Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	TRAUMA UNIT SELF ASSESSMENT
SPONSORING DIRECTOR:	MIKE SHARON
AUTHOR:	MIKE SHARON
DATE OF MEETING:	25 AUGUST 2011

SUMMARY OF KEY POINTS:

The Trust has completed a self assessment to comply with a requirement to apply to become a Trauma Unit

The Board is asked to support the application of the Trust to become a Trauma Unit

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 **support** the Trust's application to become a Trauma Unit

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Supports the delivery of Safe, High Quality Care
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

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

Financial	**Y**	
Business and market share	**Y**	
Clinical	**Y**	
Workforce	**Y**	
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience	**Y**	
Communications & Media		
Risks		*Risk that the Trust does not succeed in its application*

PREVIOUS CONSIDERATION:

Previously discussed at Reconfiguration Board

West Midlands Specialised Commissioning Group

Trauma Unit Designation Standards and Assessment Form

Version	**Local Designation Standards Document**
Author(s)	**West Midlands Specialist Commissioning Team**
Date Issue	**1st August 2011**

Contents

1. INTRODUCTION

1.1 Specialised Commissioning Groups (SCGs) have the authority to designate specific providers to provide specified specialised services. Whilst Trauma services are not currently defined as a specialised service, some areas of the activity associated with trauma, such as neurosurgery and cardiothoracic services are. It is on this basis that Major Trauma Centre's and Trauma Units are expected to be selected through a designation process. West Midlands Strategic Commissioning Group (WMSCG) has been asked by PCTs and Clusters to lead the review, development, selection and implementation of a regional Trauma Care System.

1.2 This document sets out the timetable and the process to be followed locally for the designation of service providers and the standards against which the providers will be measured. It is intended for existing Acute Service Hospitals and new entrants in relation to the designation of specialised Trauma Unit services for adults and Paediatrics.

1.3 This document is based on the Service Specification for the West Midlands Regional Network for Adult and Paediatric Major Trauma Services and follows a review of evidence based practice and consultation with all SCGs in England and with clinicians and patient representative groups.

2. COMMISSIONING PRINCIPLES AND PROCESS

2.1 Prior to setting out 'tools' for designating Trauma Unit Standards it is important to restate the principles that underpin commissioning and how designation 'fits' with the process of commissioning. The main aim of commissioning arrangements for specialised services is to ensure that there is fair access to clinically effective, high quality, cost effective, specialised services right across England.

2.2 Effective commissioning of specialised services ensures that:

- the *right* patient (clear patient selection criteria and referral guidelines) is offered
- the *right* treatment (evidence based, clinically and cost effective interventions, in the appropriate setting) by
- the *right* provider (monitored against agreed service/clinical quality standards) in
- the *right* place (optimising geographical access but avoiding unnecessary duplication of provision) at

- the *right* cost (robust costing and information systems and demonstrable value for money)

- *with the full involvement of the patient* (adequate information to enable supported choice).

2.3 Designation is not an isolated activity: it is part of the commissioning process which repeats itself in a continuous cycle. The commissioning cycle involves:

- carrying out/updating the health care needs assessment
- agreeing the overall service model
- agreeing the service strategy including configuration issues and service developments
- agreeing the contract with the providers which will include the service specification
- monitoring activity, quality; including clinical outcomes and equity of access.

2.4 The Specialist Commissioning Team has developed a local service specification for the Regional Network in relation to Adult and Paediatric Major Trauma Services and this should be read alongside this designation document. This model of care will be facilitated through a Trauma Network (TN); the collaboration between the providers commissioned to deliver trauma care services in a geographical area. A TN should include all providers of trauma care, including: pre-hospital services and rehabilitation services. The TN has appropriate links to social care and the independent sector. While individual units retain responsibility for their clinical governance, members of the TN collaborate in order to provide continuous Quality Improvement.

3.0 TIMETABLE FOR DESIGNATION

During 2011 providers will first be selected by a Multi Cluster group for Trauma Unit Status with formal designation taking place according to the following timetable.

Action	Deadline
Trauma Unit (TU) specification finalised with Steering Group.	April 2011
Trauma Unit workshop.	July 2011
Trauma Units to make an informal expression of interest in being selected for Trauma Unit status to Sue Gadd, Trauma Project Support, (WMSCT) copied to the Cluster	By 28th July 2011

CEO.	
Trauma Unit specification approved through Specialised Commissioning Operational Group and West Midlands Strategic Commissioning Group.	August 2011
Trauma Units carry out a baseline self assessment of where they are against the full and minimum TU service specification standards and the provider applies to be considered for Trauma Unit Status to WMSCT with supporting letter from host Cluster board.	9th Aug 2011
WMSCT pre-screening of applications, and modelling of implications for Project Board.	9-11th Aug 2011
Project Board to review submitted applications and implications.	12th August 2011
Multi- Cluster group to meet to consider applications and their implications.	12th August - 9th September 2011
Providers to send evidence against TU Designation Standards to be reviewed by WMSCT Trauma Project team.	9th September 2011
Designation to be awarded to Trauma Units, for commencement in TU role from March 2012. WMSCG approval of those organisations suitable for TU designation.	September 2011
WMQRS Trauma Peer Review process	2013

4.0 PROCESS

4.1 This is a self assessment process for providers who have expressed an interest in becoming a Trauma Unit within the West Midlands. This process is to determine where providers are currently compliant in delivering aspects of trauma care. If in undertaking your self assessment, you identify areas where you are not currently complaint, please provide the date by which you will be compliant and detail the actions you will undertake to ensure you reach compliance by.

4.2 Providers will have from 1st August to 9th August 2011 to complete a self assessment. Submission of the self assessment should be sent to Ben Smith ben.smith@wmsc.nhs.uk (Queries 0121 6952525) at the West Midlands Specialised Commissioning Team no later that **9th August 2011**. A Multi-Cluster group will come together with nominated clinical representation from the Trauma Steering Group to formally consider your submitted self assessment. The Multi-Cluster Group will then advise you of your suitability or not for designation, and advise the Project Board and you of what would be required if not suitable at this point in time. The Multi-Cluster group will then ask the West Midlands Strategic Commissioning group to approve those organisations that are suitable for Trauma Unit designation at the Boards September meeting.

