in the immediate post operative period may be stored in the THEATRE blood fridge (Sandwell) or a cool box as packaged by the blood transfusion staff.

19.3 Size of cannula: there is no minimum or maximum size, but the size must be appropriate as determined by venous access, age and condition of the patient.

19.4 Giving Sets

- Only sets specified for use for blood/blood components must be used
- A new giving set must be used after 12 hours in order to prevent bacterial growth
- A new giving set should be used if another infusion is to continue after the blood transfusion. This applies if platelets are to be transfused after red cells.

19.5 Infusion pumps: Only pumps that have been verified by the manufacturer as safe for blood transfusion should be used for this purpose.

19.6 Blood Warmers: Only specifically designed devices should be used for warming blood. No improvised device should be used as this may haemolyse the blood.
A blood warmer should be used:

- When transfusing a patient with significant cold agglutinins. This would normally be stated on the compatibility form.
- At flow rate > 50ml/kg/hour in adults and > 15 ml/kg/hour in children

19.7 Drugs must not be added to blood under any circumstances

19.8 Irrespective of location, blood must never be stored or warmed using microwave ovens. Should this occur for any reason, the Blood Component must not be transfused and the incident reported to the Blood Transfusion Department immediately.

20.0 Transfer of blood to external sites

Blood must not be transferred outside the Trust except in exceptional circumstances. If this is required, the Blood Transfusion Department must be informed and the Blood Transfusion Department staff will package the units appropriately, inform the receiving hospital Transfusion Laboratory and send the appropriate documentation.

21.0 Emergency O negative red cell units

21.1 Emergency O negative red cell units (flying squad) are available in Blood Issue refrigerators at both City and Sandwell hospitals, and in the A&E blood bank refrigerator. These units are to be used in an emergency when blood is required immediately.

21.2 When emergency O negative red cell units are removed from the Blood Bank, transfusion staff **MUST** be informed immediately. This is to ensure rapid replacement and to facilitate the provision of further red cell support.

21.3 A pre transfusion sample is required prior to administration of O negative units so that a blood group can be done and subsequent group specific and/or cross matched blood can be made available.

21.4 The traceability tags attached to emergency O negatives must be completed and returned to the Blood Transfusion Department.

21.5 Removal of emergency O negative blood using BloodTrack Courier

a) Scan user ID barcode under the barcode reader.
b) Select the ‘Emergency Blood’ button on the touch screen
c) The fridge will automatically select a suitable O negative unit and open at the appropriate compartment.
d) Using your left hand push the glass door open (This will not require any force if unlocked) and remove the unit using your left hand. The door will automatically lock.
e) The unit number on the blood must be scanned under the barcode reader.
f) There is now an option to select more Emergency blood if required.
h) If yes repeat from step 2 above. If no, the screen will log out.

22.0 Training and Competency Assessment

22.1 It is a Trust requirement that all staff involved in the transfusion process receive mandatory training in line with the Trust Training Needs Analysis as set out in the Induction, Statutory and Mandatory Training Policy. Failure to attend training will be followed up in line with the policy.

22.2 It is a Trust requirement that all staff involved in the transfusion process undergo competency assessments in line with the NPSA Safer Practice Notice 14 in all the parts of the process with which they are involved. These must be updated on a 3 yearly basis.

23.0 Equality

The Trust recognises the diversity of the local community and those in its employ. Our aim is, to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their need. The Trust recognises that equality impacts on all aspects of daily living and has produced an equality policy statement to reflect this. All policies are assessed and monitored in accordance with the equality screening tool kit.

Clinical staff need to be aware that certain patient groups are at greater risk of transfusion complications and in such situations the risk and benefits of transfusions should be especially considered. It is important to acknowledge the beliefs of Jehovah 's Witness' patients and to discuss their treatment options. A separate policy exists for this latter patient group.

24.0 Policy Review

This current version Blood Transfusion Policy will be reviewed in 1 year. An immediate review will occur in response to any updates in National Guidelines that may impact upon this policy.

25.0 Monitoring

Implementation of this policy will be done via the Trust Transfusion committee. The BloodTrack system will facilitate real time monitoring of the transfusion process.

26.0 References

- SHOT Reports
- NPSA recommendations
- Epic Guidelines
- Blood Transfusion; Fresh Frozen Plasma (FFP) and platelets; indications for use (ClinHaem/014) (SWBH)
- Blood transfusion: Guidelines for the clinical use of Red Cell Transfusions in Adults (ClinHaem/09)

27.0 Bibliography

- Guidelines for the Administration of Blood Components December 2009. British Committee for the Standards in Haematology, Blood Transfusion Task Force. http://www.bcshguidelines.com/pdf/Admin_blood_components050110.pdf/

- Handbook of Transfusion Medicine. 2007 4th edition. Blood Transfusion Services of the United Kingdom, Editor D B L McClelland http://www.transfusionguidelines.org.uk/docs/pdfs/htm_edition-4 all-pages.pdf/

- Patient, right time. Authors: Alexandra Grey and Jennifer Illingworth. http://www.rcn.org.uk/publications/

- Minimum Standards for Investigation of Transfusion Related Adverse Reactions. Serious Hazards of Transfusion. http://www.shotuk.org/

- www.transfusionguidelines.org/

28.0 Further Enquiries

Questions about this policy should be directed to the Trust Transfusion Officer(s) or a member of the Trust Transfusion Team.

Appendix 1

Administration of blood components using the electronic BloodTrack system

1.0 Collecting blood using BloodTrack Courier

Blood/Component collection can only be undertaken by trained, competent staff that have been issued with a barcode to access the new electronic blood system.

Collection Locations
Red cells and Fresh Frozen Plasma can be collected from the HemoSafe Issue fridges
Platelets from the platelet shaker at City and the Blood Bank at Sandwell
Cryoprecipitate can be collected from the Blood Banks
Albumin and Anti-D can be collected from the Blood Banks

2.0 To collect a unit of blood for a specific patient

i) Scan user ID barcode under the barcode reader.
j) Select the 'taking out' option on the touch screen
k) Select transport method. This is a choice of room temp or cooler box. (If the cooler box option is selected, the blood must be packed by the Blood Bank staff). The small red transport boxes used at Sandwell are classed as room temp transport)
l) Enter the patient's hospital number. The patient's full RXK number must be entered on the screen using the keyboard displayed on the touch screen.
m) The patient's details will be displayed on the screen. Select the 'yes' option only if these identifiers match those on the Prescription chart or blood collection form. If they do not match exactly select 'no' and return to the clinical area to check the patient information.
n) If 'yes' is selected, the HemoSafe will select the appropriate unit and unlock the door.
o) Using your left hand push the glass door open (This will not require any force if unlocked) and remove the unit using your left hand. The door will automatically lock.
p) The unit number on the blood must be scanned under the barcode reader before leaving the fridge.

3.0 Emergency Blood

Scan user ID barcode under the barcode reader.

i) Select the 'Emergency Blood' button on the touch screen
j) The fridge will automatically select a suitable O negative unit and open at the appropriate compartment.

k) Using your left hand push the glass door open (This will not require any force if unlocked) and remove the unit using your left hand. The door will automatically lock.
l) The unit number on the blood must be scanned under the barcode reader.
m) There is now an option to select more Emergency blood if required.
n) If yes repeat from step 2 above.
o) If no, the screen will log out.

4.0 Scanning the arrival of the blood onto the ward using SafeTx.

h) Scan your ID
i) Scan porter ID
j) Scan Blood Unit ID
k) Scan Blood Product Code
l) PDA gives message of recent arrivals i.e. Unit number and the hang by time.

5.0 Blood administration using SafeTx

Blood component administration by SafeTx requires one trained health care professional. Step by step guide:

- Turn on the PDA and select 'Transfusion'
- Choose 'Begin Transfusion'
- Scan your ID
- Scan patient identification (wristband)
- Ask patient to state name and date of birth. Ensure that the patient's response matches the details on the wristband /PDA. Press the next button.
- Scan compatibility label barcode
- The PDA will now display the compatibility label details and the patients details. Ensure that these details match.
- Scan blood unit number
- Scan blood product code
- Compare details on screen. Press the next button
- Complete all reminders (tick the boxes)
- Enter the patient's observations as prompted by the PDA. If the printer is attached and turned on you will then get the option to print. Press the print button and stick into the patient's medical notes.

6.0 Vital Signs / Reactions

- Scan your ID
- Scan patient identification (wristband)
- Scan blood unit number

- Scan blood product code
- Enter the patient's observations as prompted by the PDA
- Assess patient for signs of a transfusion reaction. Tick the appropriate boxes on the PDA.
- If the printer is attached to the PDA, and turned on, you will get the option to print. Press the print button and stick into the medical notes.

7.0 End Transfusion

- Scan you ID
- Scan patient's ID (wristband)
- Scan blood unit number
- Ensure that the details on the PDA match the blood unit number on the blood bag
- Enter the volume of blood that was transfused
- Enter patient's observations as prompted by the PDA.
- Note transfusion reactions by ticking the appropriate boxes on the PDA.
- Was the transfusion completed? Tick the appropriate box.
- If printer is connected to PDA, and turned on, you will now get the option to print. This should be printed out and stuck into the patient's medical notes.

8.0 Emergency Transfusion

- Scan your ID
- Scan patient's ID (wristband)
- Ask patient to state their name and date of birth. Ensure that the patient's response matches the details on their wristband/PDA.
- Scan blood unit number
- Scan product code
- Check the unit number on the bag matches the unit number displayed on the PDA.
- If printer is attached and turned on, you can now print details of this transfusion. This should be stuck into the patient's medical notes.

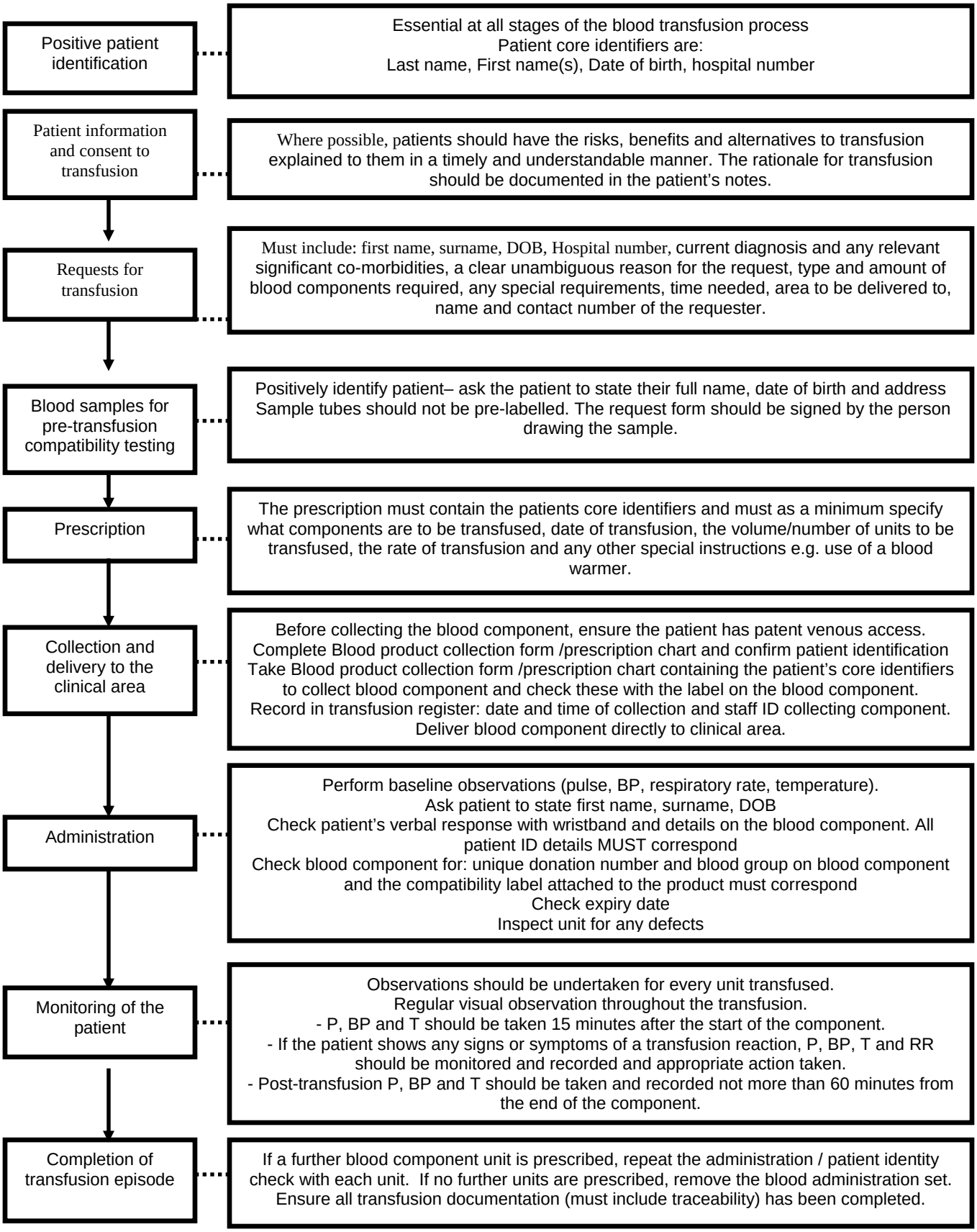
9.0 Crossmatched Blood

- Scan your ID
- Scan patient's ID (wristband)

- If possible, ask the patient to state their name and date of birth. Ensure that these details match.
- Scan compatibility label, and ensure that these details match.
- Scan blood unit number
- Scan product code
- If the printer is attached and turned on, you can now print details of this transfusion. This should be printed out and stuck into the medical notes.

Appendix 2

THE ADMINISTRATION OF BLOOD COMPONENTS – traditional system



Appendix 3

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Blood product collection form

ONLY STAFF TRAINED IN THIS PROCEDURE WILL BE PERMITTED TO COLLECT BLOOD PRODUCTS

Indicate requirements	PLEASE WRITE LEGIBLY	
☐ Red Cells	Surname	Hospital Number
☐ Platelets	First name	Date of birth
☐ Plasma	Clinical Area	
☐ Cryoprecipitate		
☐ Anti-D immunoglobulin	Requested by (Doctor/Nurse/Midwife/Dther) Date …… Time……..	
☐ Other	Collected by Name …… Signature…… Contact number	
Arrival in clinical area Received by:	Date:	Time

Please retain on ward for 1 month to facilitate audit trail

Appendix 4

Investigation of an Apparent Transfusion Reaction

TO BE COMPLETED BY THE **MEDICAL OFFICER RESPONSIBLE** FOR THE PATIENT

Post transfusion samples to be collected if a blood transfusion reaction is suspected.

1. Donor pack involved.
2. 10 ml of clotted blood.
3. 5 ml of EDTA blood.
4. First available urine after reaction.
5. Blood cultures

Additional samples may be required please liaise directly with the Blood Transfusion Laboratory

If more than one pack has been transfused during this episode, please return all packs.

PATIENT'S DETAILS – please print; do not use a documentation label

Surname:	Forename:	Reg Number:
Address:	Date of Birth:	M/F:
	Consultant:	Ward:

THE PATIENT

Reason for this transfusion:	
Pre-transfusion Haemoglobin ,plts & coag:	

If the answer is YES to any of the questions below, please give details.

Previous transfusions:	Y/N	
Previous reactions:	Y/N	
Pregnancies :	Y/N	
Abortion/Miscarriage/Still births:	Y/N	
Known atypical antibodies:	Y/N	

SYMPTOMS OF REACTION

Pyrexia		Y/N
Baseline	15 mins	
30 mins	1 hour	
Rigor/Chills		Y/N
Lumbar Pain		Y/N
Rash/Itching		Y/N
Hypotension/Tachycardia		Y/N
BP Range	HR Range	
Dark Urine		Y/N
Vomiting		Y/N
Jaundice		Y/N
Oliguria or anuria		Y/N
Chest Pain or chest discomfort		Y/N
Dyspnoea		Y/N
Restlessness		Y/N

THE BLOOD PACK

Blood component:	
Unit number :	
Expiry date:	
Blood group:	
Date & time unit removed from blood bank:	
Was the blood warmed prior to transfusion?	
Time transfusion commenced:	
Time of onset of symptoms:	
Time transfusion stopped:	
Volume of blood given before reaction (Approx):	
Was anything added to the blood or giving set?	

M.O. SIGNATURE…..... DATE…..

PRINT NAME…..... BLEEP NO. ….....

Appendix A

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Equality Impact Assessment

Stage 2
Initial Assessment form

The Initial Impact Assessment is a quick and easy screening process. It should:

1. Identify those policies, functions, services, functions or strategies which require a full EIA by looking at:

    - Negative, positive or no impact on any of the equality groups.
    - Opportunity to promote equality for the equality groups
    - Data / feedback prioritise if and when a full EIA should be completed

2. Justify reasons why a full EIA is not going to be completed

Division:	**Trust wide policy**
Is it a Service, Policy or Function:	**Policy - Outline steps in the blood transfusion process**
Lead officer:	**Dr S Pancham**
Title of policy, function or service:	Blood transfusion policy

Existing: ☐

New/proposed: ☐

Changed: ☐x

Equality & Diversity Team

Q1) What is the aim of your policy/service/function (you may want to refer to the Operational Policy for your service)?

The aim of the policy is to clearly define all the processes involved in blood transfusion from collecting a blood sample through to administration of blood, handing of blood products and recognition of transfusion reactions. The policy aims to ensure a consistent approach with the ultimate aim of reducing transfusion errors. The policy has been revised to incorporate the electronic BloodTrack system.

Q2) Who benefits from your policy /service/function?

All patients who receive a blood transfusion; all clinical staff involved in the blood transfusion process.

Q3) Do you have any feedback data that influences, affects or shapes this policy, function or service?

Yes	No
☐x Please complete comments below.	☐ Please go to question 5

What is your source of feedback?

- ☐ Previous EIAs
- x☐ National Reports
- ☐ Internal Audits
- ☐ Patient Surveys
- ☐ Complaints
- ☐ Focus Groups
- ☐ Equality & Diversity Training
- ☐ Equality & Diversity Team

What does this source of feedback reveal?
National SHOT (serious Hazards of Blood Transfusion) reports which are published annually. This report identifies sources of transfusion errors and recommends steps to reduce these errors. These steps are incorporated into transfusion practice nationally and locally.

Q4) Thinking about each group below does or could the policy, function, or service have a negative impact on members of the equality groups below?

Group	Yes	No	Unclear
Age	☐	x☐	☐
Disability	☐	x☐	☐
Ethnicity	☐	x☐	☐
Gender	☐	x☐	☐
Transgender	☐	x☐	☐

Sexual orientation	☐	x☐	☐
Religion or belief	x☐	x☐	☐
Other socially excluded groups	☐	x☐	☐

If the answer is "yes" or "Unclear" please complete a full EIA

A separate policy exists for those who refuse blood products **Blood Transfusion Refusal; Jehovah's Witnesses and Others (Pt Care/041) (SWBH)**

Q5) Who was involved in the EIA and how?

Who:

☐ Staff members
x☐ Consultants
☐ Doctors
☐ Nurses
☐ Local patient/user groups

☐ Other | Please specify:

How were they involved?

☐ Surveys
☐x Team Meeting
☐ Via the Single Equality Scheme
☐ Divisional Review

☐ Other | Please specify:

Q6) Have you identified a negative/potential negative impact (direct /indirect discrimination)?

No	☐	yes	x☐

Q6a) If 'No' Explain why you have made this decision?

The processes in the transfusion policy apply equally to all patients receiving a blood transfusion. As mentioned , a separate policy exists for patients who refuse a blood transfusion **Blood Transfusion Refusal; Jehovah's Witnesses and Others (Pt Care/041) (SWBH)**

Q6b) If 'yes' explain the negative impact – you may need to complete a full EIA

The processes in the transfusion policy apply equally to all patients receiving a blood transfusion. As mentioned , a separate policy exists for patients who refuse a blood transfusion **Blood Transfusion Refusal; Jehovah's Witnesses and Others (Pt Care/041) (SWBH)**.
As a separate policy exists for this patient group, a full EIA was not done.

If a negative impact has been identified please continue to Stage 3. If no negative impact has been identified please submit your Initial Equality Impact Assessment to the Head of Equality and Diversity (pauline.richards@swbh.nhs.uk) or 0121 507 5169 for approval.

Please note: Issues relating to either interpreting/translating or ensuring single-sex accommodation have been identified as corporate issues, therefore if the negative impact you have identified falls within these categories a full impact assessment is not required.

Justification Statement: As member of SWBH staff carrying out a review of an existing or proposal for a new service, policy or function you are required to complete this EIA by law. By stating that you have not identified a negative impact, you are agreeing that the organisation has not discriminated against any of the equality groups. Please ensure that you have the evidence to support this decision as the Trust will be liable for any breaches in the Equality Legislation.

Completed by:

Name: Please Print Dr S Pancham	Signature:
Designation:	Consultant Haematologist/ Transfusion lead
Date:	1/04/10
Contact number:	07528 969 866

This EIA has been approved by the Divisional General Manager/Clinical Lead

Name: Please Print	Signature:
Designation:	
Date:	
Contact number:	

This EIA has been signed off by the Head of Equality & Diversity

Name: Please Print	Signature:
Designation:	
Date:	
Contact number:	

Step 7) Now that you have ensured a full impact assessment does not need to be completed we need to publish your results for the public to view.

Tick list

☐ Send an electronic copy of ratified EIA to the Equality and diversity team who will publish it on the website

Please email all EIAs to Equality&Diversity@swbh.nhs.uk

Equality & Diversity team contact details

For further advice, please contact:

- Pauline Richards (Head of Equality & Diversity) 0121 507 5169
- Belinder Virk (Equality & Diversity Advisor) 0121 507 5561
- Estelle Hickman (Equality & Diversity Advisor) 012 507 5561

Equality & Diversity Team
Arden House
City Hospital
Birmingham B18 7QH

Sandwell and West Birmingham Hospitals NHS
NHS Trust

POLICY IMPLEMENTATION PLAN

POLICY TITLE:	Blood Transfusion Policy
ACCOUNTABLE DIRECTOR:	Medical Director
POLICY AUTHOR:	Dr S Pancham
APPROVED BY:	
DATE OF APPROVAL:	

An implementation plan must be developed for all policies. This will ensure that a systematic approach is taken to the introduction of policies in order to secure effective working practices.

The following template provides a list of activities to consider as a starting point for thinking about implementation in a systematic manner.

KEY ACTIVITY	ACTIONS PLANNED TO DELIVER ACTIVITY	PLANNED COMPLETION DATE
Coordination of Plan		
Identify an individual to oversee the implementation plan	Trust Transfusion Committee	April 2011
Communication and Engagement		
Identify the key messages to communicate to the different stakeholder.	All staff involved in the blood transfusion process will need to be trained in the electronic system	
Consider how these messages will be disseminated.	Staff communications, transfusion training sessions, senior nursing forum	
Identify which groups or members of staff are affected by the policy, either directly or indirectly.	All involved in transfusion- doctors, nurses, midwives, porters, phlebotomists etc	
Identify which groups of service users are affected by the policy, either directly or indirectly	All those who receive a blood transfusion	
Update or produce new patient information regarding the policy	Not applicable	
Identify any service users who could contribute to the implementation of the policy	NA	
Arrange an appropriate engagement exercise where appropriate	NA	
Training		
Identify the training needs arising from the implementation of the policy	All nursing, portering, and medical staff will need to be trained in the electronic system Laboratory staff already trained	April 2011
Identify the skills and knowledge needed to deliver the training	Transfusion practitioners will deliver training predominantly by ward	April 2011
Ensure that the corporate induction and other mandatory training programmes incorporate any changes required as a result of implementing the policy	Blood transfusion training is mandatory and the training programmes have already been modified to incorporate BloodTrack	ongoing
Resources		
Determine the financial impacts of any changes arising from the introduction of the policy	Securing funding for the post of a second transfusion practitioner	
Identify any other resource implications arising from the implementation of the policy		
Monitoring and Evaluating		
Determine the main changes you would expect to see once the policy is embedded	Improvement in traceability of blood Reduction in transfusion errors	Ongoing as the electronic system will facilitate real time monitoring

KEY ACTIVITY	ACTIONS PLANNED TO DELIVER ACTIVITY	PLANNED COMPLETION DATE
	Observations on patients receiving a transfusion to be done as specified in policy in all cases	
Devise a means of confirming that the changes expected have occurred	Audit both local and the national comparative audit	Ongoing
Devise a means of evaluating the effectiveness of the changes resulting from the policy introduction	Real time monitoring	Ongoing
Arrange for an evaluation of the policy introduction to be presented to an appropriate monitoring body after the latest activity completion date	Report to the Transfusion committee	
Consider how lessons learned from the implementation of the policy may be fed back into the organisation		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Single Tender Arrangement: Transport of Krypton Generators
SPONSORING DIRECTOR:	Richard Kirby, Chief Operating Officer
AUTHOR:	Jackie Morton, DGM for Imaging
DATE OF MEETING:	29 April 2010

SUMMARY OF KEY POINTS:

The Board is asked to ratify a Chair's action against a single tender agreement for payment of £144,000 to DSB Active Limited for provision of specialist transport services.

The company provides services for the delivery of radioactive krypton generators that are produced by the Trust in conjunction with Birmingham University. The method of transportation to Trusts across the country is in adherence with the stringent legislation surrounding movement of this equipment.

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 ratify the Single Tender Arrangement.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	None specifically
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		
Clinical	**X**	
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		None identified

PREVIOUS CONSIDERATION:

Chair's action previously given.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Single Equality Scheme (SES) Progress Report
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Pauline Richards, Head of Equality and Diversity
DATE OF MEETING:	29 April 2010

KEY POINTS:

This report is designed to assure the Trust Board of the latest progress achieved against the Single Equality Scheme action plan.

Good Progress continues to be achieved in the delivery of the plan.

Equality and Diversity Training has been integrated into existing training.

There has been an increase in the number of Equality Impact Assessments completed which has highlighted issues that impact at all levels of the organisation.

Interpreting/translating has been identified as an issue in need of attention.
Also the need to explore the translation of patient information into alternative media formats.

PURPOSE OF THE REPORT:

To provide the Trust Board with assurance of progress in relation to the Single Equality Scheme.

◉ **Noting**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is recommended to note progress to date.

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

The action plan aligns with the Trust Strategic Objectives:

- Customer Care Promises
- No. 1 – Accessible and Responsive Care
- No. 2 – High Quality care
- No. 4 – Good Uses of Our resources
- Promote education, training and research, CQC core standards, Essence of Care standards.

IMPACT ASSESSMENT:

FINANCIAL	☑	None known currently although there may be some as the action plan is implemented
ALE	☐	
CLINICAL	☐	
WORKFORCE	☐	
LEGAL	☑	Equality Legislation
EQUALITY & DIVERSITY	☑	Single Equality Scheme (SES)
COMMUNICATIONS	☑	Public dates for publishing and access to information under equality legislation
PPI	☑	Consultation and engagement active as required under public duties of equality legislation.
RISKS		

Trust Board Update Report April 2010

IMPLEMENTATION OF THE SINGLE EQUALITY SCHEME

1.0 Introduction

This report is intended to assure members of the Trust Board of the progress achieved against the Single Equality Scheme (SES) since the last update SWBTB (1/10) 009 (a) in January 2010.

2.0 Update Summary

The Equality Bill, which is designed to modernise and streamline discrimination legislation, is expected to come into force from autumn 2010. Since the last update the delivery of the Equality and Diversity [E&D] agenda continues to make good progress.

Work continues to be undertaken to mainstream E&D into the organisation. A key achievement has been the inclusion of E&D training into several of the Trust mandatory programmes. As a result in quarter 4,1391 members of staff have received training in E&D and 46 have completed Equality Impact Assessment training

Priority for E&D Awareness and Equality Impact Assessment [EIA] training has been given to managers and recruiting staff to facilitate effective recruitment practices and improved staff and patient experience.

EIAs have highlighted a number of issues which impacts on service delivery across all divisions, in particular, access to information in different languages, interpreted and translated.

An E&D mailbox has been set up. This is intended to provide staff with a central point for E&D issues, including Equality Impact Assessments toolkits and advice.

3.0 Reporting and Monitoring Framework

3.1 E&D Steering Group

The group receives a quarterly update from all of the subgroups on their contribution to the goal of mainstreaming E&D within the organisation.

3.2 Workforce Monitoring Group

The arrangements for setting up a volunteer harassment advisor network are ongoing. The network is scheduled to be up and running by the start of May, following a training programme for the initial 5 harassment advisors. Applications for a further 5 harassment advisors will be invited via Staff Communications at the start of May.

An equal pay audit has been undertaken and does not indicate any serious significant underlying issues relating to gender or ethnicity. The report was presented at the Equality and Diversity Steering Group in February.

Uptake of the Trust's e-learning Diversity training has been lower than expected and the Workforce Monitoring Sub Group is to explore ways of increasing uptake at the next meeting in May.

The recently published workforce Dashboard contains the required Workforce diversity data and relevant extracts are included as enclosure one. This information is also presented to the Finance Management and Performance Committee and Trust Management Board on a quarterly basis. This data will be published on the Trust's website in order that the Trust complies with its statutory obligation to publish relevant diversity data.

Analysis of non medical training accessed by staff during the period 01/04/09 – 31/03/10 compared against an in-post figure (as at a point in time), broken down by grouped ethnicity and gender, shows that at a high level, access to training is equitable across ethnicity and gender

3.3 Independent Living Group (ILG)

The Equality and Diversity resource pack is now completed and copies have been distributed to all wards and departments within the Trust. The pack is designed as a guide to help staff gain a better understanding of the needs and concerns of the diverse range of patients, carers, families and friends. It is intended to be used for everyday reference, inducting new staff and team training.

New guidance in relation to compliance with the Disability Discrimination Act [DDA] has been issued by the Commission for Equality and Human Rights. This is being addressed within the DDA action plan ensuring that reasonable adjustments have been made to meet the needs of disabled people.

Work continues to improve services with the involvement of disabled users to ensure there is a clear patient involvement.

As part of the DDA compliance program a significant investment in deaf minicom loops for hard of hearing has been made resulting in the installation of 70 loops across the Trusts reception areas.

Also as a result of the Learning Disability audit each ward has a communication book for patients with communication problems.

The E & D team continues to promote diversity awareness and publish activity through the E & D website and Newsletter

3.4 Service & Policy Assessment Group

The corporate register of policies has been discussed on an individual basis with most directors to determine priority for full Equality Impact Assessment. A priority schedule has been produced. This will feed into the timetable of policies for approval with either the Trust Management Board or Governance Board, starting in May 2010

The list of Trust services and functions has been discussed with relevant Divisional Managers and has been amended where necessary.

All services and functions have been prioritised for Equality Impact Assessment. This is reviewed at quarterly divisional reviews. The divisions are being supported to complete their service and functions impact assessments which are being monitored and recorded on the central database for EIAs.

To date a total of 100 EIAs have been completed, a further 50 are work-in-progress across the divisions. Interpreting/translating is being identified as an issue and work is in hand with the Patient Experience team to improve this.

The E&D team continue to work with the Divisions to ensure that assessments are robust, relevant action plans are developed and that monitoring of the plans is undertaken.

4.0 Summary

The Trust board is asked to note the continued progress made on delivering the E&D agenda and that the following areas are identified as areas for action.

- Staff need to be encouraged to disclose essential data in relation to their ethnicity, religion, disability, sexual orientation and transgender to ensure Trust compliance with equality legislation.

- IT systems need to be improved to capture all equality strands for patients. The patient management system needs to capture patients who are from hard to reach groups such as asylum seekers and migrant communities

- More work is required on patient information to increase the amount of translated information available and to provide alternative media formats

HR Dashboard March 2010 Narrative

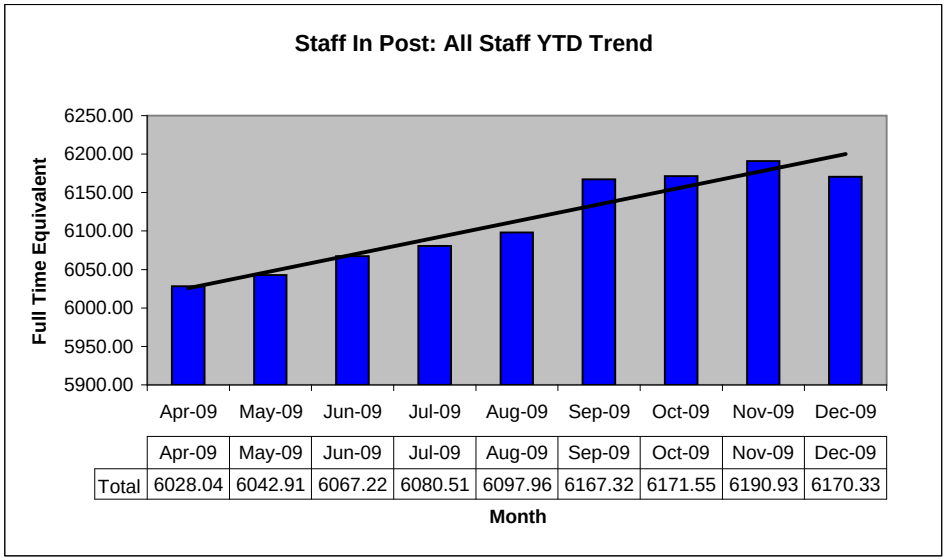
1	Staff in Post Page 3	All SIP reports are run as at the last day of the month. Headcount figures have been modified to include all assignments. This means that a member of staff who works two roles within the organisation is now recorded for both roles. **Please Note:** The figures from ESR are contracted FTE, not paid FTE as per the budget reports.
2	SIP Graphs Page 4	This clearly shows that from the beginning of the financial year there has been a steady monthly increase in the number of new staff recruited to the organisation. However, this appears to have peaked in November, with December showing a reduction in 20 WTE staff.
		The Ethnicity Trends are also showing similar growth/reduction rates to the overall staffing numbers.
3	Sickness Absence Page 5	The table identifies the deteriation in Trust sickness absence levels through the autumn. Small improvements were seen in November and December but were not sustained in January. Levels of both short-term and long-term sickness absence have increased over the period.
4	iView Sickness Absence	SWBH sickness against 4 other large acute Trusts in the region: Dudley Group, Royal Wolves, Uni B'Ham, Uni Cov & Warks. Our sickness rates remain slightly higher against the average of the comparison group. However, both sets have remained stable, therefore it is not a worsening position.
5	Cases in Formal Procedure	The table identifies the total number of live and closed cases as at 3 March 2010, as well as average length of time for each case. The graphs are a visual representation of the figures in the table. The second graph (% Cases in Formal Procedure v % In-Post by Grouped Ethnicity) highlights an issue for investigation given that an even and equitable application of HR procedures should result in a graph with each of the skyscrapers broadly in line. However, if you look at Black staff, you will notice the % in-post skyscraper (pink) is relatively low, however, the % of cases across this staff group is relatively high. This indicates that the number of cases against this staff group are disproportionate compared to the remainder of the Trust. Further investigation would seem warranted. Investigation is also warranted for the length of suspensions for Asian staff, which, currently is an average of 6 weeks longer than other groups of staff.
6	Non-medical Recruitment Activity	Should Trust recruitment procedures be applied evenly and equitably, we would expect to see the same percentage of staff who enquire for vacancies each month to be replicated across each of the recruitment stages (applied, shortlisted, appointed). The table highlights in red where there is a variation between the shortlisted to appointed stage of greater than 25%. Decembers recruitment figures are showing a predominance of reds which indicates that further investigation is required to determine the reasons.
7	Non-medical Recruitment timescales	The table identifes the average number of weeks each Division takes to recruit to posts. The column headed 'average admin time' identies the number of weeks excluding employee notice periods. The column headed 'average start time' is the average number of weeks from receipt of vacancy approval through to the employee commencing in post. Data has not been provided for IM&T due to a recruitment practice of recruiting to one open job reference. This practice has been stopped and data will be populated in future reports. Recruitment timescales differ between divisions, which will be a reflection of some local recruitment difficulties and the need to complete CRB checks in particular. Reasons behind the Divisional variations will be considered further with the recruitment office.

8	Professional Registration	There are a few reds over the last quarter reported. It should not be assumed that this means that staff are working unregistered, rather it is a note that, in a couple of areas, managers have not submitted new registration details to the Workforce Information team on time. The Trust is currently piloting Manager Self Service through ESR, one of the benefits would be to allow managers to update staff registrations directly, which should reduce the amount of monthly reported reds by speeding up the update process. If the pilot is successful, Manager Self Service would take approximately 12/18 months to implement across the Trust.
9	Appraisals	The table shows a month on month 'compliance' view of in date PDR's by Division. The graph shows that PDRs are being carried out evenly across the majority of Ethnic groups when measured against in-post figures, however, the figures for Asian and Other Ethnic staff would warrant further investigation. These figures include Medical staff.
10	Leavers	Leavers by grouped AfC band have been added. In general terms there are no significant trends. Grouped Ethnicity leavers follows a similar trend to White leavers, which indicates a spread of leavers across the board.
11	Leavers Graphs	All Graphs show no issues of significance to note. Leavers appear to be spread across all staff groups and bands, indicating a healthy level of staff turnover.
12	Promotions	Promotions now has a graphical display showing Promotions % v In-Post % by Grouped Ethnicity. The graph would indicate that promotions occur evenly across the Trust.
13	Mandatory Training	The Mandatory Training report was taken from the CDA system on 3 March 2010. given the turnround for getting attendees onto Safeguard, it effectively shows compliance as at the end of February, for all mandatory training apart from Trust and Local Induction. Trust Induction figures are for all Trust Induction sessions carried out over the period 1 April 2009 - 28 February 2010 as recorded in safeguard. Local Induction figures are for Local Induction checklists returned/notified back to the Learning & Development department and are not necessarily recorded in Safeguard.

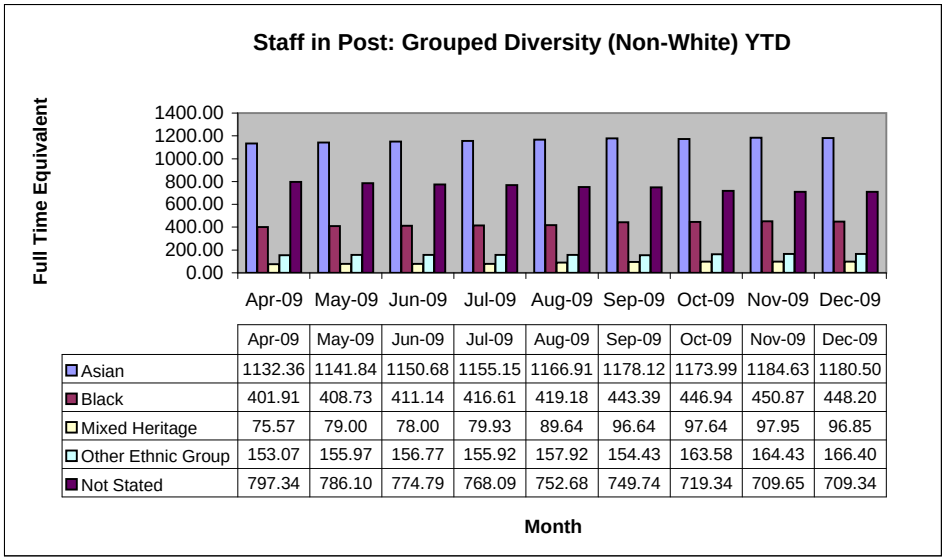
1. Staff in Post

			July		August		September		October		November		December			
			Contracted FTE	Headcount	Contracted FTE	Headcount	Contracted FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	YTD (FTE) Avg	YTD (Headcount) Avg
1/. Staff in Post	Total	No.	6080.51	6988	6097.96	7005	6167.32	7077	6171.55	7090	6190.93	7113	6170.33	7093	6112.97	7022
	Anaesthesia & Critical Care	No.	249.94	272	247.13	269	244.98	267	251.83	275	256.10	279	257.70	281	251.56	274
	Chief Executive	No.	18.00	19	18.00	19	18.20	19	18.20	19	18.21	20	20.01	22	18.29	19
	Estates/New Hospital Project	No.	108.77	110	108.37	110	107.37	109	110.37	112	110.37	112	110.37	112	108.99	110
	Finance	No.	79.84	85	79.65	85	82.84	88	82.04	87	83.17	88	82.57	88	82.23	87
	Governance	No.	81.13	89	88.93	97	86.93	95	84.60	93	87.16	96	85.16	94	83.63	92
	IM&T	No.	389.42	438	383.46	432	385.19	434	380.92	429	379.48	427	377.06	425	385.44	434
	Imaging	No.	317.72	364	317.59	367	330.96	382	315.30	365	315.40	365	316.50	366	317.43	365
	Medicine A	No.	843.48	943	852.46	954	884.77	986	880.47	981	877.89	977	859.24	953	857.91	957
	Medicine B	No.	653.03	726	644.25	716	650.63	722	659.81	732	656.77	730	677.52	757	655.78	729
	Nursing, Therapies & Facilities	No.	887.08	1163	889.03	1163	908.38	1180	904.34	1179	905.90	1183	902.51	1178	888.20	1162
	Operations	No.	108.85	118	108.99	118	105.56	116	105.39	116	107.99	119	109.19	120	107.06	117
	Pathology	No.	339.81	391	338.45	388	341.81	392	343.43	396	344.49	396	341.35	393	338.16	389
	Strategy	No.	34.49	38	34.29	38	31.71	36	31.71	36	33.29	37	31.29	35	33.94	38
	Surgery A	No.	777.99	836	784.98	841	791.79	851	786.37	846	794.26	855	787.68	849	787.69	847
	Surgery B	No.	347.37	407	351.87	412	353.61	416	357.51	422	361.75	427	360.45	424	350.63	411
	Women & Child Health	No.	718.58	839	722.89	843	719.92	836	737.72	855	736.72	854	729.17	847	722.33	841
	Workforce	No.	125.01	150	127.62	153	122.67	148	121.54	147	121.98	148	122.56	149	123.69	149
			July		August		September		October		November		December			
			Contracted FTE	Headcount	Contracted FTE	Headcount	Contracted FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	YTD (FTE) Average	YTD (Headcount) Avg
	Disability	No.														
	Ethnicity	No.														
	Asian	No.	1155.15	1306	1166.91	1319	1178.12	1328	1173.99	1327	1184.63	1340	1180.50	1335	1162.69	1312
	Black	No.	416.61	462	419.18	465	443.39	491	446.94	496	450.87	500	448.20	497	427.44	474
	Mixed Heritage	No.	79.93	90	89.64	100	96.64	107	97.64	108	97.95	108	96.85	107	87.91	98
	Other Ethnic Group	No.	155.92	167	157.92	169	154.43	167	163.58	178	164.43	179	166.40	181	158.72	171
	White	No.	3528.32	4112	3533.55	4116	3567.52	4151	3594.40	4185	3605.75	4200	3591.38	4188	3547.80	4133
	Not Stated	No.	768.09	875	752.68	858	749.74	856	719.34	821	709.65	809	709.34	808	751.90	857
	Gender	No.														
	Male	No.	1594.12	1702	1595.42	1704	1603.64	1714	1597.01	1706	1603.01	1713	1600.09	1710	1592.52	1701
	Female	No.	4509.89	5310	4526.05	5325	4587.2	5387	4598.88	5409	4610.27	5423	4592.59	5406	4544.22	5345
	Religion/Belief	No.														
	Sexual Orientation	No.														