4.3 WMSCT will collect evidence from selected Trauma Units of compliance between 9th August and 9th September which will include an action plan of how they will ensure full compliance by July 2012. Evidence packs need to be submitted to Sue Gadd sgadd@nhs.net (Queries 0121 695 2369) no later than **9th September 2011**.

4.4 Provisional design of Trauma Units will be held between April 2012 and June 2013 with formal designation taking place in 2013.

5.0 FINANCE

Providers should note that they will not receive any top up of funding over standard tariff prices to deliver either the activity of the trauma unit specification and standards. There are no guaranteed activity levels with becoming a Trauma Unit.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Churchvale/Hollyoak Rooms, Sandwell Hospital **Date** 25 August 2011; 1530h - 1730h

Members			**In Attendance**		
Mrs S Davis	(SD)	[Chair]	Mr G Seager	(GS)	
Mr R Trotman	(RT)		Miss K Dhami	(KD)	
Dr S Sahota	(SS)		Mrs J Kinghorn	(JK)	
Mrs G Hunjan	(GH)		Mrs L Pascall	(LP)	
Prof D Alderson	(DA)		Mrs C Rickards	(CR)	
Mr G Clarke	(GC)				
Mrs O Dutton	(OD)		**Guests**		
Mr J Adler	(JA)		Mrs H Shoker	(HS)	[Item 7]
Mr D O'Donoghue	(DO'D)		Dr N Ratnaraja	(NR)	[Items 8.1 & 8.2]
Mr R White	(RW)		Mrs G Deakin	(GD)	[Item 8.5]
Miss R Overfield	(RO)				
Miss R Barlow	(RB)		**Secretariat**		
			Mr S Grainger-Payne	(SGP)	[Secretariat]

Item	Title		Lead
1	**Apologies**	**Verbal**	**SGP**
2	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting*	**Verbal**	**All**
3	**Chair's opening comments**	**Verbal**	**Chair**
4	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 28 July 2011 as true and accurate records of discussions*	**SWBTB (7/11) 169**	**Chair**
5	**Update on actions arising from previous meetings**	**SWBTB (7/11) 169 (a)**	**Chair**
6	**Questions from members of the public**	**Verbal**	**Public**
	FOR APPROVAL		
7	**Trauma and Orthopaedics staffing options**	**SWBTB (8/11) 178** **SWBTB (8/11) 178 (a)**	**LP/HS**

MATTERS FOR INFORMATION/NOTING			
8	**Safety, Quality and Governance**		
8.1	Infection Control quarterly update	SWBTB (8/11) 176 SWBTB (8/11) 176 (a)	NR
8.2	Tuberculosis (TB) in Sandwell and West Birmingham Hospitals NHS Trust	SWBTB (8/11) 175 SWBTB (8/11) 175 (a)	NR
8.3	Cleanliness and PEAT update	SWBTB (8/11) 171 SWBTB (8/11) 171 (a)	NR
8.4	Newton 4 Progress Report and Future Plans	SWBTB (8/11) 177 SWBTB (8/11) 177 (a) SWBTB (8/11) 177 (b)	RO/LP
8.5	Annual risk report	SWBTB (8/11) 172 SWBTB (8/11) 172 (a)	KD
8.6	Update on complaints handling	Hard copy paper	KD
8.7	Health and Wellbeing update	SWBTB (8/11) 182 SWBTB (8/11) 182 (a)	GD
8.8	Draft minutes of the Quality and Safety Committee held on 21 July 2011	SWBQS (7/11) 027	DA
9	**Performance Management**		
9.1	Monthly finance report	SWBTB (8/11) 180 SWBTB (8/11) 180 (a)	RW
9.2	Draft minutes from the Finance and Performance Management Committee meeting held on 18 August 2011	To follow	RT
9.3	Monthly performance monitoring report	SWBTB (8/11) 183 SWBTB (8/11) 183(a)	RW
9.4	NHS Performance Framework/FT Compliance monitoring report	SWBTB (8/11) 184 SWBTB (8/11) 184 (a)	RW
10	**Strategy and Development**		
10.1	'Right Care, Right Here' programme: progress report	SWBTB (8/11) 179 SWBTB (8/11) 179 (a)	JA
10.2	Foundation Trust application programme		
▶	Programme Director's report	SWBTB (8/11) 181 SWBTB (8/11) 181 (a)	JA
▶	Draft minutes from the Foundation Trust Programme Board meeting held on 28 July 2011	SWBFT (7/11) 047	RT
10.3	Midland Metropolitan Hospital project: Programme Director's report	Verbal Update	GS

105	Trauma Unit Self-Assessment	SWBTB (8/11) 174 SWBTB (8/11) 174 (a) SWBTB (8/11) 174 (b)	JA
11	**Any other business**	**Verbal**	**All**
12	**Details of next meeting** *The next public Trust Board will be held on 29 September 2011 at 1500h in the Anne Gibson Boardroom, City Hospital*	**Verbal**	**Chair**

MINUTES

Trust Board (Public Session) – Version 0.1

Venue Anne Gibson Boardroom, City Hospital **Date** 28 July 2011

Present	**In Attendance**
Mr Roger Trotman (Chair)	Miss Kam Dhami
Mrs Gianjeet Hunjan	Mr Graham Seager
Dr Sarindar Sahota	Mrs Jessamy Kinghorn
Prof Derek Alderson	Mr Matthew Dodd
Mr Gary Clarke	
Mr John Adler	**Guests**
Mr Robert White	Ms Francesca Higginson [Item 8 only]
Mr Donal O'Donoghue	Mr Steve Lawley [Item 8 only]
Miss Rachel Overfield	
Mr Mike Sharon	**Observers**
	Prof Davide Nicolini

Secretariat

Mr Simon Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Mrs Sue Davis, Mrs Olwen Dutton and Miss Rachel Barlow.	
2 Declaration of Interests	**Verbal**
There were no declarations of interest raised.	
3 Chair's Opening Comments	**Verbal**
Mr Trotman, acting as chair of the meeting in place of Mrs Davis, did not make any opening comments.	
4 Minutes of the previous meeting	**SWBTB (6/11) 147**

The minutes of the previous meeting were presented for approval and subject to the addition of Mrs Hunjan to the attendance list, were accepted as a true and accurate reflection of discussions held on 30 June 2011.	
AGREEMENT: The Trust Board approved the minutes of the last meetings	
5 Update on actions arising from previous meetings	**SWBTB (6/11) 147 (a)**
The updated actions list was reviewed and it was noted that there were no outstanding actions requiring discussion or escalation.	
6 Questions from members of the public	**Verbal**
No questions were raised by members of the public present.	
Items for Approval	
7 Application for a Capital Investment Loan	**SWBTB (7/11) 165** **SWBTB (7/11) 165 (a)**
Mr White advised that the Trust's capital plan for 2011/12 had included the purchase of a significant proportion of the land for the new hospital, which would be funded by an £8m loan from the Department of Health. It was noted that that proposal to submit the application for the loan had been considered by the Finance and Performance Management Committee at its meeting on 21 July 2011, at which it had been agreed to recommend to the Trust Board that it should approve this course of action. The Trust Board accepted the recommendation of the Finance and Performance Committee, in approving the proposal that the application for the loan should be made.	
AGREEMENT: The Trust Board accepted the recommendation of the Finance and Performance Committee to approve the application for the capital investment loan being made for the purchase of land for the new hospital scheme	
8 Sustainability update and Sustainability and Environment policy	**SWBTB (7/11) 149** **SWBTB (7/11) 149 (a) -** **SWBTB (7/11) 149 (c)**
Mr Graham Seager provided a general update on progress with key activities to embed the sustainability agenda within the Trust. Ms Francesca Higginson and Mr Steve Lawley joined the meeting to present Sustainability and Environment policy. The Board was advised that the policy had been previously approved by the Trust Management Board and it was asked to ratify this decision.	

Dr Sahota noted that sustainability considerations in respect of procurement did not appear to be factored into the policy. Ms Higginson advised that as part of the work of the Sustainability Working Group, the Head of Supplies had been engaged to bring a greater focus to sustainability matters as part of the Trust's procurement strategy. Mr Seager advised that procurement represented 30-40% of the Trust's carbon footprint at present and he asked the Board to note that at present, the Trust procured largely based on value for money, however the policy presented encouraged environmental considerations to be made when making purchases. Dr Sahota acknowledged that value for money should be borne in mind as part of the procurement process but also encouraged the use of local suppliers where possible.

Mr Trotman asked what sanctions were in place for contractors not complying with sustainability requirements set down by the Trust and nationally. Mr Lawley reported that sustainability requirements were made clear within contracts and were also being included within tender documentation. Mr Seager added that the Midland Metropolitan Hospital project would be evaluated for environmental impact. Mr Trotman asked whether evidence that correct waste disposal techniques were being used was obtained from contractors responsible for this work. He was advised that this information was obtained from the consignment notes received.

Dr Sahota asked what work was planned with local employers to deliver training. Miss Overfield reported that a learning hub, involving local partners, was being established, which would provide a learning centre for employees employed on Agenda for Change bands 1 to 4. The Board was further advised that an apprenticeship strategy was also being developed. Mr Seager added that in terms of developing staff qualifications and experience in sustainability matters, the Trust's sustainability champions had been offered the opportunity to complete a NVQ in Developing Environmental Management and a NEBOSH National Certificate in Environmental Management.

Mr Adler asked what the financial impact of the sustainability plans was likely to be. Mr Lawley advised that a Carbon Reduction Commitment had been set from the 2010/11 baseline. He advised that carbon related tax for the current year was expected to be c. £182k and that the Carbon Reduction Commitment would effect a decrease in the levy in forthcoming years. The Board was advised that the Trust was awarded carbon credits, the number of which was based on the Trust's carbon footprint. It was noted that these credits could be traded if necessary. Mr White advised that the carbon credits had been built into the Trust's financial plans as intangible assets and he suggested that the anticipated position with the credits may benefit discussion at a forthcoming meeting of the Finance and Performance Management Committee.

Mr Sharon asked, in respect of the Good Citizen indicators, whether any benchmarks had been used to assess the Trust's position. He was advised that this was the case and that a plan for each element had been developed where

shortfalls had been identified. The Trust Board was asked for and gave its approval to the Sustainability and Environment policy.	
ACTION: **Mr Seager to arrange for the anticipated position in respect of the Trust's carbon credit allocation to be presented at a future meeting of the Finance and Performance Management Committee** **AGREEMENT:** **The Trust Board approved the Sustainability and Environment policy**	
9 Safety, Quality and Governance	
9.1 CQC reports on Privacy, Dignity and Nutrition inspections and action plans	**SWBTB (7/11) 155** **SWBTB (7/11) 155 (a) - SWBTB (7/11) 155 (e)**
Miss Overfield presented the reports received from the Care Quality Commission (CQC), following the recent visits to review the Trust's compliance with the essential standards of care concerning privacy, dignity and nutrition. The Board was advised that the reports, together with the action plans to address the recommendations raised, had been reviewed in detail by the Quality and Safety Committee. The action plans were also reported to have been submitted to the CQC and feedback on them was awaited. The Board was advised that when the Trust was regarded as being compliant with the standards, the CQC would be notified, which would prompt an unannounced visit to verify the Trust's position. Miss Overfield reported that the area of main concern identified by the visit was Ward Newton 4 at Sandwell Hospital. As such, a specific action plan had been developed to improve standards of care on the ward, progress with the delivery of which was highlighted to be good. The Board was advised that a 'task and finish' group had been established to oversee progress with the action plans developed in response to the CQC reports. Mr Adler asked when there was an expectation that the Trust would be compliant with the standards. He was advised that it was hoped that compliance would be regained within a month, with the inspection to confirm this being held in September 2011. The Board was advised that the West Midlands Quality Review Group had recently reviewed the Trust's position against a number of areas similar to those covered by the CQC inspections and that positive feedback had been received from the review. Mr Clarke asked whether there any specific staffing concerns on Ward Newton 4.	