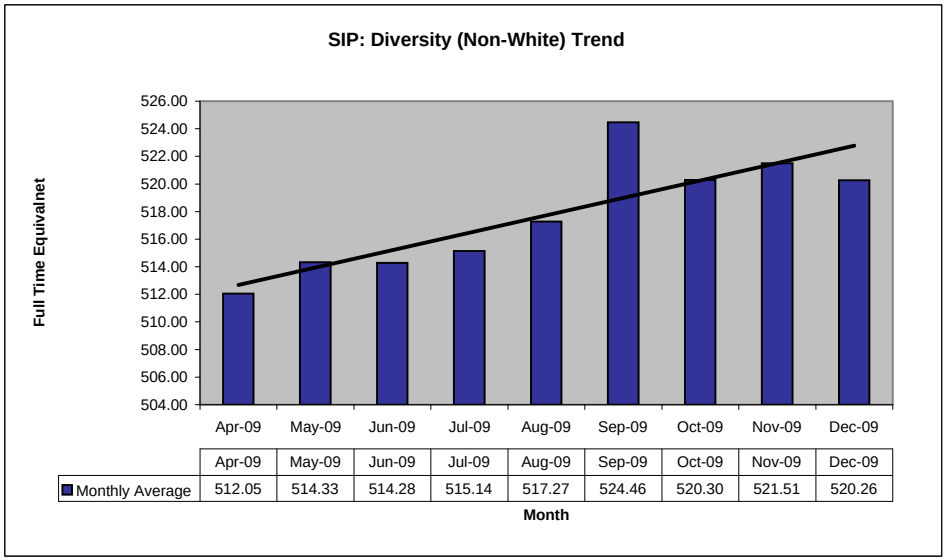
2. SIP Graphs



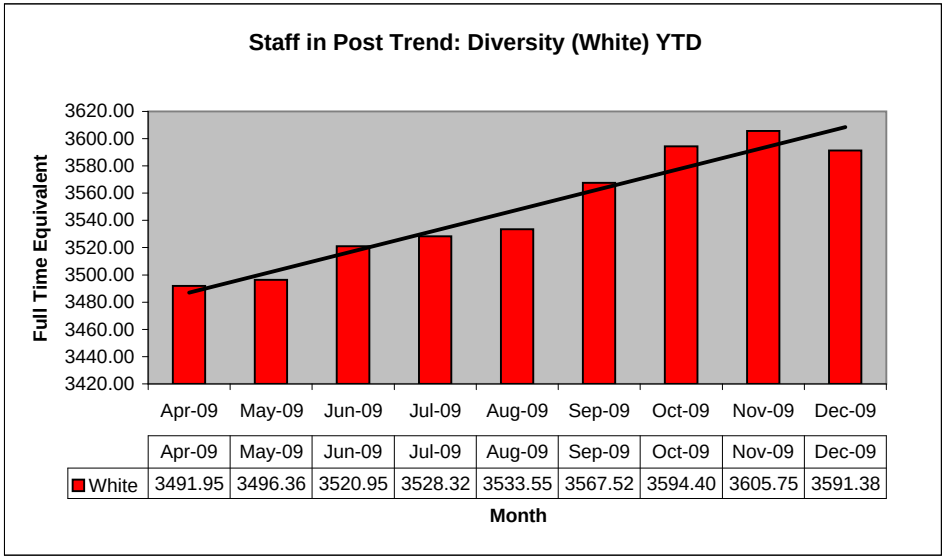
	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09
Total	6028.04	6042.91	6067.22	6080.51	6097.96	6167.32	6171.55	6190.93	6170.33



	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09
Asian	1132.36	1141.84	1150.68	1155.15	1166.91	1178.12	1173.99	1184.63	1180.50
Black	401.91	408.73	411.14	416.61	419.18	443.39	446.94	450.87	448.20
Mixed Heritage	75.57	79.00	78.00	79.93	89.64	96.64	97.64	97.95	96.85
Other Ethnic Group	153.07	155.97	156.77	155.92	157.92	154.43	163.58	164.43	166.40
Not Stated	797.34	786.10	774.79	768.09	752.68	749.74	719.34	709.65	709.34



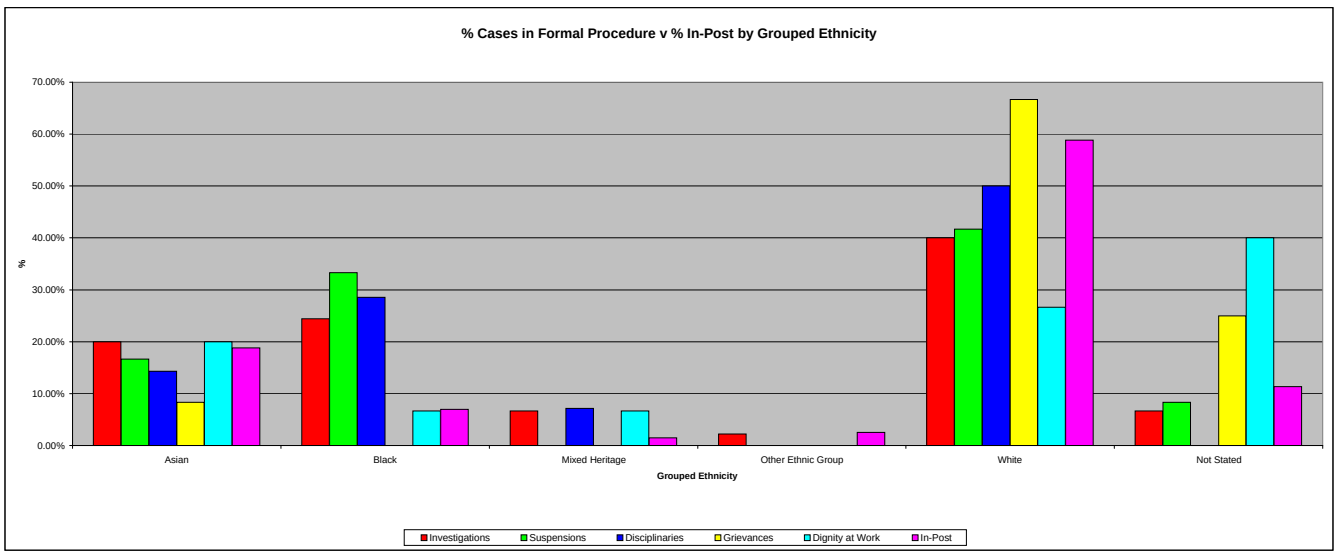
	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09
Monthly Average	512.05	514.33	514.28	515.14	517.27	524.46	520.30	521.51	520.26



	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09
White	3491.95	3496.36	3520.95	3528.32	3533.55	3567.52	3594.40	3605.75	3591.38

5. Cases in Formal Procedure

5/. Cases In Formal Procedure			Investigations					Suspensions				Disciplinaries				Grievances				Dignity at Work			
			Live	Closed		Total	Avg Time	Live	Closed	Total	Avg Time	Live	Closed	Total	Avg Time	Live	Closed	Total	Avg Time	Live	Closed	Total	Avg Time
	Total	No.	24	21		45	5	8	4	12	18	1	13	14	16	5	7	12	14	12	3	15	17
	Anaesthesia & Critical Care	No.	0	0		0	0	0	0	0		0	0	0		0	0	0		0	1	1	9
	Chief Executive	No.	0	0		0	0	0	0	0		0	0	0		0	0	0		0	0	0	
	Estates/New Hospital Project	No.	2	0		2	0	1	0	1		0	0	0		0	0	0		0	0	0	
	Finance	No.	0	1		1	4	1	0	1		0	1	1	16	0	0	0		1	0	1	
	Governance	No.	0	1		1	0	0	0	0		0	0	0		0	0	0		0	0	0	
	IM&T	No.	3	0		3	0	0	0	0		0	0	0		0	0	0		2	0	2	
	Imaging	No.	2	0		2	0	1	0	1		0	0	0		0	2	2	3	1	0	1	
	Medicine A	No.	8	5		13	9	3	0	3		1	1	2	13	0	1	1		1	0	1	
	Medicine B	No.	4	3		7	13	1	2	3	16	0	2	2	22	2	2	4	6	2	0	2	
	Nursing, Therapies & Facilities	No.	0	4		4	6	0	1	1	16	0	4	4	6	0	0	0		2	0	2	
	Operations	No.	0	0		0	0	0	0	0		0	0	0		0	0	0		0	1	1	16
	Pathology	No.	2	1		3	0	0	0	0		0	0	0		1	0	1	16	0	0	0	
	Strategy	No.	0	0		0	0	0	0	0		0	0	0		0	0	0		0	0	0	
	Surgery A	No.	3	4		7	26	1	0	1		0	4	4	23	0	1	1	31	0	0	0	
	Surgery B	No.	0	1		1	15	0	0	0		0	1	1	15	1	0	1		0	1	1	25
	Women & Child Health	No.	0	1		1	0	0	1	1	22	0	0	0		1	1	2	13	3	0	3	
	Workforce	No.	0	0		0	18	0	0	0		0	0	0		0	0	0		0	0	0	
			Investigations					Suspensions				Disciplinaries				Grievances				Dignity at Work			
			Live	Closed		Total	Avg Time	Live	Closed	Total	Avg Time	Live	Closed	Total	Avg Time	Live	Closed	Total	Avg Time	Live	Closed	Total	Avg Time
	Age	No.																					
	Disability	No.																					
	Ethnicity	No.																					
	Asian	No.	5	4		9	17	1	1	2	22	1	1	2	20	1	0	1	16	3	0	3	
	Black	No.	7	4		11	7	3	1	4	16	0	4	4	9	0	0	0		1	0	1	
	Mixed Heritage	No.	2	1		3	17	0	0	0		0	1	1	17	0	0	0		1	0	1	
	Other Ethnic Group	No.	1	0		1	0	0	0	0		0	0	0		0	0	0		0	0	0	
	White	No.	7	11		18	13	3	2	5	16	0	7	7	18	3	5	8	10	2	2	4	13
	Not Stated	No.	3	1		4		1	0	1		0	0	0		1	2	3	17	5	1	6	25
	Gender	No.																					
	Male	No.	9	10		19	7	5	1	6	16	1	7	8	12	3	2	5	11	2	1	3	16
	Female	No.	15	11		26	17	3	3	6	18	0	6	6	21	1	4	5	8	10	2	12	17
	Religion/Belief	No.																					
	Sexual Orientation	No.																					



6/. Recruitment Activity

			July					August					September					October					November					December				
			Enquired	Applied	S/Listed	Appt	SL v Appointed Variation	Enquired	Applied	S/Listed	Appt	SL v Appointed Variation	Enquired	Applied	S/Listed	Appt	SL v Appointed Variation	Enquired	Applied	S/Listed	Appt	SL v Appointed Variation	Enquired	Applied	S/Listed	Appt	SL v Appointed Variation	Enquired	Applied	S/Listed	Appt	SL v Appointed Variation
Ethnicity		%																														
	Asian	%	12.90	13.56	12.50	10.64	14.88%	39.70	40.82	47.37	22.35	52.82%	13.22	16.79	11.11	10.00	9.99%	12	14	14	13	7.14%	26	26	13	24	84.62%	20	20	9	14	55.56%
	Black	%	3.23	3.39	4.17	2.13	48.92%	10.55	10.71	14.04	10.59	24.57%	7.44	7.30	0.00	2.50	#DIV/0!	15	16	8	10	25.00%	8	9	10	8	20.00%	15	15	14	11	21.43%
	Mixed Heritage	%	6.45	6.78	12.50	6.38	48.96%	1.51	1.53	0.00	1.18	#DIV/0!	3.31	2.92	0.00	0.00	0.00%	0	0	0	0	#DIV/0!	0	0	0	0	#DIV/0!	3	3	5	3	40.00%
	Other Ethnic Group	%	0.00	0.00	0.00	0.00	0.00%	0.50	0.51	0.00	1.18	#DIV/0!	0.00	0.00	0.00	0.00	0.00%	1	1	0	2	#DIV/0!	1	2	3	3	0.00%	5	5	9	5	44.44%
	White	%	70.97	72.88	70.83	68.09	3.87%	43.72	44.39	38.60	51.76	34.09%	71.07	71.53	77.78	70.00	10.00%	65	67	75	64	14.67%	57	59	70	56	20.00%	38	40	50	46	8.00%
	Not Stated	%	6.36	3.39	0.00	12.77	#DIV/0!	4.02	2.04	0.00	12.94	#DIV/0!	4.56	1.46	11.11	17.50	57.52%	6	2	3	11	266.67%	7	5	3	9	200.00%	20	18	14	21	50.00%

Threshold Value Only	<15.00	15.00-25.00	>25.00
Threshold Value Only	<15.00	15.00-25.00	>25.00
Threshold Value Only	<15.00	15.00-25.00	>25.00
Threshold Value Only	<15.00	15.00-25.00	>25.00
Threshold Value Only	<15.00	15.00-25.00	>25.00
Threshold Value Only	<15.00	15.00-25.00	>25.00

7/. Recruitment Timescales

		July		August		September		October		November		December		Average YTD				
		Average Admin Time	Average Start Time	Average Admin Time	Average Start Time	Average Admin Time	Average Start Time	Average Admin Time	Average Start Time	Average Admin Time	Average Start Time	Average Admin Time	Average Start Time	YTD Average Admin	YTD Average Start			
Total	Weeks	6	10	9	14	7	13	9	19	10	14	5	17	9	15	<10	10-15	>15
Anaesthesia & Critical Care	Weeks	N/A	N/A	7	23	N/A	N/A	8	9	11	14	N/A	N/A	6	10	<10	10-15	>15
Chief Executive	Weeks	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1	1	<10	10-15	>15
Estates/New Hospital Project	Weeks	N/A	N/A	N/A	N/A	N/A	N/A	7	9	10	14	N/A	N/A	5	7	<10	10-15	>15
Finance	Weeks	N/A	N/A	N/A	N/A	12	14	N/A	N/A	7	10	N/A	N/A	5	7	<10	10-15	>15
Governance	Weeks	N/A	N/A	11	39	N/A	N/A	10	71	14	17	N/A	N/A	6	20	<10	10-15	>15
IM&T	Weeks	N/A		N/A	N/A	N/A	N/A	0	0	0	0	0	0	19	22	<10	10-15	>15
Imaging	Weeks	17	19	5	8	7	10	10	34	9	10	N/A	N/A	8	15	<10	10-15	>15
Medicine A	Weeks	10	16	14	18	12	16	11	23	20	22	9	14	13	19	<10	10-15	>15
Medicine B	Weeks	9	12	12	16	16	18	10	13	13	21	11	14	12	15	<10	10-15	>15
Nursing, Therapies & Facilities	Weeks	12	15	10	13	18	23	21	22	14	15	9	9	13	16	<10	10-15	>15
Operations	Weeks	N/A	N/A	29	37	N/A	N/A	14	14	N/A	N/A	N/A	N/A	9	15	<10	10-15	>15
Pathology	Weeks	9	11	8	13	8	9	10	12	10	11	6	15	10	13	<10	10-15	>15
Strategy	Weeks	6	43	11	8	5	36	N/A	N/A	8	10	N/A	N/A	3	14	<10	10-15	>15
Surgery A	Weeks	8	9	15	24	12	29	16	20	20	23	10	57	13	25	<10	10-15	>15
Surgery B	Weeks	12	14	5	9	8	29	11	15	10	14	9	13	11	17	<10	10-15	>15
Women & Child Health	Weeks	9	11	11	15	12	15	17	20	16	20	15	23	14	17	<10	10-15	>15
Workforce	Weeks	6	7	9	16	9	15	8	9	5	6	10	10	10	13	<10	10-15	>15

8/. Professional Registrations Overdue

		July	August	September	October	November	December
Total	No.	42	116	96	148	67	113
Anaesthesia & Critical Care	No.	0	8	14	14	2	1
Chief Executive	No.						
Estates/New Hospital Project	No.						
Finance	No.						
Governance	No.						
IM&T	No.	0	0	1	0	0	0
Imaging	No.	4	2	1	3	0	1
Medicine A	No.	7	10	12	15	7	3
Medicine B	No.	4	1	2	8	2	0
Nursing, Therapies & Facilities	No.	16	17	9	51	37	27
Operations	No.	0	1	1	1	0	0
Pathology	No.	1	2	1	1	1	69
Strategy	No.						
Surgery A	No.	0	0	4	2	1	1
Surgery B	No.	1	10	22	9	1	1
Women & Child Health	No.	1	1	11	5	5	1
Workforce	No.	0	1	4	6	4	4
GMC (Doctors)	No.	8	63	14	33	7	5

Div	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Total										>2.00
ACC										>2.00
IM&T										>2.00
IMG										>2.00
MedA										>2.00
MedB										>2.00
NTF										>2.00
Ops										>2.00
Path										>2.00
										>2.00
Surg A										>2.00
Surg B										>2.00
WCH										>2.00
WKF										>2.00
GMC										>2.00

9/. Appraisals

			July				August				September				October				November				December			
			In-post	Done	%		In-post	Done	%		In-post	Done	%		In-post	Done	%		In-post	Done	%		In-post	Done	%	
Total		No.	6883	2835	41.19%		6896	2369	34.35%		6966	3017	43.31%		6984	3486	49.91%		7002	3585	51.20%		6981	3684	52.77%	
Anaesthesia & Critical Care		No.	265	121	45.66%		262	110	41.98%		260	110	42.31%		266	121	45.49%		270	117	43.33%		272	121	44.49%	
Chief Executive		No.	19	13	68.42%		19	13	68.42%		19	13	68.42%		19	15	78.95%		20	17	85.00%		22	18	81.82%	
Estates/New Hospital Project		No.	110	75	68.18%		110	35	31.82%		109	95	87.16%		112	103	91.96%		112	101	90.18%		112	101	90.18%	
Finance		No.	85	58	68.24%		85	30	35.29%		88	50	56.82%		87	54	62.07%		88	57	64.77%		87	59	67.82%	
Governance		No.	86	37	43.02%		94	40	42.55%		92	45	48.91%		91	50	54.95%		94	55	58.51%		92	55	59.78%	
IM&T		No.	428	113	26.40%		422	100	23.70%		424	146	34.43%		422	173	41.00%		421	206	48.93%		417	212	50.84%	
Imaging		No.	338	137	40.53%		339	125	36.87%		349	134	38.40%		345	148	42.90%		345	159	46.09%		346	160	46.24%	
Medicine A		No.	931	337	36.20%		941	332	35.28%		973	347	35.66%		969	374	38.60%		965	378	39.17%		942	403	42.78%	
Medicine B		No.	722	329	45.57%		712	195	27.39%		720	291	40.42%		721	382	52.98%		719	402	55.91%		745	417	55.97%	
Nursing, Therapies & Facilities		No.	1130	359	31.77%		1130	228	20.18%		1147	462	40.28%		1147	678	59.11%		1151	698	60.64%		1146	709	61.87%	
Operations		No.	118	79	66.95%		118	63	53.39%		116	64	55.17%		116	76	65.52%		119	77	64.71%		121	77	63.64%	
Pathology		No.	381	236	61.94%		378	245	64.81%		382	259	67.80%		387	298	77.00%		387	287	74.16%		384	297	77.34%	
Strategy		No.	38	30	78.95%		38	19	50.00%		36	23	63.89%		36	31	86.11%		37	29	78.38%		35	29	82.86%	
Surgery A		No.	828	363	43.84%		834	308	36.93%		843	333	39.50%		837	299	35.72%		846	312	36.88%		841	321	38.17%	
Surgery B		No.	404	147	36.39%		409	118	28.85%		413	136	32.93%		415	158	38.07%		418	156	37.32%		416	163	39.18%	
Women & Child Health		No.	828	296	35.75%		830	307	36.99%		825	422	51.15%		844	435	51.54%		843	439	52.08%		835	446	53.41%	
Workforce		No.	148	101	68.24%		151	94	62.25%		146	78	53.42%		145	83	57.24%		144	85	59.03%		145	86	59.31%	
			July				August				September				October				November				December			
			In-post	Done	%		In-post	Done	%		In-post	Done	%		In-post	Done	%		In-post	Done	%		In-post	Done	%	
Ethnicity		No.																								
	Asian	No.	1272	398	31.29%		1282	341	26.60%		1293	437	33.80%		1293	500	38.67%		1305	518	39.69%		1300	532	40.92%	
	Black	No.	461	16	3.47%		464	136	29.31%		490	177	36.12%		494	252	51.01%		498	260	52.21%		495	264	53.33%	
	Mixed Heritage	No.	90	25	27.78%		100	22	22.00%		107	32	29.91%		108	44	40.74%		108	43	39.81%		107	44	41.12%	
	Other Ethnic Group	No.	169	43	25.44%		171	36	21.05%		170	40	23.53%		174	42	24.14%		175	46	26.29%		177	47	26.55%	
	White	No.	4045	1756	43.41%		4049	1482	36.60%		4080	1878	46.03%		4110	2216	53.92%		4122	2275	55.19%		4109	2336	56.85%	
	Not Stated	No.	846	453	53.55%		830	352	42.41%		826	453	54.84%		805	432	53.66%		794	443	55.79%		793	461	58.13%	
Gender		No.																								
	Male	No.	1660	530	31.93%		1662	393	23.65%		1673	535	31.98%		1668	652	39.09%		1676	676	40.33%		1672	699	41.81%	
	Female	No.	5223	2305	44.13%		5234	1976	37.75%		5293	2482	46.89%		5316	2834	53.31%		5326	2909	54.62%		5309	2985	56.23%	
Religion/Belief		No.																								
Sexual Orientation		No.																								

Threshholds		
<50	>50 - <80	>80
<50	>50 - <80	>80
<50	>50 - <80	>80
<50	>50 - <80	>80
<50	>50 - <80	>80
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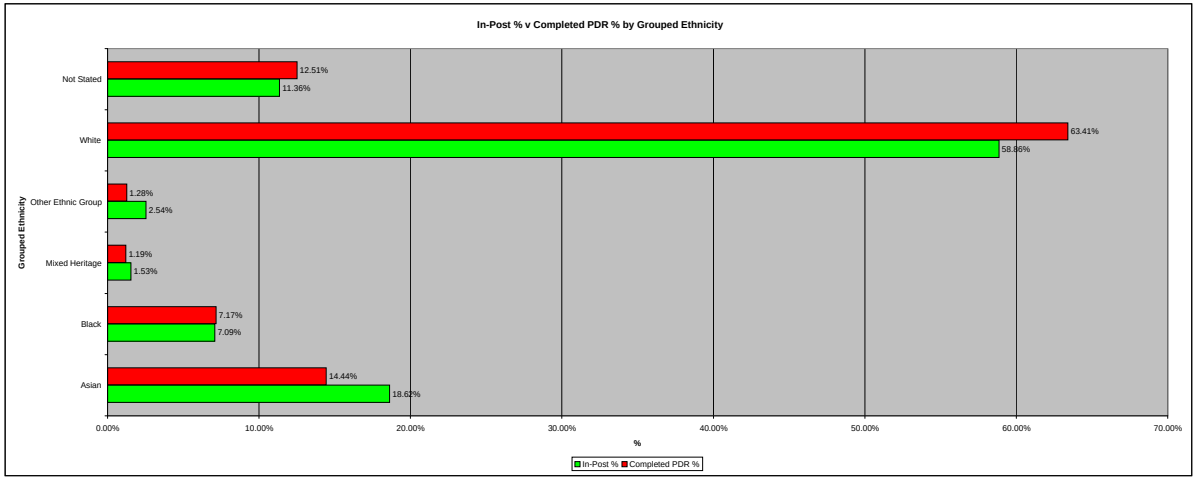


10. Leavers

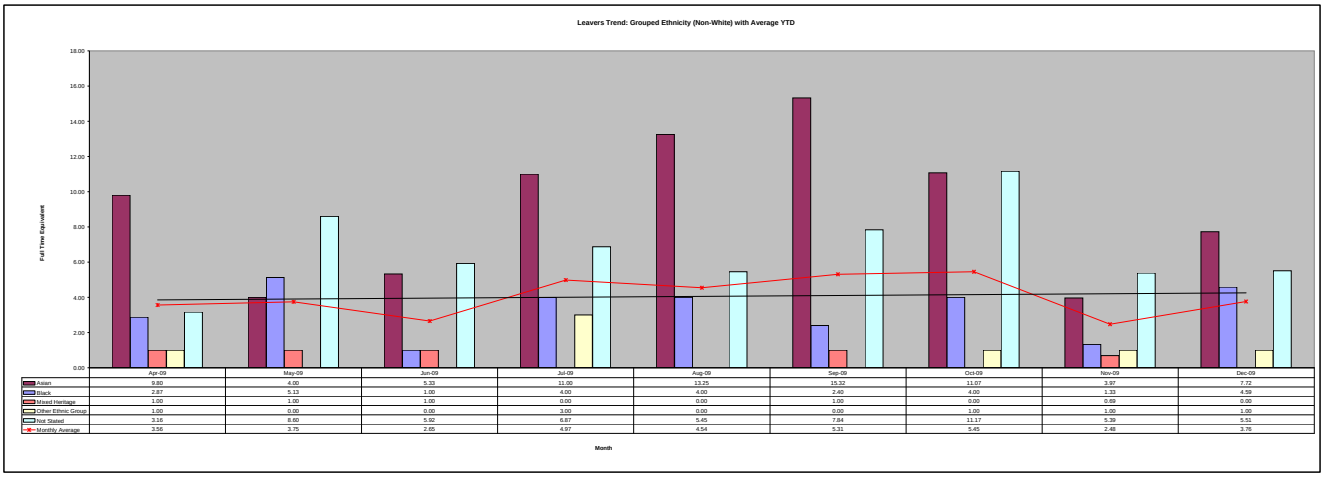
8/. Leavers

			July		August		September		October		November		December				
			FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount			
Total		No.	49.71	56	56.45	66	59.44	68	52.49	58	35.18	45	45.74	52			No. Only
Anaesthesia & Critical Care		No.	1.00	1	3.11	4	2.00	2	0.67	1	1.00	1					No. Only
Chief Executive		No.							1.00	1							No. Only
Estates/New Hospital Project		No.									1.00	1	1.00	1			No. Only
Finance		No.	2.00	2					0.80	1							No. Only
Governance		No.							1.00	1							No. Only
IM&T		No.	6.55	7	2.75	3	2.00	2	4.81	5	1.00	1	3.72	4			No. Only
Imaging		No.	2.60	3	1.00	1	2.84	3	2.00	2			1.61	3			No. Only
Medicine A		No.	7.00	8	7.34	8	6.00	6	10.80	11	7.00	8	10.29	12			No. Only
Medicine B		No.	2.00	2	8.90	10	7.01	8	7.67	9	3.20	4	6.00	6			No. Only
Nursing, Therapies & Facilities		No.	7.88	10	7.41	11	5.67	7	7.37	9	5.77	10	4.87	6			No. Only
Operations		No.					1.00	1									No. Only
Pathology		No.	3.00	3	5.15	6	4.31	5	2.00	2	3.83	5	2.89	4			No. Only
Strategy		No.			1.00	1			1.00	1			1.00	1			No. Only
Surgery A		No.	6.03	7	7.93	9	8.80	9	5.40	6	2.85	3	8.68	9			No. Only
Surgery B		No.	3.40	4	4.64	5	1.43	2	1.00	1	2.40	3	1.96	2			No. Only
Women & Child Health		No.	8.25	9	7.21	8	16.38	21	4.97	6	5.33	7	3.72	4			No. Only
Workforce		No.					2.00	2	2.00	2	1.80	2					No. Only

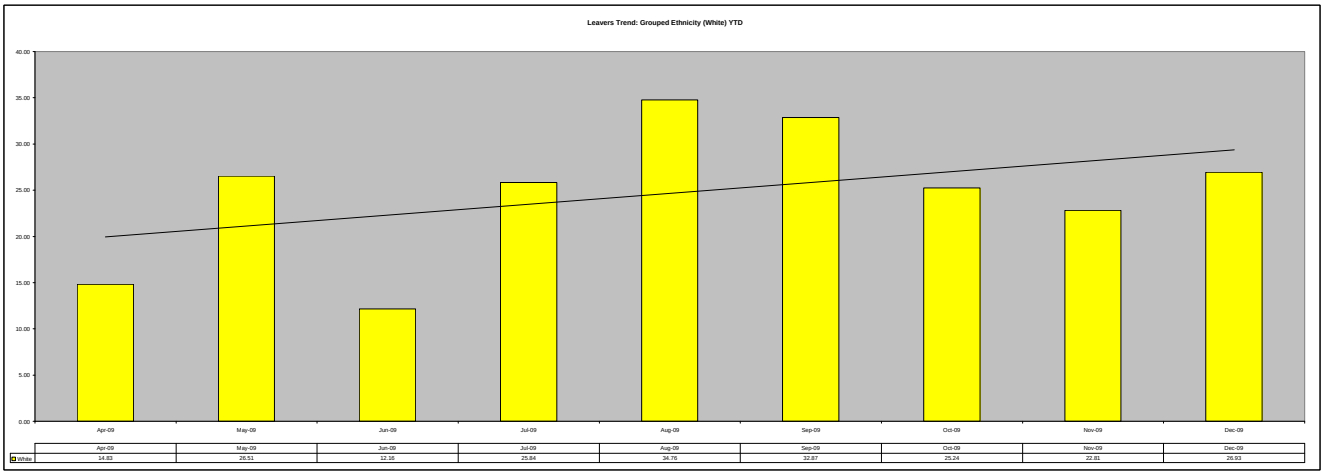
			July				August				September				October				November				December						
			FTE			Headcount			FTE			Headcount			FTE			Headcount			FTE			Headcount			FTE			Headcount			FTE YTD			HC YTD		
	AfC Band		1-4	5-7	8-9	1-4	5-7	8-9	1-4	5-7	8-9	1-4	5-7	8-9	1-4	5-7	8-9	1-4	5-7	8-9	1-4	5-7	8-9	1-4	5-7	8-9	1-4	5-7	8-9	1-4	5-7	8-9	1-4	5-7	8-9	1-4	5-7	8-9
Add Prof Scientific and Technic	No.			3.00			3		2.00	2.00		2	2			2.00			2			3.00	1.00		3	1		0.85			1		1.00	1.00		1	1		3.00	15.65	2.60	3	16	2
Additional Clinical Services	No.	7.12			8			11.43			14			13.17			15			4.40			5			2.73			4			9.37			10			61.08	1.00	0.00	71	1	0
Administrative and Clerical	No.	5.97	3.00		7	3		5.85	2.00	1.00	7	2	1	7.77	2.80		8	3		7.88	2.00		9	2		4.20	1.00	1.00	5	1	1	6.69	3.00		8	3		58.17	16.60	8.00	66	17	5
Allied Health Professionals	No.		1.60	0.83		2	1								2.00			2			3.00			3			2.00			2			1.40			2		0.00	12.00	2.23	0	13	1
Estates and Ancillary	No.	2.05			4			6.41			10			2.67			4			4.37			6			4.77			9			3.59			5			40.01	0.00	0.00	60	0	0
Healthcare Scientists	No.		4.00			4			4.00			4			1.00	1.41		1	2		3.00			3			2.00			2			2.00			2		0.00	19.00	3.41	0	19	2
Nursing and Midwifery	No.		15.20			16			21.12			23			20.45			24		1.00	16.64		1	18			12.33			15			14.69			17		1.00	132.46	17.69	1	149	3
Students	No.																																					0.00	0.00	0.00	0	0	0

			July		August		September		October		November		December				
			FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount			
Disability		No.															No. Only
Ethnicity		No.															
	Asian	No.	11.00	11	13.25	15	15.32	18	11.07	12	3.97	5	7.72	8			No. Only
	Black	No.	4.00	4	4.00	4	2.40	3	4.00	4	1.33	3	4.59	6			No. Only
	Mixed Heritage	No.					1.00	1			0.69	1					No. Only
	Other Ethnic Group	No.	3.00	3					1.00	1	1.00	1	1.00	1			No. Only
	White	No.	25.84	31	34.76	40	32.87	37	25.24	28	22.81	29	26.93	31			No. Only
	Not Stated	No.	6.87	8	5.45	8	7.84	9	11.17	13	5.39	6	5.51	6			No. Only
Gender		No.															
	Male	No.	13.53	15	12.53	13	13.45	15	16.57	19	10.53	11	12.84	14			No. Only
	Female	No.	37.17	42	44.92	54	45.98	53	35.92	39	24.66	34	32.90	38			No. Only
Religion/Belief		No.															No. Only
Sexual Orientation		No.															No. Only

		July		August		September		October		November		December				
		FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount			
Dismissal		1.00	1	3.03	4	0.80	1	4.00	4			1.87	3			No. Only
End of Fixed Term Contract		4.20	5	4.00	4	1.00	1	1.00	1			2.00	2			No. Only
Redundancy																No. Only
Retirement		6.75	8	5.14	7	10.90	14	10.72	12	5.72	9	15.81	18			No. Only
Resignation		37.76	42	45.28	52	44.94	50	36.77	41	29.47	36	26.06	29			No. Only
Other		1.00	1			1.80	2									No. Only



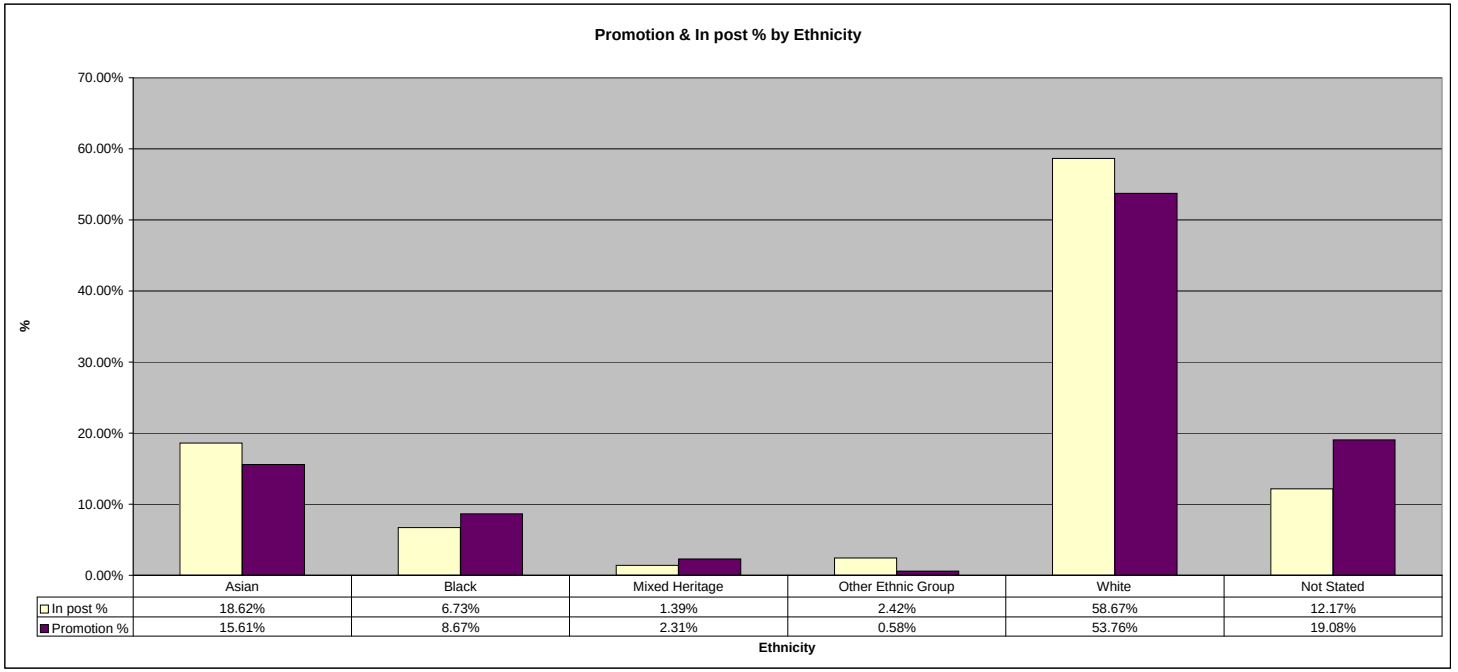
	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09
Asian	9.80	4.00	5.33	11.00	13.25	15.32	11.07	3.97	7.72
Black	2.87	5.13	1.00	4.00	4.00	2.40	4.00	1.33	4.59
Mixed Heritage	1.00	1.00	1.00	0.00	0.00	1.00	0.00	0.69	0.00
Other Ethnic Group	1.00	0.00	0.00	3.00	0.00	0.00	1.00	1.00	1.00
Not Stated	3.16	8.60	5.92	6.87	5.45	7.84	11.17	5.39	5.51
Monthly Average	3.56	3.75	2.65	4.87	4.54	5.31	5.45	2.48	3.76



	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09
White	14.83	26.51	12.16	25.84	34.76	32.87	25.24	22.81	26.93

12. Promotions

			July	August	September	October	November	December	YTD
	Total	No.	18	22	20	36	20	12	173
	Anaesthesia & Critical Care	No.		2	2				4
	Chief Executive	No.							0
	Estates/New Hospital Project	No.							0
	Finance	No.							0
	Governance	No.							0
	IM&T	No.	3	1	1				7
	Imaging	No.	2		1	2			7
	Medicine A	No.	4	4	3	3	3		24
	Medicine B	No.		1	1	13		1	25
	Nursing, Therapies & Facilities	No.	1	1	5	2	2	2	17
	Operations	No.			2			2	5
	Pathology	No.	1		2	1	1	3	11
	Strategy	No.		3		1			4
	Surgery A	No.	2	5		6	4	2	26
10/. Promotions	Surgery B	No.	2	3	1	3			10
	Women & Child Health	No.	3	2	2	5	8	2	30
	Workforce	No.					2		3
			July	August	September	October	November	December	YTD
	Disability	No.							
	Ethnicity	No.							
	Asian	No.	1	4	5	3	3	1	27
	Black	No.	1	1	2	3	3	3	15
	Mixed Heritage	No.	1			3			4
	Other Ethnic Group	No.					1		1
	White	No.	11	14	7	21	12	4	93
	Not Stated	No.	4	3	6	6	1	4	33
	Gender	No.							
	Male	No.	3	4	7	5	3	2	33
	Female	No.	15	18	13	31	17	10	140
	Religion/Belief	No.							
	Sexual Orientation	No.							



Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Progress on adult and children safeguarding agenda Meetings – 19.12.09, 18.01.10, 19.03.10
SPONSORING DIRECTOR:	Rachel Overfield
AUTHOR:	Rachel Overfield
DATE OF MEETING:	29 April 2010

SUMMARY OF KEY POINTS:

The attached report is provided to inform the Board of progress and issues with regard to child and adult safeguarding within the Trust. The Trust operates a joint Safeguarding Committee which has a sub-committee structure to lead and drive specific action plans related to child or adult safeguarding.

There continues to be good progress made against the following action plans:

- Adult Safeguarding
- Child Safeguarding
- Childrens Serious Case Reviews

The Trust provides a variety of information to the following external bodies and also sits on a number of Committees and Boards in support of this agenda:

- Birmingham Safeguarding Children's Board (new)
- Sandwell Safeguarding Children's Board
- Birmingham Safeguarding Adults Board
- Sandwell Safeguarding Adults Board

Both Children's Boards have been subject to Ofsted inspections within the last 6 months. The report from Sandwell has previously been reported to the Trust Board together with the CQC parallel report.

Birmingham received an unannounced Ofsted inspection in December 2009. A formal report has not been shared with the Trust but the summary letter following the visit is available. The findings relate to the work of the Safeguarding Board and Social Services responsibilities and there is no specific reference to health. The Trust has not received a parallel CQC report regarding the Birmingham visit and did not participate in the visit specifically.

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 note the attached report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High Quality Care Ensuring vulnerable people are protected
Annual priorities	Improving Safeguarding systems
NHS LA standards	Safeguarding Adults
Core Standards	Yes
Auditors' Local Evaluation	No

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

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

PREVIOUS CONSIDERATION:

The paper was considered by the Governance Board on 9 April 2010.

The Ofsted inspection report from Sandwell has previously been reported to the Trust Board together with the CQC parallel report.

Trust Board Report
29.04.10

Progress on Adult and Children Safeguarding agenda (Meetings 19.12.09, 18.01.10, 19.03.10)

Rachel Overfield, Chief Nurse

1) Adults Safeguarding

Includes:

- Vulnerable Adults
- Mental capacity and mental health
- Deprivation of Liberty
- Domestic Violence
- Pressure ulceration/Falls – reported separately
- Suspicious death

1.1 Findings of 'No secrets' consultation

One of the key findings from 'No secrets' consultation was the absence of Adults Safeguarding systems within the NHS to ensure that healthcare incidents that raise safeguarding concerns are considered within the wider safeguarding arena. In the past, such incidents were largely dealt with 'in house' and, unlike children, safeguarding incidents do actually occur when adults are in the care of the NHS, eg pressure damage or failure to consent for treatment appropriately. In the past such incidents may have been reported via 'in house' governance systems but rarely would have been considered as part of a multi-agency approach. 'No secrets' states that whilst investigatory processes should not be duplicated the internal and wider governance systems should be seen as distinctly separate.

1.2 Referral thresholds

With this in mind the Adult Safeguarding Boards are now asking for information regarding hospital acquired pressure sores, medication errors and falls which could be considered as 'neglect'. The process for determining which of these have a safeguarding element to them and should therefore be raised as an alert is still not clear but the Trust is working with the Boards to try to establish realistic referral thresholds.

1.3 Safeguarding Policy

There is now a Safeguarding Policy in place but an audit of case notes is required in order to be NHSLA Level 2 compliant. This is planned and results will be reported in due course.

1.4 Referrals

There has been a marked increase in referrals to the safeguarding service noted in the past 12 months. The number of referrals in the 6 months between January and June 09 were 30, in the last 8 months there has been 92. It is felt that this is due to increased awareness of the process and the issues surrounding Adult Safeguarding rather than an increase in actual cases. The bulk of referrals relate to negligence issues. The second most common cause for referrals is mental health and capacity followed by domestic violence.

1.5 Adult Safeguarding Training

Capacity for training is limited as it is purchased in from an external company.

It is currently targeted at Senior Nurses, Consultants and other decision makers. Next year it will be widened out to include the next tier down of clinical staff.

The whole day programme has been well received and there is now a waiting list to attend. The Trust is compliant with its adult safeguarding training requirements.

Two days have been booked to offer a combined adult and child safeguarding day at some staffs request.

1.6 Wider Links

Good linked arrangements have been made with both the Complaints and Risk departments to ensure safeguarding issues are being identified through those sources as well as through specific direct reports. This is especially the case for falls and pressure damage incidents.