Miss Overfield informed the Board that the issues raised during the visit were reflective of the insufficient staffing levels to manage the additional beds that had been opened on the ward at that particular time. The Board was advised however that tighter controls had now been implemented to prevent a repeat of this situation. The Trust Board approved the action plans developed to address the CQC review recommendations.	
AGREEMENT: The Trust Board supported the action plans to address the CQC review recommendations following the inspections to assess compliance with the essential standards of care related to privacy, dignity and nutrition	
9.2 Integrated risk report	**SWBTB (7/11) 162** **SWBTB (7/11) 162 (a)**
Miss Dhami presented the quarterly integrated risk report which it was noted had been discussed in detail by the Quality and Safety Committee at its recent meeting. The Board was asked to note in particular that the number of incidents reported had declined by 6%, which indicated that reporting of yellow and green incidents had deteriorated. It was suggested that this position could be reflective of the recent implementation and embedding of the electronic incident reporting system. The Board was asked to note that although reporting of the less serious cases appeared to have declined, the more serious incidents continued to be routinely reported. It was highlighted that incidents related to safe staffing levels had reduced which was pleasing. Mr Sharon asked how the Trust compared in its reporting of incidents with other trusts. Miss Dhami advised that the Trust received routine reports from the National Patient Safety Agency (NPSA) which provided this comparative data, which it reported that the Trust was within the lower quartile for incident reporting, therefore work was underway to improve the position.	
9.3 Update on complaints handling	**Hard copy paper**
The Board considered a tabled paper which set out the summary profile of complaints being handled by the Trust at present. Miss Dhami advised that complaints handling had been discussed in detail at the recent meeting of the Quality and Safety Committee. The Board was asked to note that 96 complaints responses had been issued during the 21 day period, against a target of 95. The backlog of complaints outside the failsafe target was reported to have reduced by seven as a result of the work undertaken in the period. The Board's attention was drawn to the significant rise in the number of	

complaints received, with 106 having been accepted by the Trust during the 21 day timeframe. Miss Dhami reported that although the number of complaints was high, there were no obvious themes emerging from the incoming complaints. The Board was advised that although the plan to clear the backlog by December 2011 was still on track, this may need to be reviewed should the amount of complaints being received remain at levels seen recently. Mr Adler remarked that the quality and output of the complaints responses was very high at present, however he asked whether it was realistic to expect that the backlog of complaints would be cleared by December 2011 should the number of complaints outside the failsafe target only be reduced by similar levels as seen in the previous period. Miss Dhami advised that additional focus would be needed on the 62 cases currently within the backlog over the next few months. Mr Adler asked that a discussion be held to consider available resourcing of the complaints team to enable the backlog of complaints to be cleared as planned.	
ACTION: **Miss Dhami to discuss resourcing of the complaints team with Mr Adler**	
9.4 Minutes of the Quality and Safety Committee held on 19 May 2011	**SWBQS (5/11) 015**
The Board received and noted the minutes of the Quality and Safety Committee meeting held on 19 May 2011. It was noted that Mrs Hunjan was not present at the meeting despite the inclusion of her name in the list present.	
10 Performance Management	
10.1 Monthly finance report	**SWBTB (7/11) 131** **SWBTB (7/11) 131 (a)**
Mr White reported that during the month a surplus of £216k had been achieved, resulting in a year to date surplus of £6k. Overall however, the Trust was reported to be £107k short of the anticipated position. The Board was advised that the Medicine & Emergency Care and the Surgery, Anaesthetics and Critical Care divisions continued to experience financial pressure, however recovery plans to mitigate the positions were being followed. It was noted that the performance of the corporate divisions needed to be maintained to bolster the overall position. In terms of the external perspective, the Board was advised that Sandwell PCT continued to forecast meeting its year end financial target, however financial pressure was reported in the Birmingham & Solihull cluster, within which Heart of Birmingham tPCT belonged. Mr White reported that the strong cash position reflected the phasing of the capital programme and some slippage in the timing of the land purchase for the Midland Metropolitan Hospital scheme.	

10.2 Draft minutes from the meeting of the Finance and Performance Management Committee held on 21 July 2011	**Hard copy paper**
Mr Trotman asked the Trust Board to receive and note the draft minutes from the meeting of the Finance and Performance Management Committee held on 21 July 2011. The Board was advised that the clear focus of the meeting had been on the financial position of the Trust as at the end of Month 3. In conjunction with this analysis, the Committee was reported to have considered the recovery plans for the Medicine & Emergency Care and the Surgery, Anaesthetics and Critical Care divisions, in addition to the supporting corporate initiatives. The Board was advised that it had been noted at the meeting that despite the use of reserves to fund divisional costs pressures, a shortfall of £107k had been reported. In terms of the concerns expressed by the Non Executive directors at the meeting, the Board was advised that while it was recognised that in any organisation of the size of the Trust, turnaround was expected to take some time and inevitably entails some complex issues, there was disappointment nevertheless, that the Medicine & Emergency Care and the Surgery, Anaesthetics and Critical Care divisions had reported another month of poor performance. Despite this however, Mr Trotman reported that it had been encouraging to receive the details of the actions being taken in the areas of concern and of the additional 1% Cost Improvement Plan (CIP) from corporate areas. Mr Trotman advised that in his view, the proposal to establish a Transformation Support Office to continue the work of the Atos consultants once their work was complete, was imperative. The Board was encouraged to read the draft minutes of the meeting in full.	
10.3 Monthly performance monitoring report	**SWBTB (7/11) 164** **SWBTB (7/11) 164 (a)**
Mr White reported that the performance against the cancer waiting time targets was good. The favourable position against the cancelled operations target was highlighted, although it was noted that the situation was not consistent between sites. Performance against the stroke care target was reported to be poor and was the subject of an improvement plan at present to improve performance against the target for stroke patients to spend 90% of more of their stay on a stroke unit. Performance against the TIA target was also noted to be of concern, although it was highlighted that the position was improving. The Trust Board was pleased to note that there had been no breaches of the same	

sex accommodation requirements. In terms of performance against the CQuIN targets, it was reported that measures were underway to improve the level of smoking cessation referrals. Targets related to health visiting and falls prevention were reported to be being discussed with the Community Services divisional managers at present. Dr Sahota observed that delayed transfers of care appeared to have increased in June 2011. Mr Dodd reported that the number of delayed discharges had been high for a number of weeks, both in Sandwell and Birmingham. To address the issues, the Board was advised that meetings had been planned with Sandwell PCT and Adult Social Care to understand the problems and work through solutions. It was reported that the situation reflected a number of issues, including a lack of nursing home capacity in the community and revised funding levels. The internal processes were also reported to be being reviewed to determine whether any measures could be implemented to deliver a more robust service within the Trust. In Birmingham, the Board was advised that reablement money would be used to alleviate the position where possible. Mr Adler added that there was growing concern across the region about delayed transfers of care and work to resolve the issues was being led by the Black Country cluster. Mr Adler congratulated operational colleagues on the pleasing position regarding same sex accommodation breaches.	
10.4 NHS Performance Framework monitoring report	**SWBTB (7/11) 151** **SWBTB (7/11) 151 (a)**
Mr White presented the NHS Performance Framework update for information. The Trust Board received and noted the report and was pleased to note that the Trust remained classified as a 'performing' organisation. Mr Sharon noted that the implications of the current non-compliance with the CQC essential standards of care needed to be determined and suggested that this should be presented at the next meeting. Mr Adler reported that from July 2011, the Trust would be measured against a new set of indicators related to Accident and Emergency services. It was highlighted that these would be incorporated into the Operating Framework suite of targets and into the NHS Performance Framework. Mr Adler advised that these targets would be challenging to meet given the current level of performance in Accident and Emergency. This was a national issue.	
ACTION: Mr White to present the impact of the current non-compliance with the CQC essential standards of care on the Trust's performance against the NHS Performance Framework at the next meeting	
10.5 Update on progress with the delivery of the Trust's corporate objectives	**SWBTB (7/11) 152**

2011/12 – Quarter 1	**SWBTB (7/11) 152 (a)**
Mr Sharon presented an update on progress with the delivery of the Trust's corporate objectives 2011/12 as at the end of Quarter 1, which he advised had been discussed in detail at the recent meeting of the Trust Management Board. The Board was asked to note the red status against the delivery of the objective related to decommissioning as part of the 'Right Care, Right Here' programme, which was reported to be reflective of the shortfall in the identification of the full quantum of the plan to achieve £16m of cost savings through decommissioning. It was noted that the PCTs had yet to identify the actions that would need to be undertaken to achieve the portion of the target for which they are responsible. A further red status against the delivery of the objective concerning the procurement of the new hospital was highlighted, which Mr Sharon informed the Board concerned the continued delay to the approval of the Outline Business Case for the Midland Metropolitan Hospital.	
11 Strategy and Development	
11.1 'Right Care, Right Here' programme: progress report	**SWBTB (7/11) 144** **SWBTB (7/11) 144 (a)**
Mr Sharon presented the latest 'Right Care, Right Here' programme progress report, which the Board received and noted. The Board was advised that in terms of the progress with the programme that there was little change in the position since previously reported. It was reported that a meeting had been held with the commissioning leads and the PCTs to discuss the decommissioning plans. Mr O'Donoghue emphasised the need for the relevant Trust's clinicians to be engaged with the agreements being made in respect of the decommissioning plans. Mr Dodd advised that an initial plan would be constructed which could then be refined and might include discussions between clinicians and GPs to finalise the list of procedures of limited clinical value which could be decommissioned. The Board was advised that the new governance arrangements for the 'Right Care, Right Here' Programme remained to be discussed and approved by the 'Right Care, Right Here' Partnership Board. Mr Adler reported that the local commissioning groups had been recently approached, in response to a DH request, to seek confirmation of their support for the new hospital proposals. He advised that all those approached had reiterated their support for the plans in writing. Dr Sahota asked what impact the Health and Wellbeing boards would have on the plans. Mr Sharon advised that the local commissioning groups would be required to have their service plans agreed by these bodies, however it was too premature	

to determine the full impact that these boards would have.	
11.2 Foundation Trust application: progress update	
Programme Director's report	**SWBTB (7/11) 166** **SWBTB (7/11) 166 (a)**
Mr Sharon advised that there had been much activity during the previous period, including the completion of the Long Term Financial Model (LTFM) and the preparation of the first draft of the Integrated Business Plan (IBP). The Board was advised that agreement had been reached with the Overview and Scrutiny Committee regarding the approach to public engagement. It was reported that there had been much work undertaken on board development. Mr Sharon reported that the second draft of the IBP would be submitted to the Strategic Health Authority (SHA) on 12 August 2011 and that the external stakeholder survey would be completed. The Board was informed that the delay in approving the Outline Business Case for the new hospital may impact on the FT application process in the coming months. Mr Trotman reported that the version of the IBP due for submission to the Strategic Health Authority had been considered by the FT Programme Board at its meeting earlier in the day and had been approved by the Board in its preceding closed session.	
Draft minutes from the Foundation Trust Programme Board meeting held on 30 June 2011	**SWBFT (6/11) 039**
The tabled minutes of the FT Programme Board held on 30 June 2011 were received and noted.	
11.3 Midland Metropolitan Hospital project: progress report	**SWBTB (7/11) 156** **SWBTB (7/11) 156 (a)** **SWBTB (7/11) 156 (b)**
Mr Seager reported that approval of the Outline Business Case (OBC) for the Midland Metropolitan Hospital remained awaited. The Board was advised that the issue concerning the Deed of Safeguard appeared to be resolved, following an earlier announcement that the Department of Health would act as guarantor for loans granted for Private Finance Initiatives (PFIs). It was reported that the outcome of the review of PFI schemes on FT applicants remained awaited. The Board was informed that visits to PFI schemes in Enniskillen and Tunbridge Wells had been undertaken with a view to garnering some points of learning.	
11.4 Clinical Services Reconfiguration Programme	