1.7 Mental Capacity

Mental capacity training is now in place and being delivered predominantly by the RAID team with an e-learning module also available. This has been well received and demand for more training is growing.

The Mental Health Policy us currently under rewrite.

Safe storage of mental health records within the Trust (section papers) is currently creating some operational difficulties but will be resolved.

1.8 Deprivation of Liberty Training

Deprivation of Liberty training is delivered as part of safeguarding and a paragraph has been inserted into relevant Trust policies to ensure correct protocols are followed in respect of this legislation, eg Control and Restraint Policy.

As Deprivation of Liberty awareness increases there will be increased requests for IMCA's. An audit is planned to see how many patients should have been referred and whether Sandwell and HoB would have sufficient resources.

1.9 Joint Working Group

A joint working group between adults and children safeguarding leads is being established to determine what else the Trust needs to do around domestic violence, forced marriage, substance misuse and maternal mental health issues.

Domestic Violence training is now available via SODA for Sandwell but access to training is very limited for the City site. This is being taken up with Safeguarding Boards.

1.10 Suspicious Death Policy

The Trust does not currently have a policy for what to do in the event of a suspicious death on site, eg suicide. This will be produced within the next few months.

1.11 The Future with Adult Safeguarding

The Serious Case Review process used for Child Safeguarding cases will be applied to adult cases. The Trust is expecting requests for management reviews to commence in the near future. This is likely to be very resource intensive and generate many recommendations for the Trust.

2) <u>Children's Safeguarding</u>

Includes:

- Vulnerable Children/Safeguarding
- Child and adolescent mental health
- Medical examinations for abuse allegations
- Child death reporting process

2.1 Safeguarding Children Action Plan

The Safeguarding Children action plan is progressing well with a significant number of completed actions.

2.2 Level 2 and 3 training

Level 2 and 3 training is now well established and being delivered in the main by an external company (same as adults). The Trust is on target to have trained around 1500 members of staff this year. On a three yearly mandatory update for clinical staff this figure is on the right trajectory.

2.3 Resources

With the increased interest in Child Safeguarding cases, heightened publicity and poor Ofsted reports the Safeguarding Boards are demanding much more detailed management reports on all safeguarding issues and much tighter deadlines. All 'open' cases are currently being reviewed by the Boards and all management reviews rewritten in light of recent guidance.

This is putting significant pressure on very limited resources. Resourcing of Safeguarding by the Trust was noted within the CQC report and is on both Safeguarding Boards action plans. Additional resources have been identified via cost pressure funding.

2.9 Safeguarding Newsletter

A Safeguarding (adult and child) newsletter is being developed as a means of sharing lessons to be learnt.

2.11 Progress against serious case reviews recommendations

The Trust is progressing well with these and has no actions that are significantly delayed.

Number of open serious case reviews involving the Trust		**Number of serious case reviews with the Trust – actions still to complete**	**Number of serious case reviews with the Trust – actions beyond planned completion date**
LSCB	BSCB		
9	6	6	1

3) <u>Workforce</u>

A policy (Safeguarding Children Investigations Policy) is now in place for 'dealing with allegations against staff/workers' which is within accordance with national policy although has not been accepted by the JCNC.

4) <u>In Conclusion</u>

The Trust has good structures in place now to identify safeguarding risks and to deal with incidents as they occur.

Resources are very limited and being stretched severely as both adult and child safeguarding agendas grow – this is subject to budget setting discussions and support for this year has been given.

Action plans are in place for both safeguarding areas and also for child serious case reviews – these are monitored via the Trust Safeguarding Committee and reported to the Governance Board.

Child Protection issues that involve the Trust are now included in red incident reports to the Trust Board.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Progress on adult and children safeguarding agenda Meetings – 19.12.09, 18.01.10, 19.03.10
SPONSORING DIRECTOR:	Rachel Overfield
AUTHOR:	Rachel Overfield
DATE OF MEETING:	29 April 2010

SUMMARY OF KEY POINTS:

The attached report is provided to inform the Board of progress and issues with regard to child and adult safeguarding within the Trust. The Trust operates a joint Safeguarding Committee which has a sub-committee structure to lead and drive specific action plans related to child or adult safeguarding.

There continues to be good progress made against the following action plans:

- Adult Safeguarding
- Child Safeguarding
- Childrens Serious Case Reviews

The Trust provides a variety of information to the following external bodies and also sits on a number of Committees and Boards in support of this agenda:

- Birmingham Safeguarding Children's Board (new)
- Sandwell Safeguarding Children's Board
- Birmingham Safeguarding Adults Board
- Sandwell Safeguarding Adults Board

Both Children's Boards have been subject to Ofsted inspections within the last 6 months. The report from Sandwell has previously been reported to the Trust Board together with the CQC parallel report.

Birmingham received an unannounced Ofsted inspection in December 2009. A formal report has not been shared with the Trust but the summary letter following the visit is available. The findings relate to the work of the Safeguarding Board and Social Services responsibilities and there is no specific reference to health. The Trust has not received a parallel CQC report regarding the Birmingham visit and did not participate in the visit specifically.

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 note the attached report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High Quality Care Ensuring vulnerable people are protected
Annual priorities	Improving Safeguarding systems
NHS LA standards	Safeguarding Adults
Core Standards	Yes
Auditors' Local Evaluation	No

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

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

PREVIOUS CONSIDERATION:

The paper was considered by the Governance Board on 9 April 2010.

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Trust Board Report
29.04.10

Progress on Adult and Children Safeguarding agenda (Meetings 19.12.09, 18.01.10, 19.03.10)

Rachel Overfield, Chief Nurse

1) Adults Safeguarding

Includes:

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1.1 Findings of 'No secrets' consultation

One of the key findings from 'No secrets' consultation was the absence of Adults Safeguarding systems within the NHS to ensure that healthcare incidents that raise safeguarding concerns are considered within the wider safeguarding arena. In the past, such incidents were largely dealt with 'in house' and, unlike children, safeguarding incidents do actually occur when adults are in the care of the NHS, eg pressure damage or failure to consent for treatment appropriately. In the past such incidents may have been reported via 'in house' governance systems but rarely would have been considered as part of a multi-agency approach. 'No secrets' states that whilst investigatory processes should not be duplicated the internal and wider governance systems should be seen as distinctly separate.

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The Trust has good structures in place now to identify safeguarding risks and to deal with incidents as they occur.

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Child Protection issues that involve the Trust are now included in red incident reports to the Trust Board.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Registration with the Care Quality Commission: Compliance Monitoring
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Kam Dhami, Director of Governance
DATE OF MEETING:	29 April 2010

SUMMARY OF KEY POINTS:

From April 2010 health and adult social care providers have to be registered with the Care Quality Commission (CQC). This requires compliance with the new essential standards of safety and quality set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 and the Care Quality Commission (Registration) Regulations 2009.

The Commission published the registration status for all 378 NHS trusts providing services in England on 1st April 2010. The CQC attached registration compliance conditions to 22 Trusts.

The Trust was considered by the CQC to meet the essential standards of quality and safety and, therefore, licensed to continue to provide the above regulated activities with no conditions applied.

This paper sets out how the CQC will monitor ongoing compliance with the standards and the Trust's plans do the same at a local level.

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

Approval	Receipt and Noting	Discussion
	✓	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Board is asked to NOTE the registration status with the CQC and the compliance monitoring arrangements.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	
Annual priorities	
NHS LA standards	
Core Standards	The new CQC Essential Standards of Quality and Safety will superseded the Standards for Better Health core standards from 1 April 2010
Auditors' Local Evaluation	

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

Financial	✓	There will be an annual registration fee to be paid to the CQC, the amount to be finally determined but provisionally could be £60,000
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy	✓	With effect from 1st April 2010, under the Health and Social Care Act 2008 and the Health and Social Care Act (Registration Requirements) Regulations 2009, it has become unlawful to provide regulated activities without being registered with the CQC
Equality and Diversity		
Patient Experience	✓	Achieving full compliance with the Essential Standards of Quality and Patient Safety and relevant regulations will contribute to quality improvements for patients
Communications & Media		
Risks		Failure to meet the Trust's statutory duty of quality (Health Act 1999) and comply with the Health and Social Care Act 2008 (Registration Requirements) Regulations 2009 will mean that the organisation is at risk of being refused registration or being registered with conditions.

PREVIOUS CONSIDERATION:

The Trust Board was previously advised of the process and requirements for registration at its meeting in January 2010.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Registration with the Care Quality Commission: Compliance Monitoring

1. Introduction

1.1 From April 2010 health and adult social care providers have to be registered with the Care Quality Commission (CQC). This requires compliance with the new essential standards of safety and quality set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 and the Care Quality Commission (Registration) Regulations 2009.

1.2 Sandwell and West Birmingham Hospitals NHS Trust applied to register the following regulated activities undertaken at its three hospitals:

Regulated Activity	City Hospital	Sandwell Hospital	Rowley Regis Hospital
Treatment of disease, disorder	✓	✓	✓
Diagnostic and screening procedures	✓	✓	✓
Surgical procedures	✓	✓	-
Maternity and midwifery services	✓	✓	-

1.3 The Commission published the registration status for all 378 NHS trusts providing services in England on 1st April 2010. The CQC attached registration compliance conditions to 22 Trusts.

1.4 The Trust was considered by the CQC to meet the essential standards of quality and safety and, therefore, licensed to continue to provide the above regulated activities with no conditions applied.

1.5 This paper sets out how the CQC will monitor ongoing compliance with the standards and the Trust's plans do the same at a local level.

2. Compliance monitoring by the CQC

2.1 Once registered, the CQC will continuously monitor a provider's compliance with the essential standards through a *'dynamic and responsive system of regulation'*.

2.2 The key stages of the CQC monitoring process are set out below:

Information capture – the CQC will continuously capture information about registered providers from a range of sources, including providers themselves.

- Quality and Risk Profile (QRP)

  A QRP of each provider will be held by the CQC. This contains all the information known about the provider in one place and will be used to assess risk and act as a prompt for regulatory action.

Information from people using the service, LINks, overview and scrutiny committees and other relevant organisations representing the user voice will be held on the QRP.

Information from other sources will be used by the CQC such as:

- NHS Litigation Authority
- the National Institute for Health and Clinical Excellence
- Health and Safety Executive
- Parliamentary and Health Service Ombudsman
- Royal College data

- Registered providers have a statutory duty to notify the CQC in writing about certain events that affect people who use the services they provide. These include:

  - Changes to the statement of purpose
  - Certain changes to, and other events concerning, the service
  - Certain deaths of people who use the service.
  - Deaths and unauthorised absences of people detained or liable to be detained under the Mental Health Act 1983
  - Certain serious injuries
  - Applications to deprive a person of their liberty under the Mental Capacity Act 2005
  - Allegations of abuse
  - Events that prevent, or threaten to prevent, the registered person from carrying on the service

  The information gathered from notifications will inform the QRP and help the CQC to continuously monitor whether services are meeting the essential standards, as well as to identify risks to people who uses services.

Information analysis – the CQC will carry out planned and responsive reviews of a provider's compliance with essential standards as part of their ongoing monitoring of compliance.

- Planned reviews – this is a scheduled check of compliance with all of the 16 essential standards that are most directly related to quality and safety. Compliance across all the regulated activities carried out at a location will be reviewed. The frequency of a planned review of compliance will be between three months and two years.

- Responsive reviews – this is triggered when information, or a gap in information, raises concerns about the outcome people are experiencing. The review will target the areas and outcomes that the specific concern or gaps relate to. This may be extended if broader or additional concerns arise during the review.

The CQC will always review information held in the QRP together with any other relevant information provided by partners, public and people who use services. If compliance cannot be confirmed because of gaps in the information and/or concerns about people experiencing the necessary outcomes, additional information will be gathered through:

- Contacting people who use services
- Contacting the LINks and OSCs
- Requesting information from providers or partners by phone or email
- Conducting a site visit

The CQC's intention is to always take a proportionate approach to ensure the most effective activity for gathering further information and that it focuses on outcomes for people who use services.

Judgement on risk – this will be made when the information capture and analysis processes are completed.

Case studies in the judgement framework will be used to validate any decisions about compliance. Where concerns about compliance exist, a judgement will be made about the impact on people using services and the likelihood the impact will happen, including any influencing factors. This will determine whether the concerns are "minor", "moderate" or "major".

Regulatory response – when a judgement on risk has been made, the CQC will decide on an appropriate regulatory response.

Where concerns with compliance exist or non-compliance is identified, the most appropriate regulatory response will be used by the CQC to make sure that the necessary improvements are made. This is determined by using the "setting the bar" framework (see Appendix 1).

The regulatory response will depend on the concerns identified and can be either:

- Informal regulatory action,
- Formal regulatory action, or
- Enforcement action

3. Compliance monitoring by the Trust

3.1 Executive leads have been identified for each outcome area/regulation and will oversee the ongoing monitoring of compliance at a local level.

3.2 Evidence to support compliance with the regulations was shared with Board members earlier this year, together with details of relevant documentation and an assessment of the adequacy and robustness of the available information. Identified operational leads will be responsible for ensuring that

the information is kept up to date and any areas of concern are brought to the attention of the relevant Director.

3.3 Evidence of assurance of compliance will be retained and made available to the CQC should it be requested. The Trust Secretary will be responsible for managing the central database.

3.4 The QRP will be reviewed on a regular basis and corrective action taken in response to any items that are 'flagged' by the CQC as being of concern. The Director of Governance will be responsible for overseeing this work.

3.5 Progress reports will be presented to the Governance Board and Governance and Risk Management Committee on a quarterly basis to provide assurance of ongoing compliance with the essential standards of quality and safety. Any areas of non-compliance will be brought to the attention of Trust Board members together with details of the action taken/planned to address the situation.

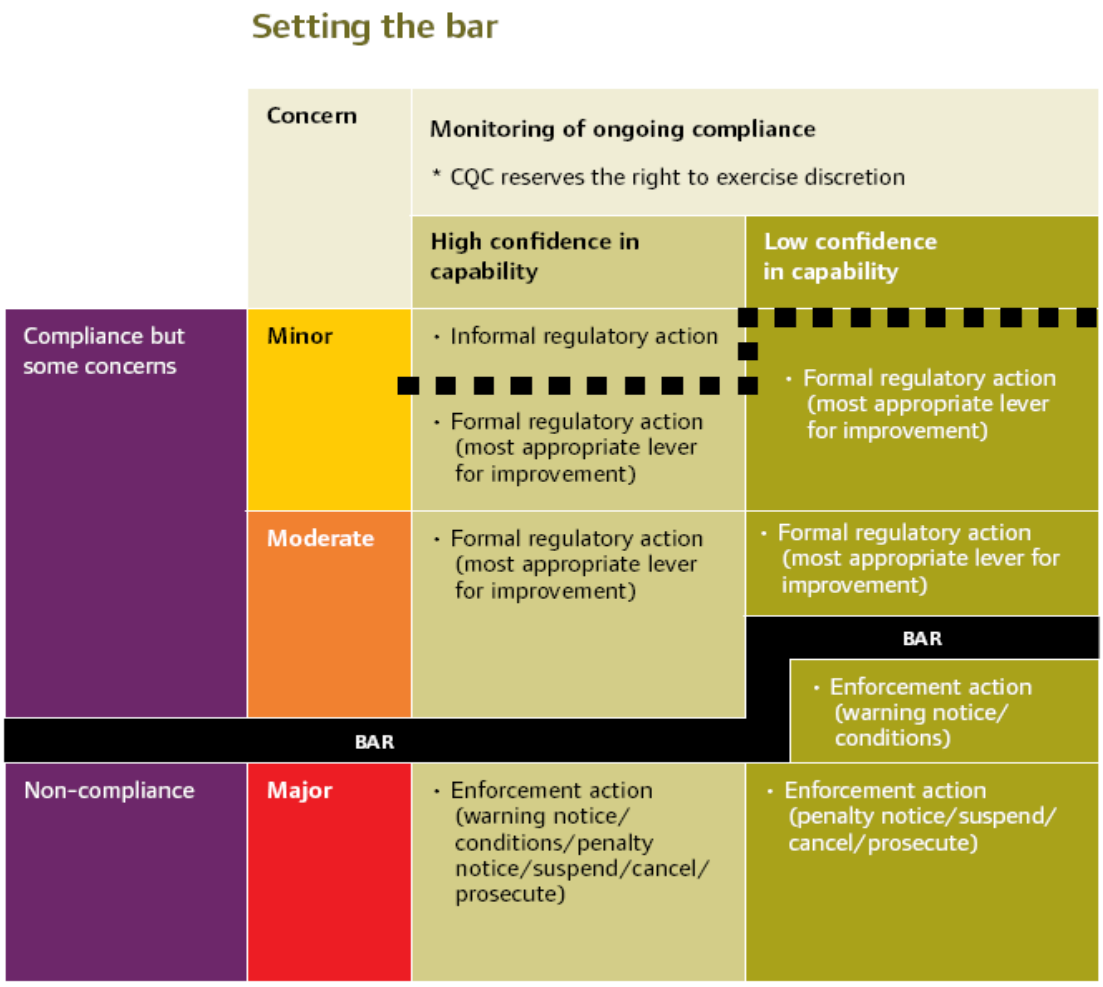
4. Recommendation

The Board is asked to NOTE the registration status with the CQC and the compliance monitoring arrangements.

Kam Dhami
Director of Governance April 2010

Care Quality Commission

Setting the bar
NHS providers: Ongoing monitoring of compliance



Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Register of Sealed Documents
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	29 April 2010

KEY POINTS:

An application for use of the Trust Seal is made when required. The Trust's Standing Orders (section 8) require a register to be kept of all documents to which the Trust Seal has been affixed.

Details of all documents that have been made under seal during the period 1st April 2009 to 31st March 2010 is attached.

PURPOSE OF THE REPORT:

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

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

To RECEIVE and NOTE the list of official sealings as detailed for 2009/10.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

4.1- None specifically, although ensures compliance with the Trust's Standing Orders

IMPACT ASSESSMENT:

FINANCIAL	☑	
ALE	☐	
CLINICAL	☐	
WORKFORCE	☐	
LEGAL	☑	Compliance with Section 8 of the Trust's Standing Orders
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

REGISTER OF SEALED DOCUMENTS

Detailed below is a summary of the documents sealed by the Trust during the period 1st April 2009 to 31st March 2010.

Register Ref. No.	Description of Document	Date Sealed
137	Compulsory Purchase Order 2009 for acquisition of land for the new acute hospital and Order map for the same	25.9.09
138	Contract documents – Capital works for the Urgent Care Centre at City Hospital	3.12.09
139	Contract documents – Capital work for the Midwifery Led Unit at City Hospital	3.12.09
140	Contract documents – Capital works to Ward D16 at City Hospital	3.12.09
141	Deed of Novation for transfer agreement from Olympus to Heamonetics Ltd. for blood tracking system	18.3.10

April 2010

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	National Outpatient Survey 2009
SPONSORING DIRECTOR:	Jessamy Kinghorn, Head of Communications and Engagement
AUTHOR:	Nick Howells, Senior Communications Manager
DATE OF MEETING:	29 April 2010

SUMMARY OF KEY POINTS:

The 2009 National Outpatient Survey was published by the Care Quality Commission on 25th February 2010. This report highlights the key findings. A full benchmark report is available on the CQC website. This is the first national outpatient survey to be carried out since 2004.

The Trust response rate was 52%, (national average was 53%). The Trust's individual report has previously been circulated to Board members and is available from the communications department, as is a 21 page document containing comments made by patients completing the questionnaire.

The Trust was rated in the top 20% of trusts nationally for:

- the promptness of appointment time,
- the doctor listening to the patient,
- confidence and trust in doctors,
- the amount of information given to patients,
- staff telling patients how they would find out their test results,
- staff explaining the results of tests in a way patients could understand, and
- hospital staff telling patients who to contact if they were worried after they left hospital.

The Trust was rated amongst the worst performing 20% for:

- Choice of appointment time
- Patients knowing what would happen during their appointment before they arrived
- Changing the appointment to a later date
- Doctors and other staff talking in front of patients as if they weren't there
- Privacy when discussing condition or treatment
- Privacy when being examined
- One member of staff saying one thing and someone else saying something different
- Staff explaining what would happen before treatment
- Staff explaining risks and benefits before treatment in a way patients could understand

On most of the occasions we are in the top or bottom 20%, the Trust is sitting very close to the threshold and is not an outlier.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

1. NOTE the report

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High Quality Care
Annual priorities	The views of patients have helped set the priorities for 2010/11, the outpatient booking system is one example
NHS LA standards	
Core Standards	National patient surveys are used as evidence for several core standards
Auditors' Local Evaluation	

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

Financial		
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity	**X**	The data has been analysed by patient demographics as far as is statistically valid
Patient Experience	**X**	
Communications & Media	**X**	This information was published on 25th February 2010 by the CQC
Risks		

PREVIOUS CONSIDERATION: The initial findings were circulated to the Trust Board by email after the survey closed in October 2010.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

National Outpatient Survey 2009 - Findings

April 2010

INTRODUCTION

To improve the quality of services that the NHS delivers, it is important to understand what patients think about their care and treatment. One way of doing this is by asking patients who have recently used their local health services to tell us about their experiences.

The national survey of adult outpatient services involved 163 acute and specialist NHS trusts. Responses were received from more than 72,000 patients, a response rate of 53%. People were eligible for the survey if they were aged 16 years or older and attended an outpatient department during any one month period in March, April or May 2009.

The survey was undertaken by Quality Health between July and October 2009, and published by the Care Quality Commission on 25th February 2010. It follows the previous adult outpatient survey which was carried out in 2004 and published in 2005.

From a sample of 850 Sandwell and West Birmingham Hospitals NHS Trust patients, 437 completed questionnaires were returned, a response rate of 52%.

The detailed graphs in this report compare the Trust results to a group of peer organisations whose surveys were conducted by Quality Health. Where the Trust results are in the top or bottom 20% of all trusts nationally (or is on the borderline of the 20% threshold), this has been highlighted. On most of the occasions when the Trust is in the top or bottom 20%, it is sitting very close to the threshold and is not an outlier.

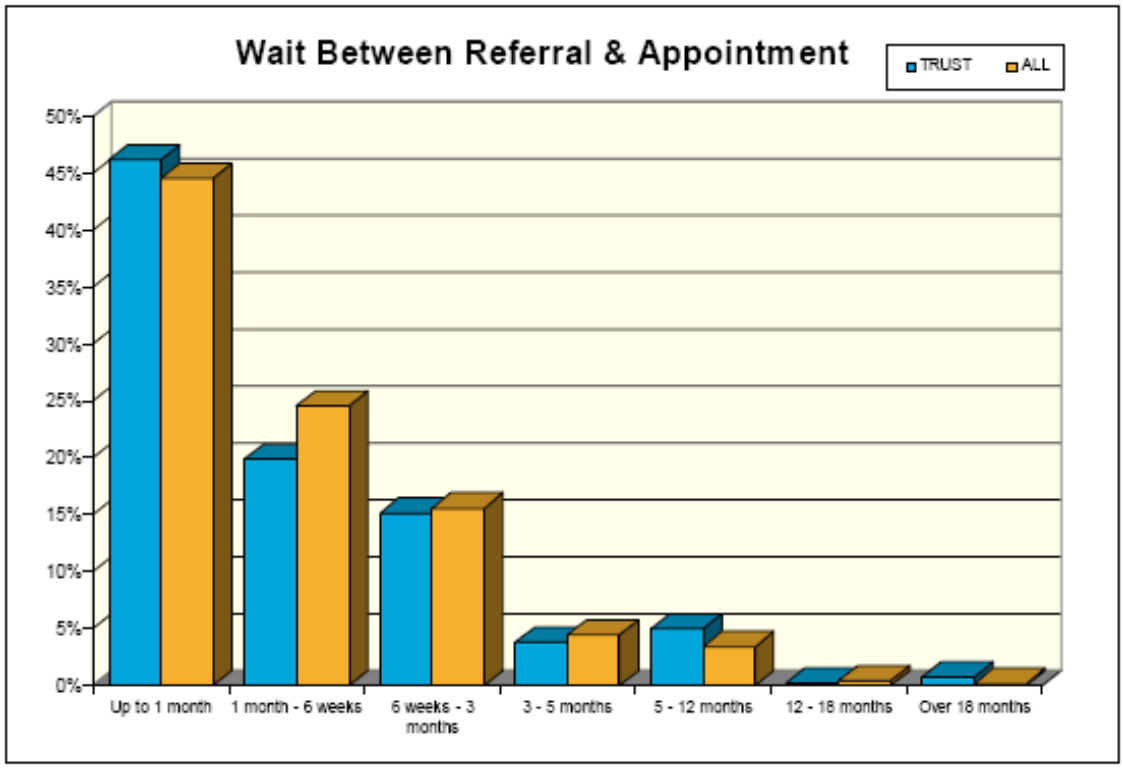
Where statistically possible, the information has also been analysed by the demography and clinical specialty of the patients responding, although the relatively small number of completed questionnaires and significant diversity of our patients and wide range of our services means there is very limited potential to carry out such a statistically valid analysis. As a result of these, the Trust's larger specialties, such as Trauma and Orthopaedics, are more likely to be singled out for good or poor performance.

BEFORE THE APPOINTMENT

Where we did well…

The length of time patients wait for an outpatient appointment has improved noticeably since 2005 when the last Outpatients Survey was carried out.

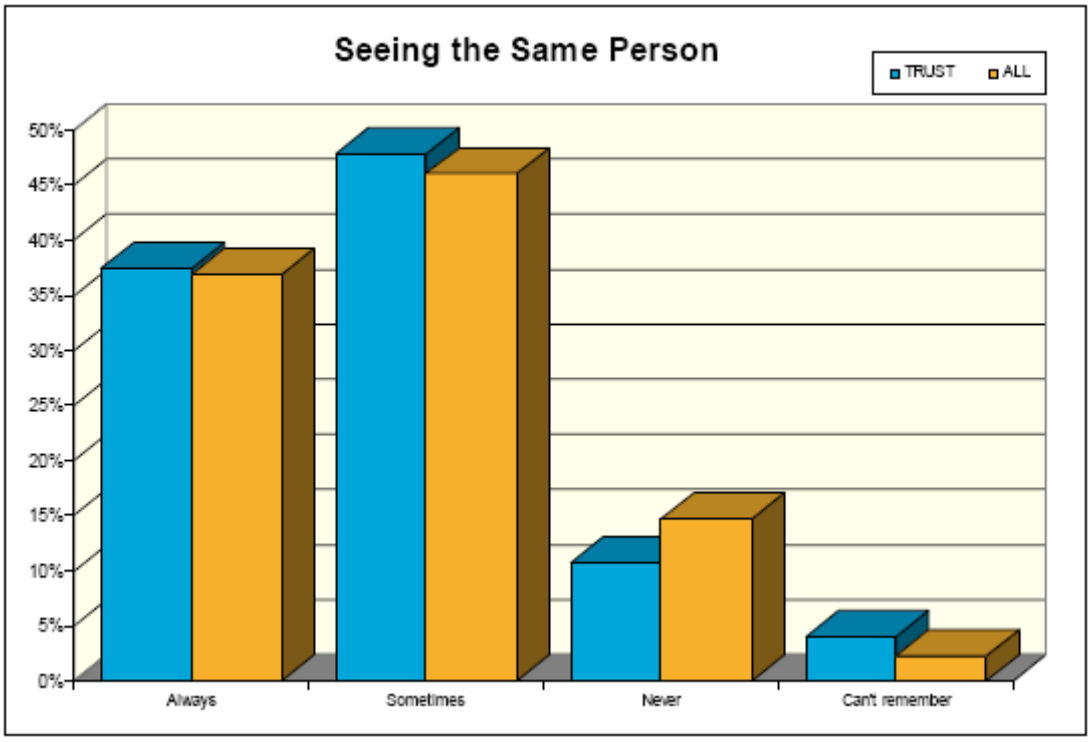
The number of patients waiting less than a month before their first outpatient appointment has risen by 13% to 46% since 2005.



Although waiting times for outpatient appointments had improved, we still have 6% waiting more than 5 months, which is twice the average when compared to a similar group of Trusts nationally.

Continuity of care offered is better than the average when compared to a similar group of Trusts nationally.

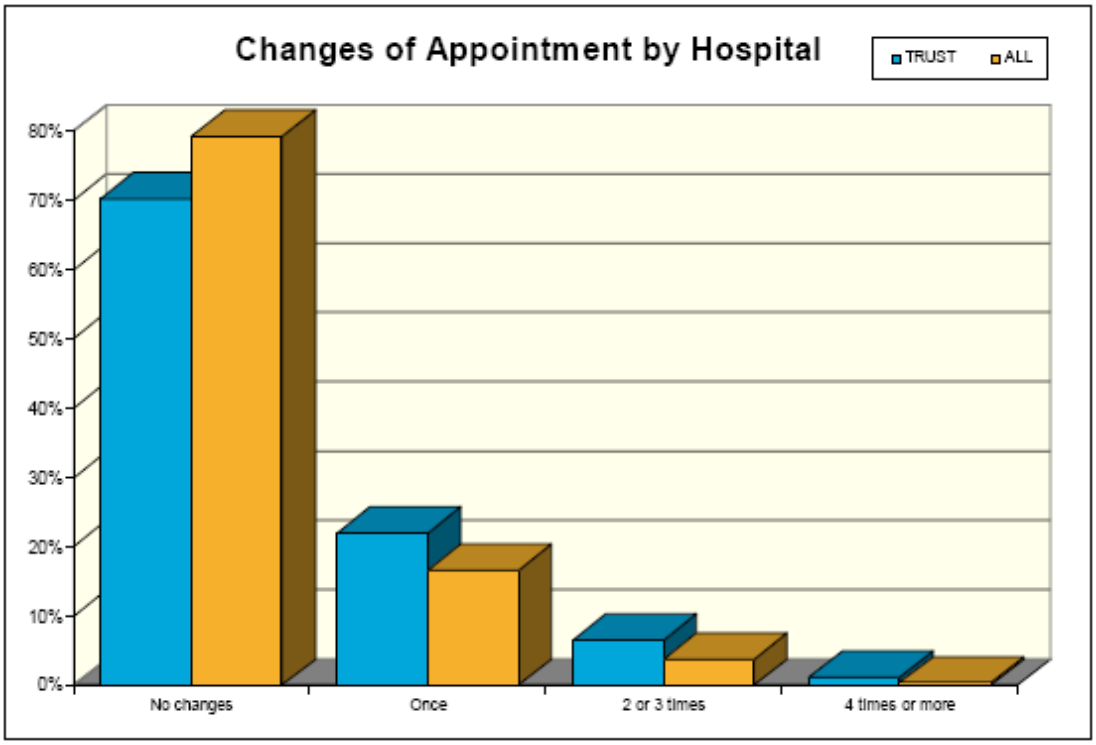
85% of patients said they either always or sometimes saw the same doctor.



Where more work may be needed…

The number of patients being offered a choice of appointment time has fallen by 2% since 2005. Just 26% say they were given a choice, 7% less than the average when compared to a similar group of Trusts nationally, although the majority, 54%, said they didn't need or want a choice.

The Trust changes appointment times significantly more often than the national average, although work is underway to improve the appointment service.



The number of times appointments are changed by us hasn't changed since 2005. 22% of appointments, 5% more than the national average, are changed once, and 7%, nearly double the average when compared to a similar group of Trusts nationally, are changed two or three times. Cardiology was the worst offender, being 33% more likely than average for the Trust to change appointment times at least once.

The national benchmarking report published by the CQC shows that the Trust is in the bottom 20% of trusts nationally for:

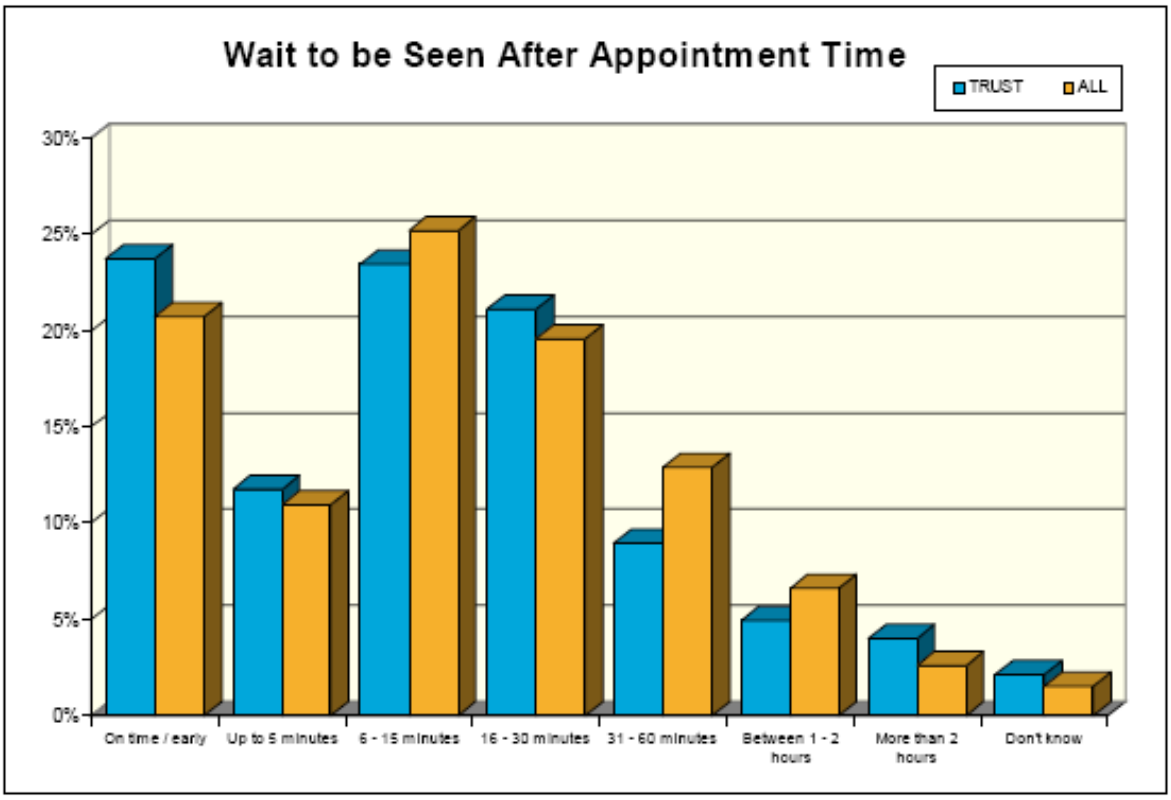
- Choice of appointment time
- Patients knowing what would happen during their appointment before they arrived
- Changing the appointment to a later date

WAITING

Where we did well…

The amount of time patients are kept waiting in outpatients has improved since 2005.

24% are being seen either on time or early, up 4% since 2005. The number waiting up to five minutes is up 3% to 12% since 2005. The number waiting for between half an hour and one hour is down 6% to 9% since 2005. The majority of patients are seen within 15 minutes.



Waits were much longer in Trauma and Orthopaedics, where 31% of patients waited over 30 minutes.

The Trust was rated in the top 20% of trusts nationally by the CQC for:

- the promptness of appointment time,

Where more work may be needed…

Patients who waited more than 15 minutes were asked if they were told how long they would have to wait; 64% said they were not told, 6% worse than the average when compared to a similar group of Trusts nationally.

Of these, only 1 in 4 were told why they had to wait. 31% said they were not told but would have liked an explanation.

HOSPITAL ENVIRONMENT AND FACILITIES

Where we did well…

The number of people saying the outpatients department was very clean was up by 15% since 2005 to 61%. Only 2% said it wasn't very clean.

The number saying the toilets were very clean was up by 12% to 51%.

Where more work may be needed…

7% said the toilets were not very clean, which is 2% more than the average when compared to a similar group of Trusts nationally. 14% said the toilets in Trauma and Orthopaedics were not very clean.

SEEING A DOCTOR

Where we did well…

Trust in our doctors in higher than the national average. Patients were happy with the time they were given with doctors, said they explained the reasons for any treatment and listened to what they had to say.

81% had seen a doctor and 98% said they had enough time to discuss their health problems with the doctor.

82% were with the doctor for between five and 20 minutes, which is 5% better than the average when compared to a similar group of Trusts nationally.

The number who said the doctor had completely explained the reasons for any treatment or action in a way they could understand was up by 5% since 2005 to 79%.

83% said the doctor definitely listened to what they had to say.

The number who said they had confidence and trust in the doctor examining them was up by 5% since 2005 to 89%, 5% higher than the average when compared to a similar group of Trusts nationally.

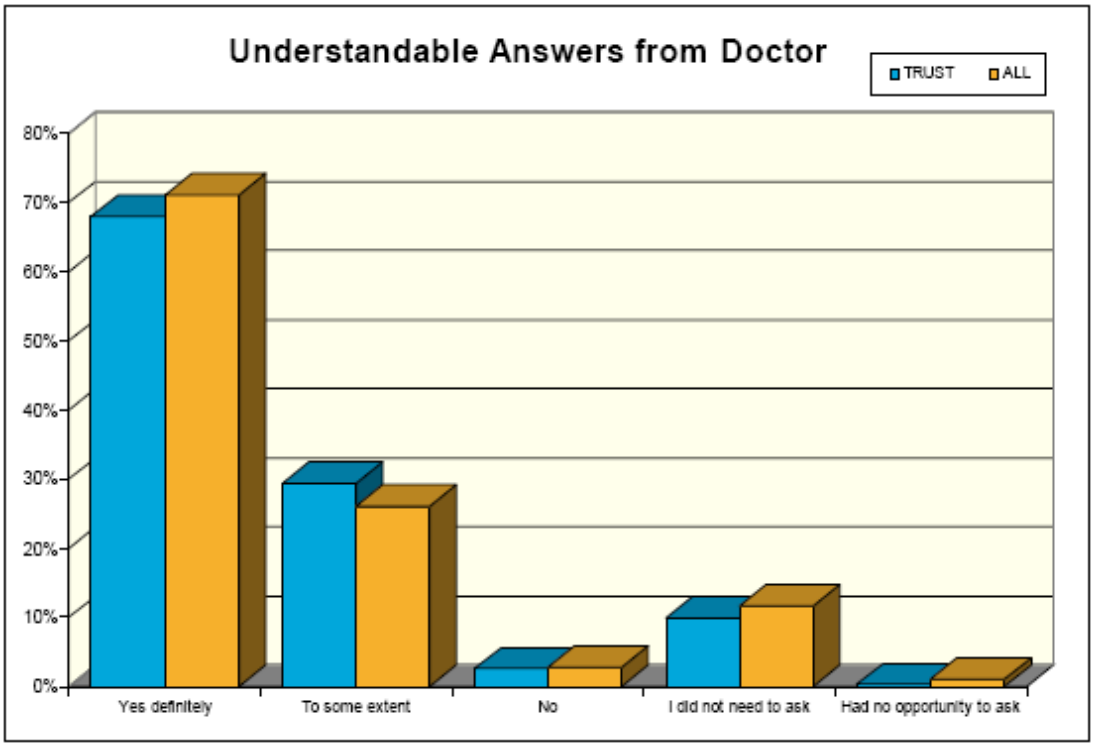
The Trust was rated in the top 20% of trusts nationally by the CQC for:

- the doctor listening to the patient,
- confidence and trust in doctors,

Where more work may be needed…

The number of patients who said the doctor knew something, but not enough, or little or nothing about their medical history was up by 4% to 19% since 2005, which is 2% worse than the average when compared to a similar group of Trusts nationally.

Patients were asked about the comprehensibility of answers to their questions and 3% of patients said that the answers they received from the doctor were not understandable.



SEEING ANOTHER PROFESSIONAL

Where we did well…

Since 2005 the number of patients who also saw someone other than a doctor during their appointment was up by 6% to 61%. Of these, 70% saw a nurse.

83% said they definitely had confidence and trust in the person they saw.

OVERALL ABOUT THE APPOINTMENT

Where we did well…

98% said they were given enough privacy when discussing their treatment.

98% said they were given enough privacy when being examined or treated.

94% said they were involved as much as they wanted to be in decisions about their care and treatment.

89% said they were given the right amount of information about their condition or treatment.

The Trust was rated in the top 20% of trusts nationally by the CQC for:

- the amount of information given to patients,

Where more work may be needed…

15% of the patients said that they were not given any information at all, or were given too little information, about their condition or treatment. Among departments, the worst figure for this was Trauma and Orthopaedics with 27%.

1 in 20 said they were not involved as much as they wanted to be in decisions about their care and treatment.

As in 2005, there were still 18% who said doctors and other staff talked in front of them as if they weren't there, which is 6% worse than the average when compared to a similar group of Trusts nationally.

The number of patients who said that all staff had introduced themselves before treating and examining them is up by 7% since 2005, but at 69% is still 2% below the average when compared to a similar group of Trusts nationally.

The Trust was rated in the bottom 20% of trusts nationally by the CQC for:

- Doctors and other staff talking in front of patients as if they weren't there
- Privacy when discussing condition or treatment
- Privacy when being examined
- One member of staff saying one thing and someone else saying something different

TESTS AND TREATMENT

Where we did well…

67% of patients said they had tests (such as x-rays, scans or blood tests) during their outpatient visit. 43% said they had treatment during their outpatient appointment, 11% higher than the average when compared to a similar group of Trusts nationally.

Of patients having tests, 75% said a member of staff had explained why they needed these in a way they could understand, up 5% on 2005.

66% said a member of staff had explained the results of the tests in a way they could understand, up 10% on 2005.

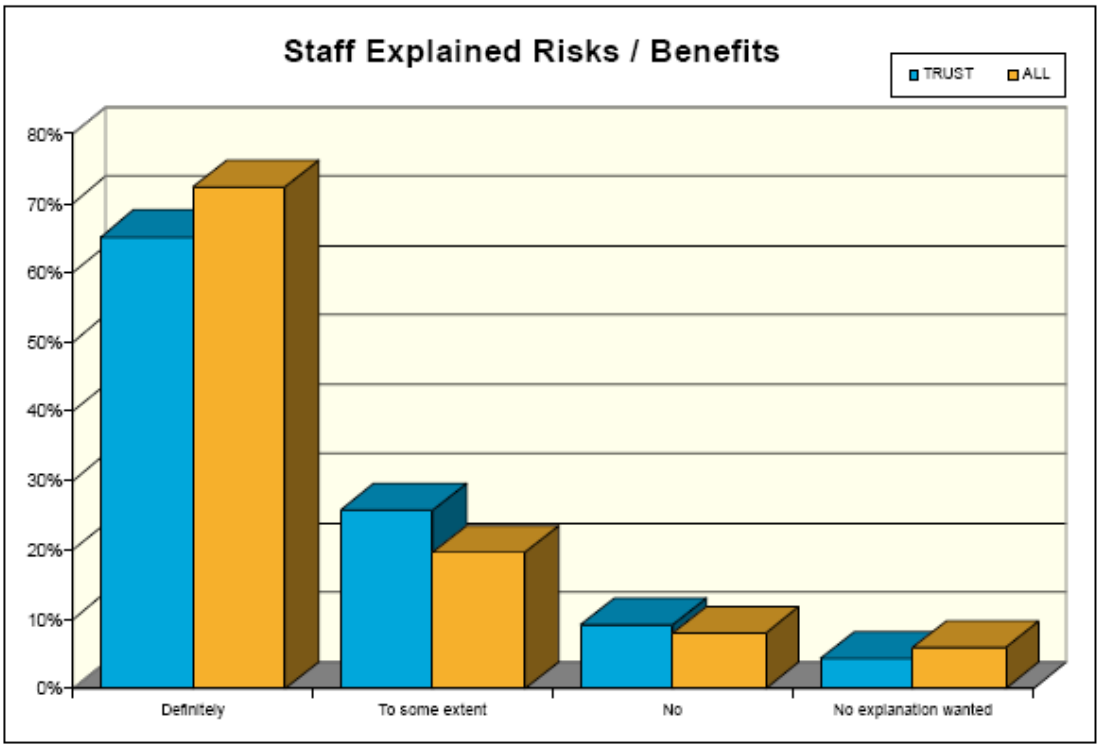
80% said a member of staff had told them how they would find out the results of their test(s), up 6% on 2005.