Progress report	**SWBTB (7/11) 167** **SWBTB (7/11) 167 (a)**
Mr Sharon reported that a Clinical Services Reconfiguration Board had been established, which had met for its inaugural meeting and had approved the terms of reference for the Clinical Services Reconfiguration Programme. The proposals for reconfiguration were reported to have been shared with the Overview and Scrutiny Committee, which had accepted the Trust's proposed approaches to public consultation. In terms of ongoing reconfiguration activity, the Board was informed that the Maternity Reconfiguration had recently been subjected to a third Gateway Review and had been assessed as being at green status, which was noted to be a pleasing result. Proposed reconfiguration plans were highlighted to include emergency gynaecology, which it had been agreed would not require public consultation, and stroke services, which would need to be formally consulted upon	
Draft minutes from the Clinical Services Reconfiguration Board meeting held on 30 June 2011	**SWBTB (7/11) 167** **SWBTB (7/11) 167 (a)**
Mrs Hunjan presented the draft minutes from the Clinical Services Reconfiguration Board meeting held on 30 June 2011, which the Board was asked to receive and note.	
12 Minutes of the Board Committees	
12.1 Draft minutes from the Audit Committee meeting held on 12 May and 9 June 2011	**SWBAC (5/11) 037** **SWBAC (6/11) 038**
Mrs Hunjan presented the draft minutes from the Audit Committee meetings held on 12 May and 9 June 2011. She highlighted that at the May 2011 meeting, the draft annual accounts had been reviewed. The Committee was also reported to have considered a report outlining the findings of a review undertaken by the Internal Audit function into outpatient utilisation. Mrs Hunjan reported that the level of assurance provided by the review was 'moderate' and highlighted a number of areas for improvement. It was noted that the Atos consultants had considered this review as part of their programme of work with the Trust. Regarding the June meeting of the Audit Committee, Mrs Hunjan reported that it had been agreed that the adoption of the annual accounts should be recommended to the Trust Board. It was noted that the Quality Account 2010/11 had also been considered.	
12.2 Draft minutes from the Charitable Committee meeting held on 12 May 2011	**SWBCF (5/11) 012**
Dr Sahota presented the draft minutes from the Charitable Funds Committee	

meeting held on 12 May 2011, which the Board was asked to receive and note	
13 Any other business	**Verbal**
There was none.	
14 Details of the next meeting	**Verbal**
The next public session of the Trust Board meeting was noted to be scheduled to start at 15.30h on 25 August 2011 and would be held in the Churchvale/Hollyoak Rooms at Sandwell Hospital.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 25 August 2011, Churchvale/Hollyoak Rooms @ Sandwell Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

28 July 2011, Anne Gibson Boardroom @ City Hospital

Members present: Mr R Trotman (RT), Dr S Sahota (SS), Mrs G Hunjan (GH), Prof D Alderson (DA), Mr G Clarke (GC), Mr J Adler (JA), Mr R White (RW), Miss R Overfield (RO), Mr M Sharon (MS), Mr Donal O'Donoghue (DO'D)

In Attendance: Mr G Seager (GS), Miss K Dhami (KD), Mr M Dodd (MD), Mrs J Kinghorn (JK), Prof D Nicolini (DN) [Observer]

Apologies: Mrs S Davis, Mrs O Dutton, Miss R Barlow

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 2 August 2011

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.195	Update on complaints handling	Hard copy papers	28-Apr-11	Consider the suggestion made to organise a 'walk through' a complainant's experience and the complaints process	KD	~~31/07/2011~~ 22/09/2011	Process flow of complaints process being developed at present which will be shared with the Q & S Committee. Thought will be given to 'walking through' a complainant's experience in due course	G
SWBTBACT.196	Right Care, Right Here' programme: progress report	SWBTB (4/11) 094 SWBTB (4/11) 094 (a)	28-Apr-11	Present an update on delivery of the decommissioning plan at a future meeting of the Trust Board	MS	~~25/08/2011~~ 29/09/2011	Progress to be reported at ~~August~~ September meeting of Trust Board	G
SWBTBACT.208	Sustainability update and Sustainability & Environment policy	SWBTB (7/11) 149 SWBTB (7/11) 149 (a) - SWBTB (7/11) 149 (c)	28-Jul-11	Arrange for the anticipated position in respect of the Trust's carbon credit allocation to be presented at a future meeting of the Finance and Performance Management Committee	GS	20/10/11	Scheduled for October 2011	G
SWBTBACT.200	Infection control annual and quarterly reports	SWBTB (5/11) 099 SWBTB (5/11) 099 (a) SWBTB (5/11) 100 SWBTB (5/11) 100 (a)	26-May-11	Ensure that commentary on the community services Infection Control position is included in the next quarterly update on Infection Control	RO	25/08/11	Included in version to Trust Board in August 2011	B
SWBTBACT.209	Update on complaints handling	Hard copy paper	28-Jul-11	Discuss resourcing of the complaints team with Mr Adler	KD	25/08/11	Discussed as requested and KD will be keeping matters under review	B
SWBTBACT.210	NHS Performance Framework monitoring report	SWBTB (7/11) 151 SWBTB (7/11) 151 (a)	28-Jul-11	Present the impact of the current non-compliance with the CQC essential standards of care in the Trust's performance against the NHS Performance Framework at the next meeting	RW	25/08/11	Will be covered as a verbal update to the Finance & Performance Management Committee and Trust Board	B

KEY:

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

Next Meeting: 25 August 2011, Churchvale/Hollyoak Rooms @ Sandwell Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

28 July 2011, Anne Gibson Boardroom @ City Hospital

Members present: Mr R Trotman (RT), Dr S Sahota (SS), Mrs G Hunjan (GH), Prof D Alderson (DA), Mr G Clarke (GC), Mr J Adler (JA), Mr R White (RW), Miss R Overfield (RO), Mr M Sharon (MS), Mr Donal O'Donoghue (DO'D)

In Attendance: Mr G Seager (GS), Miss K Dhami (KD), Mr M Dodd (MD), Mrs J Kinghorn (JK), Prof D Nicolini (DN) [Observer]

Apologies: Mrs S Davis, Mrs O Dutton, Miss R Barlow

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 2 August 2011

Reference No	Item	Paper Ref	Date	Agreement
SWBTBAGR.238	Minutes of the previous meeting	SWBTB (6/11) 147	28/07/2011	The Trust Board approved the minutes of the previous meetings as a true and accurate records of discussions held
SWBTBAGR.239	Application for a Capital Investment Loan	SWBTB (7/11) 165 SWBTB (7/11) 165 (a)	28/07/2011	The Trust Board accepted the recommendation of the Finance and Performance Management Committee to approve the application for the capital investment loan being made for the purchase of land for the new hospital scheme
SWBTBAGR.240	Sustainability and Environment policy	SWBTB (7/11) 149 SWBTB (7/11) 149 (a) - SWBTB (7/11) 149 (c)	28/07/2011	The Trust Board approved the Sustainability and Environment policy
SWBTBAGR.241	CQC reports on privacy, Dignity and Nutrition inspections and action plans	SWBTB (7/11) 155 SWBTB (7/11) 155 (a) - SWBTB (7/11) 155 (e)	28/07/2011	The Trust Board supported the action plans to address the CQC review recommendations, following the inspections to assess compliance with the essential standards of care related to privacy, dignity and nutrition

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD	
DOCUMENT TITLE:	Trauma Unit Nurse Staffing
SPONSORING DIRECTOR:	Rachel Overfield
AUTHOR:	Helen Shoker, Head of Nursing Surgery A, Alison Hughes, Matron Trauma and Orthopaedics
DATE OF MEETING:	28.07.11

In 2009 the Trust's Orthopaedic service was reconfigured to develop a Trauma unit - with the separation of elective and emergency cases. The nurse staffing establishment was set according to perceived/anticipated patient and service needs. Subsequently it has become apparent that these staffing numbers are insufficient to deliver high quality patient care as the actual level of patient dependency is above the level predicted at the time of reconfiguration on the trauma site (Sandwell). This shortfall in sufficient nursing staff has the potential to increase risk to patients, staff and the organisation.

This paper highlights the main issues and how the proposed increase to staffing establishment will address these.

The Division has been working hard to manage this issue and has introduced measures to mitigate risk in the short term. This has enabled staffing levels to be increases temporarily through bank staffing in order to maintain a safe environment**.** However , the Division is seeking an investment of £199 410 to the recurrent pay budget to increase WTE by 6.69 unit staff on a permanent basis. This will be accompanied by a redesigned shift pattern to ensure a more cost effective service is delivered that will improve patient care and safety and moreover allow the Division to effect sustainable change.

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

Trust Board are asked to note the contents of this paper and approve the funding of the proposed staffing plan.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	**Accessible and Responsive Care** 1.2 , Continue to improve the experiences of our patients by focusing on basic nursing care and standards towards privacy and dignity 1.5 ensure our customer care promises become part of our day to day behaviour and are incorporated into the recruitment process **High Quality Care**

	2.1Continue to keep up high standards of infection control and cleanliness. 2.2 Formalise our quality system to bring together all that we can do to maintain and improve our quality of care. 2.3 Improve the protection and care we provide to vulnerable children and adults. 2.8 Achieve the new Quality and Innovation targets. 2.9 Improve our key patient pathways so that they improve patient experience and use of resources. 2.11 Implement the national Nursing High Impact Changes. Good Use of Resources 4.4 ensure we have the right amount of ward…capacity for our needs. **An Effective Organisation** 6.1 Ensure that the Trust is registered with the Care Quality Commission and maintains its registration throughout 2010/11. 6.2 Embed Listening into Action as part of the way we do things in the Trust ensuring all areas of the Trust are involved and that the approach can be maintained. 6.5 Progress plans for a new organisational status and structure which will give staff and public a clear voice in the organisation in the future. 6.11 Make improvements to the health and well-being of staff, including reducing sickness absence.
Annual priorities	
NHS LA standards	
CQC Essential Standards of Quality and Safety	All standards
Auditors' Local Evaluation	

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

Financial	**X**	Investment to pay budget
Business and market share	**X**	Commissioners may be concerned with quality standards
Clinical	**X**	Safe, quality care Length of stay
Workforce	**X**	Staff safety, well being, role satisfaction Changes to shift patterns proposed
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience	**X**	Improving the patient experience
Communications & Media	**X**	Trust reputation
Risks		

PREVIOUS CONSIDERATION:

None

Trauma Unit Nurse Staffing

Introduction

The current 61 bedded Trauma Unit was developed following the reconfiguration of services in 2009 at which time a staffing establishment was set according to perceived patient and service needs at that time. The business case assumed that the T&O nurse staffing implications across sites would be neutral as patient numbers remained the same. However, the level of patient activity on the Trauma Unit (Sandwell) site has meant that this establishment is insufficient to maintain safe, high quality care and there is no scope to redeploy staff from the City site. As a result a modest net increase in staffing is required.

Proposal

It is proposed that an investment of £199 410 to the recurrent pay budget is approved to increase WTE by 6.69 staff, at the same time a change to a more effective, service led shift pattern will improve patient care and safety. Directorate changes have been made and mitigation of the risks put in place through temporary additional staffing. However further investment is required to directly effect further, sustainable change.

Rationale

The end of year report by the Chief Nurse noted the Trauma Unit as a 'worry ward' and this position continues despite notable action by the ward managers and Matron. Ward reviews were undertaken in March and June of this year. The Unit is at the bottom of the Divisional league table. Table 1.

Table 1

Assurance process	Specific aspect	Rating
Ward Review process	Basic patient care Patient experience Care of vulnerable adults All other aspects	Red Red Red Amber
Quality audits	All fundamental aspects of patient care	87% compliance = Amber rating = Bottom 30% poor performers, Trustwide.

Staff to bed ratios have been collated over the previous three months, during which time bed numbers have been lowered by 6 which achieves across the Unit 1 WTE per bed, this is the lowest acceptable level of staff to patient ratio. Sustaining this decrease in bed numbers is a risky strategy and has been achieved during summertime with in-week breaches of this already experienced. Thus it is now necessary to increase the establishment on a permanent basis.

Table 2

Pre-reconfiguration plan	Current status	Proposal
68 bedded single sex wards	61 bedded unit WTE 59.79 1.0 WTE staff per bed	61 bedded unit WTE 66.48 1.08 WTE staff per bed
	Rota plan per ward	Rota plan for unit
Mitigation	Staff rotation Mixed sex ward (bedded bays)	

Bank, Agency Use and Sickness Absence

At 11.25% the Trauma unit is running at well above acceptable sickness absence levels. This high level is a direct consequence of pressures on staff. This level of sickness results in an over reliance on bank staff which in turn can potentially compromise patient care as bank staff are inherently unfamiliar with the unit and can impact adversely on continuity of care. It should be noted that the use of bank staff has been less than the shortfall identified but has been sufficient to maintain adequate staffing in the short term. However this in time creates a cost pressure within the Division.