The Trust was rated in the top 20% of trusts nationally by the CQC for:

- staff telling patients how they would find out their test results,
- staff explaining the results of tests in a way patients could understand

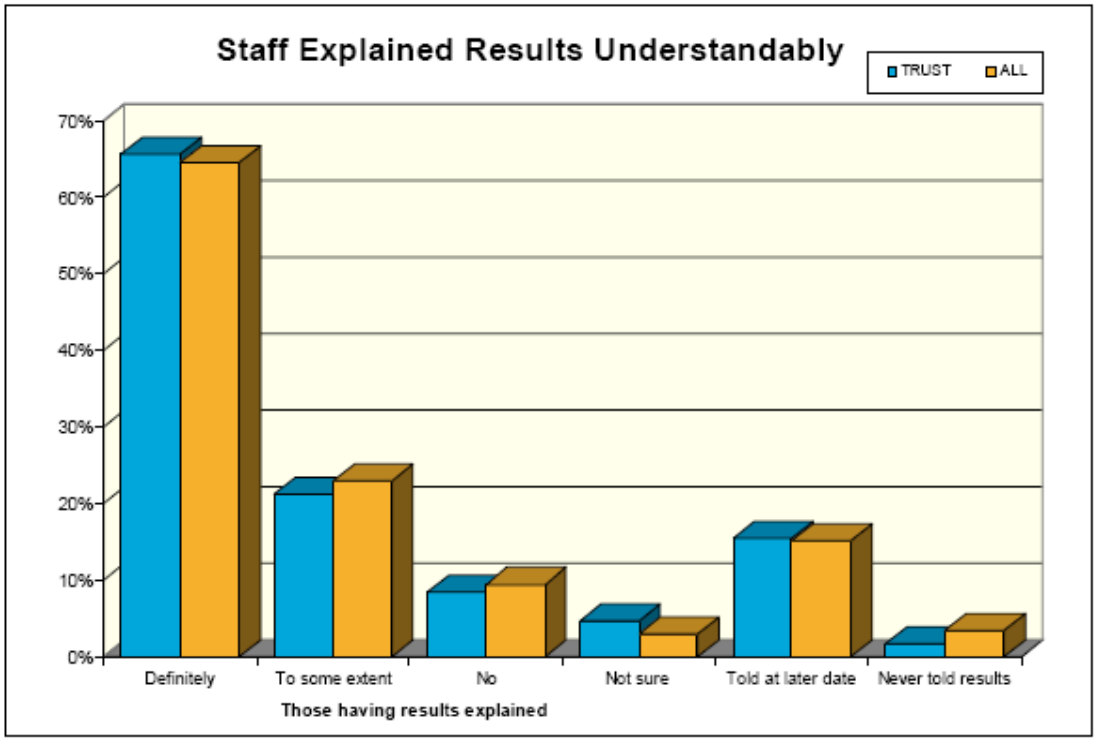
Where more work may be needed…

The number of patients who had their treatment fully explained to them first and the risks and benefits of the treatment had fallen since 2005.



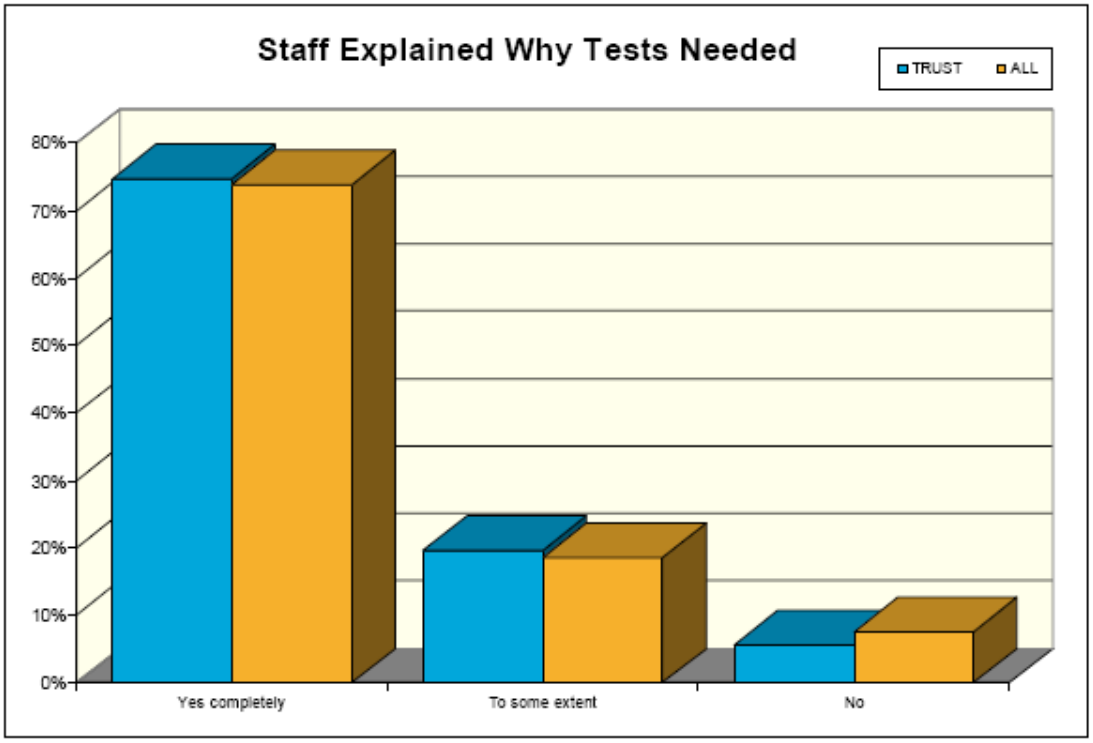
One in ten patients were not being told about risks and benefits in a way they understood.

Despite being amongst the best 20% of results in the country, one in ten patients didn't have the results of tests explained in a way they could understand.



13% weren't told how to find out the results of their tests.

Patients having tests were asked whether they were told why they needed the tests in a way they could understand. 75% said they were told this completely, but 6% said they did not receive an explanation they could understand.



The worst results were from Trauma and Orthopaedics, where 11% of patients said they were not told why they need tests in a way they could understand; 25% said they weren't told how they would find the results of the tests; 15% said the results of tests were not explained in a way they could understand: and 18% said

they were not given an explanation of risks and benefits which they could understand before treatment. These figures are double the Trust average.

The Trust was rated in the bottom 20% of trusts nationally by the CQC for:

- Staff explaining what would happen before treatment
- Staff explaining risks and benefits before treatment in a way patients could understand

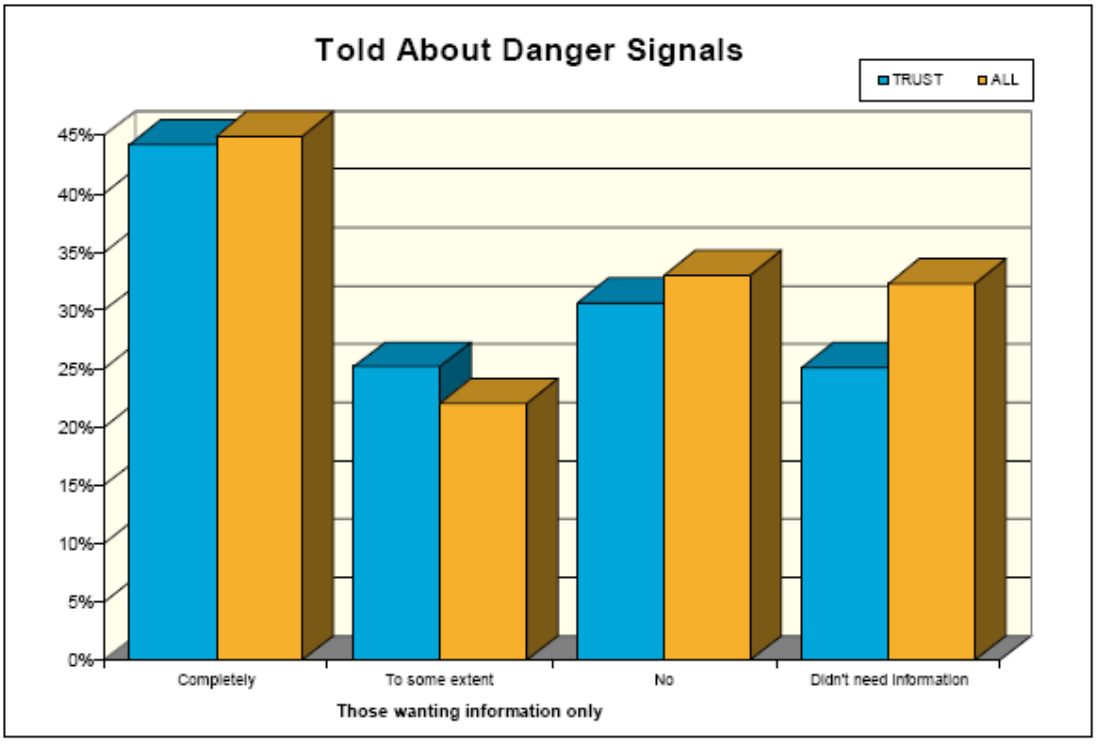
LEAVING THE OUTPATIENTS DEPARTMENT

Where we did well…

37% had new medications prescribed before they left the outpatients department, 13% higher than the average when compared to a similar group of Trusts nationally. 82% said staff explained how to take the new medications. 84% said the purpose of the medications was explained completely in a way the patient could understand.

70% of patients said staff told them who to contact if they were worried about their condition or treatment after they left hospital, up 9% on 2005 and 8% higher than the average when compared to a similar group of Trusts nationally. There were still 1 in 4 patients who were not who were not given these basic contact details.

44% said a member of staff had told them about what danger signals regarding their illness or treatment to watch for after they went home, a rise since 2005, but 31% said they were not told.



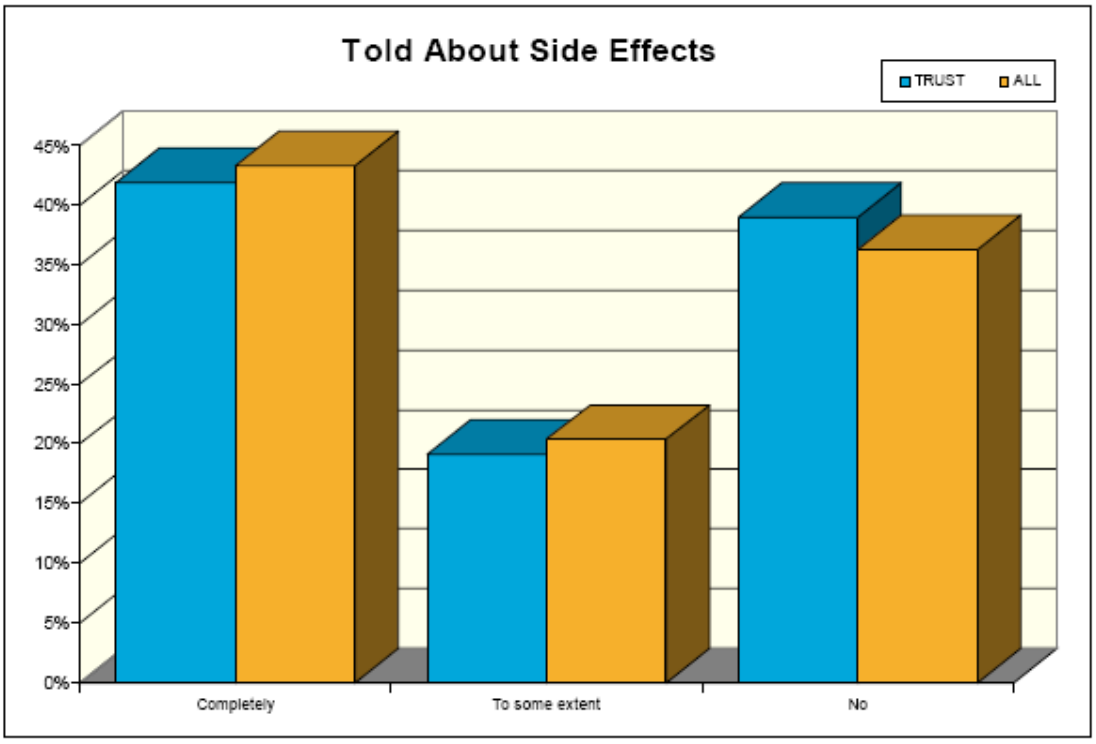
The number of patients who said they did receive copies of letters sent between hospital doctors and their GPs had risen by 11% since 2005 to 28%. Those who said they didn't receive letters fell by 17% but was still 48%.

The Trust was rated in the top 20% of trusts nationally by the CQC for:

- hospital staff telling patients who to contact if they were worried after they left hospital.

Where more work may be needed…

39% of patients, 5% more than in 2005, said they were not told by staff about the possible medication side effects to watch out for.



OVERALL IMPRESSION

Where we did well…

93% rated their overall care in outpatients as good or excellent, with the number rating it excellent going up by 6% since 2005 to 36%, although this is still 5% less than the average when compared to a similar group of Trusts nationally.

77%, up 7% since 2005 and 3% higher than the average, said the main reason they visited Outpatients was dealt with completely to their satisfaction.

Where more work may be needed…

56%, up 5% since 2005 but 4% below the average when compared to a similar group of Trusts nationally, said their trip to Outpatients was very well organised. The number who didn't went up from 2% to 4%.

The number who said they felt they had been treated with respect and dignity rose by 1% to 85%, 3% below the average.

ETHNICITY

13% of patients described themselves as Asian or Asian British (Indian, Pakistani, Bangladeshi or other Asian background). This equates to approximately 57 patients. 79% of responders were White, compared to 93% nationally. The next largest group of responses by ethnicity was Black or Black British which made up 6% of the responses (26 people). This is too small a group to be analysed in detail.

Despite the small numbers, there are some notable observations about the experience of Asian or Asian British responders to the survey.

According to those responding Asian patients were significantly more likely to wait more than three months for an appointment and much more likely to have their appointment times changed. They were less likely to know what would happen to them during an appointment or to see the same doctor.

Asian patients were generally alot more negative about cleanliness, information they received and the involvement in their care. Respect and dignity and waiting times were other issues they raised.
Asian patients had a worst opinion of their overall care then white patients.

There is a significant amount of research that shows that patients from a black and minority ethnic background are generally more negative about their experiences, but the findings in this report should not be dismissed on these grounds and will be examined further.

NEXT STEPS

These findings will be fed into the relevant Patient Experience work which is being led by the Chief Nurse and work being led by the Chief Operator to improve Outpatient.

It is expected that there will be a further national outpatient survey in the next year or two when progress will be fully measured.

RECOMMENDATIONS

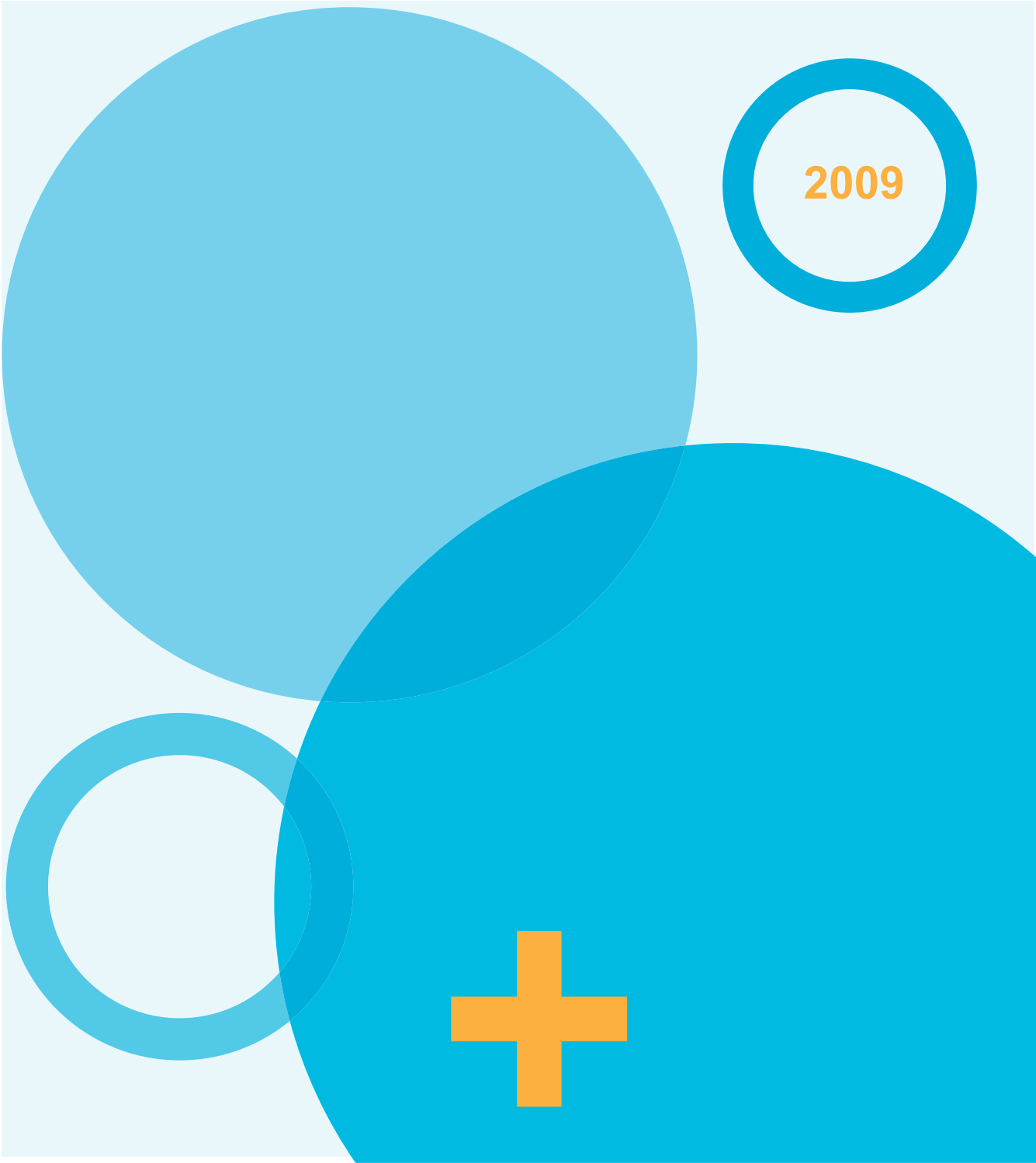
The Board is asked to NOTE this report.

SWBTB (4/10) 089 (b)

Quality Health

Listening to patients

Sandwell and West Birmingham Hospitals NHS Trust
National Outpatients Department Survey
Comments



1. Was there anything particularly good about your visit to the Outpatients Department?

The staff were pleasant, helpful and polite.

Waiting.

The doctor I saw gave me complete confidence in him.

Yes. Doctors and nursing staff were all very friendly and kind. Helpful too.

Receptionists are very helpful and efficient. In relation to Birmingham treatment centre waiting area is well planned and clean and airy.

Everyone was very pleasant (stroke clinic).

Please note I have never been to West Bromwich Hospital only to City Hospital. Dudley PCT. Also to ROP Northfield. Thank you.

Yes.

The staff were very helpful.

Reception information very good. Hospital A1.

Staff very helpful and kind in day unit.

Good to you.

Yes.

Doctor, Nursing care very good. Didn't have to wait too long.

Not really.

The staff were very good, very clean; they were all friendly and sociable.

Yes in that I felt more reassured on my condition.

My visits have been to Rowley Regis Hospital O/P and Russell's Hall Hospital O/P. Staff at these have been most helpful.

From entry to department and introduction to nursing staff to consultant and his assistants after treatment. Care by the nurses was excellent. They were all 100% plus.

Usually there are fifty or more patients waiting for the doctor / consultant. My appointments were one on one. Always very quick.

No waiting after booking in at reception.

Very good.

All staff seemed to be competent.

The appointment staff were accommodating in that I have a 100 mile motorway trip to get to the centre and always arranged midday appointment without my requesting same.

Very clean well organised.

Everyone was by my being treated with respect.

Made to feel at ease.

Medical staff explained things well.

I had all my questions answered.

Very clean, little waiting. Pleasant staff. Very good consultant. New department great improvement on old facilitator.

Yes, It has been at least 2 ½ years since I attended O.P. for (unreadable word). I was advised to try the exercise classes at Arden House Cardiac Rehab. Since then I regularly go to the gym. We have a programme to follow; from time to time this is upgraded. This has been a tremendous help and would advise anyone with claudication to do the same.

The outpatient Dept has improved quite a bit but not hearing aid dept. I wish the NHS should do some improvements in this area.

I found all the doctors and nurses so kind and caring.

I am very happy with the treatment I receive from all members and staff of the N.H.S.

Yes I am getting better thanks to my treatment.

Staff are busy but friendly when they can.

All of it was good.

I have always been treated very well from everyone.

Very nice people.

I have had cause to visit the O/P department over the last few years and on each occasion I have been treated very well and the medical staff have all been polite and kept me informed as to my medical conditions and explained fully the treatments that would be necessary.

Everybody was helpful.

Yes very good. Very satisfied.

Yes. The Doctor was very good & informative.

Some pleasantry.

I am able to speak & listen to my consultant; He takes an interest in my medical condition.

I did find in eye clinic that water was only available in bottles in cafe you could find a nurse to ask but as they were busy I bought water to take medication.

The care and treatment seems excellent.

All the staff were friendly and competent.

They helped you straight away.

Yes my right eye was still blurred slightly but not necessary to have any operation till later on in life if it gets any worse.

I always find the ladies in phlebotomy to be friendly and helpful.

They always tried to cheer you up no matter how ill you were and I thanked them for that.

I was impressed with the professionalism of all staff from reception to medical.

This is for outpatients after having a new knee.

My doctor arranged a fast track appointment at your eye clinic. The services and treatment I received was first class as was my follow up appointment to check and be discharged.

Yes I got to know more about my eye condition.

As the x-ray machine wasn't working the appointment made was for a fortnight later - we couldn't do a week later as was suggested.

Everyone was so pleasant and kind thank you.

I have always been well looked after.

I could not fault anything and was treated with respect.

I was treated very well on my visit.

I have nothing bad to say about my treatment and am very grateful for the care I have received from the NHS with thanks.

I was impressed at this visit :

1. The clinic appeared to be well organised.

2. We were approached immediately on arrival in the clinic and welcomed by a staff member.

3. My husband and I were treated with courtesy and respect and my husband was included in all discussions with the consultants.

Very punctual when visiting the outpatients.

I always find the staff excellent and helpful. I have injections to my eyes and have to have a taxi home and they are always happy to help me.

Everything works well. Sometimes you have to queue, but seen as staff are free.

Staff are friendly and helpful.

I did not have to wait long. Staff were very observant and help every one.

All patients including myself were content to wait when offered to cancel appointment and rescheduled another day or wait as backlog 2-3 or more hours due to not enough doctors (or staff) on duty, with swine flu in news half expected can hit staff and patients.

Medical staff very efficient & pleasant & professional. I felt like a person not a number.

The departments that treated me was well organized the nursing staff were diligent and friendly during my treatment (colonoscopy) I was treated with respect and all the procedure was thoroughly explained to me before it commenced.

I received excellent attention at all times.

I had excellent treatment from all staff from Doctors through to the friendly Receptionist.

First appointments very good. Second good day unit (keyhole surgery) arrived 08:00 to theatre at 16:00. Totally disgusting.

Dealt with quite well clear explanation.

I had an emergency problem with my eye which was resolved.

The area was clean light and airy.

The nurses are always cheerful and helpful.

Average.

All staff helpful.

Everyone was friendly and supportive and eased my fears.

Staff very friendly.

Nurses always pleasant and so is (name removed).

Apart from one visit which involved a very long wait because outpatients was particularly busy, I received excellent care. I thought all of the Nursing staff were very caring and understanding of my visual impairment (HM only). I have every praise for the ophthalmology department from Mr *name removed* and his team to all of the Nursing staff. I couldn't have asked for better treatment. Thank you all very much.

Felt confident when meeting consultant.

I found doctors, nurses, reception, very professional and friendly.

Quick Services & proper directing.

They are always helpful and friendly and efficient.

Seems to run quite efficiently.

The staff that I meet in the Glaucoma department are always polite and friendly.

Yes, very friendly staff and quite efficient.

My treatment was excellent.

Doctors and nurses very considerate, receptionist helpful.

Nobody likes to visit hospital, but for me the staff have always been helpful and at times funny. This helps people to relax.

I visit the oncology department regularly the staff are very good and welcoming.

Doctors and staff are friendly.

Clean & friendly.

I have been attending the R/A department for some time and I have excellent treatment and caring friendly atmosphere.

The Receptionists were helpful in directing me the MRI scan department.

Eye clinic on one level.

I was treated very well and was very happy with the treatment I received.

The NHS is the best and people need to stop having a go at NHS.

NO.

Reception staff were friendly. I was also seen quickly by nurses, very efficient and helpful.

Appointment system seems better.

Waiting time. Friendly staff.

The nurses were all pleasant and friendly and, despite the long queues, were empathetic.

Dr *name removed* eye clinic is brilliant.

Staff were always polite and friendly.

Avery body very kind and I like that. Thank you.

Seen quickly and efficiently by Consultant.

I was treated with respect & informed about what would happen during my scans.

Overall the treatment I have received from City Hospital, Birmingham has been excellent - no complaints whatsoever.

Nice cafe.

I was made to feel at home: The staff was extremely pleasant. They are very nice staff.

Polite and very helpful staff.

Fantastic people. Skills of staff to make procedures not embarrassing.

Staff were very good and helpful.

The doctor saw that I was the only male in the breast clinic, saw my embarrassment and saw me quickly.

Do not understand why you have to wait so long to see a Doctor, I am a member of staff and would be nice to be seen on time especially when I am on duty at work anyway.

The staff are clearly very, very busy but work well as a team. I have regular check-ups at the hospital and am very pleased with the treatment given.

Extremely polite and helpful surgeon/staff. Great manner, positive, happy environment.

Yes it was all good. I was treated well by the doctors.

Dr (Name Removed) I thought was excellent dealing with my care. I would have no problem or worries if I had to have another operation under his care.

The nurse that looked after me from beginning to end was fantastic. All staff was very friendly.

Cleanness.

Generally it was friendly and my wait was not too arduous. The Doctor was extremely helpful.

Yes all the Nurses in the chemo treatment Rheumatology block. 100% treatment.

Having tests at same time as appointment to save a further visit.

Staff was friendly. I got true quickly.

I went (and regularly got to) Rowley Regis Hospital. The staff are always very friendly, helpful and efficient.

My consultant is excellent knows me and my medical history very well.

I was treated for cellulites and I'm afraid the name of the dept I visited now escapes me. Please, please could you pass on my genuine heart felt thanks to nurse (name removed) who was absolutely wonderful and made the whole process much easier.

The level of commitment from the staff.

Easy parking near to department.

Accessibility toilets.

Staff are very helpful.

The hospital was all clean and I was treated with great respect in the waiting room, considering the fact of my ethnic background.

I'm very happy with visits in the Outpatients Department. Thank you.

The doctor and nurse who examined me were friendly, kind and gentle!

Bad levels of privacy, only a curtain separates patients so can hear one another. Bad privacy, details of home address and other details written everywhere.

Helped clear up my condition and kept me informed. Alternative appointments were made if I needed them.

Helpful staff in physio, pain clinic, orthotics and the fracture clinic plaster room.

They all do their upmost to in sure you get better.

2. Was there anything that could have been improved?

The waiting time was unacceptable. Over two hours was quite unexpected and then the appointment was quite rushed when we finally went in to the Doctor. Maybe the times of appointments should be later to fit with the Doctors availability because the previous appointment was very similar in the amount of time we had to wait but not quite as long.

The waiting area was a little disorganised. Names were called out but from a distance so that I had to move my seat to be nearer, due to deafness.

Not really.

I wish they would stagger appointment times instead of having a large number all arriving at the same time. Not knowing when their time to go for their treatment. I myself have waited several hours after arriving early.

The problem I had was with the follow-on appointments for brain scan and ultra-sound. The 1st appointment to brain scan was given on a card on first visit (for following week) but when I arrived they said the scanner was out of order. Eventually I rang them again and they had never heard of me. Referred me back to stroke clinic. Same thing happened for ultra-sound. In all I made 5 phone calls, which meant it took from 16th February to 27th April before having final follow on ultra sound.

Mixed wards are not liked by many, many patients. I do not think one can feel relaxed under these conditions.

Yes too many people not using tissues more notice board please, or free tissues.

I do not think so.

A little more help at getting to where I had to go.

No.

Too many patients waiting in close proximity to each other - in particular during the present swine flue situation.

Sometimes you had to wait a while after your appointment time.

Not really no.

Not on time of my visit.

In my visit. No.

MORE BRITISH STAFF.

None that I am aware of.

I can think of nothing off hand.

More communication with patients.

Waiting time.

Not really.

The waiting time, sometimes appointment given later in the day and takes less than an hour to be seen, earlier appointments take longer and ensure what there are delays.

Maybe from others, but I was completely satisfied.

No.

Yes, they took away the toaster and I couldn't get any was looking forward to it because was at the hospital early because I have to go by Ambulance so I missed it. Please get it returned.

This was my third sixth-monthly appointment and for everyone I have had to wait well past my appointment time before seeing a Doctor. As I'm retired it doesn't particularly affect my day but I do think it is rather discourteous to not keep to the correct time.

Having water dispenser in waiting area for patients.

They should let you know if clinics are running late and how much after your scheduled appointment time you will actually be seen.

Waiting time.

I don't think so.

Big, big question.

I found toilets for the disabled were not checked enough times (unreadable word) people could not cope too much on the own.

Yes. My appointment was confused.

1. Sandwell Hospital transferred to Oldbury clinic.
2. Cancel at clinic.
3. Transferred back to Sandwell. All ok except Sandwell didn't know. Tried to send me back to clinic.

Keeping to the time of my appointment.

Water fountain.

No.

Because my session involved eye test, followed by eye drops, followed by a scan and then a consultation it feels disjointed and I am not always certain what will happen next or how long it may take. A little more explanation of the route would be useful.

No.

Nothing.

The waiting time in oncology.

When you go to the out-patient Dept it takes 3 Hours to see the Doctor. It should be improved.

Appointment waiting times could be improved.

Although I have need to make regular visits to the outpatients department. I have never yet been seen at the appointment time. Perhaps not sufficient time is allowed for an appointment although not applicable to the visit. I also have to see another consultant for a different consultation. You often wait for a period of months to see a stand in doctor who has less knowledge than your own GP.

More parking facilities.

No.

I use a walking aid when passing through doorways. It would have been helpful if staff had held doors open for me to pass through.

No.

Length of waiting time. Available translator when needed.

Paragraph unreadable.

There will always be room for some improvement but this will always be a challenge in hospitals such as this dealing with vast numbers of outpatients. This is only a realistic comment and not relating to anything specific, nor is it a criticism.

Don't like the new curtained rooms to read eye chart - noise confusing. Prefer as every other time door to consultant room be closed so jut my husband doctor and me. I feel the unit is outgrowing patients, is too small.

Dress code for younger members of Reception left nothing to the imagination (ok for recreation & social events).

Yes if late appointments no where to get hot drink or snacks as WVRS closed before clinic closes.

Admin i.e. appointments being made and follow up letters.

No.

No not really. Everything ran smoothly if you did not know where you were going there was always staff there ready to help.

My visit to clinic this time was distressing as there was only 1 doctor and the clinic was running over 1 hour late. Several people left not seeing a doctor.

No.

No.

Time to being seen and waiting to be treated.

Signs to the different Departments my be more visible

Less waiting time at the eye centre at Sandwell hospital. It's absolutely terrible. I think everybody has the same time appointment.

No.

The time I have to wait to be seen by a doctor.

The parking and cost of it, but that will always be a problem.

Not enough care. Kept waiting to be called to see staff nurse.

I had to wait for over 1 hour after seeing the doctor to have a scan/photograph. I had to find someone and ask why I had to wait; waiting was not the problem not knowing why I was waiting was.

No.

Toilets at Sandwell Hospital were not very clean.

Waiting for long periods between each stage involved with appointment i.e. nurse, to eye scan, and then waiting to see member of (name removed) team. Prefer doctor to be fully aware of details of condition and previous visits.

Maybe Victorian starched uniforms with matrons. E.g. Carry on nurse, or the Royal 1909.

N/A

Would like to be seen closer to time of appointment.

I think that the doctors should ask patients for their opinions of their condition because some people are reluctant to say anything, as I was until 2 years ago when I was not told to stop taking eye drops of a certain kind till I asked.

Waiting times sometimes a little long.

More signs when you go up the stairs to the outpatients to guide you to the correct bay.

You could do with a numbers or a tanoy system or on the wall system.

More comfortable chairs as there is sometimes a long wait. Newspaper stand, one major complaint is the number of times and shortness of notice of appointment changes. Nearly every appointment was changed a few days before.

Waiting area too dark for my eye condition.

Less waiting.

More nurses trained to give (unreadable word).

The whole area seems chaotic and I sure is not conducive the staff morale.

Not really.

Being told which reception desk to report to. I queued at 2 only to be told to go to another. Ideal if these were numbered and when reporting to the main reception they can tell you.

Not everyone was using the hand sterilising liquid when they came in or left various areas. Staff and members of the public ignored the bottles placed by various doorways. No one was making sure that this was done.

No.

More information would not have had my procedure if all information given.

More organisations.

No visit was under a 3 hour wait. Appointments are meaningless.

On a lighter note = lady serving toast & teas could give the odd smile :) lol

No.

Cleanliness/Decoration. Chairs/walls/floor/toilets need to be clean. Some staff could be friendlier/approachable.

The Doctors need to show more warmth, humour and empathy. Be less aloof.

The wait time between scan and seeing doctor was 1 hour 20 minutes in a corridor. Timescales were excessive; many were unhappy waiting with me.

Beverage facilities.

Waiting times reduced more staff.

Appropriate seating cheaper drink costs due to very long waits and affordability better updates on waiting time communication. Rough individual wait times.

Corridors are really busy at times, seating is not enough.

The registrar I saw seemed to be new to the job. She did not adequately know appropriate medications. After fingering through the index of BMF she found the one which was being advertised widely in my local GP surgery. How come she didn't know this? What confidence does it give you?

You know better every time. You know how to improve the (word unreadable).

No not at all.

Information about waiting times, more seats available.

Stop (word unreadable) Nurses.

Doctors were taking notes from front & back of pile - there should be one system that all doctors know about.

Yes to see staff more on time when having an appointment if they are on duty. The waiting time is far too long.

More could have been done regarding swine flu. There were no hand gel containers to disinfect your hands when entering/leaving the ward/department.

I do not agree with having to pay to park at the hospital I drive over 1 and a half for every outpatient appointment which then costs me about £5 to park. I thought that is why I pay so much national insurance.

The toilet was quite unclean so I think it should have been cleaner.

No.

Waiting time.

Waiting time on the day (and for bloods).

Quicker appointment times. Not to wait too long to see somebody.

Receptionists. I was told to cancel at the last minute, yet on the computer I was down as non attendance despite counselling 2 days earlier.

More access to hand wash.

Waiting times in pain clinic and rheumatology. Attitude of staff in fracture clinic.

The thing that could have been improved was my timing. I had to wait 2 wks before I could go back for my operation. It could have saved me from a lot of pain, during the 2 weeks

The waiting time should be quicker.

Waiting time, or even letting the patients know what was/is going on.

No.

No.

I would have liked to stick to seeing one doctor at all times as some doctors said I was diabetic and others said no.

No.

3. Any other comments?

A more modern electronic calling system would be an advantage.

Overall good.

I myself have been treated very well. Long standing ailments include: Vertigo, irritable bowel, arthritis in hands and lower back, spondylitis.

Needed escort assistance to assist walking. Mobility affected and always need walking frame. Transport provision necessary to attend outpatients.

My husband had a pace maker fitted in City Hospital and goes every 6 months to have it tested.

I was treated very well, but I am totally dependant on a relative taking me and bringing me home.

I have no complaints on this section.

All doctors and staff have been very good to me. After three heart attacks I have nothing but praise for their care, under stress they work.

My 1st visit, very impressed.

Being a diabetic, you are not offered drink or sandwich when you have been there for 1 hour or 2 so I take a few biscuits. Hope for the best.

I found it very difficult to get to the dept. I could have done with some help could not breath properly and chest very uncomfortable. Sorry if writing is bad (blind).

All in all no complaints. I'm sure they will get me well.

The comments on this form are with regard to the eye hospital city road, Birmingham.

My apologies for delay in returning this survey due to not feeling too well.

Pass my thanks to every one at Sandwell General.

I went for x-ray of my Right knee (after a fall). This was followed by a blood test. These were done on the same day.

Who ever the staff were in my particular department. I found them both courteous and friendly in their approach and duty. I have no complaints with regards Birmingham outpatients at City hospital.

I was well satisfied.

NHS very good except delays for appointments.

I was told to go back to hospital for another camera as the first one was not good enough; when I arrived there was no doctor until 40 minutes.

I was notified of an appointment date then two letters notifying me of new date. All received on same day in separate envelopes. Cost 75p.

I have been to outpatients since 2006 for the same condition and on every occasion been treated very well by the doctors and nursing staff for skins sessions with (name removed).

Every department and every test/scan etc was carried out efficiently and happily by all staff.

None.

Pleased to be dealt with efficiently and pleasantly and helpfully.

Please keep Arden House Cardiac Rehab open. Over the years it must have helped thousands of patients to improve their lifestyle and health. I cannot fault the nurses and staff, everyone is so kind and friendly and you know you're in safe hands when exercising. Thank you

Seating can be a problem when busy.

I think they are trying their best but number of patients is too many. Doctors don't have that much time to listen to Everyone properly. They are tired once I was inserted the (word unreadable) lens in my left eye. I am still going for that treatment every three months.

I would like to thank the staff, doctors and nurses for all the excellent treatment I have received, at Dudley Road Eye Centre Birmingham.

I have visited *name removed* and *name removed* hospitals and have been treated very well at each. The NHS has treated me very well over the years.

No.

A big improvement in the last few years, a lot cleaner and friendly and helpful staff!

Receptionist finally sorted it out. P.S. excuse spelling mistakes.

I have been very pleased with all of the treatment that I received particularly good treatment from oncology, endoscopy and the department that fitted my (unreadable word) line.

No.

Sorry for the delay it was mislaid. Yours sincerely (name removed).

The whole experience inspired confidence.

With mobility blue card I still had to pay sometime up to two hours not acceptable.

Keep up the good work.

I have been a patient at city hospital for a number of years and have always been treated with care and respect. Their cardiac rehabilitation centre is excellent.

Instead of making another appointment which you have been told you need, when you leave the hospital you are forwarded a postal appointment. This is often not practiced and you have to obtain a different time/date. Again you receive another posted appointment. Same problem. This was not previously the ease and they employ the same amount of staff. What a waste.

name removed hospital is my second home it is cleaner now than it has been for a long time. I've had 4 children, cancer op, vascular and I am a long term patient at skin hospital I wouldn't want to go to any other hospital.

I was seen at Ashfurlong Clinic Sutton Coldfield not City Hospital Birmingham.

Thank God we have them!

N/A.

Everything. Satisfactory.

It was fellow outpatients who got up and held door open for me.

Sandwell was the hospital I had my knee replacement. Everything was first class and the follow up appointments as well. I have to have my other knee replaced and have been told it will be at City Hospital. I am very disappointed.

Apologies - form delayed in returning, due to holidays.

Question 1 - Routine 6 monthly appointments, therefore question not really appropriate.

Unfortunate today's appointment was my most recent. They had provided both midland eye centre and city hospital are hospitals I feel privileged to be a patient at. Unlike other hospitals I use, the minute you walk through the door I have confidence I will be listened to, given time I need, they will be pro-active looking after me. Need to tell doctors I am (word unreadable) or could files have (word unreadable).

Overall I was very impressed with the NHS service I received.

The purpose of the visit was to discuss further treatment with my consultant.

I would happily recommend the hospital to anyone.

Just like to thank everyone who has cared for me. (*) nurses and doctors (*) outpatients and everyone who has cared for me over the years. God bless you all.

I felt this was very unfair on the doctor doing the clinic.

Since keyhole have been in more pain. Had appointment for injection and draining fluid on knee. After waiting in day unit for 4 hours walked out in disgust. Have still not had a reappointment after making complaint. Still waiting after 5 weeks.

I have not received any results of my tests.

The eye specialist (Name Removed) is not always there to see his patients - not good enough!! And this happens frequently!!

Make complaints about PCT with support from ICAS. Waiting to hear outcome.

Whenever I have visited a consultant at the outpatients dept, I have been very well treated. No complaints.

I forward to seeing you all again soon.

Files are not always updated and I have to explain to doctors what treatment I have been given two examples. I was supposed to have a CT scan but someone put wrong date and it got delayed. I am waiting to see a gastruentologist. The secretary forgot to send appointment I have been waiting 2 months so far.

Some nurses are too ignorant and don't want to know your problem. Ask any question and answer is don't know.

Overall on my several visits treatment was on time and very efficient.

NHS is still the best.

I think 99% of hospital staff are hardworking angels.

N/A.

Good service. Would be hard to improve it!

Car parking charges excessively high.

Thank you.

When tests are taken more information about the tests and went he results will be available would help. I find you always have to ask when the results will come through.

Is my prize a car or money?

Overall good, doctors very efficient. Sometimes used technical terms but would explain when asked.

(name removed) is an excellent consultant, caring with good people skills.

I have added Asthma to the long standing illness question (51) as I am an Asthma sufferer and am on inhalers for life. This also affects the treatment I can have for other conditions, e.g. tablets (anti inflammatory drugs).

Attitudes towards me varied greatly from one member of staff to another. Some were very polite and helpful, while others were very offhand.

Well done NHS.

The staff nurses could be more polite.

Did have 3 o'clock appointment with consultant, didn't get to see him until 4.30pm :(

Generally good.

Not enough staff to manage the amount of people waiting which leads to frustration and both staff and patients become cross and irritable.

Provide free additional disabled parking due to very many visits to hospital is very expensive. The process of reclaim is totally ridiculous.

A member of staff will say one thing and another will say something quite different.

On 2 occasions recently I have checked in with the receptionist (in 2 different departments) only for the receptionist to forget or fail to tell medical staff that I was present. On both occasions I waited for more than an hour before the problem was identified. On one occasion a nurse was picking her nose as I arrived. There have been several errors in sending on appointments. Again major administrative malfunction, when you have a history of cancer this is very unsettling.

Since being diagnosed with MS the care and treatment I have received from all staff at above hospital has been faultless - excellent hospital.

A counter system to inform patients where they are in the queue e.g. blood test ticket system.

I am still awaiting a follow up appointment for August as the doctor recommended.

I was very pleased with the whole staff at Sandwell Hospital. Thank you very much.

Generally my experience was quite good but there is a little room for improvement. As I'm a Doctor I understood the process and nature of my condition which helped.

Yes I'm concerned about the prescribing Nurse at the clinic. She was unaware of my condition as she told me and she did not listen to me. When I told her how ill I was she was acting like a Dr without the qualification or experience. Very dangerous. I feel 60% (word unreadable).

Staff should have priority when having an appointment if on duty. Don't get any other perks of the job. This should be one of them.

I didn't see one member of staff use any hand gel at all whilst in that department, I find this very disturbing as regards to health and hygiene.

Every time I go to the hospital I see a different person. Although I am under the care of (name removed) I have never been seen by her.

The staff work very hard given too often far too large workload. They do a great job.

Detached retina operation post-op final visit. Eye back to normal. Very impressed/happy with complete experience from very first to very last. Thank you all.

It was good.

The only problem was the consultant told me what meds to take but a locum gave me the right meds but different dose. I rang back and the receptionist said all was ok so I was happy with that.

The Nurses leave doors open and chat to each other so there is no privacy. So other patients can see and hear what's going on.

There should be more disabled parking near entrances.

Fairly v. good compared to other hospitals overall.

Carry on good work.

Name & address removed.

All staff were very pleasant and polite.

Taking into account my age, I have filled this form in to the best of my ability.

I would like to thank the doctors and staff for all their care and attention given to me whenever I attended the Outpatients Dept. Thank you.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	'Right Care, Right Here' Progress Report
SPONSORING DIRECTOR:	Richard Kirby, Chief Operating Officer
AUTHOR:	Angela Thomas, Deputy Redesign Director – RCRH
DATE OF MEETING:	29 April 2010

SUMMARY OF KEY POINTS:

The paper provides a progress report on the work of the *Right Care Right Here* Programme as at the end of March 2010 and includes a copy of the *Right Care Right Here* Programme Director's report to the Right Care Right Here Partnership.

It covers:

- Progress of the Programme including performance data for exemplar projects against targets for April – January 2010.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

1. NOTE the progress made with the Right Care Right Here Programme.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Care Closer to Home: Ensure full Trust participation in the delivery of Right Care, Right Here programme exemplars project
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**	The Right Care Right Here Programme sets out the future activity model for the local health economy including the transfer of activity into the community and to new PBC provider services.
Business and market share		
Clinical	**X**	The Right Care Right Here Programme sets the context for future clinical service models.
Workforce	**X**	The service redesign within the Right Care Right Here Programme will require development of the workforce to deliver redesigned services in a new way and in alternative locations. This will be overseen by the Workforce workstream within the Right Care Right Here programme.
Environmental		
Legal & Policy		
Equality and Diversity	**X**	The service redesign elements of the Right Care Right Here Programme will require equality impact assessments.
Patient Experience		
Communications & Media	**X**	Within the Right Care Right Here Programme there is a Communications and Engagement workstream.
Risks		

PREVIOUS CONSIDERATION:

Usual monthly update

SWBTB (4/10) 090 (a)

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

RIGHT CARE RIGHT HERE PROGRAMME: PROGRESS REPORT APRIL 2010

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 March 2010.

This report is in three sections:

a) Overview of the work of the Right Care Right Here Programme
b) Programme Director's report as presented to the Right Care Right Here Partnership and the Boards of Sandwell and HoB PCTs (appendix 1)
c) Service Redesign Performance Report for April – January 2010 (Appendix 2 – summary of the performance & Appendix 3 - separate spreadsheet with performance data)

OVERVIEW

This section provides an overview of the work of the Right Care Right Here Programme. This work is set out in more detail in the Programme Director's report in Appendix 1. 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:

Dashboard Reporting of Performance
This is being developed to be incorporated within the Programme Directors report to the Right Care Right Here Partnership Board to encompass the reporting of existing projects, the three new service redesign work-streams and the Care Pathway Reviews as these are established

.

Project Performance – appendix 3 presents the performance of the exemplar projects for the period April – January 2010 (first and second wave) whilst appendix 2 provides some more detailed explanation around the performance.

Only two projects are now rated at 'Amber', all others have moved to a 'Green' rating following considerable work being undertaken to validate data collection.

The following two projects are rated as 'Amber':

- *Musculoskeletal:* consultant led community orthopaedics and community pain management activity remain below target
- *Respiratory*: the commencement of the Sandwell Spirometry service has been delayed until at least May.

Service Redesign Activity :

The Strategic Model Of Care Steering (SMOCS) Groups – All 8 SMOC reports have been presented to Sandwell and HoBt PECs. Executive summaries are now available and all documents will be uploaded onto the web site in April. Further work is being undertaken on the Mental Health SMOC Strategy which is now due to be ready for approval in May 2010.

New Service Redesign Workstreams - Each work-stream has been asked to develop a paper setting out a view on the priority areas to be pursued and which is based on the SMOCs recommendations and is to be used in a workshop in April to agree priorities for service redesign.

SWBTB (4/10) 090 (a)

Care Pathways – A workshop is to be held in April to agree a forward schedule of care pathway reviews.

Overall Programme Plan:

The main developments since the previous report are:

- The forecast of availability of new locations has been revised.
- Determination of critical mass by zone based on V5.1 of the activity and capacity modelling compared to facilities is to be undertaken.
- A Key Event Schedule for each new facility and service relocation is being developed and will be used to map and synchronise other essential activities e.g. workforce planning, IM&T.
- The final draft of the Programme Objectives for 2010/11 has been completed and presented. The major emphasis is the move away from planning into delivery of service changes through redesign.
- A programme of engagement with primary and secondary care doctors has been completed during January and February 2010 with four main themes emerging:

    - effective clinical communications;
    - consistent evidence based pathways;
    - joint education and engagement opportunities;
    - Re-aligning incentives to support and enable clinicians to lead change.

RECOMMENDATIONS

The Trust Board is recommended to:

1. NOTE the progress made with the Right Care Right Here Programme.

Angela Thomas
Deputy Redesign Director – Right Care Right Here
22nd April 2010

APPENDIX 1

Sandwell and the Heart of Birmingham Health and Social Care Community

RIGHT CARE, RIGHT HERE PROGRAMME

Report to:	**Right Care, Right Here Partnership Board**
Report of:	**Les Williams, Programme Director**
Subject:	**Programme Director's Report**
Date:	**Monday, 29th March, 2010**

1. Summary and Recommendation

This paper summarises the main issues and developments in the Programme since the previous report.

The Partnership Board is recommended to:

- Consider the options for Dashboard Reporting of Performance (Section 2, Appendix 1)
- Agree the Programme Objectives for 2010/11 (Section 5 and Appendix 5)
- Note the content of the remainder of the report

2. Dashboard Reporting of Performance

As previously noted, there is a need to develop the reporting of performance for existing projects, the three new service redesign workstreams, and the Care Pathway Reviews as these are established.

The usual format for reporting the performance of projects by month and period to date is shown in the Programme Manager's Service Redesign Performance Report for consistency.

We have now used this data to look at a dashboard approach to reporting performance, which would allow access to reports through the Activeplan web interface, and give colleagues the ability to look in more detail at drill down options for reporting on specific elements of performance.

Appendix 1 shows how this may operate. This is a powerpoint presentation to show the range of options available. Given below is a brief description of each of the slides.

Slide No.	Label	Description of Content
1	Overall Performance by Project: Results Year to Date	Overall performance by project, with RAG status and percentage performance against target
2	Overall Performance by Project: Results by Month	Shows data for April – each month available to view from drop down menu in top left corner
3	Individual Project Performance: Musculoskeletal Performance by Sub Group: Results Drill Down	Displays performance in each element of a project, year to date and allows view of each month by using drop down menu in top left corner. Shows line graphs for individual element, in this case Community Orthopaedics
4	Individual Project Performance: Musculoskeletal Performance by Sub Group: Trends and Comparisons	Displays performance in each element for a single month, with alternative presentation for individual elements, this time shown as bar charts
5	Individual Project Performance: Urgent Care, HoB	Displays performance in each element for year to date, an alternative view to Slide 3 for a less complex project

Slide No.	Label	Description of Content

6	Individual Project Performance: Urgent Care, HoB: Month by Month Analysis	Displays performance in each element for year to date, demonstrating ability to highlight specific month
7	Personal: Example 1: Customisable Views	Shows range of options available to users of the web interface, to develop user defined views.
8 to 12	Personal Example 1	Further examples of customised views

I anticipate that the Partnership Board will continue to wish to receive the Activity Transfer Performance Report, for projects which are continuing or completed. It will be possible to add to this style of presentation to include progress on areas of work undertaken by the three service redesign workstreams and Care Pathway Reviews. These will be in addition to the development of the Overall Programme Plan.

I would welcome views from Partnership Board members on this style of presentation of activity transfer against targets.

I recommend that the Partnership Board receives the Activity Transfer Performance Report each month as shown in slides 1 and 2, with a slide for each project giving more detail, as in slide 3.

3. Overall Programme Plan

The development of the Overall Programme Plan continues.

An updated version of the control sheet has been prepared, as shown in Appendix 2. This revision includes latest amendments and revised forecast availability dates for new activity locations (facilities projects) where advised.

3.1 Capacity Definition

A provisional activity data set has been generated from Version 5.1 of the Activity and Capacity Model showing the composition of projected activity by specialty, aggregated within each Zone (HoB) and Town (Sandwell). It is intended, over the next few months, to use this in conjunction with capacity planning exercises to allocate activity levels to zones and towns and then to specific locations. This will require decisions to be made on the critical mass of activity to be undertaken in facilities and will enable a clear view on whether or not the existing and planned capacity is competent to deliver the expected activity levels.

3.2 Critical Path Analysis

A series of milestone events and (where known) associated delivery dates have been extracted from each project to create a Key Event Schedule, shown at Appendix 3. This illustrates the sequence and timing of key activities and events to bring new facilities and services into operation (readiness for service). The KES document will be used to map and synchronise other essential activities and events to the facility delivery timeline – e.g. workforce planning /allocation, IM&T provision to support the determination of the overall programme Critical Path. An extract from the Critical Path Summary is shown in Appendix 4. This will continue to be developed as more activities are added and will become an essential monitoring tool for the Programme Delivery Group, and, at a summary level, for the Partnership Board.

4. Medical Engagement Process

As members will be aware, a programme of engagement with doctors in primary and secondary care has been undertaken, using the Listening into Action methodology. This has generated a great deal of interest

and enthusiasm from medical colleagues, with 300 consultants and GPs (50% of the total employed) attending the six sessions in January and February 2010.

All the points raised and suggestions made have been captured, along with offers for further involvement from a broad cross section of colleagues.

Four clear themes and a series of suggested actions have emerged. These are as shown below:

- **Effective clinical communications.**

We need easy ways of talking to each other and getting advice or input about our patients, we need to be able to access the information we need without delay, and we need to optimise our IT systems - including Choose and Book - and make them work for us rather than against us

Suggested Actions:
'Phone a friend' (directory of mobile numbers, speciality advice lines for GPs, instantly accessible contact number in all GP practices); all clinicians on nhs.net; contact details for flagging clinical governance issues; email address on all letterheads; electronic GP letter for emergency appointments; awareness about pilot on portable communication devices in the community; Choose and Book clinically-led Action Group; directory of consultants on SWBH website; IT Group including clinicians to ensure access to all systems; getting the basics right for effective clinical communication

2. Consistent, evidence-based pathways
We need to have shared understanding of what 'quality care' means, we need to make the most of what we have to improve the patient experience and focus our limited resources in the most important places, we need to work together in a way which enables consistency

Suggested Actions:
'Pathway in a Month' (pioneering new way of working to crack through issues, get everyone on board and make changes): 1) Define the process, 2) first 3 pathways to pilot and refine process, 3) share the stories, the learning and the process to inspire wider spread - GP to emergency department pathway for patient who had an episode 'collapse' - shared insight about Map of Medicine - tackle Outpatients 'shambles'

3. Joint education and engagement opportunities
We need to have opportunities to meet, learn and work together across the usual boundaries, we need to know who is who and build relationships so we can deliver the best care together, we need to share our knowledge and expertise

Suggested Actions:
Joint social events for clinicians - align protected learning days (GPs) and clinical governance days (consultants) twice a year to enable cross-learning - Right Care Right Here annual 'Recognising Innovation' awards - clinician-led education sessions on Top 10 Pathways at lunchtimes - shadowing programme between primary and secondary care clinicians

4. Re-aligning incentives to support and enable
We need to enable rather than disable the system so we are all pulling in the same direction, we need to empower clinicians to lead change and share stories to help spread new ways of working

Suggested Actions:
Developing a new approach for next year's contracts which encourage effective joint working by removing the financial incentives to do more and more activity, ensuring clinicians have real control over resources through new approaches to service line management in acute and practice-based commissioning in PCTs, embracing and encouraging commissioning group initiatives and thinking beyond the limitations of PbR, maintaining and further developing the health economy-wide financial plan and pushing ahead with whole system workforce planning.

The Sponsor Group, made up of lead clinicians, Chief Executives and the Programme Director, has agreed that the monitoring of actions developed should be undertaken through Programme governance structures. The next stages to take this work forward are:

- Identification of sponsors to lead each of the four main themes (I have agreed to sponsor the 'Consistent, evidence-based pathways' theme)
- Assignment of clinical leaders to each proposed action, to work with the identified sponsor to produce a detailed action plan
- Implementation of actions, monitored through the Programme Delivery Group and Clinical Group.

5. Programme Objectives 2010/11

At the last meeting, it was agreed that I would represent the Programme Objectives for 2010/11 with measures included, with lead responsibilities and timescales attached. This has now been completed and the final draft is attached at Appendix 5. The major emphasis within these objectives is to move from planning into delivery of service changes through redesign during the coming year.

The Partnership Board is recommended to:

- Discuss, amend as required, and agree the Programme Objectives for 2010/11.

An analysis of performance against the 2009/10 objectives, which was seriously disrupted and delayed by the Review of the Programme, will be presented at the April Partnership Board meeting.

6. Recommendation

The Partnership Board is recommended to:

- Consider the options for Dashboard Reporting of Performance (Section 2, Appendix 1)
- Agree the Programme Objectives for 2010/11 (Section 5 and Appendix 5)
- Note the content of the remainder of the report

Les Williams
Programme Director

2010-03-18 – prog dir report – lnw

APPENDIX 2

Sandwell and the Heart of Birmingham Health and Social Care Community

RIGHT CARE, RIGHT HERE PROGRAMME

Report to:	**Right Care, Right Here Partnership Board**
Report of:	**Angela Poulton, Programme Manager**
Subject:	**Service Redesign Performance Report**
Date:	**Monday, 29th March 2010**

7. Summary and Recommendation

This paper summarises the main issues and developments in relation to Programme service redesign activities since the previous report.

The Partnership Board is recommended to:

- To approve the SMOC Executive Summaries
- Note the content of the report

8. Acute to Community Activity Transfer Report (previously Project Performance Report) April to January 2009/10

To note, the RAG status assigned indicates the extent to which services have transferred to community locations in accordance with 09/10 targets set. Where monthly monitoring data has not been provided, an amber or red status is assigned dependent upon the previous month's reported performance against year-to-date targets.

Significant data collection and validation work has been undertaken by the Programme Manager and interim Business Analyst with the Information leads and the range of other data providers identified. This was in response to concerns raised by the Board regarding the completeness of the information presented.

It is clear that the current approach to producing the activity performance report, involving data provided in a variety of formats by an assortment of data contributors (25 individuals) to differing timescales/levels of completeness and integrity, has significant scope to be streamlined to become more reliable and efficient. A full report of the findings of the exercise and recommended actions will be presented to the Programme Delivery Group. It is essential that key learning is reflected in the processes established to support future workstream performance reporting.

Given at Appendix 1 is the Acute to Community Activity Transfer report for April to January 2010. The results of the in-depth work undertaken have resulted in this month's report reflecting the most up-to-date and accurate information available.

In summary, it is pleasing to report that all project areas have been assigned a 'green' RAG status, with the exception of Musculoskeletal and Respiratory Medicine. Musculoskeletal has been assigned 'amber' status owing to consultant led community orthopaedics and community pain management activity being significantly below target for the year-to-date. Furthermore the IT lead for the Sandwell Community Orthopaedic Service is undertaking and audit to validate that data extracted from IPM reconciles with manual records. Whilst the nurse-led Respiratory service is significantly exceeding target, the commencement of the Sandwell Spirometry service by GPs is likely to be May 2010 at the earliest as the LES is not expected to be signed off until April.

9. SMOCS Update

All 8 SMOCS reports signed off by the Clinical Group have been presented to Sandwell and HoBt PECs. In addition, an Executive Summary for each SMOC has been produced and these are presented in Appendix 2 for approval. Arrangements are in place for the SMOC documents to be uploaded onto the website by the end of April, with options to print single documents or the full set.

As previously reported, in order to address commissioning concerns regarding the Mental Health SMOCS it was agreed that the document needed to:

- increase its focus upon the acute/mental health/primary care interface, setting out the respective patient pathway;
- identify the priorities for service redesign across this interface.

The recommendations have been submitted to the Programme from the commissioners and other members of the SMOCS group, and a final version will be produced by the end of March. The revised draft will then be taken to a workshop event involving GPs and clinicians prior to the final version being re-presented to the Clinical Group in May.

4. Care Pathway Reviews

A workshop session will be held on 7th April to agree the forward schedule of care pathway reviews in order to enable the Map of Medicine Manager to put in place the arrangements required to achieve the target of developing a new care pathway within a month. Members of the Clinical, Strategy and Strategic Workforce Groups have been invited to attend this session. Key information inputs to the workshop will be the priorities for service redesign identified by the SMOCS groups and the recommendations from the three service redesign workstreams. The criteria for prioritising care pathways have been agreed by the Clinical Group and shared with the Strategy and Programme Delivery Groups, and the areas for redesign will be scored against these at the session resulting in a prioritised list of care pathways to be undertaken.

The Map of Medicine Project Initiation Document (PID) is in the final stages of development, involving discussions with senior clinicians to ensure the balance is struck between due process to meet governance requirements and the pace of service redesign required. The document will be presented at the workshop session on 7th April for final sign off.

Submission of the draft PID to the SHA enabled the Map of Medicine Manager to complete the final stage of training to enable her to edit and localise pathways to the Map of Medicine.

The arrangements to enable the Cardiology pathway reviews (Acute Coronary Syndrome, Arrhythmia and Heart Failure) to commence are being finalised, with the members of the 3 Care Pathway Review groups awaiting final confirmation. The Map of Medicine is working to schedule the first review to take place early April.

IT support has been secured to ensure Map of Medicine icons will be set up on all clinicians desktops within SWBH, HoB PCT and Sandwell PCT within the next 2 weeks. In addition, the Map of Medicine HoB view will be set up by the end of next week, which will allow locality specific editing for both Sandwell PCT and HoB PCT areas.

The Map of Medicine Manager has continued to undertake awareness sessions, with 71 clinicians within the locality having received the Map of Medicine presentation (mainly within SWBH and HoB). The questionnaire designed to ascertain the level of awareness of the Map of Medicine and identify who currently has access and/or is using the tool in practice is being sent to key social care individuals within the local authorities.

5. Establishment of Workstreams – Progress Update

Each workstream has been asked to develop a paper setting out a view on the priority areas to be pursued through the workstream based upon SMOCS recommendations. These workstream proposals will provide key information for consideration during the workshop session scheduled for 7th April at which the priorities for service redesign to be undertaken by the workstreams will be agreed. There is evidence that key workstream members have significant workloads impacting upon the time they can commit to the redesign work.

5.1 Demand Management - Referrals/Outpatients

The core workstream group has developed the scope of the redesign work that will reduce demand for secondary care, align to best practice and making the referral system work more efficiently. Work is now underway to collect relevant data to identify areas that can be targeted to enable processes to work more efficiently across the local health economy to inform the priorities for service redesign.

5.2 Demand Management - Urgent and Emergency Care

The workstream has reaffirmed the need to have a mental health project, and work is progressing to identify measureable targets. The terms of reference for the Urgent Care Centres project team have been agreed, and the vision for this area of work established. The Project Manager is working to produce a full set of priority areas for action, with related objectives and metrics for measurement.

5.3 Intermediate Care

The Project Manager has confirmed that there is an agreed long-term model of care for Intermediate Care (attached in Appendix 3), and whilst work is progressing to identify short term areas for redesign that will contribute to achieving the longer term model the focus of work has been to respond to the need to determine the service to be provided at Rowley Hospital following the closure of Eliza Tinsley beds. The core group is currently in the process of identifying priorities for service redesign. A wider stakeholder meeting will then be convened to take the workstream forward

6. Recommendation

The Programme Delivery Group is recommended to:

- To approve the SMOC Executive Summaries
- Note the content of the report

Angela Poulton
Programme Manager

RIGHT CARE, RIGHT HERE PROGRAMME
Acute to Community Activity Transfer Report
Report April-January 09/10

Key: **CL OPs** Consultant Led Outpatients **NCL Ops** Non Consultant Led Outpatients

PROJECT	MONTH (2009/10) April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	% Over/ Under YTD	2009/10 Yearend Target	Status	PROJECT LEAD (former)	Comments
URGENT CARE - SANDWELL																		
Target (Attendances)	976	976	976	976	976	976	976	975	976	975	0	0	9,758		11,710		Gill Gadd	Activity exceeding target - December figure lower than previously reported due to data validation
Actual	865	927	1,008	865	905	1,143	1,392	1,243	884	989	0	0	10,221				SWBH	by SWBH.
Variance													**463**	**5**				Whilst Parsonage Street data is available it is not broken down to the level needed to report the number of A&E diversions (SPCT pursuing the data).
URGENT CARE - HoB																		
Targets (Attendances):																		Activity below target for UCC - City but primacy are activity significantly exceeding target.
City	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	0	0	25,000		30,000		Mark Curran	Summerfield Health Centre commenced 1st March and arrangements are in place for performance
Actual	2,424	2,433	2,113	3,176	2,233	2,014	2,157	1,993	1,964	1,604	0	0	22,111				HOB PCT	information to be submitted to the Programme. SWBH have retained GP presence in A&E until the
Variance													**-2,889**	**-12**				the end of May.
Primary Care (Percy Road/Greet HC)	1,083	1,083	1,083	1,083	1,083	1,083	1,083	1,083	1,083	1,083	0	0	10,833		13,000			Primary care activity reported relates to urgent care activity undertaken by the Darzi Practice
Actual	89	531	1,156	1,747	1,461	1,645	2,565	2,393	2,789	2,324	0	0	16,700					at Greet HC (first time of reporting).
Variance													**5,867**	**54**				
REHAB BEDS - SHELDON																		
Targets:																		
Community - D43 (OBDs)	647	647	646	646	647	647	647	646	647	647	0	0	6,467		7,760		Angela Young	Activity exceeding targets.
Actual	638	783	631	643	643	584	693	716	630	663	0	0	6,624				HOB PCT	
Variance													**157**	**2**				Previous reports included a line for D47 activity - it has been confirmed by Angela Young that D47
Care Centres (OBDs)	571	571	571	570	571	571	571	570	571	571	0	0	5,708		6,850			is no being used for Sub-Acute activity and should not be reported by the Programme.
Actual	595	657	592	662	606	625	652	650	607	661	0	0	**6,307**					
Variance													**599**	**10**				
Comm. Alternatives Rehabilitation (Patient Package)	292	292	292	291	291	292	292	291	292	292	0	0	2,917		3,500			
Actual	836	977	1,045	1,132	943	974	935	1,110	918	783	0	0	9,653					
Variance													**6,736**	**231**				
REHAB BEDS - ROWLEY																		
Targets:																		
Community Step Up - ET Ward (OBDs)	317	317	317	316	316	317	317	316	317	317	0	0	3,167		3,800		Chris Gibbs	Step-up activity continues to be below target YTD. However, based upon Nov to Jan (964 OBDs
Actual	48	231	246	285	300	266	279	312	310	342	0	0	2,619				(interim)	against a target of 950 for the 3 months) projected across a full year the target would have been
Variance													**-548**	**-17**			SPCT	achieved if not slightly exceeded. It should be noted that Eliza Tinsley beds closed temporarily
Community Step Down - Mc Ward (OBDs)	642	642	642	641	641	642	642	641	642	642	0	0	6,417		7,700			during March.
Actual	1,526	1,663	1,611	1,627	1,588	1,611	1,654	1,598	1,674	1,596	0	0	16,148					
Variance													**9,731**	**152**				Step-down activity continues to exceed target.
STAR (Av Admits)	83	83	84	83	83	84	83	83	84	84	0	0	834		1,000			
Actual	60	77	75	91	62	86	88	116	116	135	0	0	906					STAR activity exceeding target.
Variance													**72**	**9**				
MUSCULOSKELETAL (includes Orthopaedic beds & outpatients, Rheumatology outpatients & Pain Management																		
Targets:																		
HoB Orthopaedics Triage (NCL OPs)	545	545	545	545	543	543	546	545	544	545	0	0	5,446		6,535		Paul Hazle	Whilst some activity exceeds target others fall short of target and there is outstanding data
Actual	641	556	902	884	739	918	1,019	1,222	1,042	970	0	0	8,893				SWBH	validation work to be completed.
Variance													**3,447**	**63**				
Sandwell COS Triage (NCL OPs)	574	574	574	574	573	574	573	574	574	574	0	0	5,738		6,885			An audit is being undertaken by Vicky Sheldon, IT lead for COS service, to validate the data
Actual	580	521	617	661	506	642	687	584	489	488	0	0	5,775					extracted via Bluefish from the IPM system. The results of the audit to be made available to the
Variance													**37**	**1**				Programme.
Community Rheumatology (CL OPs)	381	381	381	381	378	380	380	380	380	381	0	0	3,803		4,564			
Actual	426	410	453	496	404	468	512	458	486	451	0	0	4,564					
Variance													**761**	**20**				
Primary Care Rheumatology (CL OPs)	0	0	0	16	16	16	16	16	16	16	0	0	109		140			Data reported relates to HoBtPCT GPwSI service provided by Dr Epson at Laurie Pike Health Centre
Actual	0	0	0	43	35	53	56	72	60	63	0	0	382					(First time of reporting). Current status regarding SPCT GP led service (Drug Monitoring LES) to be
Variance													**273**	**251**				confirmed by Jason Evans.
Community Orthopaedics (CL OPs)	74	74	74	74	74	75	74	74	74	74	0	0	741		889			
Actual	106	18	43	47	72	56	29	34	19	15	0	0	439					Community Consultant Led Orthopaedics April - May activity levels higher than previously reported,
Variance													**-302**	**-41**				owing to data validation process.
Community Pain Management (CL OPs)	59	59	59	59	59	56	59	58	59	58	0	0	585		702			
Actual	11	13	15	20	27	35	26	23	42	45	0	0	257					The activity reported relates to Pain Management provided by Sandwell COS. SWBH CL activity
Variance													**-328**	**-56**				at the Lyng is expected to commence during March.

RIGHT CARE, RIGHT HERE PROGRAMME
Acute to Community Activity Transfer Report
Report April-January 09/10

PROJECT	MONTH (2009/10) April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	% Over/ Under YTD	2009/10 Yearend Target		PROJECT LEAD	
OPHTHALMOLOGY																		
Target (CL OPs)	1,273	1,273	1,273	1,272	1,273	1,273	1,273	1,273	1,272	1,273	0	0	12,728		15,274		Vacant	Activity exceeding target. 100% of activity is reported for Lyng, Rowley Regis and Regis Medical
Actual	1,730	1,498	1,797	1,946	1,662	1,814	1,866	1,911	1,602	1,686	0	0	17,512				SPCT	Centre activity and 80% of Sandwell activity.
Variance													**4,784**	**38**				
DERMATOLOGY																		
Targets:																		
Community (CL OPs)	267	267	267	265	266	267	266	267	267	266	0	0	2,665		3,198		Vacant	Activity exceeding targets overall.
Actual	219	250	246	268	138	221	205	137	159	133	0	0	1,976				HOB PCT	
Variance													**-689**	**-26**				
Community - GPwSI (OPs)	134	134	134	132	134	133	134	133	134	133	0	0	1,335		1,602			
Actual	178	187	260	275	188	288	290	258	280	202	0	0	2,406					
Variance													**1,072**	**80**				
RESPIRATORY																		
Targets:																		
Community - Nurse-led (OPs)	80	80	90	100	100	80	80	70	60	90	0	0	830		1,034		Vacant	Community Nurse-led activity significantly exceeding target but Spirometry service delayed until
Actual	276	281	258	248	208	163	193	194	146	153	0	0	2,120				SPCT	2010/11.
Variance													**1,290**	**155**				
Primary Care - GP/Nurse/GPwSI (OPs)	0	0	0	0	0	0	0	0	0	0	0	0	0		432			It has been confirmed that the Primary Care activity relates to the proposed Spirometry service
Actual	0	0	0	0	0	0	0	0	0	0	0	0	0					that had been anticipated to commence during Jan/Feb. The Spirometry LES is now expected to
Variance													**0**	**n/a**				be signed off by the end of Apr with the service commencing as soon as possible after that date.
ENT																		
Target (CL Outpatients)	822	822	822	821	821	822	822	821	822	822	0	0	8,217		9,860		Jane Clark	Activity exceeding target.
Actual	852	883	978	991	739	900	999	740	840	645	0	0	8,567				SWBH	
Variance													**350**	**4**				
CARDIOLOGY																		
Targets:																		
Community (CL OPs)	65	65	65	65	65	66	65	66	65	65	0	0	652		782			Activity exceeding targets overall.
Actual	61	61	54	79	37	80	66	61	43	68	0	0	610				Vacant	
Variance													**-42**	**-6**			SPCT	Community Consultant led activity includes activity undertaken at Rowley Regis Hospital, Aston
Community (NCL OPs)	156	156	155	156	155	155	156	156	155	156	0	0	1,556		1,867			and Neptune.
SPCT Heart Failure Team	254	246	365	600	325	364	305	369	313	344	0	0						
SPCT Cardiac Rehab Team	321	261	154	70	54	12	10	14	10	9	0	0						Community nurse led activity has been validated by Information leads at HoBt and Sandwell PCTs.
HoB Heart Failure Nurse Clinics	33	31	37	24	23	15	27	16	33	23	0	0						
Actual	608	538	556	694	402	391	342	399	356	376	0	0	4,662					
Variance													**3,106**	**200**				
GYNAECOLOGY																		
Target (CL OPs)	88	88	88	88	87	87	88	88	88	88	0	0	878		1,053		Therese	Activity exceeding targets.
Actual	141	151	140	171	104	125	126	104	109	76	0	0	1,247				McMahon	
Variance													**369**	**42**			HOB PCT	Data sourced from SWBH & HoBt PCT Information leads - includes activity undertaken at Aston,
																		Lyng, Rowley Hospital, Neptune & Oldbury (latter location ceased owing to Swine Flu)
DIABETES																		
Targets:																		
Community (CL OPs)	486	487	486	486	487	486	486	486	486	487	0	0	4,863		5,835		Olivia Amartey	Activity has exceeded targets overall.
Actual	281	286	342	322	270	351	271	360	261	306	0	0	3,050				HOB PCT	
Variance													**-1,813**	**-37**				HoBt PCT and SWBH Information leads have confirmed that data previously reported against
Primary Care (NCL OPs)	30	31	30	30	30	30	30	30	30	30	0	0	301		361			consultant led community included primary care non Consultant led data.
Actual	102	183	306	287	134	181	227	242	178	119	0	0	1,959					
Variance													**1,658**	**551**				

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	RCRH Acute Hospital Development: Project Director's Report
SPONSORING DIRECTOR:	New Hospital Project Director
AUTHOR:	Andrea Bigmore, New Hospital Project Manager Graham Seager, Director of Estates and New Hospital Project
DATE OF MEETING:	29 April 2010

SUMMARY OF KEY POINTS:

The Project Director's report includes reference to the following for discussion:

- Progress with the Compulsory Purchase Order
- Regeneration programme and involvement in 'Growing Green'
- Development of an IM&T Vision for the Acute Hospital
- Project review prior to update of the Outline Business Case

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	21st Century Facilities
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	**X**	
Workforce	**X**	
Environmental	**X**	
Legal & Policy	**X**	
Equality and Diversity	**X**	
Patient Experience	**X**	
Communications & Media	**X**	
Risks		Risks identified in project risk register and where appropriate included in Trust risk register

PREVIOUS CONSIDERATION:

Usual monthly update

Sandwell and West Birmingham Hospitals NHS
NHS Trust

right care right here

Report to:	**Trust Board**
Report of:	**Graham Seager / Andrea Bigmore**
Subject:	**Project Update**
Date:	**April 2010**

1. Compulsory Purchase Order (CPO)

The CPO inquiry has now been organised with dates scheduled from 15th to 24th June. This event will involve members of the team presenting evidence at the Inquiry where the inspector will consider the CPO required by the Trust. The full details (location, times etc) of the inquiry will be posted in accordance with procedure.

2. Growing Green

Following a regeneration event held in January the team has been working with local partners to develop plans that will support local regeneration.

One of the outcomes of this has been for the Trust to initiate partnership working with an organisation called *'Find it in Sandwell'.* This organisation supports the development of local businesses in Sandwell and several joint activities are currently being planned to ensure that the Acute Hospital Project will provide opportunities for employment during construction and beyond.

The team was invited to attend *'Growing Green',* an event showcasing some of the biggest Midlands organisations currently operating in the 'green' market. Expert speakers on sustainable development presented to this well attended event in March.

Both local businesses and large development consortia were invited to the event to provide networking opportunities and to show the huge scope for local businesses doing business with the larger organisations. Businesses were able to hear first-hand about the materials, components and fabrications they could provide in the future.

The team presented a stand at this event to raise awareness about the Acute Hospital Project. This gave local businesses the opportunity to find out more about us and to register an interest in providing goods and services for the new hospital in the future.

The event was really successful, providing sources of information on sustainable development and new local business contacts to involve in future regeneration events.

3. IM&T Vision

The IM&T Workstream has been working on a Vision to support the Acute Hospital Development. This vision defines, at high level, how our future information and communications technology will be developed in the future.

It is important that a robust vision and specification is developed prior to initiation of the Procurement Phase of the project to ensure that the Private Finance Initiative (PFI) bidders are able to respond with proposals that can stand the test of time and to avoid the requirement for expensive upgrades to infrastructure early in the life of the hospital.

To inform this work the team has:

- Used the lessons learned from other PFI projects
- Invited Dr Mark Farrar, National Director of Infrastructure, to speak to us about national plans for the future of IT technology and infrastructure
- Asked IT providers to advise on developing technology they are aware of
- Undertaken as much future scanning as possible.
- Arranged for key members of the team to go to Oslo to look at a digital hospital to understand how technology can support the quality, safety and efficiency of care

The next steps will be to:

- Develop a technical specification for the IT and communications infrastructure that will be built into the fabric of the new hospital building. This specification will ensure that sufficient capacity and connectivity will be provided in the building to facilitate the high tech care of the future.
- Develop an Information Management and Communications strategy to help the Trust plan future development in time for opening of the new hospital in 2016.
- Work with local health economy colleagues to develop a strategy that will enable delivery of the Right Care, Right Here (RCRH) models of care.

4. Outline Business Case (OBC)

The Project Team has undertaken a project review in response to current economic conditions and changes to the RCRH Programme activity model.

The outcome is that there will be some change to the scope of the Acute Hospital Development. However, all changes will:

- Maintain the integrity of the of the RCRH model of care
- Ensure best quality of care
- Provide best value for money and support approval of the business case

This work will inform the detailed work required to update the OBC prior to approval by the Treasury, which will allow us to initiate the procurement process. Details of the changes will be presented to the Board as they develop.

It has recently been announced that the Royal Liverpool and Broadgreen University Hospitals NHS Trust has received approval for their OBC allowing them to proceed with the PFI procurement route. This is encouraging news in current economic conditions. The team will ensure that lessons learned will inform our approval process.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Workforce Strategy – Update (April 2010)
SPONSORING DIRECTOR:	Rachel Overfield – Chief Nurse (Executive Lead for Workforce)
AUTHOR:	Lesley Barnett/Gayna Deakin, Deputy Directors of Workforce
DATE OF MEETING:	29 April 2010

SUMMARY OF KEY POINTS:

This paper sets out the main objectives of the Workforce Strategy, as set out below:

- To recruit, retain, and deploy the workforce needed to deliver the Trust's vision;
- To identify, nurture, and develop leaders and managers whose practice will support the Trust's vision and values;
- To engage with staff in ways that will directly improve patient care and staff satisfaction;
- To develop, implement, and maintain first class employment practices.

Appendix 1 sets out full progress against each of the actions to be delivered the main highlights are as follows:

- Development and review of HR and employment policies and practices to ensure compliance with NHSLA Risk Management Standards and CQC Staffing standards and requirements;
- Completion of the review of the Trust's Leadership and Development activity and resulting action plan;
- Revision of Trust's Mandatory Training Policy and requirements and increased access to training modules, including e-learning;
- Continued good progress in raising awareness about LiA and spreading and embedding this approach into daily practices;
- Significant progress towards integrating workforce planning systems and processes with financial and service planning;
- Production of workforce plans to support the Trust's Outline Business Plan and Integrated Business Plan;
- Revised approach to sickness absence management with an increased emphasis on rehabilitation arrangements;
- Leading the Establishment Review process (QuEP).

The paper concludes by confirming that significant progress has been made in implementing the Trusts strategy which will now be reviewed and updated to reflect the trust's priorities for 2010/11.

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

To **receive** and **note** the progress made to date on the implementation of the Trust's Workforce Strategy

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:N/A

Strategic objectives	The Workforce Strategy aligns with and supports the Trust's strategic objectives.
Annual priorities	
NHS LA standards	Workforce and Employment
Core Standards	Staffing requirements
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Annual update to the Trust Board.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Workforce Strategy Update

April 2010

1. Introduction

The purpose of this paper is to highlight progress made in implementing the Trust's Workforce Strategy. Arrangements for reviewing the strategy and developing priorities for the work programme for 2010/11 are also set out below.

2. Background

The Trust's Workforce Strategy 2008-2015 was approved by the Trust Board in January 2007 and updated in November 2007. In April 2008 the strategy was reviewed to ensure that it was fit for purpose for the Integrated Business Plan for the Trust's Foundation Trust application. This was undertaken with the engagement of staff, trade unions, service managers, and a key external stakeholders.

3. Workforce Strategic Vision and Objectives

The following extract from the workforce strategy (the full document is available on the HR pages of the Trust's intranet) sets out the Trust's vision for its workforce and the key objectives of the strategy:

> *"Maintaining a highly performing and engaged workforce is the key to future success and progressive HT and employment practices, with a strong emphasis on organisational development are essential to delivering the Trust's strategic objectives, and wider NHS reform.*
>
> *This Strategy is designed to support the delivery of our challenging workforce agenda, and to compliment and work in conjunction with the key national HR themes: the four pillars set out in HR in the NHS (2002), and the NHS West Midlands strategic direction Investing for Health, Workforce Transformation (Project 9).*

The specific actions detailed within the strategy will ensure that the Trust will be able to:

- Recruit, retain, and deploy the workforce needed to deliver the Trust's vision;
- Identify, nurture, and develop leaders and managers whose practice will support the Trust's vision and values;
- Engage with staff in ways that will directly improve patient care and staff satisfaction;
- Develop, implement, and maintain first class employment practices.

The table below shows how the Trust's Workforce Strategy aligns with and supports the Trust's strategic objectives:

Strategic Objectives	Workforce Strategy and HR Objectives
Accessible and Responsive Care	To support the reorganisation of service delivery by producing workforce plans that will ensure that we have optimum numbers of staff available at the right times and in the right place to care for patients. To develop agreements with staff and trade unions that will facilitate effective organisational change designed to support the introduction of new models of care.
High Quality Care	To ensure that all staff are fully competent to undertake their role. To facilitate approaches and education programmes that will encourage all staff to behave in ways that promote respect and dignity for patients and colleagues.
Care Closer to Home	To ensure that all employment terms and conditions provide for maximum flexibility including joint working with other health and social care partners.
Good Use of Resources	To ensure that all staff are able to positively influence how care is delivered and improve outcomes to patients by promoting the LiA approach for leadership and engagement.
21st Century Facilities	To ensure that the design and development of facilities takes account of work flows that will allow staff to work with maximum efficiency.
An Effective NHS FT/Organisation	To develop effective leaders and adopt best employment practices designed to ensure that staff understand the important role that they have to play in ensuring the best patient experience possible and to contribute to the Trust's success.

4. Summary of Progress

Progress against the key actions within the Workforce Strategy is set out in full in Appendix 1. Listed below are the priority areas that received particular focus in 2009:

- Development and review of HR and employment policies and practices to ensure compliance with NHSLA Risk Management Standards and CQC Staffing standards and requirements;

- Completion of the review of the Trust's Leadership and Development activity and resulting action plan;

- Revision of Trust's Mandatory Training Policy and requirements and increased access to training modules, including e-learning;

- Good progress has continued to be made in raising awareness about LiA and spreading and embedding and this approach is starting to feature more prominently into daily practices;

- Significant progress towards integrating workforce planning systems and processes with financial and service planning;

- Production of workforce plans to support the Trust's Outline Business Plan and Integrated Business Plan;

- Revised approach to sickness absence management with an increased emphasis on rehabilitation arrangements;

- Leading the Establishment Review process (QuEP).

Areas where further action is required will be included in the 2010/11 work plan.

5. Next Steps

The review of the Workforce Strategy will be undertaken using the LiA approach and will build upon and add to the following areas:

- NHSLA Risk Management Standards (HR & workforce)
- CQC staffing requirements and risk profile
- Response to NHS Staff Survey 2009
- Development of Health and Well-being strategy (Boorman)
- Review of HR processes and policies to ensure compatibility with Trust's approach to staff engagement (LiA) and leadership development
- Further development of the Workforce Model for the new acute hospital
- Refresh of the Workforce Chapter for the OBC refresh
- Further embedding and connecting workforce planning activity
- Support delivery of the workforce elements of the Trust's Quality and Efficiency Programme (QueP) with a particular emphasis on service & workforce redesign

6. Conclusion

This update concludes that although in general considerable and valuable progress has been made the strategy now needs reviewing and updating to reflect the recent changes in the environment in which we operate and the possible future changes to how we deliver our services.

7. Recommendations

That the Trust Board is asked to **receive** and **note** the progress made to date on the implementation of the Trust's Workforce Strategy.

Workforce Strategy Update – April 2010

	Not Started		On Hold		Significantly delayed		Behind Schedule		On Target		Completed

Number	Action	Progress	RAG Rating
4. Employee Relations			
4.4.1	To undertake a review of the current Recognition Agreement in full consultation with all the signatories.	The review of the Trade Union Recognition Agreement will be undertaken in the 2010/11 work plan.	
4.4.2	To continue to jointly develop HR and employment policies and procedures	A process of joint policy development working closely with the staff side is in place and this way of joint working is embedded and is working effectively. Over the past 12 months 27 of the Trust's HR and employment policies were reviewed/revised to take account of legislative, policy changes and best practice and as part of the Trust's approach to ensure compliance with NHSLA Risk Management Standards	
5. Staff Engagement			
5.4.1	To engage and involve staff in the Trust's service developments i.e. Towards 2010.	The Trust embarked upon an intense programme of staff engagement in 2008 and to date approximately half of all of our staff have been involved in one of the corporate and/or local staff engagement events relating to service development and service improvements (led by LiA facilitator).	
5.4.2	To encourage staff to seize the opportunities provide by achieving Foundation Trust Status i.e. staff members.	Consultation on the benefits and progress with developing the Trust's application for Foundation Trust status took place on a regular basis with the JCNC. Staff have been encouraged to become members and benefits have been promoted and explained via Staff Communications, Hot Topics and 'Heartbeat' (led by Communications team).	
5.4.3	To ensure that we understand what was said during the initial organisation wide 'Listening into Action' conversations and that we have an appropriate plan of action based on what we heard. This will include adjustments to local procedures, specific priority projects in discrete areas which demonstrate delivery of better outcomes through more engaging ways of working and escalation of particular issues to national level where appropriate.	The outputs from the first corporate staff conversations were synthesised and a series of enabling projects (corporate) and divisional projects (divisional teams) were mobilised. A number of quick wins were identified and actioned (led by LiA facilitator)	
5.4.4	To support identified priority projects in adopting new, engaging ways of working, profiling these across the organisation to	There is a programme of corporate enabling projects taking place in addition to local teams using the Trust's approach to staff engagement. Led by Trust's LiA Facilitator.	

	create a “pull” and the basis for wider spread.	There is an agreed action plan for spreading and embedding LiA that is monitored at the Executive LiA Sponsor Group.	
5.4.5	To commission a research project designed to evaluate the long term effect on organisational performance of “Listening into Action”.	The University of Birmingham will be undertaking a research project to evaluate the organisational impact of LIA. This work is scheduled to be completed by 30th June 2010.	
5.4.6	To develop a cadre of in house experts/ champions who are embedded within the divisions and directorates to support the adoption of the “Listening into Action” methodology as a new way of leading/managing.	A network of LiA leads and champions is being set up with members being identified. A forum is being established for a an email network and action learning sets and this will be established by June 2010 as set out in the Action Plan for embedding LiA and is being led by the LiA Facilitator.	
5.4.7	To use appropriate measures to evidence the impact of “Listening into Action” on service delivery.	A set of measures have been identified to assess the impact of LiA i.e., national patient and staff surveys, sickness absence data and this will form part of the evaluation referred to 5.4.5	
Workforce Governance And Risk Management			
6.4.1	To ensure that all managers are prepared and competent to operate in an environment wherin staff are fully engaged by appropriate management development activities.	This is continuing to be addressed using the Knowledge and Skills Framework and PDR, and the LiA approach to engaging staff has been threaded through the Trust’s ongoing leadership and management development programme. The Managing for Managers programme continues to be delivered, however, the waiting list also continues to grow. A small number of staff attended the leadership programme delivered by the Trust to learners from across the Locality. Some staff are attending the ‘Leadership for Healthcare Practitioners’ course via commissioned places at Wolverhampton University. Internal programmes reflect the LiA staff engagement approach within taught content. A review of Leadership for the Future has recently been completed by the LiA Facilitator, and the recommendations were accepted by the Trust Board in March 2010.	
6.4.2	To ensure that all managers understand the importance of complying with the Employment Charter and Code of Conduct.	A review has taken place and the standards are now included in the Trust’s induction and employment processes e.g. contract of employment, corporate induction booklet, and internal training and development programmes.	
6.4.3	To ensure that all employment policies and procedures are developed in partnership with the Trade Unions and updated when necessary	Employment policies are developed with the staff side at the Policies and Procedures Advisory Committee (sub-group of the JCNC). There is a system and schedule for all policy revisions and new additions.	
6.4.4	To ensure that the requirements of the EWTD are met within the statutory timescale.	An October 2009 internal audit report confirmed an overall significant level of compliance with the operation of internal controls. A small number of actions were agreed and monitored via the Trust’s Audit Committee.	

6.4.5	To put in place all necessary controls on remuneration and the aplication of terms and conditions to mitigate the risks of equal pay challenges.	Systems and controls to ensure that all posts are appropriately evaluated are in place. Commencement salaries are dealt with strictly in accordance with AfC terms and conditions and rules for application. Any deviation must be approved by the Director of Workforce. An Equal Pay Audit was completed in March 2010. This was reported to and received by the Trust's Equality and Diversity Steering Group. No significant concerns were identified.	
6.4.6	To develop appropriate information and reporting mechanisms that allow for performance to be monitored and risks identified.	A comprehensive HR dashboard was introduced in September 2009 containing key HR performance and activity data. This is monitored at the Workforce DMT and is reported and monitored on a quarterly basis at the Trust Management Board, Trust Board, and PCT Clinical Quality Meetings. Work is currently being undertaken to feed key workforce metrics into the Trust's Quality Management Framework. There is a system in place for the identification of corporate workforce risks. This is compiled by the Workforce Directorate Management Team and where appropriate feeds into the Trust's corporate risk register.	
Workforce Planning Capability and Capacity			
7.4.1	To ensure that strucures, processes, and plans are in place to address and facilitate the workforce planning and employee development elements of the Acute Hospital Services Project i.e. intergrated workforce planning processes, transitional planning, organisation development, and change management.	Trust Workforce Planning Steering Group established and Terms of Reference agreed. Trust-wide workforce planning process has been introduced and workforce plans developed at divisional level, this will be further embedded over the next 12 months. Workforce plans that link to service and financial plans have been developed to support the Trust's Integrated Business plan for Foundation Trust application and the Outline Business Case for the New Acute Hospital Project. Work is on-going through the RCRH programme to ensure that all partner organisations adopt a similar policy to that within SWBH to ensure consistency of approach. The Trust is an active partner and leading many of the key actions set out by the RCRH programme Staff Council that has been established to enable staff side engagement and consultation across all partner organisations to support programmes of change and workforce transition.	
7.4.2	To have in place all necessary procedures to support any workforce changes in 2008/09 and 2009/10, i.e. service re-	The organisational change requirements of workforce reconfiguration and changes have been addressed.	

	configuration	The Trust's Organisational Change Policy has been reviewed and updated to ensure the Trust has effective change management procedures in place to support service re-configuration.	
7.4.3	To ensure that the development of the 2010 workforce plans include proposals for the development of new roles and new ways of working.	A new programme of learning for Assistant Practitioners that tracks new service competencies has been introduced. The Programme of learning for Foundation degree students has been revised . A new and innovative programme is currently being developed for the Maternity Family Support Workers to support the transition to the new maternity service. A programme of development is being prepared for the wider Maternity service to support the "Baby Friendly Award".	
7.4.4	To ensure that plans are in place to effectively deal with effects of introducing Modernising Medical Careers i.e. Hospital at Night.	The Hospital at Night Project has been implemented. This was led by the governance and nursing directorates. Further initiatives and projects will be identified as part of the development of the Trusts Clinical Workforce Strategy being developed for the new acute hospital service model.	
7.4.5	To support the 'Towards 2010' Programme by developing and implementing appropriate methodolgy and tools to inform workforce planning requirements, including capacity, capability requirements, productivity, and service re-design.	The National Workforce Projects Six-step integrated workforce planning methodology ('the six-step plan') was introduced across the Trust by division/directorate during the early part of 2009. Divisional workforce plans have been developed using this as a framework. A number of staff have been trained to use this methodology and various workforce planning tools and techniques. Approximately 30 members of staff have or are in the process of undertaking formal workforce planning qualifications and periods of study and this will be encouraged further.	
Learning and Development			
8.4.1	To introduce a Trust wide appraisal system utilising the principles of the national Knowledge and Skills Framework (KSF).	The PDR Policy has been reviewed and updated to reflect the requirements of the KSF. Compliance with the policy is now monitored via the ESR system and managers are now receiving regular compliance reports. Overall PDR compliance is reported quarterly via the Workforce Dashboard. All non-mandatory training and clinical development programmes track KSF competencies when assessing to National Occupational Standards.	

		The PDR compliance rate for the period April 09-February 2010 is 80% of the total plan for the year suggesting that the PDR systems and processes are in place and are embedding. Feedback from the annual staff opinion survey has confirmed improvements in compliance, and the feedback from the 2009 survey has demonstrated improvements in the quality of appraisals undertaken.	
8.4.2	To develop evaluation mechanisms that demonstate the value of specific learning and development interventions.	Some longer programmes are evaluated up to Kirkpatrick level 3 (application at work) e.g. management programme. Others are evaluated at level 1 (reactions to the training) or 2 (knowledge/skill gain) – some are sampled rather than evaluated on every session (e.g. very large volume training). Further work now needs to be undertaken to ensure that feedback from the evaluation process informs further training provision	
8.4.3	To continue to roll out the first line managers development programme.	The Managing for Managers programme is on-going although demand for the programme is beyond the capacity of the team to provide.	
8.4.4	To review the induction and mandatory training programme to ensure they are fit for purpose and use, wherever possible, methods of delivery designed to increase ease of access.	The deliver and design of the Trust's induction and mandatory training programme has been reviewed during the course of 2009, and will continue to be reviewed throughout 2010 to ensure that it is as effective and as accessible as possible. Methods of delivery and design of programmes have been reviewed and e-learning has been introduced. E-learning will continue to be rolled out during 2010/11 The Trust's compliance with Mandatory Training reporting system has been reviewed and revised and data validation is being finalised. The Trust's overall compliance rate is currently 73%	
8.4.5	To develop evaluation mechanisms that demonstate the value of specific learning and development interventions.	Refer 8.4.2	
8.4.6	To put in place recording systems that will allow all learning and development activity to be monitored and reported on as appropriate.	All training activity managed or administered by the L & D Department is recorded on the Safeguard system. The L & D Department have been encouraging all managers responsible for the delivery of training elsewhere within the organisation to notify the L & D Department accordingly, to ensure central recording is undertaken. Further work to ensure improvements in this area do now need to be undertaken to ensure that a comprehensive training record is maintained.	

		All NVQ candidates are recorded on a central electronic recording system. All learners, on programmes, are formally reviewed on a 10 weekly basis, this data is formally recorded on their Individual Learning Plan and collated within their personal records file within L&D.	
8.4.7	To continue to modify and improve on training provision to take advantage of new technologies, to ensure training provision is as effective as possible and increases the ways staff are able to access training.	The design of training programmes is reviewed and modified on an on-going basis as evidenced in 7.4.1. In addition the use of e-learning technology has been developed within the mandatory training programme. Feedback to date on this style of training has been encouraging and plans are in place to expand upon the range of e-learning opportunities available. Plans are also being developed in conjunction with ESR Self Service to further develop the ESR system to use the training (OLM) functionality. Benefits of so doing will enable managers to access their staff's training record, run reports and book training places.	
8.4.8	To work closely with education providers to ensure the provision of appropriate training and development activity.	L&D are engaged with three local colleges sourcing fully funded training provision and/or collaborative working opportunities. L&D have outsourced AMSPAR via e-learning provision and partial tutor support through L&D. This is a need for the Trust as local colleges do not support this award and this route has proven popular and cost effective.	
8.4.9	To design and implement appropriate programmes for the development of nurse practitioners .	Refer 7.4.1	
8.4.10	To work with the Trust Chair and Chief Executive to design appropriate development programmes for Executive Directors, non executive Directors and Governors.	This was completed as part of the Trust's preparation for applying for Foundation Trust Status and was led by the Director of Governance.	
8.4.11	To design and implement programmes that will ensure appropriate staff have the correct level of competency to operate the trusts current and future IT systems.	Refer 7.4.1, 7.4.2 and 8.4.8 AMSPAR	
Productivity			
9.4.1	To develop a set of key performance indicators that can be used to identify future improvement.	A comprehensive HR dashboard was introduced in September 2009 containing key HR performance and activity data. In addition the Trust is working closely with the Regional QIPP workforce workstream to develop a set of standardised metrics that can be used to benchmark workforce performance indicators.	
9.4.2	To ensure that Trust managers and staff are equipped with the appropriate skills to assess productivity issues and have the	The Trust's Quality and Efficiency Programme (QuEP) sets out a series of projects that require changes to the workforce. The HR team are supporting the Establishment	

	necessary skills, to ensure effective resolution.	Reduction Programme and will focus over the coming months on supporting divisions with their service and workforce redesign projects.	
9.4.3	To use AfC flexibility creatively to support the creation new job roles and ways of working as appropriate.	The Trust has examples of many new and redesigned roles in place i.e. Surgical Care Practitioners, Assistant Practitioners, and Midwifery Support Workers.	
9.4.4	To ensure the effective use of current ESR functionality and continue to roll out WEBADE and manager self serve.	The core ESR system has been fully implemented within the Trust. The WEBDE system (electronic turnaround system) has been fully rolled out across the Trust and has significantly reduced the level of data input repetition. Plans to roll out Manager Self Serve (MSS) are at the piloting stage. Full roll-out is expected within the next 12-18 months.	
9.4.5	To review sickness absence management procedures to ensure that all appropriate action is being taken and in particular pay special attention to those departments where rates are higher than 5%.	The HR Department created a sickness absence team in December 2008. Systems and processes, including the Sickness Absence policy were reviewed and updated. Detailed management guidance notes have also been made available. The team runs a management training programme on sickness absence requirements. Compliance with sickness absence procedures are now regularly audited to ensure compliance. All long-term absence, high level short-term (prioritised via the Bradford Factor system) and department with a sickness level greater than 5% are reviewed by the sickness team. They will then work closely with the relevant managers to ensure that all sickness absences are appropriately managed. Sickness absence reports are provided monthly by the ESR Workforce Information team and access to sickness absence reports via the CDA system on the intranet has recently been developed in conjunction with the Information Department. Sickness absence levels were significantly reduced up until July 2009 but then showed a deterioration until January 2010. This is now showing an improving trend. A further review of sickness absence Management procedures is currently underway to enable effective absence management as well as reflect recommendations made by the Boorman Review.	
Occupational, Health, Safety and Welfare			
10.4.1	To facilitate the development of the healthy workplace conducive to health and well being.	In addition to the normal range of Occupational Health services expected the Trust compared favourably in the DH/NHS Westmidlands Health and Well-being audit and offers a range of support to staff e.g.Physiotherapy service, Counselling Service,Staff gym etc.	

		The Trust is now reviewing its approach as part of developing its approach to the NHS Health and Well-being Review (The Boorman Report), and is setting up a Health and Well-being Committee.	
10.4.2	To develop and improve integrated working between Occupational Health nursing and HR team and at divisional level.	Occupational Health work on an ongoing basis in conjunction with the HR Sickness Absence Management team to facilitate reduction in sickness absence figures. Training workshops have been introduced to improve working links with HR and Occupational Health.	
10.4.3	To actively promote and facilitate increased opportunites for rehabilitation programmes.	The introduction of the revised Sickness Absence Policy in 2008 and the on-going sickness absence management training programme has strengthened the rehabilitation position and has facilitated an increase in the use of rehabilitation programmes. The Trust's approach will be further supported by the introduction of 'fit notes' in April 2010. To date the central recording of all rehabilitation activity has been problematic as the ESR system did not allow for this type of recording. The system was modified in March 2010, so we are now hopeful that more meaningful monitoring data will become available in due course. The sickness absence and occupational Health team s are also encouraging managers to work with staff to plan for 'return to work' in advance in the case of planned absences e.g. for surgical procedures. Work in this area is currently limited and will be the focus of further development over the coming year.	
10.4.4	To ensure that systems and processes are in place to achieve a reduction in the number of needlestick injuries.	A pilot is currently being conducted to identify causes with a view to understanding and reducing the number of needlestick incidents.	
Managing Diversity			
11.4.1	To organise a diversity awareness raising event for Board members and senior managers.	Awareness training was undertaken in 2008. Requirements will now need to be reviewed in the light of changes in Trust Board membership.	
11.4.2	To comply with statutory obligations to monitor, evaluate and publish employment activity data annually.	This is currently delivered on a quarterly basis via the Trust's website.	
11.4.3	To improve employment activity recording systems to ensure that any undue trends or bias are identified as quickly as possible and remedial action taken as appropriate.	HR operational activity is now routinely recorded and monitored. Data is reported quarterly within the Workforce Dashboard report. The workforce monitoring sub-group is responsible for overseeing the data and ensuring that any undue trends or bias are reviewed and action plans developed as appropriate.	

11.4.4	To undertake an impact assessment on all new HR and employment policies and monitor the impact of existing HR policies and procedures to ensure that they do not have any unintended adverse impact.	All workforce policies are impact assessed upon review. The majority of our policies have now been impact assessed and this includes all the key operational policies. Monitoring of the impact of the policies is undertaken as detailed in section 11.4.3 above. EIA's undertaken for Occ Health and Recruitment functions.	
11.4.5	To continue to ensure the provision of diversity training, and ensure provision within mandatory training programme in addition to the provision of a regular 'stand alone' training programme.	Half day workshops are delivered for staff requiring to be trained at mandatory level 2 (this includes equality & diversity and harassment & bullying). An equality and diversity e-learning option is available for all staff members. An e-learning option is available for harassment & bullying training. In addition all Learning and Development programmes integrate diversity training within the whole content.	
Operational Support Services			
12.4.1	To examine opportunities to develop shared services where appropriate.	The Occupational Health service currently provide services to a number of external providers, including Sandwell PCT and Sandwell Mental Health Trust. Shared services opportunities within Learning and Development and Recruitment functions in particular will now be considered.	
12.4.2	To benchmark HR transactional services to ensure best value.	This work will has still to be undertaken and will be considered as a part of the Benchmarking QUEP workstream.	
12.4.3	To identify, evaluate, and co-ordinate opportunities for cost savings and efficiency gains from pay modernisation and to minimise additional cost pressures from national agreements.	Work is on-going as part of the QUEP and QIP workstreams to ensure that use of additional contractual payments is appropriate and is in line with other healthcare providers.	
12.4.4	To continue the development of E-Recruitment by introducing a fully 'on-line' service and maximising the benefits of using the ESR recruitment functionality.	The recruitment service (non-medical) now uses e-recruitment and ESR functionality.	
12.4.5	To monitor and review existing recruitment and study leave procedures to ensure that they are as efficient and streamlined as possible.	Recruitment procedures were reviewed in 2008 and are in line with NHS Employers Employment check standards. A further review will be required in 2010 as new Vetting and Barring standards are introduced this year. A review of the study leave process is currently being instigated with a view to moving from a manual to electronic system.	
12.4.6	To develop proposals and ensure the implemenation of approved developments designed to maximise the benefits from the ESR.	The Manager Self Service (MSS) functionality of ESR is currently being piloted within a number of departments within the Trust.	

		This will reduce the amount of manual inputting of data reducing duplication and error, and will improve the range and access of information available to managers. Work to integrate Oracle Learning Management (OLM) functionality is currently on-going and it is envisaged that the roll-out of OLM will be undertaken alongside the roll-out of MSS over the next 12-18 months.	
12.4.7	To develop, implement and review management standards for the provision of formal disciplinary, grievance, dignity at work and capability investigations to enable consistency of approach and the monitoring and recording of such activity.	Quality standards have been developed and introduced and form the basis against which HR operational performance is monitored and reported by the Directorate Management Team.	
12.4.8	To ensure that HR and employment policies that support service delivery are developed and updated in accordance with legal requirements and best practice.	There is a system in place for developing new policies and revising existing policies to reflect both best practice and new employment legislation.	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance – Month 12
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Tony Wharram, Deputy Director of Finance
DATE OF MEETING:	29 April 2010

SUMMARY OF KEY POINTS:

The report provides a summary review of financial performance against key targets for the year ended 31st March 2010.

The income and expenditure surplus for the year is £2,279k, £10k better than plan.

Capital expenditure of £15,827k is £239k lower than plan.

Cash balance is approximately £8m greater than the planned position for the year end.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

- To receive and note the monthly finance report.

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:

Finance and Performance Management Committee on 22 April 2010

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – March 2010

EXECUTIVE SUMMARY

• For the financial year to 31st March 2010, after adjustments in respect of revaluation related impairments, the Trust delivered an overall I&E surplus of £2,279,000 which is £10,000 better than the planned position.

•The Trust held a cash balance at the year end of £15,867k.

• Capital expenditure had reached £15,827k by the year end which is £239k lower than plan.

• In terms of financial targets, performance is summarised in the table below:

- **• performance against the bottom line I&E target is £10k better than plan**
- **• an under spend of £239k against the Capital Resource Limit which is permitted**
- **• an under spend of £7,921 against the External Financing Limit which is permitted**

• A summary income and expenditure account is shown in the table below.

2009/2010 Summary Income & Expenditure Performance at March 2010	Annual Plan £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's
Income from Activities	331,473	331,473	341,371	9,898
Other Income	41,048	41,048	43,404	2,356
Operating Expenses	(344,504)	(344,504)	(354,339)	(9,835)
EBITDA	28,017	28,017	30,436	2,419
Interest Receivable	150	150	80	(70)
Loss On Disposal	0	0	(102)	(102)
Depreciation & Amortisation	(16,062)	(16,062)	(13,395)	2,667
Asset Impairment	0	0	(36,463)	(36,463)
PDC Dividend	(7,656)	(7,656)	(6,945)	711
Interest Payable	(2,180)	(2,180)	(2,179)	1
Net Surplus/(Deficit) Before Adjustments	2,269	2,269	(28,568)	(30,837)
Revaluation Adjustments	0	0	30,847	30,847
Net Surplus/(Deficit)	**2,269**	**2,269**	**2,279**	**10**

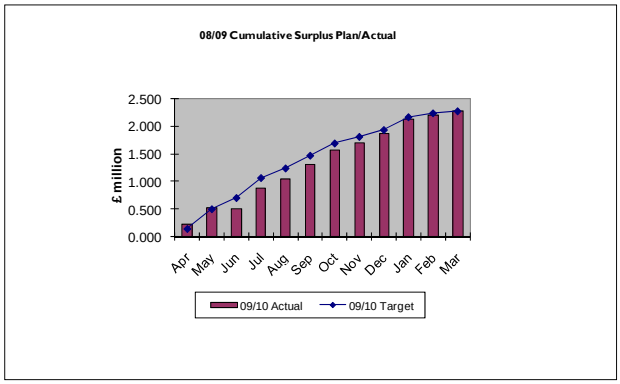
Performance Against Key Financial Targets		
	Year to Date	
Target	Plan £000	Actual £000
Income and Expenditure	2,269	2,279
Capital Resource Limit	16,066	15,827
External Financing Limit	(568)	7,921
Return on Assets Employed	3.50%	3.50%

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – March 2010

Overall income & Expenditure Position

The graph shows the monthly performance against the Trust's "bottom line" income and expenditure target.



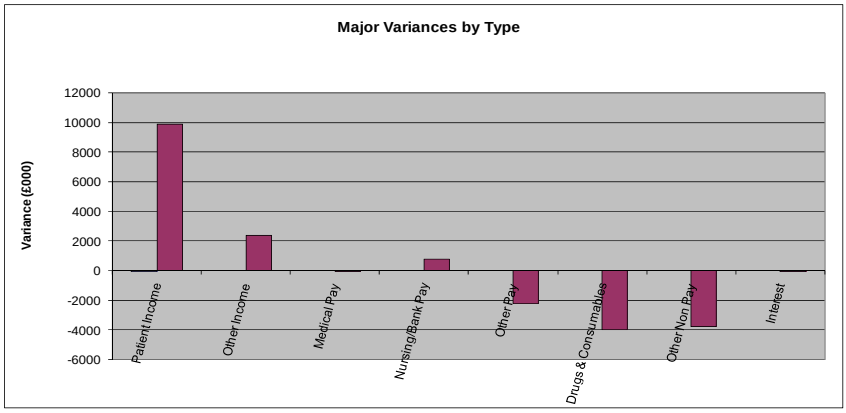
Operational Performance

• Overall operational performance has continued to be largely driven by higher levels of activity and income which in turn have driven higher levels of costs, both pay and non pay.

•The year end over performance position had been agreed with Sandwell PCT, acting on behalf of the PCT commissioners, some weeks ago and this agreement has been incorporated into the financial position.

The table and graph below illustrate that overall, income performed significantly better than plan, primarily driven by higher levels of patient related activity. Overall pay expenditure was also above plan and expenditure on bank and agency continued to be high for much of the year.

Variance From Plan by Expenditure Type	Year to Date £000
Patient Income	9,898
Other Income	2,356
Medical Pay	-70
Nursing/Bank Pay	756
Other Pay	-2,220
Drugs & Consumables	-4,000
Other Non Pay	-3,763
Interest	-70

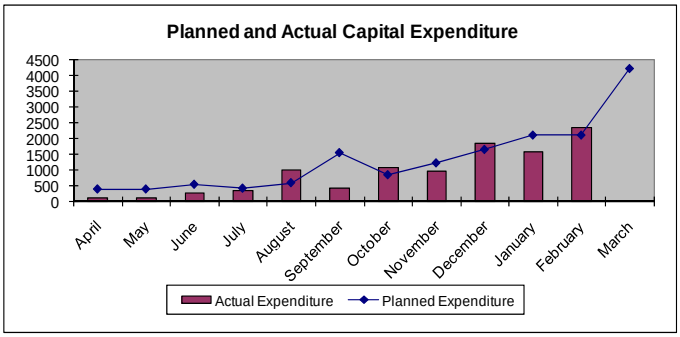


Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – March 2010

Capital Expenditure

• Planned and actual capital expenditure by month is summarised in the adjacent graph. Expenditure of £5.7m was incurred in March with the greatest proportion made up of imaging equipment (primarily the Sandwell CT scanner) , statutory standards and the completion of various building related projects. This brings total capital expenditure for the year to date up to £15,827,000.



Balance Sheet

• The opening Statement of Financial Position (balance sheet) for the year at 1st April reflects the IFRS based audited accounts for 2008/2009.

• The closing balance sheet reflects a significantly changed position largely as a result of the revaluation of assets which has seen a significant fall in the value of non current assets matched by a fall in the value of the revaluation reserve and the retained earnings reserve.

• Cash balances at 31st March are approximately £8m higher than the revised plan, a reflection largely of better than expected collection of income, particularly from PCTs. The Trust is permitted to under spend its External Financing Limit and it has done this. This generates a stronger cash position going into the new financial year.

Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION

		Opening Balance as at March 2009 £000	Closing Balance at March 2010 £000
Non Current Assets	Intangible Assets	547	426
	Tangible Assets	277,912	220,300
	Investments	0	0
	Receivables	1,158	1,250
Current Assets	Inventories	3,295	3,439
	Receivables and Accrued Income	19,138	19,320
	Investments	0	0
	Cash	8,752	15,867
Current Liabilities	Payables and Accrued Expenditure	(28,516)	(32,301)
	Loans	0	0
	Borrowings	(1,885)	(1,698)
	Provisions	(5,440)	(5,048)
Non Current Liabilities	Payables and Accrued Expenditure	0	0
	Loans	0	0
	Borrowings	(33,627)	(32,476)
	Provisions	(2,193)	(2,175)
		239,141	186,904
Financed By			
Taxpayers Equity	Public Dividend Capital	160,231	160,231
	Revaluation Reserve	60,699	36,575
	Donated Asset Reserve	2,531	2,148
	Government Grant Reserve	1,985	1,103
	Other Reserves	9,058	9,058
	Income and Expenditure Reserve	4,637	(22,211)
		239,141	186,904

Sandwell and West Birmingham Hospitals NHS
NHS Trust

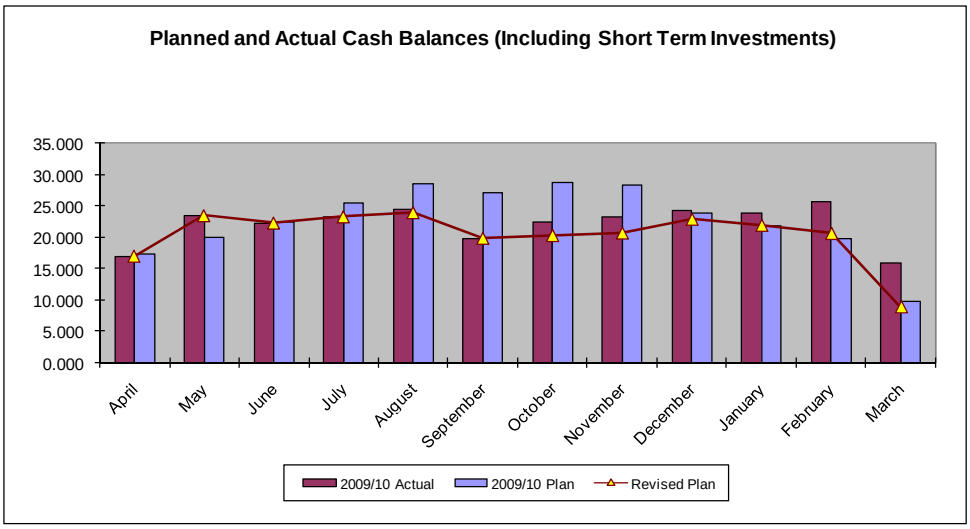
Financial Performance Report –March 2010

Balance Sheet Continued

• Impairments of property amounting to £82m have been incurred as a result of revaluation of land and buildings using Modern Equivalent Asset techniques plus £5m of economic impairments in relation to assets no longer in use. Of this, almost £51m has been charged to brought forward accumulated revaluation reserves and £36m to the income and expenditure account. Of this £31m (the charge to Income & Expenditure relating to MEA revaluation), is treated as a technical adjustment.

Cash

• The graph below demonstrates the fall in cash balances in March but still being maintained at significantly higher levels than planned.



Risk Ratings

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

•The only significantly weak area remains liquidity which will only be substantially corrected with the introduction of a working capital facility.

Risk Ratings

Measure	Description	Value	Score
EBITDA Margin	Excess of income over operational costs	8.1%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	100.1%	5
Return on Assets	Surplus before dividends over average assets employed	4.1%	3
I&E Surplus Margin	I&E Surplus as % of total income	0.6%	2
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	3.4	1
Overall Rating			**2.5**

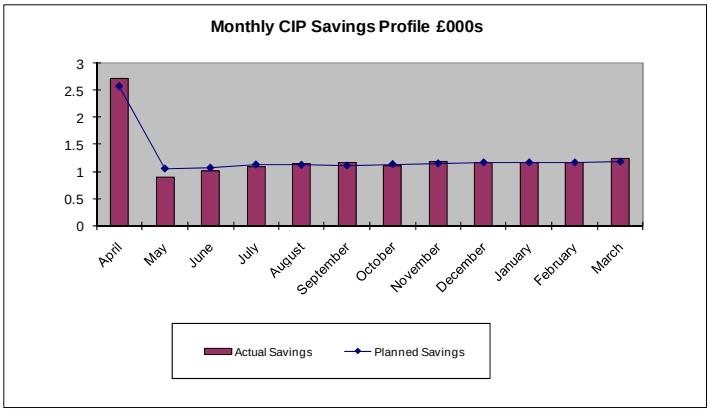
Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – March 2010

Cost improvement Programme

•The adjacent graph shows the monthly profile of the Trust's cost improvement programme and actuals achieved up to March.

•As at the year end, the overall cost improvement programme has performed in line with plan with only minor variations in individual divisions performance.



Conclusions

• For the year end 31st March 2010, the Trust has generated an overall income and expenditure surplus of £2,279,000 which is £10,000 above plan.

• Capital expenditure in March continued and accelerated the higher levels of spend being witnessed in the latter part of the year, the result of which is that the Trust has only marginally under spent its CRL (which it is permitted to do).

•At the year end, cash balances were approximately £8m higher than planned.

Recommendations

The Board is asked to:

i. NOTE the contents of the report.

Robert White

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Monthly Performance Monitoring Report
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of planning & Performance Management
DATE OF MEETING:	29 April 2010

SUMMARY OF KEY POINTS:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April 2009 – March 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 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 on 20 April 2010 and Finance and Performance Management Committee on 22 April 2010.

SANDWELL AND WEST BIRMINGHAM HOSPITALS PERFORMANCE MONITORING REPORT - MARCH 2010

SWBTB (4/10) 091 (a)

EXECUTIVE SUMMARY

<table>
<tr><th>Note</th><th>Comments</th></tr>
<tr><td>a</td><td>During the month of March the percentage of Cancelled Operations increased to 1.0% overall, influenced by an increase from 0.8% in February to 1.5% in March on the City Hospital site. An increase in absolute numbers is seen in a number of specialties.</td></tr>
<tr><td>b</td><td>Increases in the number and proportion of Delayed Transfers of Care on both sites during March contributed to an overall level of 4.9%. Of the 28 Social Care delays on the census date, 17 were attributable to Sandwell, 10 to Birmingham and 1 to Walsall.</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 has exceeded the Department Of Health NHS Performance Framework 'Achieve' threshold of 60% for each of the last 4 months, with performance during the last quarter of 71.4%.</td></tr>
<tr><td>d</td><td>Accident & Emergency 4-hour waits - performance improved overall to 98.8% for the month of March, with all 3 units meeting the 98.0% operational target. Performance for the year is reported as 98.4%.</td></tr>
<tr><td>e</td><td>The overall number of cases of C Diff reported across the Trust during the month of March was 16, with an even distribution across sites. One case of MRSA Bacteraemia was reported during the month. The Trust has met National and Local performance trajectories for the month and year.</td></tr>
<tr><td>f</td><td>Overall Referral to Treatment Time targets for Admitted Care (=>90%) and Non-Admitted Care (=>95%) were both met during the month of March, although the percentage of Admitted patients in Trauma & Orthopaedics whose treatment commenced within 18 weeks of referral is reported as 75.93%.</td></tr>
<tr><td rowspan="6">g</td><td>CQUIN:</td></tr>
<tr><td>Outpatient source of Referral - Overall performance for the year (1.39%) is well within the agreed target.</td></tr>
<tr><td>Caesarean Section Rate - the overall rate for March was 22.7%, and for the year 23.3%, again within the target of reduction set for the period.</td></tr>
<tr><td>Brain Imaging - performance against this indicator has exceeded 80% for several months. Provisional year to date performance is reported as 81.2%.</td></tr>
<tr><td>Hip Fracture - Provisional data for March indicates that 100% of patients admitted as an emergency with a Fractured Neck of Femur were operated upon within 48 hours of admission. The CQUIN final goal value for this indicator was 87% by 31 March 2010.</td></tr>
<tr><td>Smoking Cessation Referrals - The total number of referrals made to PCT smoking cessation services of patients specifically prior to listing for Elective Surgery for the year is recorded as 1164, thus ensuring the targetted number of referrals of 1000 was met.</td></tr>
<tr><td>Inpatient Patient Satisfaction Survey - The second survey has been concluded with at least 50 responses received to the questionnaire per ward.</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>Activity (trust-wide) to date is compared with the contracted activity plan for 2009 / 2010 - Month and Year to Date.
<table>
<tr><th></th><th colspan="4">Month</th><th colspan="4">Year to Date</th></tr>
<tr><th></th><th>Actual</th><th>Plan</th><th>Variance</th><th>%</th><th>Actual</th><th>Plan</th><th>Variance</th><th>%</th></tr>
<tr><td>IP Elective</td><td>1341</td><td>1140</td><td>201</td><td>17.6</td><td>13722</td><td>13077</td><td>645</td><td>4.9</td></tr>
<tr><td>Day case</td><td>5105</td><td>4328</td><td>777</td><td>18.0</td><td>52729</td><td>49636</td><td>3093</td><td>6.2</td></tr>
<tr><td>IPE plus DC</td><td>6446</td><td>5468</td><td>978</td><td>17.9</td><td>66451</td><td>62713</td><td>3738</td><td>6.0</td></tr>
<tr><td>IP Non-Elective</td><td>5378</td><td>5371</td><td>7</td><td>0.1</td><td>65841</td><td>65065</td><td>776</td><td>1.2</td></tr>
<tr><td>OP New</td><td>15595</td><td>13523</td><td>2072</td><td>15.3</td><td>164358</td><td>163114</td><td>1244</td><td>0.8</td></tr>
<tr><td>OP Review</td><td>42309</td><td>30700</td><td>11609</td><td>37.8</td><td>425850</td><td>385680</td><td>40170</td><td>10.4</td></tr>
</table>
Activity to date is compared with 2008 / 09 for the corresponding period
<table>
<tr><th></th><th>2008 / 09</th><th>2009 / 10</th><th>Variance</th><th>%</th></tr>
<tr><td>IP Elective</td><td>13098</td><td>13722</td><td>624</td><td>4.8</td></tr>
<tr><td>Day case</td><td>50872</td><td>52729</td><td>1857</td><td>3.7</td></tr>
<tr><td>IPE plus DC</td><td>63970</td><td>66451</td><td>2481</td><td>3.9</td></tr>
<tr><td>IP Non-Elective</td><td>65521</td><td>65841</td><td>320</td><td>0.5</td></tr>
<tr><td>OP New</td><td>155974</td><td>164358</td><td>8384</td><td>5.4</td></tr>
<tr><td>OP Review</td><td>374709</td><td>425850</td><td>51141</td><td>13.6</td></tr>
</table></td></tr>
<tr><td>j</td><td>Overall compliance with Mandatory Training modules is reported as 71.1% at the end of March, with compliance by Division ranging from 59 - 98%. The number of PDRs reported as completed during the year increased to 4681, representing almost 88% of the plan for the year.</td></tr>
</table>

SANDWELL AND WEST BIRMINGHAM HOSPITALS CORPORATE QUALITY AND PERFORMANCE MONITORING REPORT - MARCH 2010

Exec Lead	NATIONAL AND LOCAL PRIORITY INDICATORS			November	December	January	February			March			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	135 ▼	160 ▲	258 ▼	→		96 ▼	→				2269	2269		0%	0 - 1%	>1%	3399	6547	2535
RK	Cancer	2 weeks	%	96.1 ▲	93.6 ▼	93.9 ▲	→		94.7 ▲	→			93.9	=>93	=>93		No variation		Any variation	100	97.1	98.6
		2 weeks (Breast Symptomatic)	%			93.2 ■	→		93.5 ▲	→			93.4	=>93	=>93		No variation		Any variation	n/a	n/a	n/a
		31 Days	%	99.4 ■	100 ▲	99.3 ▼	→		100 ▲	→			99.7	=>96	=>96		No variation		Any variation	99.9	99.9	100
		62 Days	%	89.9 ▲	89.1 ▼	86.5 ▼	→		85.0 ▼	→			89.0	=>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	%	1.0 ■	0.7 ■	1.0 ■	0.4 ■	0.8 ■	0.6 ■	0.4 ■	1.5 ■	1.0 ■	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	%	2.6 ■	3.9 ■	2.6 ■	2.8 ▼	3.5 ■	3.1 ■	4.5 ■	5.3 ■	4.9 ■	3.0	<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)	%	64 ■	62 ▼	89 ■	100 ▲	80 ▼	92 ▲				77.8	80	80		>80	75-80	<75	n/a	63.0	70.5
		Primary Angioplasty (<150 mins)		75 ■	64 ■	88 ■	100 ▲	100 ▲	100 ▲				85.4	80	80		>80	75-80	<75	n/a	n/a	83.6
		Rapid Access Chest Pain	%	100 ■	100 ■	98.3 ▼	100 ■	100 ■	100 ■	100 ■	100 ■	100 ■	99.7	=>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				no pts	80	80		>80	75-80	<75	57	50	0
DO'D	Stroke Care	>90% stay on Stroke Unit	%	51.7 ■	64.0 ■	73.3 ▲	→		74.1 ▲	→		66.7 ▼	61.7	70	70	c	=>60	31-59	=<30	n/a	n/a	36.5
RK	A/E 4 Hour Waits		%	96.7 ■	96.2 ▼	97.8 ▲	99.3 ▲	97.3 ▲	98.0 ■	99.1 ▼	98.6 ■	98.8 ▲	98.41	=>98	=>98	d	=>98		<98	98.20	98.28	98.16
	GUM 48 Hours	Patients seen within 48 hours	%	86.3 ▼	87.5 ▲	87.3 ▼	→		80.7 ▼	→		82.5 ▲	86.8	=>90	=>90		=>90	80-89	<80	n/a	n/a	81.0
		Patients offered app't within 48 hrs	%	100 ▲	100 ■	100 ■	→		100 ■	→		100 ■	99.8	=>98	=>98		=>98	95-98	<95	35.8	80.7	98.3
R0	Infection Control	C. Diff - EXTERNAL (DH) TARGET	No.	14 ■	14 ■	17 ▼	3 ■	9 ■	12 ■	8 ▼	8 ▲	16 ▼	158	264	264	e	No variation		Any variation	n/a	355	163
		C. Diff - INTERNAL (LHE) TARGET	No.	14 ■	14 ■	17 ▼	3 ■	9 ■	12 ■	8 ▼	8 ▲	16 ▼	158	220	220		No variation		Any variation	n/a	355	163
		MRSA - EXTERNAL (DH) TARGET	No.	2 ▼	0 ▲	1 ▼	2 ■	0 ■	2 ▼	0 ■	1 ▼	1 ▲	14	33	33		No variation		Any variation	61	43	15
		MRSA - INTERNAL (LHE) TARGET	No.	2 ▼	0 ▲	1 ▼	2 ■	0 ■	2 ▼	0 ■	1 ▼	1 ▲	14	33	23		No variation		Any variation	61	43	15
RK	Data Quality	Valid Coding for Ethnic Category (FCEs)	%	94 ■	95 ▲	94 ▼	→		94 ■	→			94.5	90	90		>/=90	89.0-89.9	<89	90.0	89.0	87.0
		Maternity HES	%		5.7 ■		→			→			5.7	<15	<15		=<15	16-30	>30	n/a	n/a	
RO	Infant Health & Inequalities	Maternal Smoking Status Data Complete	%	→	99.0 ■	→	→			→		99.3 ▲	99.3	=>98.0	=>98.0		=>98	95-98	<95	99.9	99.5	99.9
		Breast Feeding Status Data Complete	%	→	99.3 ■	→	→			→		99.8 ▲	99.3	=>98.0	=>98.0		=>98	95-98	<95	98.3	99.8	97.8
		Maternal Smoking Rates	%	→	10.9 ▲	→	→			→		11.0 ▼	11.6	<12.0	<12.0		<12.0	12-14	>14.0	13.2	13.1	12.6
		Breast Feeding Initiation Rates	%	→	63.3 ▲	→	→			→		64.2 ▲	63.1	>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 ■	0 ■	0 ■	→		0 ■	→		0 ■	0.001	0	0		<0.03		>0.03	4	0	5
RK	RTT Milestones	Admitted Care (RTT <18 weeks)	%	93.4 ▼	92.8 ▼	95.5 ▲	→		94.1 ▼	→		93.4 ▼	93.4	=>90.0	=>90.0	f	=>90.0		<90.0	52.0	90.6	98.6
		Admitted Care - Data Completeness	%	103.5 ■	99.8 ■	102.8 ■	→		101.3 ■	→		102.6 ■	102.6	90-110	<90 or >110		90-110		<90 or >110	n/a	n/a	100.4
		Non-Admitted Care (RTT <18 weeks)	%	97.3 ▼	96.7 ▼	98.4 ▲	→		98.9 ▲	→		97.6 ▼	97.6	=>95.0	=>95.0		=>95.0		=<95.0	n/a	95.5	98.8
		Non-Admitted Care - Data Completeness	%	98.4 ■	90.9 ■	96.3 ■	→		97.7 ■	→		90-110 ■	90-110	90-110	<90 or >110		90-110		<90 or >110	n/a	n/a	98.1
		Audiology Direct Access Waits (<18 wks)	%	100 ■	100 ■	100 ■	→		100 ■	→		100 ■	100	=>95	=>95		=>95		<95	n/a	n/a	99.0
		Audiology Data Completeness	%	110.0 ■	102.0 ■	108.0 ■	→		108.0 ■	→		94.0	94.0	90-110	<90 or >110		90-110		<90 or >110	n/a	n/a	96.0
		Diagnostic Waits greater than 6 weeks	No.	2 ■	1 ▲	0 ■	→		5 ■	→		3 ▲	3	0	0		0		>0	996	25	26
DO'D	Mortality in Hospital	Hospital Standardised Mortality Rate	HSMR	82.3 Aug '09	97.8 Sept '09	90.0 Oct '09	→		99.7 Nov '09	→		98.6 Dec '09	91.9	Rate only	Rate only					96.4	100.9	105.1
		Peer (SHA) HSMR	HSMR	91.5	85.7	90.4	→		90.6	→		89.8	93.0	Rate only	Rate only					108.8	106.0	103.9
RK	CQUIN	OP Source of Referral Information	%	1.04 ▲	1.64 ▼	1.13 ▲	→		1.81 ▼	→		1.01 ▲	1.39	5.0	5.0	g	No variation		Any variation	n/a	n/a	10.0
DO'D		Caesarean Section Rate	%	24.2 ▼	22.0 ▲	25.8 ▼	19.1 ▲	25.8 ■	23.1 ▲	19.9 ▼	24.8 ▲	22.7 ▲	23.3	26.0	26.0		=<26.0		>26.0	n/a	27.7	27.0
		Brain Imaging for Em. Stroke Admissions	%	82.4 ▼	85.2 ▲	84.7 ▼	→		86.9 ▲	→		87.0 ▲	81.2	72.0	72.0		=>72.0		<72.0	n/a	n/a	72.0
		Hip Fracture Op's <48 hours of admission	%	80.0 ■	89.7 ■	86.7 ▼	→		79.3 ■	→		100 ■	100	87.0	87.0		No Variation	0 - 2% Variation	>2% Variation	63.6	70.1	77.8
		Smoking Cesssation Referrals	No.	65 ■	59 ▼	172 ■	→		260 ▲	→		264 ▲	1164	1000	1000		=>83	per month	<83	n/a	n/a	7
RO		IP Patient Satisfaction (Survey Coverage)	%										Completed				=>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)	%	12.3	11.9	11.4	13.0	10.8	11.7				11.6	No. Only	No. Only					10.1	n/a	11.6
		(Within 14 days of discharge)	%	9.0	8.8	8.5	10.0	7.8	8.7				8.5	No. Only	No. Only					n/a	n/a	7.3
R0	Infection Control	Savings Lives Compliance	%	99 ▼	100 ▲	99 ▼	→		99 ■	→		99 ■	99	>95	>95		< YTD target		> YTD target	n/a	n/a	99.0
		MRSA Screening (Elective)	No.	2192	1611	2248	→		2231	→		2707	24710	No. Only	No. Only					n/a	n/a	6495
		MRSA Screening (Non-Elective)	No.	2125	2175	2203	→		2112	→		2408	18571	No. Only	No. Only					n/a	n/a	n/a
DO'D	Obstetrics	Post Partum Haemorrhage (>2000 ml)	No.	0 ▲	0 ■	0 ■	0 ■	1 ▼	1 ▼	0 ■	0 ▲	0 ▲	10	48	48		=<2	3 - 4	>4	n/a	n/a	
		Admissions to Neonatal ICU	%	4.1 ▲	4.6 ▼	5.0 ▼	3.0 ▲	6.9 ▼	5.3 ▼	2.2 ▲	4.1 ▲	3.3 ▲	5.5	=<10	=<10		=<10	10.0-12.0	>12.0	n/a	9.6	
		Adjusted Perinatal Mortality Rate	/1000	16.6 ■	7.1 ■	5.3 ▲	0.0 ▲	3.4 ▲	2.0 ▲				2.0	<8.0	<8.0		<8	8.1 - 10.0	>10	n/a	n/a	
	FINANCE & FINANCIAL EFFICIENCY																					
RW	Gross Margin		£000s	2377 ▼	2402 ▲	2501 ▲	→		2259 ▼	→				29805	29805		0%	0 - 1%	>1%	26429	33250	26436
	CIP		£000s	1151 ■	1113 ■	1169 ■	→		1168 ▼	→				15075	15075		0 - 2.5%	2.5 - 7.5%	>7.5%	19679	14027	11084
	In Year Monthly Run Rate		%	14.41 ▲	29.03 ▲	11.69 ▼	→		37.14 ▲	→				0	0		NO or a + variation	0 - 5% variation	>5% variation	329	45	1.4
RK	Income / WTE		£s	5001 ▲	5087 ▲	5088 ▲	→		5022 ▼	→			4982	5127	5127		No variation	0 - 5% variation	>5% variation	5460	4924	5014
	Income / Open Bed		£s	32048 ▼	32518 ▲	30217 ■	→		31920 ■	→			32131	31184	31184		No variation	0 - 5% variation	>5% variation	24774	29065	30498
	Income per Spell	Total Income	£s	2892 ▲	2994 ▲	3066 ▲	→		3101 ▲	→			2873	2762	2762		No Variation	0 - 4% Variation	>4% Variation	2635	2740	2701
		Clinical Income	£s	2572 ▲	2695 ▲	2755 ▲	→		2775 ▲	→			2582	2454	2454		No Variation	0 - 4% Variation	>4% Variation	2317	2449	2400
		Non-Clinical Income	£s	320 ■	299 ■	311 ■	→		326 ▲	→			291	308	308	h	No Variation	0 - 4% Variation	>4% Variation	318	291	301
	Cost per Spell	Total Cost	£s	2880 ■	2980 ▼	3042 ▼	→		3092 ▼	→			2855	2742	2742		No Variation	0 - 4% Variation	>4% Variation	n/a	2643	2682
		Total Pay Cost	£s	1937 ■	1960 ▼	2027 ▼	→		2072 ▼	→			1915	1825	1825		No Variation	0 - 4% Variation	>4% Variation	1772	1737	1785
		Medical Pay Cost	£s	580 ▼	564 ■	585 ■	→		594 ▼	→			558	544	544		No Variation	0 - 4% Variation	>4% Variation	543	517	532
		Nursing Pay Cost (including Bank)	£s	671 ■	680 ▼	713 ▼	→		735 ▼	→			666	639	639		No Variation	0 - 4% Variation	>4% Variation	609	615	625
		Non-Pay Cost	£s	943 ■	1019 ■	1015 ▲	→		1020 ▼	→			940	917	917		No Variation	0 - 4% Variation	>4% Variation	n/a	906	897
		Mean Drug Cost / IP Spell	£s	130 ■	134 ▼	139 ▼	→		126 ■	→			122	123	123		No Variation	0 - 4% Variation	>4% Variation	n/a	95	120
		Mean Drug Cost / Occupied Bed Day	£s	52 ■	52 ■	50 ■	→		51 ■	→			49	48	48		No Variation	0 - 4% Variation	>4% Variation	n/a	35	47
	PATIENT EXPERIENCE																					
RK	Same Sex Accommodation Breaches	Number of Breaches	No.	604 ■	917 ■	865 ▲	→		604 ■	→		721 ▼	3711	2500	2500	Data since 1 Nov 2009	<500 pcm	501 -800 pcm	>800 pcm	n/a	n/a	n/a
		Percentage of overall admissions	%	5.09 ■	8.06 ■	7.77 ▲	→		5.70 ■	→		5.81 ▼	6.47	<3%	<3%		<3%	3 - 6%	>6%	n/a	n/a	n/a
KD	Complaints	Number Received	No.	→	217	→	→		→				662	No. Only	No. Only					673	697	789
		Response within initial negotiated date	%	→	70.5 ■	→	→		→				70.7	85	85		80%+	70 - 79%	<70%	77.4	81.2	81.1
	Thank You Letters		No.	→	729	→	→		→				1622	No. Only	No. Only					6026	3491	2912
RK	Elective Access Contact Centre	Number of Calls Received	No.	no data	no data	no data	→		no data	→		no data	12667	No. Only	No. Only					n/a	n/a	190434
		Average Length of Queue	mins	no data	no data	no data	→		no data	→		no data	1.54	0.5	0.5		No variation	0 - 10% variation	>10% variation	n/a	n/a	0.44
		Maximum Length of Queue	mins	no data	no data	no data	→		no data	→		no data	7.4	6.0	6.0		No variation	0 - 10% variation	>10% variation	n/a	n/a	17.4
	Telephone Exchange	Number of Calls Received	No.	86020	81214	86311	→		75208	→		84026	1100521	No. Only	No. Only					n/a	1826476	1559688
		Calls Answered	%	86.9	87.9	81.4			84.0			84.1	83.6	No. Only	No. Only					n/a	81.0	82.3
		Answered within 15 seconds	%	42.1	45.1	36.2			39.8			39.0	43.8	No. Only	No. Only					n/a	n/a	39.1
		Answered within 30 seconds	%	58.5	61.0	49.3			53.9			53.2	58.8	No. Only	No. Only					n/a	n/a	55.5
		Average Ring Time	Secs	30.7	29.5	39.2			35.9			36.0	36.0	No. Only	No. Only					n/a	n/a	28.8
		Longest Ring Time	Secs	1068	447	650			485			646	646	No. Only	No. Only					n/a	n/a	695
	STRATEGY																					
RK	Referrals	Total By Site	No.	16033 ▲	14438 ▼	14518 ■	→		15500 ■	→			174164	161153	178070		No Variation	0 - 2% Variation	>2% Variation	138580	151755	178070
		Total GP Referrals	No.	10399 ■	9555 ▲	9644 ■	→		10449 ■	→			114630	108845	120138		No Variation	0 - 2% Variation	>2% Variation	98476	95857	120138
		Total Other Referrals	No.	5634 ▲	4883 ▼	4874 ■	→		5051 ■	→			59534	52308	57932		No Variation	0 - 2% Variation	>2% Variation	40104	55898	57932
		By PCT - Heart of B'ham	No.	4507 ▲	4030 ▼	4064 ■	→		4371 ■	→			47666	45023	49859		No Variation	0 - 2% Variation	>2% Variation	40394	41628	49859
		By PCT - Sandwell	No.	7832 ▲	7214 ▼	7339 ■	→		7719 ■	→			87217	79528	87779		No Variation	0 - 2% Variation	>2% Variation	72580	77592	87779
		By PCT - Other	No.	3694 ▲	3194 ▼	3115 ■	→		3410 ■	→			39281	36603	40453		No Variation	0 - 2% Variation	>2% Variation	25606	32535	40453
		Conversion (all referrals) to New OP Att'd	%	87.3	87.2	85.2	→		83.8	→			85.3	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.	1163	1059	1117	354	732	1086	423	918	1341	13722	13077	13077	i	No Variation	0 - 2% Variation	>2% Variation	13887	13395	13106
		Elective DC	No.	4636	4181	4130	1833	2351	4184	2366	2739	5105	52729	49636	49636		No Variation	0 - 2% Variation	>2% Variation	45831	46304	50873
		Total Elective	No.	5799	5240	5247	2187	3083	5270	2789	3657	6446	66451	62713	62713		No Variation	0 - 2% Variation	>2% Variation	59718	59699	63979
		Non-Elective - Short Stay	No.	1079	1302	1412	621	764	1385	599	829	1428	18769	13745	13745		No Variation	0 - 2% Variation	>2% Variation	12414	11575	12770
		Non-Elective - Other	No.	4202	4318	3836	1541	2034	3575	1728	2222	3950	47072	51320	51320		No Variation	0 - 2% Variation	>2% Variation	52662	55163	56226
		Total Non-Elective	No.	5281	5620	5248	2162	2798	4960	2327	3051	5378	65841	65065	65065		No Variation	0 - 2% Variation	>2% Variation	65076	66738	68996
	Outpatients	New	No.	13995	12585	12372	4494	8487	12981	5431	10164	15595	164358	163114	163114		No Variation	0 - 2% Variation	>2% Variation	127449	131941	152923
		Review	No.	35604	33118	33730	11775	22637	34412	14875	27434	42309	425850	385680	385680		No Variation	0 - 2% Variation	>2% Variation	370970	361113	374867
	A/E Attendances	Type I (Sandwell & City Main Units)	No.	14395	15165	14412	5765	7725	13490	7102	8819	15921	190254	197122	197122		No Variation	0 - 2% Variation	>2% Variation	200561	195093	191141
	A/E Attendances	Type II (BMEC)	No.	2448	2532	2572	→	2750	2750	→	3061	3061	34836	30749	30749		No Variation	0 - 2% Variation	>2% Variation	31373	29803	30800
PATIENT ACCESS & EFFICIENCY																						
RK	Length of Stay	Average Length of Stay	Days	4.5	4.7	4.4	5.1	4.0	4.5				4.5	5.0	5.0		No Variation	0 - 5% Variation	>5% Variation	5.7	5.0	5.0
		All Patients with LOS > 14 days	No.	316	344	325	184	145	329	187	169	356	356	No. Only	No. Only					n/a	345	312
		All Patients with LOS > 28 days	No.	163	157	175	96	78	174	93	102	195	195	No. Only	No. Only					190	174	152
		Min. Stay Rate (Electives (IP/DC) <2 days)	%	92.2	92.3	92.8	95.7	91.4	93.2	95.2	90.5	92.5	92.3	92.0	92.0		No Variation	0 - 5% Variation	>5% Variation	88.3	90.5	91.6
	Admissions	Day of Surgery (IP Elective Surgery)	%	85.8	87.7	87.4	94.0	85.8	88.8	90.7	85.6	87.3	85.5	82.0	82.0		No Variation	0 - 5% Variation	>5% Variation	63.2	76.5	79.4
		Day of Surgery (IP Non-Elective Surgery)	%	67.9	62.7	70.0	68.0	70.32	69.3	67.2	72.0	70.0	69.7	No. Only	No. Only					n/a	68.3	70.2
		With no Procedure (Elective Surgery)	%	10.4	7.5	8.9	9.2	9.6	9.4				9.7	No. Only	No. Only					10.6	n/a	10.6
		Per Bed (Elective)	No.	5.18	5.37	4.97	4.35	5.81	5.10	4.88	6.25	5.58	5.49	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	23	9	6	9	15	13	15	28	28	<18	<18	b	No Variation	0 - 10% Variation	>10% Variation			
		Pt.'s NHS & NHS plus S.C. Delay	No.	9	10	7	3	5	8	5	7	12	12	<10	<10		No Variation	0 - 10% Variation	>10% Variation			
	Beds	Occupied Bed Days	No.	27724	28232	29129	11695	13760	25455	12643	15316	27959	331946	342000	342000		No Variation	0 - 5% Variation	>5% Variation	378060	348676	342793
		Occupancy Rate	%	90.7	86.4	86.1	88.0	83.9	85.9	86.9	83.9	85.4	86.0	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.	1000	1000	1065	486	508	994	483	506	989	989	975	975		No Variation	0 - 2% Variation	>2% Variation	1039	1007	975
	Day Case Rates	All Procedures	%	78.2	77.8	78.7	83.8	76.3	79.4	84.8	74.9	79.2	79.4	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation	76.0	76.9	79.0
		BMEC Procedures	%	80.29	77.3	81.2	→	85.35	85.4	→	79.5	79.5	79.7	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation	71.5	77.2	79.7
	Non-Admitted Care	New : Review Rate	Ratio	2.54	2.63	2.73	2.62	2.67	2.65	2.75	2.70	2.72	2.59	2.30	2.30		No Variation	0 - 5% Variation	>5% Variation	2.91	2.74	2.45
		DNA Rate - New Referrals	%	12.8	15.9	16.8	12.1	14.6	13.8	10.8	13.4	12.5	13.5	9.0	9.0		No Variation	0 - 5% Variation	>5% Variation	10.8	10.9	12.0
		DNA Rate - Reviews	%	12.2	13.9	16.1	13.5	12.3	12.7	12.0	11.6	11.8	12.3	9.0	9.0		No Variation	0 - 5% Variation	>5% Variation	12.8	13.5	13.5
		OP Cancellations - Trust Initiated	No.	2705	3259	4175	→		3907	→			16816	No. Only	No. Only					n/a	n/a	n/a
		OP Cancellations - Patient Initiated	No.	3524	3587	4992	→		3876	→			19252	No. Only	No. Only		To date = since 1 Oct 2009			n/a	n/a	n/a
		OP Cancellations as % OP activity	%	12.6	15.0	19.9			16.4				15.0	No. Only	No. Only					n/a	n/a	n/a
	Pathology	Cervical Cytology Turnaround	Weeks	0.8	0.8		→			→			0.8	<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	%	26.6	23.0	19.3	19.4	25.1	22.6	25.2	22.9	23.9	23.9	<10.0	<10.0		<10	10 - 12.5	>12.5	n/a	29.1	19.0
		(West Midlands average)	%	35.2	31.3	27.8	→		27.4	→		25.5	25.5	No. Only	No. Only					n/a	31.1	21.0
		In Excess of 60 minutes	No.	67	60	33	4	34	38	18	28	46	46	0	0		0	1 - 5	>5	n/a	n/a	
THEATRE UTILISATION																						
RK	Sitrep Declared Late **Cancellations** by Specialty	General Surgery	No.	9	6	8	5	1	6	0	5	5	81	60	60	a	0-5% variation	5 - 15% variation	>15% variation	n/a	75	104
		Urology	No.	3	2	11	0	4	4	4	5	9	48	48	48		0-5% variation	5 - 15% variation	>15% variation	n/a	67	102
		Vascular Surgery	No.	0	0	0	0	1	1	0	2	2	8	3	3		0-5% variation	5 - 15% variation	>15% variation	n/a	1	7
		Trauma & Orthopaedics	No.	8	6	11	0	0	0	0	2	2	66	72	72		0-5% variation	5 - 15% variation	>15% variation	n/a	100	75
		ENT	No.	4	5	4	0	1	1	0	0	0	23	12	12		0-5% variation	5 - 15% variation	>15% variation	n/a	19	23
		Ophthalmology	No.	20	11	2	0	12	12	1	17	18	139	108	108		0-5% variation	5 - 15% variation	>15% variation	n/a	139	153
		Oral Surgery	No.	4	3	2	0	0	0	0	2	2	24	8	8		0-5% variation	5 - 15% variation	>15% variation	n/a	10	19
		Cardiology	No.	2	0	0	0	0	0	0	1	1	7	21	21		0-5% variation	5 - 15% variation	>15% variation	n/a	28	31
		Gynaecology / Gynae-Oncology	No.	4	3	14	0	2	2	3	6	9	63	54	54		0-5% variation	5 - 15% variation	>15% variation	n/a	69	71
		Plastic Surgery	No.	1	0	1	0	0	0	1	0	1	11	12	12		0-5% variation	5 - 15% variation	>15% variation	n/a	17	21
		Dermatology	No.	0	2	0	0	0	0	0	9	9	27	24	24		0-5% variation	5 - 15% variation	>15% variation	n/a	4	24
		TOTAL	No.	55	38	53	5	21	26	9	49	58	497	422	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.	6408 ▲	6393 ▲	6324 ▲	→		6318 ▲	→					6241		No Variation	0 - 1% Variation	>1% Variation	6000	5875	6042
		Medical and Dental	No.	770 ▲	759 ▲	757 ▲	→		752 ▲	→					761		No Variation	0 - 1% Variation	>1% Variation	822	736	755
		M'ment, Admin. & HCAs	No.	2033 ■	2025 ▲	1992 ■	→		2004 ▼	→					1952		No Variation	0 - 1% Variation	>1% Variation	1806	1765	1852
		Nursing & Midwifery (excluding Bank)	No.	2409 ▼	2404 ▲	2373 ▲	→		2363 ▲	→					2547		No Variation	0 - 1% Variation	>1% Variation	2481	2255	2259
		Scientific and Technical	No.	958 ▲	973 ▼	961 ▲	→		970 ▼	→					981		No Variation	0 - 1% Variation	>1% Variation	891	869	913
		Bank Staff	No.	238	232	241	→		229	→				No. Only	No. Only					n/a	250	260
		Gross Salary Bill	£000s	21461 ▼	21290 ▼	21272 ▼	→		21193 ▼	→					243342		No Variation	0 - 1% Variation	>1% Variation	220244	219667	238674
RK	Bank & Agency	Nurse Bank Fill Rate	%	84.8	78.6	84.1	→		83.2	→		86.9	85.1	No. Only	No. Only					n/a	87.6	81.8
		Nurse Bank Shifts covered	No.	5261 ▼	4734 ▲	4956 ▼	→		4969 ▼	→		5534 ■	61621	61836	61836		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	67330	68707	69675
		Nurse Agency Shifts covered	No.	459 ■	729 ▼	830 ▼	→		538 ▲	→		509 ▲	5388	4972	4972		0 - 5% Variation	5 - 10% Variation	>10% Variation	2879	5524	4765
		Nurse Bank AND Agency Shifts covered	No.	5720 ■	5449 ■	5722 ■	→		5507 ■	→		6043 ■	67009	66808	66808		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	70209	74231	74440
		Nurse Bank Costs	£000s	544 ▼	536 ▲	503 ▲	→		544 ▼	→		529 ▲	6263	6423	6423		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	6883	6980	6844
		Nurse Agency Costs	£000s	72 ■	167 ■	225 ▼	→		85 ■	→		249 ■	1268	992	992		0 - 5% Variation	5 - 10% Variation	>10% Variation	474	1078	832
KD		Medical Agency Costs	£000s	167 ▼	164 ▲	199 ▼	→		187 ▲	→		436 ▼	2384	1192	1192		0 - 5% Variation	5 - 10% Variation	>10% Variation	693	1296	2026
RK		Other Agency Costs	£000s	192 ▼	177 ▲	192 ▼	→		160 ▲	→		293 ▼	2600	1410	1410		0 - 5% Variation	5 - 10% Variation	>10% Variation	1661	2223	3759
KD		Medical Locum Costs	£000s	273 ▲	247 ▲	210 ▲	→		218 ▼	→		246 ▼	2896	2250	2250		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	2566	2445	2747
RK/KD		Agency Spend cf. Total Pay Spend	%	2.01 ■	2.39 ▼	2.90 ■	→		2.04 ▲	→				<2.00	<2.00		<2	2 - 2.5	>2.5	1.50	2.15	2.77
CH	Sickness Absence	Long Term	%	3.25 ■	3.40 ■	3.79 ▼	→		3.34 ■	→			3.10	<3.00	<3.00		<3.0	3.0-3.35	>3.35	2.50	3.52	3.16
		Short Term	%	1.59 ■	1.33 ■	1.60 ■	→		1.25 ■	→			1.31	<1.25	<1.25		<1.25	1.25-1.40	>1.40	2.17	1.26	1.22
		Total	%	4.84 ▲	4.73 ■	5.39 ■	→		4.59 ■	→			4.41	<4.25	<4.25		<4.25	4.25-4.75	>4.75	4.67	4.78	4.38
	Recruitment & Retention	Permission to Recruit	wte	61	42	55	→		31	→		47	813	No. Only	No. Only					n/a	1143	1124
		New Starters	wte	50	28	43	→		58	→		73	1017	No. Only	No. Only					n/a	855	1066
		Leavers	wte	43	65	40	→		66	→		121	928	No. Only	No. Only					n/a	1004	999
		Inductions	No.	71	31	52	→		38	→		49	805	No. Only	No. Only					n/a	442	896
	Learning & Development	PDRs (includes Junior Med staff)	No.	254 ▼	189 ▼	280 ▲	→		280 ▼	→		263 ▼	4681	5341	5341	j	0-5% variation	5 - 15% variation	>15% variation	n/a	1963	4518
		Mandatory Training Compliance	%	41.4 ▲	55.7 ▲	60.7 ▲	→		65.2 ▲	→		71.1 ■	71.1	100	100		=>80	50 - 79	<50	4313 (No.)	2770 (No.)	4044 (No.)

KEY TO PERFORMANCE ASSESSMENT SYMBOLS

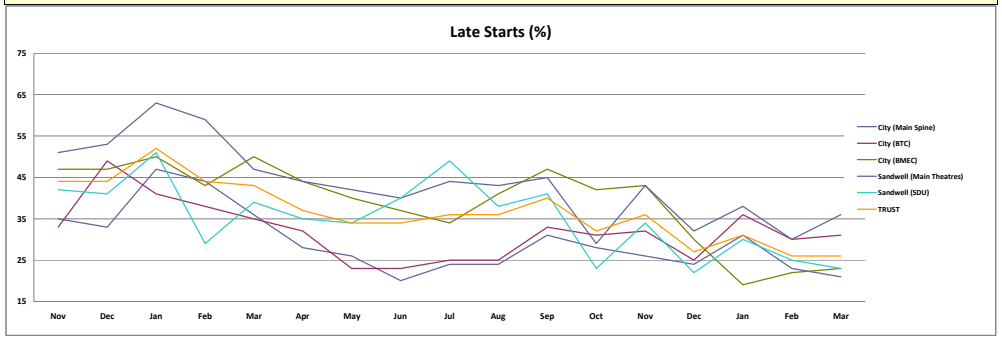
▲	Fully Met - Performance continues to improve
■	Fully Met - Performance Maintained
▼	Met, but performance has deteriorated
▲	Not quite met - performance has improved
■	Not quite met
▼	Not quite met - performance has deteriorated
▲	Not met - performance has improved
■	Not met - performance showing no 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

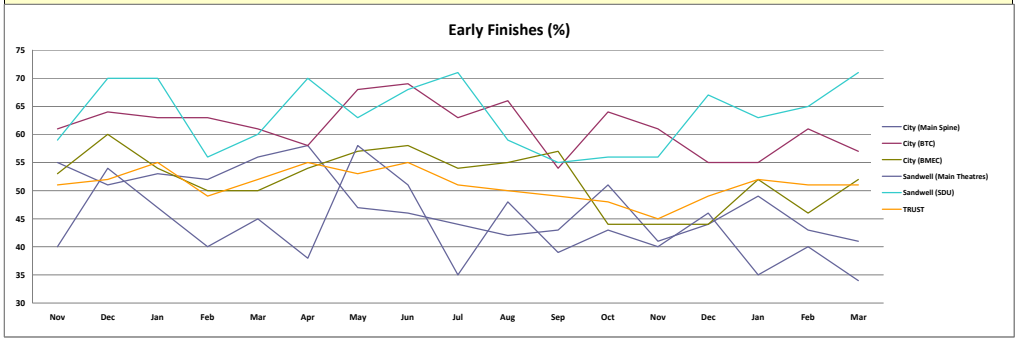
LATE STARTS (%)	2008 / 2009					2009 / 2010											
Theatre Location	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
City (Main Spine)	35	33	47	44	36	28	26	20	24	24	31	28	26	24	31	23	21
City (BTC)	33	49	41	38	35	32	23	23	25	25	33	31	32	25	36	30	31
City (BMEC)	47	47	50	43	50	44	40	37	34	41	47	42	43	30	19	22	23
Sandwell (Main Theatres)	51	53	63	59	47	44	42	40	44	43	45	29	43	32	38	30	36
Sandwell (SDU)	42	41	51	29	39	35	34	40	49	38	41	23	34	22	30	25	23
TRUST	44	44	52	44	43	37	34	34	36	36	40	32	36	27	31	26	26

KEY: GREEN = <5.1% deviation from target, AMBER = 5.1 - 15.0% deviation, RED = >15.0% deviation



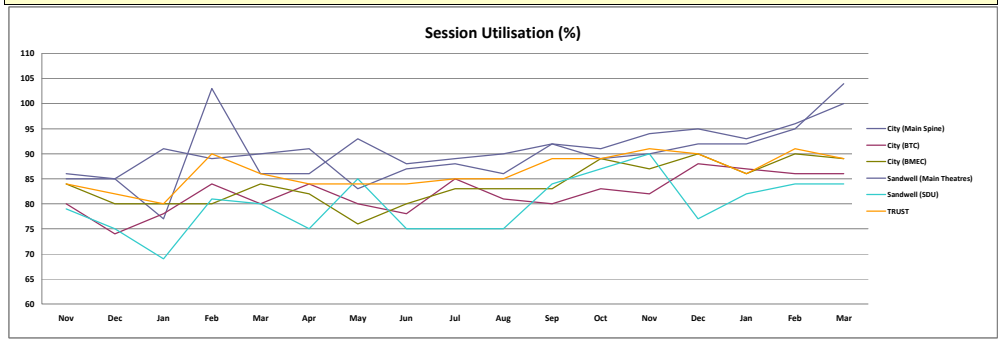
EARLY FINISHES (%)	2008 / 2009					2009 / 2010											
Theatre Location	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
City (Main Spine)	55	51	53	52	56	58	47	46	44	42	43	51	41	44	49	43	41
City (BTC)	61	64	63	63	61	58	68	69	63	66	54	64	61	55	55	61	57
City (BMEC)	53	60	54	50	50	54	57	58	54	55	57	44	44	44	52	46	52
Sandwell (Main Theatres)	40	54	47	40	45	38	58	51	35	48	39	43	40	46	35	40	34
Sandwell (SDU)	59	70	70	56	60	70	63	68	71	59	55	56	56	67	63	65	71
TRUST	51	52	55	49	52	55	53	55	51	50	49	48	45	49	52	51	51

KEY: GREEN = <5.1% deviation from target, AMBER = 5.1 - 15.0% deviation, RED = >15.0% deviation



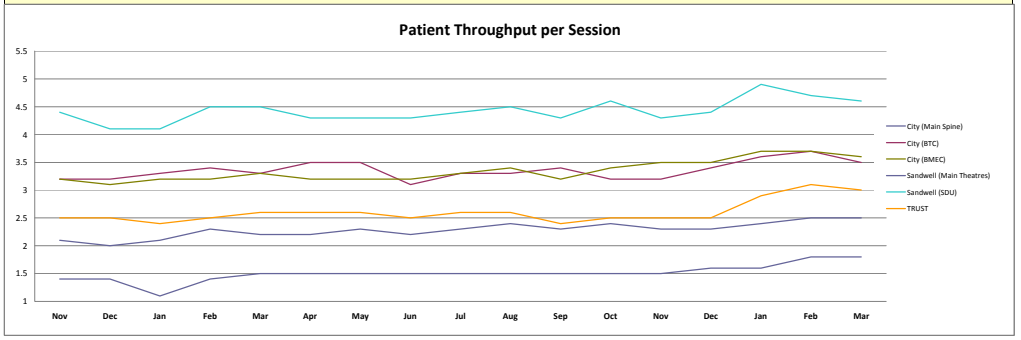
SESSION UTILISATION (%)	2008 / 2009					2009 / 2010											
Theatre Location	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
City (Main Spine)	86	85	77	103	86	86	93	88	89	90	92	91	94	95	93	96	100
City (BTC)	80	74	78	84	80	84	80	78	85	81	80	83	82	88	87	86	86
City (BMEC)	84	80	80	80	84	82	76	80	83	83	83	89	87	90	86	90	89
Sandwell (Main Theatres)	85	85	91	89	90	91	83	87	88	86	92	89	90	92	92	95	104
Sandwell (SDU)	79	75	69	81	80	75	85	75	75	75	84	87	90	77	82	84	84
TRUST	84	82	80	90	86	84	84	84	85	85	89	89	91	90	86	91	89

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	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
City (Main Spine)	1.4	1.4	1.1	1.4	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.6	1.6	1.8	1.8
City (BTC)	3.2	3.2	3.3	3.4	3.3	3.5	3.5	3.1	3.3	3.3	3.4	3.2	3.2	3.4	3.6	3.7	3.5
City (BMEC)	3.2	3.1	3.2	3.2	3.3	3.2	3.2	3.2	3.3	3.4	3.2	3.4	3.5	3.5	3.7	3.7	3.6
Sandwell (Main Theatres)	2.1	2.0	2.1	2.3	2.2	2.2	2.3	2.2	2.3	2.4	2.3	2.4	2.3	2.3	2.4	2.5	2.5
Sandwell (SDU)	4.4	4.1	4.1	4.5	4.5	4.3	4.3	4.3	4.4	4.5	4.3	4.6	4.3	4.4	4.9	4.7	4.6
TRUST	2.5	2.5	2.4	2.5	2.6	2.6	2.6	2.5	2.6	2.6	2.4	2.5	2.5	2.5	2.9	3.1	3.0

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:	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:	29 April 2010

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.

- 'Achieve' thresholds for each of the indicators which comprise the schedule of Operational Standards were met during the most recent period of assessment (Quarter 4).
- Performance against the indicators which comprise the Financial assessment is indicated.

The Weighted Overall Score for both elements of the assessment meet the 'Performing' threshold.

Foundation Trust Compliance Report – The overall Risk Score for the period remains stable and the overall Governance 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 22 April 2010.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2009/10

Operational Standards and Targets

Indicator	Weight	Thresholds Achieve	Thresholds Fail	Q1	Score	Weight x Score	Q2	Score	Weight x Score	Q3	Score	Weight x Score
A/E Waits less than 4-hours	1.00	98.00%	97.00%	99.39%	3	3.00	98.90%	3	3.00	97.26%	2	2.00
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	2	3	3.00	3	3	3.00
Clostridium Difficile	1.00	0%	>1.0SD	32	3	3.00	39	3	3.00	42	3	3.00
18-weeks RTT (Admitted)	1.00	90.0%	85.0%	98.0	3	3.00	>90.0%	3	3.00	>90.0%	3	3.00
18-weeks RTT (Non-Admitted)	1.00	95.0%	90.0%	98.5	3	3.00	>95.0%	3	3.00	>95.0%	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%	3	1.50	>95.0%	3	1.50
• Achievement in Orthopaedics	0.50	95.0%	95.0%	>95.0%	3	1.50	>95.0%	3	1.50	>95.0%	3	1.50
Cancer - 2 week GP Referral to First Outpatient Appointment	1.00	93.0%	88.0%	93.1%	3	3.00	93.3%	3	3.00	94.7%	3	3.00
Cancer - 31 day second or subsequent treatment (surgery)	0.33	94.0%	89.0%	100%	3	1.50	99.1%	3	1.50	>94.0%	3	0.99
Cancer - 31 day second or subsequent treatment (drug)	0.33	98.0%	93.0%							>98.0%	3	0.99
Cancer - 31 day diagnosis to treatment for all cancers	0.33	96.0%	91.0%	99.8%	3	1.50	99.8%	3	1.50	99.6%	3	0.99
Cancer - 62 day referral to treatment from screening	0.33	90.0%	85.0%	99.8%	3	0.99	100%	3	0.99	100%	3	0.99
Cancer - 62 day referral to treatment from hospital specialist	0.33	85.0%	80.0%	66.70%	0	0.00	98.6%	3	0.99	90%	3	0.99
Cancer - 62 day urgent referral to treatment for all cancers	0.33	85.0%	80.0%	90.6%	3	0.99	89.3%	3	0.99	89.3%	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	99.8%	3	3.00
Delayed Transfers of Care	1.00	3.5%	5.0%	2.60%	3	3.00	2.40%	3	3.00	3.40%	3	3.00
Stroke (Stay on Stroke Unit)	1.00	60%	30.0%	53.50%	2	2.00	59.60%	2	2.00	58.00%	2	2.00
Outpatient Waits >13 weeks (% of First OP Attendances)	0.50	0.03%	0.15%	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%	0.15%	0.000%	3	1.50	0.000%	3	1.50	0.000%	3	1.50
Sum	**16.00**					**45.98**			**46.97**			**45.94**
Average Score						**2.87**			**2.94**			**2.87**

Indicator	Weight	Thresholds Achieve	Thresholds Fail	January	Score	Weight x Score	February	Score	Weight x Score	March	Score	Weight x Score	Q4	Score	Weight x Score
A/E Waits less than 4-hours	1.00	98.00%	97.00%	97.80%	2	2.00	98.00%	3	3.00	98.80%	3	3.00	98.21%	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	0	3	3.00
MRSA Bacteraemia	1.00	0	>1.0SD	1	3	3.00	2	3	3.00	1	3	3.00	4	3	3.00
Clostridium Difficile	1.00	0%	>1.0SD	17	3	3.00	12	3	3.00	16	3	3.00	45	3	3.00
18-weeks RTT (Admitted)	1.00	90.0%	85.0%	95.5%	3	3.00	94.1%	3	3.00	93.4%	3	3.00	>90.0%	3	3.00
18-weeks RTT (Non-Admitted)	1.00	95.0%	90.0%	98.3%	3	3.00	98.9%	3	3.00	97.6%	3	3.00	>95.0%	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%	3	1.50	>95.0%	3	1.50	>95.0%	3	1.50
• Achievement in Orthopaedics	0.50	95.0%	95.0%	98.4%	3	1.50	97.6%	3	1.50	96.11%	3	1.50	>95.0%	3	1.50
Cancer - 2 week GP Referral to First Outpatient Appointment	1.00	93.0%	88.0%	93.9%	3	3.00	94.7%	3	3.00	>93.0%*	3	3.00	>93.0%*	3	3.00
Cancer - 31 day second or subsequent treatment (surgery)	0.33	94.0%	89.0%	100%	3	0.99	100%	3	0.99	>94.0%*	3	0.99	>94.0%*	3	0.99
Cancer - 31 day second or subsequent treatment (drug)	0.33	98.0%	93.0%	100%	3	0.99	100%	3	0.99	>98.0%*	3	0.99	>98.0%*	3	0.99
Cancer - 31 day diagnosis to treatment for all cancers	0.33	96.0%	91.0%	99.3%	3	0.99	100%	3	0.99	>96.0%*	3	0.99	>96.0%*	3	0.99
Cancer - 62 day referral to treatment from screening	0.33	90.0%	85.0%	100%	3	0.99	100%	3	0.99	>90.0%*	3	0.99	>90.0%*	3	0.99
Cancer - 62 day referral to treatment from hospital specialist	0.33	85.0%	80.0%	100%	3	0.99	100%	3	0.99	>85.0%*	3	0.99	>85.0%*	3	0.99
Cancer - 62 day urgent referral to treatment for all cancers	0.33	85.0%	80.0%	86.5%	3	0.99	85.0%	3	0.99	>85.0%*	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	0.0%	3	3.00
2-week Rapid Access Chest Pain	1.00	98.0%	95.0%	98.3%	3	3.00	100%	3	3.00	100%	3	3.00	99.0%	3	3.00
48-hours GU Medicine Access	1.00	98.0%	95.0%	100%	3	3.00	100%	3	3.00	100%	3	3.00	100%	3	3.00
Delayed Transfers of Care	1.00	3.5%	5.0%	2.60%	3	3.00	3.10%	3	3.00	4.90%	2	2.00	3.50%	3	3.00
Stroke (Stay on Stroke Unit)	1.00	60%	30.0%	73.3%	3	3.00	71.4%	3	3.00	66.7%	3	3.00	71.4%	3	3.00
Outpatient Waits >13 weeks (% of First OP Attendances)	0.50	0.03%	0.15%	0.000%	3	1.50	0.000%	3	1.50	0.000%	3	1.50	0.000%	3	1.50
Inpatient Waits >26 weeks (% of Elective Admissions)	0.50	0.03%	0.15%	0.000%	3	1.50	0.000%	3	1.50	0.000%	3	1.50	0.000%	3	1.50
				* Projected						* Projected			* Projected		
Sum	**16.00**					**46.94**			**47.94**			**46.94**			**47.94**
Average Score						**2.93**			**3.00**			**2.93**			**3.00**

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 - 2009/10

Financial Indicators				SCORING			2009 / 2010															
Criteria	Metric	Weight (%)		3	2	1	October	Score	Weight x Score	November	Score	Weight x Score	December	Score	Weight x Score	January	Score	Weight x Score	February	Score	Weight x Score	March	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	0	3	0.15	0	3	0.15	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	-0.04%	3	0.6	-0.03%	3	0.6	-0.02%	3	0.6	-0.01%	3	0.6	-0.01%	3	0.6	0.00%	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.	7.80%	3	0.15	7.86%	3	0.15	7.78%	3	0.15	7.78%	3	0.15	7.47%	3	0.15	7.91%	3	0.15
Forecast Outturn	Forecast Operating Performance	40	20	Forecast operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of income.	Operating deficit more than or equal to 2% of income	0.00%	3	0.6	0.00%	3	0.6	0.00%	3	0.6	0.00%	3	0.6	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.	7.69%	3	0.15	7.76%	3	0.15	7.73%	3	0.15	7.54%	3	0.15	7.52%	3	0.15	7.91%	3	0.15
	Rate of Change in Forecast Surplus or Deficit		15	Still forecasting an operating surplus with a movement equal to or less than 3% of forecast income	Forecasting an operating deficit with a movement less than 2% of forecast income OR an operating surplus movement more than 3% of income.	Forecasting an operating deficit with a movement of greater than 2% of forecast income.	0.00%	3	0.45	0.00%	3	0.45	0.00%	3	0.45	0.00%	3	0.45	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	0.60%	3	0.15	0.60%	3	0.15	0.60%	3	0.15	0.60%	3	0.15	0.59%	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	7.69%	3	0.15	7.77%	3	0.15	7.74%	3	0.15	7.55%	3	0.15	7.53%	3	0.15	7.92%	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	68.00%	2	0.05	69.00%	2	0.05	70.00%	2	0.05	69.00%	2	0.05	58.00%	1	0.025	76.00%	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	57.00%	1	0.025	67.00%	2	0.05	67.00%	2	0.05	62.00%	2	0.05	74.00%	2	0.05	78.00%	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	1.05	3	0.15	1.05	3	0.15	1.04	3	0.15	1.04	3	0.15	1.02	3	0.15	0.99	2	0.1
	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	20.35	3	0.15	21.00	3	0.15	22.10	3	0.15	22.76	3	0.15	21.34	3	0.15	18.33	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	42.53	2	0.1	44.19	2	0.1	46.80	2	0.1	46.61	2	0.1	45.98	2	0.1	33.27	2	0.1
						Weighted Overall Score			2.875			2.900			2.900			2.900			2.875			2.85

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

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Corporate Objectives 2009/10 – Progress Report (Quarter 4)
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Ann Charlesworth, Head of Corporate Planning
DATE OF MEETING:	29 April 2010

SUMMARY OF KEY POINTS:

The report contains a summary of progress, at the end of Quarter 4, towards the achievement of the Trust's Corporate Objectives set out in the Annual Plan 2009/10.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

To note progress made on the corporate objectives at Q4.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Outlines progress towards those objectives.
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**	All
Business and market share	**X**	
Clinical	**X**	
Workforce	**X**	
Environmental	**X**	
Legal & Policy	**X**	
Equality and Diversity	**X**	
Patient Experience	**X**	
Communications & Media	**X**	
Risks		

PREVIOUS CONSIDERATION:

Trust Management Board on 20 April 2010

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ANNUAL PLAN 2009/10
CORPORATE OBJECTIVES PROGRESS REPORT (QUARTER FOUR)

INTRODUCTION

The Trust's Annual Plan for 2009/10 set a series of corporate objectives for the year to ensure that we make progress towards our six strategic objectives. Progress on the majority of these objectives is reported to the Board at regular intervals either through routine monthly reports on finance and performance or through specific progress reports. Progress across all objectives is also reported quarterly to ensure the Board has a clear overview of our position.

QUARTER FOUR PROGRESS

A summary of the position on each objective at the end of Quarter 4 is set out in the table that accompanies this report. An overview of the Q4 RAG assessment for each objective is set out in the table below.

Objective	R / A / G Assessment			
	Q1	Q2	Q3	Q4
1. Accessible and Responsive Care				
1.1 Ensure continued achievement of national access targets				
1.2 Deliver Single Equality Scheme for 2009/10				
1.3 Improve compliance with single sex accom. standards				
1.4 Improve communication with patients about their care				
1.5 Identify key hospital actions to improve public health				
2. High Quality Care				
2.1 Infection control - achievement of national and local targets				
2.2 Complete implementation of surgical reconfiguration				
2.3 Improve quality of care for patients with stroke / TIA				
2.4 Deliver improvements in the Trust's maternity services				
2.5 Deliver the Trust's "Optimal Wards" programme				
2.6 Develop approach to clinical quality				
2.7 Deliver CQUIN targets				
2.8 Achieve NHSLA standards				
2.9 Improve care provided to Vulnerable Adults and Children				
2.10 Ensure the Trust fully meets the EWTD standards				
3. Care Closer to Home				
3.1 Right Care Right Here Programme exemplar projects				
3.2 Outpatient facilities in Aston HC, Rowley Regis Hospital				
3.3 Community Ophthalmology service for S. Birmingham PCT				
4. Good Use of Resources				
4.1 Delivery of planned surplus of £2.3m				
4.2 Delivery of CIP of £15m				
4.3 Service improvement - theatres, outpatients and bed mgt.				
4.4 Introduce routine service line reporting				

Objective	R / A / G Assessment			
	Q1	Q2	Q3	Q4
5. 21st Century Facilities				
5.1 Continue to deliver New Hospital Project as planned				
5.2 Deliver the capital programme				
5.3 With PCTs design major community facilities				
6. An Effective NHS FT				
6.1 Continue to pursue NHS FT status				
6.2 Continue to achieve Annual Healthcheck Core Standards				
6.3 Mandatory training and the LiA "Time to Learn" project				
6.4 Spread staff engagement through Listening into Action				
6.5 Next stages of the Trust's clinical research strategy				
6.6 Improve the Trust's approach to leadership development				
6.7 Improve response to the national carbon reduction strategy				

At the end of the year, 26 out of the 32 objectives have been achieved. Although the green rating is not affected it should be noted that regarding objective 1.1, delivery against national access targets, all targets were met with the exception of the referral to treatment target for admitted care in Trauma and Orthopaedics.

Although 5 objectives have been rated as amber, there has been significant progress in these areas throughout the year.

The only objective that remains red is 2.8, which reflects the fact that the NHSLA level 2 general assessments had to be deferred to 2010/11.

CONCLUSION AND RECOMMENDATIONS

This report and the accompanying table present an overview of the position on our corporate objectives for 2009/10 at the end of the year. The Trust Board is recommended to:

1. NOTE the progress made on the corporate objectives at Q4.

Ann Charlesworth
April 2010

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
TRUST OBJECTIVES 2009/10: QUARTER FOUR PROGRESS REPORT

PROGRESS REPORTING

Progress with many of the corporate objectives will be reported to the Board monthly through for example the monthly performance and finance reports (e.g. progress with 2009/10 financial plan and progress with national access targets) or through specific monthly reports (e.g. 'Right Care Right Here' programme reports). In addition to this and in order to ensure that the Board has a clear view of progress across the corporate objectives as a whole it is intended to report progress quarterly, as we have throughout the last year, using a traffic-light based system at the following Board meetings:

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

CATEGORISATION

Progress with the actions in the plan has been assessed on the scale set out in the table below.

Status	
3	Progressing as planned or completed
2	Some delay but expect to be completed as planned
1	Significant delay – unlikely to be completed as planned

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Four (March 2010)**	**Red / Amber / Green Assessment**
1.	***Accessible and Responsive Care***			
1.1	Ensure continued achievement of national access targets (A&E, cancer, inpatient, outpatient and diagnostics and GUM). RK	• A&E 4 hour target achievement • Cancer target achievement (2 weeks, 31 days and 62 days) • 18 week referral to treatment targets • Maximum waits for IP, OP and diagnostic treatment (13 wks OP, 26 wks IP, 6 wks diagnostic) • Rapid access chest pain 2 week target achievement • GUM 48 hour access targets	• A&E (4 hour) = 98.8% in Q4 (Year = 98.4%) • Cancer targets (Months 10&11): 2 Weeks = 93.3% Months 1-11 = 93.9% 31 Days = 99.7% Months 1-11 = 99.7% 62 Days = 85.7% Months 1-11 = 89.0% • 18 weeks (Month 11): Admitted RTT = 94.1% Non-Adm. RTT = 98.9% • Max. Waits: IP = max wait 20 weeks (Month 11) OP = max wait 12 weeks (Month 11) Cardiac = max wait 6 weeks (Month 11) Diagnostics = 8 greater than 6 weeks • Rapid access chest pain = 99.0% Q4 (Year = 99.7%) • GUM 48 hour access: Offered App't = 100% for Q4 (Year = 99.8%) Seen = 83.3% for Q4 (Year = 86.8%)	**3**
1.2	Deliver commitments in Single Equality Scheme for 2009/10 RO	• Evidence of Impact Assessment of both policies and services • Training reports show good update of training • Workforce demographic data published on website and an action plan for managing diversity	Impact assessments continue to be completed. A database is established and trend analysis is being undertaken.	**3**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Four (March 2010)**	**Red / Amber / Green Assessment**
1.3	Improve patient privacy and dignity by increasing compliance with single sex accommodation standards. RK	• Improvement with single sex standards demonstrated through audits	Update presented to Trust Board in March 2010 including public declaration of compliance. Further reports will be provided quarterly Reporting of breaches now included in monthly performance report and shows limited to key specialist areas and assessment units at periods of highest demand.	**3**
1.4	Continue to improve communication with patients about their care. RO	• Evidence from two inpatient surveys per year plus national survey • Patient experience action plan updated and reported to Trust Board.	Inpatient surveys continue. Plans are being developed for surveys of vulnerable patients/patients who do not speak English as a first language. Easy read version now available. Rewrite of existing survey completed in draft.	**3**
1.5	Work with Sandwell and HoBtPCTs to identify key hospital actions that will contribute to improvements in public health. DOD	• Agreement of plan with PCTs. • Achievement of measures included in plan	Discussions held with Directors of Public Health from HOB and Sandwell PCTs Agreements reached in respect of CQUIN priorities going forward, engagement of SWBH clinicians in respect of Public Health Agenda, and inclusion of some public health measures in directorate objectives and QMF.	**3**
2.	***High Quality Care***			
2.1	Ensure continued improvement in infection control and achievement of national and local targets. RO	• MRSA targets achieved. • C difficile target achieved. • Compliance with Hygiene Code • Meeting national cleanliness standards • Improvements in hand hygiene audits • Increased access to hand wash facilities	Targets continue to be achieved at Q4. MRSA Screening: • Elective Screens = 7186 (Year = 24710) • Non-Elec. Screens = 6723 (Year = 18571) C. Diff: • 45 cases (target trajectory <63) Year =158 cases (target <264) MRSA Bacteraemia: • 4 cases (target trajectory <6) Year =14 cases (target <33)	**3**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Four (March 2010)**	**Red / Amber / Green Assessment**
2.2	Complete implementation of surgical reconfiguration RK	• Reconfiguration completed by June 09	Surgical reconfiguration now complete following changes to T&O in May 2009. Initial review of impact at 6 months has been presented to TMB and will be summarised for Trust Board during Q1 2010/11.	**3**
2.3	Deliver significant improvements in quality of care for patients with stroke / TIA. DOD	• Agreement of stroke services plan • Delivery of actions set out in plan • Improved % of time on stroke unit • Improved access to CT scan within 24 hours.	Stroke Action Team set up to implement Stroke Plan developed in 2008/09. Stay on Stroke Unit (Q4): • The proportion of patients spending >90% of their hospital stay on a stroke unit was 71.4%. For the year = 61.7%. (NHS Performance Threshold achieved = >60%) Access to CT Scan (Q4): • 85.9% patients received Scan within 24 hours of admission. For the year = 81.2%	**3**
2.4	Deliver significant improvements in the Trust's maternity services. JA	• Successful delivery of action in Maternity Integrated Development Plan. • Improved performance on key measures (see monthly Performance Report). • Successful delivery of Risk Mitigation Action Plan • Complete configuration review	New Risk Mitigation Plan has been implemented following virtual completion of previous plan. Co-located low risk birth centre opens 5 May at City. Final reconfiguration plan agreed and approved by Scrutiny Ctte. Dashboard indicators show continued improvement.	**3**
2.5	Deliver the Trust's "Optimal Wards" programme. RO	• Ward reviews undertaken. • Results demonstrate progress in key areas. • Improvement in ward accreditation scores over the year.	Optimal Wards continues. 27 wards now in the programme. Ward reviews are currently being undertaken again.	**3**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Four (March 2010)**	**Red / Amber / Green Assessment**
2.6	Develop the Trust's approach to measuring and managing clinical quality. DOD	• Launch of Quality Management Framework • Production of Quality Account • Regular assessments of mortality rates at specialty level and at Trust Board	Quality Management Framework reviews of specialties commenced Oct 09. 2nd cycle commenced Jan 2010. Clinical Executive Team launched successfully. Extended to include Clinical Directors Work has commenced on producing the 09/10 Quality Account and is expected to be complete by June 2010 deadline. Service Line Management project presented to Trust Board Feb 2010.	**3**
2.7	Deliver CQUIN targets: - time to surgery for fractured neck of femur; - access to CT scan for stroke patients; - reduced caesarean section rate; - improved outpatient data quality (referral source); - introduction of patient surveys; - referral of patients to smoking cessation services - provide annual report for Neonatal and Cardiology Specialised Services - improve reporting of Neonatal Intensive Care data DOD	• Achievement of targets agreed in the detail of the CQUIN agreement.	Aim to integrate CQUIN data into QMF and monitor regularly. Hip Fracture: • 100% (month 12) [Year = 84.4%] received operation within 48 hours admission (target 85.0%) **Achieved** CT Scan Access: • 85.9% (Q4) patients received Scan within 24 hours admission (target 72%) [Year = 81.2%] **Achieved** Caesarean Section Rate: • 23.9% (Q4) (target 26.0%) [Year = 23.3%] **Achieved** OP Source of Referral Info: • 1.31% (Q4) not stated (target <5.5%) [Year = 1.39%] **Achieved** Smoking cessation • 696 (Q4) (target = 250) • 1164 for the year (target = 750) **Achieved**	**3**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Four (March 2010)**	**Red / Amber / Green Assessment**
2.8	Achieve NHSLA standards Level 2 (general) by December 2009 and new Level 1 (maternity) by March 2010. KD	• Achievement of NHSLA standards.	The Trust was successfully assessed at Level 1 NHSLA Risk Management standards on 24 March 2010 and at Level 1 CNST Maternity standards on 25-26 March 2010. A maximum score of 50/50 was awarded in both assessments. The Trust does not require reassessment until quarter 4 2011/12, although earlier assessment at a higher level can take place. A formal report confirming the outcome is expected within 20 days of the assessment. **NHSLA level 2:** Given the significant challenges posed by assessment at Level 2 this is likely to occur towards the end of 2010/11. An early interim visit will be requested to enable the Assessor to look at evidence and provide guidance as to compliance. **CNST Maternity level 2:** As this is the first year of assessments against the new standards there are to be changes in the manual. These mainly focus around making the evidence requirements more stringent, by eliminating the "cherry-picking" possible under the 2009/10 standards.	**1**
2.9	Improve the quality of care provided to Vulnerable Adults (e.g. patients with mental health difficulties or learning disabilities) and Children – to include Safeguarding Children standards. RO	• Agreement of plan for improvement for both vulnerable adults and children including performance measures • Establish structures • Delivery of plan • Compliance with core standards	Structure in place. RAG action plans in place. Training now being recorded and reported.	**3**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Four (March 2010)**	**Red / Amber / Green Assessment**
2.10	Ensure the Trust fully meets the EWTD standards for junior doctors by August 2009. KD	• Achieve EWTD compliance	EWTD compliant working patterns for all junior doctors employed by the Trust (366) have been introduced. Full compliance with the EWTD requirements for all junior doctors has therefore been achieved. This corporate objective has been met.	**3**
3.	***Care Closer to Home***			
3.1	Ensure full Trust participation in delivery of Right Care Right Here Programme exemplar projects. RK	• Exemplar projects achieve their targets for 2009/10	Exemplar projects and project targets agreed for 2009/10. Projects making progress against targets for this year and Trust teams have played full part in delivery of these objectives.	**3**
3.2	Make full use of outpatient facilities in Aston HC, Rowley Regis Hospital. RK	• Plans agreed to make maximum use of facilities • Increased volumes of outpatients delivered from these locations.	Currently delivering range of specialties from Aston. Expect to deliver 1,500 – 2,000 atts per annum on current plans. Discussions in progress with HoB in light of changed assumptions in RCRH programme. Rowley Regis delivering c. 10,000 atts per annum. Short-term expansion of services at Rowley will concentrate on Ophthalmology.	**2**
3.3	Deliver successful community ophthalmology service for South Birmingham PCT. RK	• Activity delivered in South Birmingham community service.	Community service now operational from Hall Green and Edgbaston and West Heath locations providing a range of clinics per week from each venue. Work remains in progress on options for fourth location in Selly Oak area.	**3**
4	***Good Use of Resources***			
4.1	Delivery of planned surplus of £2.3m. RW	• Achievement of financial target.	The Trust has achieved an unaudited surplus of £2.3m (£2,269,000 was the precise control total). The formal audit must be complete by 11 June 2010.	**3**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Four (March 2010)**	**Red / Amber / Green Assessment**
4.2	Delivery of CIP of £15m. RW	• Achievement of CIP.	The Trust achieved a cost improvement plan of £15m during the year.	**3**
4.3	Develop approach to service improvement concentrating on theatres, outpatients and bed management RK	• Service improvement plan agreed. • Improved theatre and outpatient utilisation.	Service improvement and elective access teams continuing to improve outpatient processes concentrating on handling of referrals. Has resulted in significant improvement in outpatient waiting times in many specialties. Next stages of work in 2010/11 will concentrate on reducing cancellations and DNA rates. Theatre productivity has improved during 2009/10 with percentage of lists starting late falling from c. 40% at start of year to c. 25% at end of Q4. Next stages of this work include launch of Productive Operating Theatre programme in 2010/11. Prototype of real-time bed-management now been developed and planning in progress for testing and roll-out during 2010/11.	**3**
4.4	Introduce routine service line reporting to support development of clinical management structure. RW	• Service line reporting in place. • Impact demonstrated through F&PC reviews of Divisions.	Progress is being made with the new system Ardentia in terms of ironing out implementation issues and a dual running period continues as the Trust has retained its current systems that provide a specialty based analysis of income and costs. Given that go-live has not been achieved in 09/10 this indicator remains amber despite there being an improvement between quarters 3 and 4.	**2**
5	***21st Century Facilities***			
5.1	Continue to deliver New Hospital Project as planned. GS	• OBC approved • Land acquired where possible through voluntary agreement • CPO launched and statutory	OBC approved by DH Some land owners engaged on voluntary basis	**2**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Four (March 2010)**	**Red / Amber / Green Assessment**
		process ongoing • Draft OJEU procurement documentation prepared and ready for PFU approval • OBC review documentation prepared	CPO launched OJEU documentation being prepared RCRH Programme affordability review to reflect revised long term financial planning assumptions initiated	
5.2	Continue to improve current facilities through the delivery of the capital programme including: - replacement MRI scanner at City - upgrade of accommodation at City (MAU and D16) GS	• Major capital projects delivered in line with programme • Programme managed to deliver Trust objectives • Capital Budget managed in line with project delivery.	Major construction projects on plan reported in detail to SIRG	**3**
5.3	Fully engage with PCTs in design of major community facilities (Aston, BTC, Rowley Regis and Sandwell). GS	• Submission of Business case/LIFT stage 1 approval for each development agreed with PCTs through Right Care Right Here Programme.	Revised guidance on business case content may challenge submission date RCRH Programme affordability review to reflect revised long term financial planning assumptions initiated	**2**
6	***An Effective NHS Foundation Trust***			
6.1	Continue to pursue NHS Foundation Trust status and explore complementary approaches to further increasing patient, public and staff engagement. JA	• Trajectory for FT or alternative status agreed with SHA by 31/3/09	New trajectory for FT status agreed with SHA (application Summer 2011). Further work completed on complementary approaches and update submitted to DH.	**3**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Four (March 2010)**	**Red / Amber / Green Assessment**
6.2	Continue to achieve Annual Healthcheck Core Standards KD	• Core standards achieved.	Compliance was achieved for the following core standards previously declared as 'not met' in the declaration to the Care Quality Commission: C20b (single sex accommodation) – December 2009 C11b (mandatory training) – March	**3**
6.3	Deliver improved uptake of mandatory training and implement the LiA "Time to Learn" project. LB/GD	• Uptake of mandatory training	The internal reporting system is now well established and significant in-roads have been made with data validation. There are still some reporting anomalies that are being addressed. Overall mandatory training compliance has significantly improved although there are still a number of 'hot spots'. The mandatory training programme has been revised and is predominantly now offered in 'block sessions'. E-learning modules are now also available and plans are in place to increase the number of e-learning options available during 2010/11. The time to learn project has been reviewed and an implementation plan has been developed with a view to piloting the proposals prior to full roll-out.	**2**
6.4	Continue to spread staff engagement through Listening into Action including delivery of the LiA "Enabling Our People" projects. JA	• Spread of LiA projects • Progress with "Enabling Our People" • Staff views reported through staff survey	Further increase in new projects. New project management arrangements in place and working well. LiA used for QuEP planning, clinical engagement and sustainability projects. Paper on future of LiA agreed at January Board and action plan agreed by Sponsor Group.	**3**

Trust Objectives 2009/10				
Ref.	**Objective**	**Success Factors**	**Summary Position as at end of Quarter Four (March 2010)**	**Red / Amber / Green Assessment**
6.5	Establish the next stages of the Trust's clinical research strategy. DOD	• Strategy agreed • Progress with implementation • Recruitment of patients into clinical trials	New Director of R&D – 1st June New Head of R&D – 4th May R&D Strategy approved and presented to Trust Board January 2010 Recruitment of patients into trials continues and will be monitored in QMF	**3**
6.6	Improve the Trust's approach to leadership development. LB/GD	• Review of current management and leadership development activity • Agreed programme of future work	The ethos and principles of the Trust's Staff Engagement approach (LiA) has been included in all existing management development programmes. The review of leadership development report was considered and approved at the March Trust Board. An associated action plan will now be developed accordingly.	**3**
6.7	Improve the environmental sustainability of the Trust's operations by responding to the national carbon reduction strategy. GS	• Agreed plan to improve sustainability • Improved performance in measures identified in the plan	Presentation on Sustainability given to Board. Sustainability plan developed and approved Work on action plan ongoing Sustainability group established	**3**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Briefing on Staff Engagement
SPONSORING DIRECTOR:	John Adler, Chief Executive
AUTHOR:	Sally Fox, 'Listening into Action' Facilitator
DATE OF MEETING:	29 April 2010

SUMMARY OF KEY POINTS:

- There are now 65 LiA work streams across the Trust
- There continues to be an encouraging level of interest from new teams looking to use the methodology
- The priority is to take forward all the work activities identified in the paper on the future of LiA , approved by Board in January, to ensure the full embedding of the LiA approach. The Executive Sponsor Group is monitoring progress.
- The 'Birthday Party' on the 14 May will see the launch of the recruitment of LiA champions to increase capacity within the Trust to support the continued development and roll out of LiA
- The SHA has commissioned the University of Birmingham to undertake an evaluation of LiA in four Trusts, including Sandwell and West Birmingham, and this process has now started.

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 note the progress with 'Listening into Action'

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Continue to spread staff engagement through Listening into Action, including the delivery of the LiA 'Enabling our People' projects
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

The last briefing on staff engagement was reported to the Board in January 2010.

Briefing on Staff Engagement

Introduction

The Trust has been using the 'Listening into Action' approach since April 2008 as the principal means of engaging with staff about improving services for patients and also their own daily experience of working within this Trust.

It is becoming increasingly difficult to maintain an accurate record of the number of LiA work streams as more and more teams adopt the approach, which is very encouraging. There are now 27 wards in the Optimal Ward programme, 22 clinical teams, 10 non clinical teams and 6 corporate work streams. In addition, other areas are expressing interest in becoming involved to look at improving the discharge process, improving levels of organ donation, and using LiA in dermatology, respiratory medicine and nuclear medicine.

Teams continue to work directly with patients, and Audiology will be conducting some patient interviews in April and May, and working with patients to get valuable feedback on the service.

Nuclear Medicine will be holding an event on the 21 May to examine revised booking systems and working arrangements to ensure that patient demand can be met.

Current position

Following Board approval of the approach to embedding LiA at the January meeting, a detailed action plan is now in place to ensure the long term sustainability of LiA across the organisation.

The Birthday Party event on the 14 May to celebrate 2 years of using the LiA approach will mark the launch of the recruitment of LiA champions, which will strengthen the capacity within the organisation to support LiA . Teams will be exhibiting the work they have done, and there will also be an opportunity to celebrate what has been achieved to date and share learning across teams.

Some recent developments have included the use of LiA with groups of administrative and clerical staff. The Team in Gynaecology used the approach to improve the provision and organisation of secretarial staff/services, and the Estates department has just begun a similar piece of work to ensure that staff can provide their views and ideas about the way in which their workload can be organised most effectively.

The Trust has also received the results of the most recent staff survey, and the responses to the local questions on LiA and its impact are very encouraging.

- 89% of respondents said they had definitely heard about LiA in the Trust compared with 70% in 2008
- 43% of respondents have heard about planned improvements/can already see improvements in services for patients being made compared with 31% in 2008
- 66% of respondents said they have a clear idea of what LiA is compared with 45% in 2008
- 45% of respondents said LiA is very likely/quite likely to succeed compared with 34% in 2008
- 47% of respondents said that LiA is giving more power to change things compared with 44% in 2008
- 74% of staff said that their manager does act/sometimes acts on staff suggestions for improving services compared to 62% in 2008

Where next?

The Executive Sponsor Group continues to monitor progress and receives reports on a quarterly basis from the Divisions. This format of reporting remains useful, and will continue for the foreseeable future.

The Executive Sponsor Group is also monitoring progress against the LiA action plan in the usual way using RAG ratings to ensure that momentum is maintained.

In addition, the University of Birmingham has just begun a formal evaluation of the use of LiA in four Trusts in the West Midlands, including Sandwell and West Birmingham. It is anticipated that this evaluation will be complete by the end of June 2010.

Sally Fox
April 2010

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Finance and Performance Management Committee – v0.2

Venue Executive Meeting Room, City Hospital **Date** 18 March 2010; 1430h – 1630h

Members Present		In Attendance		Secretariat
Mr R Trotman	[Chair]	Mr T Wharram		Mr S Grainger-Payne
Mrs S Davis				
Miss I Bartram		**Guests**		
Dr S Sahota		Miss R Overfield	[Item 4 only]	
Mrs G Hunjan		Mrs L Barnett	[Item 5.3 only]	
Mr J Adler				
Mr R White				
Mr R Kirby				

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received apologies from Derek Alderson and Mike Harding.	
2 Minutes of the previous meeting – 18 February 2010	**SWBFC (2/10) 023**
The minutes of the previous meeting were accepted as a true and accurate record of discussions held on 18 February 2010.	
AGREEMENT: The minutes of the previous meeting were approved	
3 Matters arising from the previous meeting	**SWBFC (2/10) 023 (a)**
The updated actions log was noted by the Committee.	
4 Plans for the review of bank and agency staff usage	**Presentation**
Miss Overfield joined the meeting to present an update on the progress with and the plans to address the usage of bank and agency staff within the Trust. She advised that a workstream had been included within the Quality and Efficiency Programme (QuEP) to monitor these plans specifically. The Committee was advised that work to understand where agency and banks staff are used within the Trust had been completed and robust monitoring of use had now been introduced, facilitated by the development of operational policies. Miss Overfield advised the Committee, that it was anticipated that by the year end, expenditure associated with agency staff would be reduced by £2.5m compared with previous years. The Committee was advised that although clarity had been reached on where bank and agency staff are used and the associated expenditure, the hours of work	

undertaken by bank and agency staff was not yet clear. It had been determined that in the previous year, some areas noted to have been particularly reliant on the use of bank and agency staff had been required to cover higher than expected activity. The use for 2009/10 however, had been much more level, with fewer peaks in the use of temporary staff. The Committee noted that expenditure on agency and bank staff was not confined to nursing areas; temporary staff are employed in administration and clerical environments and within specialist areas, such as radiography, the plaster room and audiology. Facilities was also noted to be a high user of agency staff.

Mrs Davis asked whether the establishment of a Trust administration bank had been considered. Miss Overfield advised that this was the case and the facility would be developed in the coming months.

In terms of nursing specifically, Miss Overfield reported that there had been a reduction in the use of staff from the registered nurse bank during the current year, suggesting that recruitment of substantive staff had successfully covered the previous vacancies. Mr Trotman observed that bank staff may not always be members of staff employed by the Trust.

Miss Overfield advised that bank staff pay rates are comparable with rates provided under Agenda for Change. A recruitment exercise aimed at bolstering the pool of bank staff had been undertaken, aimed in particular at individuals seeking a more flexible working pattern. The majority of bank staff are used on established wards to cope with additional capacity.

The trend in the use of non-registered nurses (Heathcare Assistants) was also reported to be much flatter during the current year. Some of these individuals were noted to be student nurses working as Heathcare Assistants. Approximately 6000 shifts per month are covered by non registered nurses from the Trust's bank.

Miss Overfield advised that the change in the trends in usage is monitored by the Financial Management Board on a monthly basis. Critical Care was noted to be using far fewer temporary staff, attributable in part to the revised bank rates payable to staff working within this area. A downward trend in the use by Paediatrics has been seen, however an increase in use by Gynaecology is apparent due to the current higher capacity in this area. The Maternity area is using less temporary staff, due to some degree to the reduction in sickness absence across the area. A decline in use has been seen in Medicine A, reflective of capacity closing. Medicine B and Surgery A theatres use remains static. Surgery B's use is showing a downward trend.

Regarding bank staff pay rates, Miss Overfield reported that a rationalisation exercise had been undertaken, whereby 28 rates had been reduced to just 6, based largely on Agenda for Change pay bands. Standardised enhancements were also aligned to Agenda for Change. Mr White remarked that this rationalisation of the pay rates had reduced the administration and pay error rates associated with payment to bank staff.

In terms of agency pay, work has been undertaken on a national level with Buying Solutions to set up national agreements. As from October 2009, a new national contract had been agreed which results in a significant increase in the rates paid to agency staff. A local consortium has however negotiated a temporary agreement which although involves an increase in the agency rates, is considerably less than the national agreement. Mr Adler asked Miss Overfield to send him a schedule of agency rates before and after the new national agreement had been applied. It was suggested that the increase in agency fees may need to be escalated to an

appropriate level for reconsideration. The reasons for the use of bank and agency staff was outlined. It was noted that a significant reason was to provide intensive nursing care. Improvements to the management of agency and bank staff use were described as including better data to ensure that use is monitored robustly and the ward establishment reviews, which had addressed substantive staffing issues, thereby reducing the reliance on using agency and bank staff. Recruitment strategies and the leave policy have also been revisited. The revised organisation of Mandatory Training into blocks has also reduced the need to rely on temporary staff to cover multiple absences due to attendance at separate modules. The targeted approach to usage by Critical Care and theatres has also assisted with addressing the situation and wards have been encouraged to adopt best practice in relation to rostering staff. Other flexible options are also being considered such as annualised hours or seasonal working patterns. Management of sickness absence was noted to have been a key tool to help reduce the reliance on temporary staff cover. Apprenticeships and the use of the 'Future Jobs' fund were also highlighted to be helpful to the work. In terms of the Facilities department, the high usage was noted to be attributable to the high turnover of staff in the area. In this instance, the use of agency staff minimises the employment costs of substantive individuals and an agency introduction fee is not incurred. Deep clean initiatives are undertaken across the Trust, supported by the use of agency staff. Agency staff were reported to be used most highly within domestic, catering, transport and security areas. Mr Trotman asked whether overtime was payable to medical secretaries. He was advised that this is the case and he therefore suggested that the use of digital dictation might be useful to consider. All areas using agency staff have been approached and asked to justify the use of the temporary staff. Miss Bartram remarked that she was reassured by the plans and the level of information provided concerning the issue. Mrs Davis suggested that there was a need to reflect the planned use of bank and agency staff within budgets. Mr Wharram conformed that this matter was in hand. Mr Trotman noted that there are plans to change the legislation around temporary staff from October 2011 to grant them identical employment rights to substantive employees and requested a further update at the April meeting. Mr Adler highlighted that a 30% reduction in agency costs had been reported in the latest financial performance update. Mr Trotman thanked Miss Overfield for the useful and very informative presentation.	
ACTION: **Miss Overfield to provide Mr Adler with a schedule of agency pay rates, both before and after the national agreement negotiated with Buying Solutions** **ACTION:** **Mr Grainger-Payne to arrange for a further update on the impact of revised legislation concerning employment of temporary staff to be provided at the April meeting**	
5 Trust Board performance management reports	
5.1 2009/10 month 11 financial position and forecast	**SWBFC (3/10) 027** **SWBFC (3/10) 027 a)**

	SWBFC (3/10) 027 (b)
Mr Wharram reported that the in-month surplus achieved was £96k against a target of £70k; £26k above plan. The year to date surplus was reported to be £2,202k against a plan of £2,232k. In month WTEs are 127 below plan and the cash balance is approximately £5m above plan as at 28 February 2010. In summary, the Trust is overperforming on activity, thereby incurring additional costs to deliver the work. It is anticipated that the forecast end of year surplus will be delivered as planned. Mrs Hunjan asked for an explanation of the position regarding the reserves allocation. She was advised that the expenditure against this allocation is linked to specific developments. Funds had been set aside at the beginning of the year for this purpose. Mr White reported that following a recent revaluation of assets exercise by the District Valuer, the impact of this would be reflected in the statutory accounts. Although the detail is still to be finalised, it is anticipated that this may be in the region of £7.5m beyond the provision in the revaluation reserves allocation. The audited accounts will reflect a precise figure after the impact of the revaluation has been assessed on a building by building basis. Mrs Davis asked whether this issue would make lend itself to supporting the proposed estates rationalisation plans. She was advised that this was not the case.	
5.2 Performance monitoring report	**SWBFC (3/10) 026** **SWBFC (3/10) 026 (a)**
Mr White reported that cancelled operations fell during the month, as did delayed transfers of care. Half of the cancelled operations were reported to be associated with Ophthalmology. Mr Kirby advised that these concerned specifically VR procedures, however the situation is due to be addressed with the introduction of a new rota. Performance against the stoke care target was noted to have improved. The performance against the Accident and Emergency waiting time target was 98.4% year to date. Performance against the referral to treatment time targets was reported to have been sufficient in February for both admitted and non-admitted care. Data completeness was also satisfactory. An issue with performance against the Orthopaedics target was noted however, where performance was 78% in February and 72% in January against a target of 95%. A significant backlog of patients requiring orthopaedic procedures was highlighted, a proportion of which have needed to be undertaken privately to ensure that relevant targets are achieved. In terms of performance against the CQUIN targets, the Committee was advised that it is expected that the smoking cessation target will be met. Much focus is being given to ensuring that the hip fracture target is met, at present. Regarding activity, the end of year forecast position has been agreed with Sandwell PCT, although this remains to be ratified by the Trust's additional commissioners. Dr Sahota asked whether work was in progress to address DNA rates. He was advised that a group has been established to tackle the high DNA rates and an action plan will be prepared. Some very late cancellations were noted to be	

treated as a DNA. Mr Kirby advised that the use of text messages to mobile phones, although a good concept, was difficult to implement widely as there are difficulties with obtaining mobile phone numbers from patients. If landlines are to be used to remind patients of appointments, then it was highlighted that expansion of the contact centre service to include a slot between 6pm – 8pm would be needed. It was suggested that this should be investigated and the idea could be discussed as part of conversations with GPs. Mrs Hunjan confirmed that Birmingham Children's Hospital operates a contact centre service between 6pm – 8pm.	
ACTION: **Mr Kirby to investigate the expansion of the contact centre service to support the work to reduce DNA rates**	
5.3 HR dashboard	**SWBFC (3/10) 026** **SWBFC (3/10) 026 (a)**
Mrs Lesley Barnett joined the meeting to present the updated HR dashboard. She advised that the level of detail required by the Committee had been discussed with the Non Executive Directors and the Chair. It had been agreed that a quarterly report was still required, however some of the reports will be themed to provide more detailed information, such as ethnic trends. It had also been agreed that a greater level of narrative to accompany the graphs was required. Miss Bartram asked in which other fora the content of the report would be discussed. She was advised that the Equality and Diversity Steering Group had in particular reviewed the ethnicity information and had highlighted a number of anomalies that required further investigation. It was noted that there was a disparity between the whole time equivalent (WTE) numbers included in the HR dashboard and the financial performance report. Mrs Barnett advised that the information in the HR dashboard reflected contracted full time equivalents (FTEs) as at the end of December 2009. The information in the financial performance report however, represented the average WTEs over the month and also includes bank staff. The Chair noted that there was not a report that provided a summary of expenditure associated with overtime payments. She asked whether there was a system in place for alerting to high overtime payments made and potentially inappropriate use. It was agreed that this level of detail was not currently provided. Mr Adler highlighted a growing issue concerning sickness absence. Mrs Barnett advised that there had been a reduction in February however further detail behind this trend is required. Mr Kirby suggested that the trend may be affected by some instances of multiple illness and Norovirus outbreaks over the winter season, however agreed that more work is needed to manage sickness absence on a case by case basis. Dr Sahota noted that there were a number of cases in formal procedure. Mr Trotman suggested that consideration should be given to costing the length of time involved with the resolution of a formal procedure and including this within the next version of the HR dashboard. Mr Trotman thanked Mrs Barnett for the overview.	
ACTION: **Mrs Barnett to consider costing the length of time involved with the resolution of a formal procedure and to including this within the next version of the HR dashboard**	

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5.4 Foundation Trust compliance report	**SWBFC (3/10) 030** **SWBFC (3/10) 030 (a)**
As the information presented was noted to be a subset of the monthly performance management information, the Committee noted the report. The Governance Risk Rating was green.	
5.5 NHS performance framework	**SWBFC (3/10) 029** **SWBFC (3/10) 029 (a)**
Mr White presented the Trust's performance against the indicators comprising the NHS performance framework. The Committee was pleased to note that the Trust remains classified as a 'performing' organisation and the overall rating remains green.	
6 Draft financial plan 2010/11	**SWBFC (3/10) 035** **SWBFC (3/10) 035 (a)** **SWBFC (3/10) 035 (b)**
Mr White advised that the negotiation of the LDP had been completed and a bid for funds from the Strategic Change Reserve had been formulated. Work is underway on developing the Heads of Agreement which will set out how the contract will behave in future years. The plan will be used to form the basis of the budget book and it now includes the second and third year Income and expenditure schedules. The plan will incorporate the relevant areas of the Operating Framework, including normative tariffs, such as those associated with cataracts work. The revised regulations around a patient's right to be treated is also included in the plan, whereby a patient has a right to be seen within 18 weeks of referral unless they choose to wait longer or it is clinically appropriate. Mr Kirby was asked how this impacts on the cancer waiting time targets. He advised that the same regulations apply to the two week waiting time target, although reaching these is more challenging given the shorter timeframes. It was highlighted that 1.5% of tariff is associated with achievement of the CQUIN targets. Best practice tariffs are included within the plan. In terms of the Strategic Change Reserve, it was highlighted that delivery of the plan would be problematic should the bid not be awarded. The Committee was advised that an initial review of all bids had been undertaken and of the total £160m bid submitted, only £2m had been awarded to date. Mrs Davis suggested that a special meeting of the Trust Board should be convened should the £9m bid submitted by the Trust, not be awarded. Mr White advised that the revised contract terms were being reviewed, including the upper limit of payments for over performance in connection with Accident and Emergency admissions and medical emergencies. Incentives have been built into the contract to ensure that demand for elective activity is managed downwards. A list of allocations agreed for specialist services and activities was reviewed, including for a community cardiologist and for a Vitamin D screening service. Individual CQUIN targets were reviewed, although the thresholds around the targets remain to be negotiated. This discussion will be concluded by the end of March 2010. Mrs Davis noted that the majority of CQUIN targets involve assessment.	

The Cost Improvement Plan (CIP) for the coming year was considered and it was highlighted that as some of the schemes do not commence in April, they will not deliver a full year effect during 2010/11. The transitional reserve allocation will be used to compensate for this shortfall. Dr Sahota noted that the CIP for 2010/11 was considerable and asked how it was proposed to be met given that the CIP for the current year had proved to be very challenging. Mr Kirby acknowledged that the delivery of the CIP carries a degree of risk and advised that a considerable part of the programme relies on the closure of a number of beds in line with the planned reduction in activity. Contingency is to be identified in the event that non-recurrent compensation for slippage in schemes is required. Mr Trotman noted that the risks associated with the delivery of the CIP had been reviewed by the Committee in February and suggested that the Board as a whole need to be assured that the risks had been fully analysed and considered. Mr Kirby advised that the annual plan fully documents the risks and further discussion and opportunity to review the analysis would be available prior to and at the Trust Board later in the month. Miss Bartram suggested that information concerning staffing to beds ratios associated with the CIP schemes would be useful.	
7 Cost improvement programme (2009/10) – delivery report	**SWBFC (3/10) 031 SWBFC (3/10) 031 (a) - SWBFC (3/10) 031 (c)**
Mr Wharram presented the monthly 2009/10 CIP delivery report, which it was noted had been reviewed in detail at the Financial Management Board meeting. It was noted that there had been little change from the previous month, with performance being adrift of plan by 0.5%.	
8 Quality and Efficiency Programme (QuEP) update	**SWBFC (3/10) 036 SWBFC (3/10) 036 (a)**
Mr Adler presented a summary of the progress with the workstreams forming the Quality and Efficiency Programme (QuEP). The Committee was advised that the programme was progressing well. In terms of the clinical directorate projects workstream, Mr Adler reported that projects are being collected at present. The out of hours rotas workstream was noted to have been completed. The estates workstream was noted to be at red status given the issue with obtaining recompense for the asset impairment liability incurred by decommissioning some of the Trust's buildings.	
9 Benchmarking productivity	**SWBFC (3/10) 033 SWBFC (3/10) 033 (a) - SWBFC (3/10) 033 (d)**
Mr Kirby advised that ongoing routine benchmarking was undertaken using the NHS Institute's 'Better Care, Better Value' indicators. In terms of outpatients, the DNA rate is higher than the benchmarked information for other comparable trusts, although the Trust's new to review rate is good. The work of the Strategic Health Authority (SHA) that overlaps with the 'Better Care, Better Values' indicators has been reviewed, although the split of data into individual trusts is not possible. The work highlights however, that there are opportunities for PCTs to save money and there are opportunities for acute trusts to cut costs in some areas. In terms of the acute trusts' actions to reduce costs, it has been suggested that best practice lengths of stay should be adopted. Mr Kirby	

advised that length of stay improved in Quarter 1 of 2009/10 and further work has been undertaken since to generate a further improvement. Work with Dr Foster and CHKS has also been considered, where the Trust is compared with eleven similar trusts in terms of productivity. The work suggests that the Trust's ratio of staff: beds is high and admissions are also high compared to other trusts. It is considered that for the size of the organisation, beds are being used efficiently however the number of staff per bed needs to be reviewed. Mr Trotman suggested that added value per employee may be a more useful indicator. It was agreed that the latest 'Better Care, Better Values' report should be issued to the Committee.	
ACTION: **Mr Kirby to circulate the 'Better Care, Better Value' report to the Finance and Performance Management Committee**	
10 Benchmarking the Finance function	**SWBFC (3/10) 034** **SWBFC (3/10) 034 (a)**
Mr White presented a report prepared by the Strategic Health Authority detailing an initial set of benchmarking data for finance functions across the region. The report suggests that the Trust has less qualified staff than other trusts, although the cost per employee is higher. The Trust performs well on payroll and cost per payslip indicators. Overall, the Trust was noted to perform well in comparison with other trusts. Mr Trotman remarked that the indicator concerned with credit notes raised as a percentage of invoices raised was not a useful measure.	
11 Minutes for noting	
11.1 Minutes of the Strategic Investment Review Group	**SWBSI (3/10) 001**
The Committee noted the minutes of the SIRG meeting held on 9 February 10.	
11.2 Actions and decisions from the Strategic Investment Review Group	**SWBFC (3/10) 025**
The Committee noted the actions and decisions arising from the meeting of SIRG meeting held on 9 March 10.	
11.3 Minutes of the Financial Management Board	**SWBFM (2/09) 024**
The Committee noted the minutes of the FMB meeting held on 16 February 10.	
12 Any other business	**Verbal**
Mrs Davis suggested that, following a review of practice in other trusts, consideration needed to be given to the manner in which investment proposals are reviewed and approved, and in particular the involvement of Non Executive directors. Mr White agreed to discuss tproposal with the Executive Team.	
ACTION: **Mr White to discuss the investment review and approvals process with the Executive Team**	

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13 Details of next meeting	**Verbal**
The next meeting is to be held on 22 April 2010 at 1430h in the Executive Meeting Room at City Hospital.	

Signed .....

Print .....

Date .....