Patient Risk Concerns

Of equal concern is the fact that the current permanent establishment would fail to demonstrate compliance with the CQC Essential Standards for Quality and Safety due to the nature of complex trauma care. The current establishment allows for 1.0 nurse per bed; the proposed establishment will allow 1.08 - which is still a small margin but will improve the number of nurses available to deliver care and hence improve patient safety and quality.

Impact on Staff

The Division recognises the value of effective clinical leadership and has taken steps to ensure this is evident in the Department at a senior clinical level. The nursing leadership within Trauma and Orthopaedics was restructured in February this year with the re-introduction of the third matron post which had previously been frozen. The post holder provides direct, highly visible support to the unit; this has proven fundamental to the maintenance of standards.

Apart from the very high sickness levels (which in time increase pressure on staff) there needs to be an adequate permanent establishment in order to maintain morale and allow nurses to practice to the appropriate professional standards.

The staff wish to be part of a unit with a good reputation within the organisation and the local community for excellent patient care and positive outcomes.

Recommendations

The Trust Board is asked to note the contents of this paper and support the proposal for an increase in the pay budget to support recruitment of 6.69 WTE staff to allow for the delivery of safe and appropriate care for our trauma patients on an on-going basis. The Directorate commit to improvements as a direct result including a reduction in sickness absence to the Trust Target and progress will be reported back to the Trust Board in the coming months via the Quarterly Nursing Report. The Division are also working with the Nursing Division to implement a Dependency measuring tool 'Safer Nursing Care' which is anticipated to be in regular use form Dec 2011 and will allow for regular reports on patient dependency and key nursing metrics.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Infection Control Quarterly Report (April – June 2011)
SPONSORING DIRECTOR:	Rachel Overfield – Chief Nurse. Director of Infection Prevention and Control
AUTHOR:	Rebecca Evans – Head of Infection Control Nursing Services Richard Anderson – Informatics Officer Dr Natasha Ratnaraja – Consultant Microbiologist/Infection Control Doctor.
DATE OF MEETING:	

SUMMARY OF KEY POINTS:

Organisational structures continue to work well both within our own organisation and across the wider healthcare economy.

Numbers of cases of MRSA and CDI have remained within national and local stretch targets

Continued surveillance on a range of other healthcare associated infections to include MSSA and E. Coli bacteraemia's, some of which will become mandatory during 2011.

Efforts regarding antibiotic stewardship continue and antibiotic utilisation data shows consistency of use and adherence to protocols

Continued monitoring and management of outbreaks of D&V and ward closures.

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

Approval	Receipt and Noting	Discussion
To advise the Trust Board of the work undertaken by the Infection Control Service at Sandwell & West Birmingham Hospitals NHS Trust for the period April - June 2011		

The Trust Board is asked to receive and note the Quarterly Report for the period April - June2011.

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

Strategic objectives	▪ Ensure systems are in place for the prevention and control of healthcare associated infections. ▪ C.difficile. MRSA National Targets.

Annual priorities	
NHS LA standards	NHS LA Risk Assessment - 2.4.9 – Infection Control
CQC Essential Standards of Quality and Safety	Core Standards - C1- & C9
Auditors' Local Evaluation	

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

Financial	x	It needs to be recognised that there is an associated cost attached to the management and control of outbreaks. This is difficult to quantify and finances will vary dependent on the nature and extent of the outbreak.
Business and market share		
Clinical	x	Continual improvement and maintenance of infection control standards prevents and reduces HCAI's
Workforce		
Environmental	x	It is essential that systems are in place and maintained to ensure the cleanliness and integrity of the environment.
Legal & Policy		
Equality and Diversity		
Patient Experience	x	Continual improvement and maintenance of infection control standards contributes to a positive patient outcome and prevents and reduces HCAI's
Communications & Media	x	Compliance with infection control is high on the public agenda and can influence patient choice.
Risks		

PREVIOUS CONSIDERATION:

1. Executive Summary

Organisational structures continue to work well both within our own organisation and across the wider healthcare economy.

Numbers of cases of MRSA and CDI have remained within national and local stretch targets

Continued surveillance on a range of other healthcare associated infections, some of which will become mandatory during 2011. Efforts regarding antibiotic stewardship continue and antibiotic utilisation data shows consistency of use and adherence to protocols

Continued monitoring and management of outbreaks, periods of increased incidence (PII) and ward closures. In addition this summaries other infection control related investigations are included.

Key to maintaining standards is continued commitment and compliance with infection control policies by divisions and healthcare personnel. Audit and training continue to be prioritised as a means of monitoring and delivering continuous improvements in clinical and non – clinical areas.

2. Management and Organisation

The Infection Control Operational Committee continues to work on reviewing and revising key policies, monitoring progress with the action plan against the Health and Social Care Act 2008 and receiving reports on infection control initiatives across the Trust. Partnership working with colleagues in the community is progressing well.

Since the 1st April 2011 SWBH has vertically integrated with the provider arm of Sandwell PCT. From an infection control perspective this has resulted in the inclusion of more services needing to be managed. As part of the vertical integrated 1wte staff member has been transferred. However, this does not afford cover for annual leave and sickness. As part of the integration the newly integrated team are working toward standardising practices across acute and primary care. To that end this report will incorporate a community section.

3. Surveillance

Microbiological surveillance is undertaken by the ICS identified from clinical specimens received in the hospital laboratory and focuses on organisms which are known to have the ability to cross-infect, or are multiple antibiotic-resistant and not normally present in high numbers in the patient population – Target organisms. An increase in numbers of these 'target organisms' isolated in a particular ward/department, or in similar clinical sites may indicate a problem in either the short or long term, requiring investigation and action. Monthly reports are circulated to clinical staff and relevant Executive Directors by the DIPC outlining progress against target organism surveillance and key actions required.

In addition to this the ICS focus on specific target organisms that are monitored against national targets i.e. MRSA, C.difficile and MRSA screening compliance. Outlined below is progress against key target organisms for the period April – June 2011

3.1 MRSA

3.1.1 Mandatory Reporting of MRSA bloodstream infections (pre and post 48hrs)

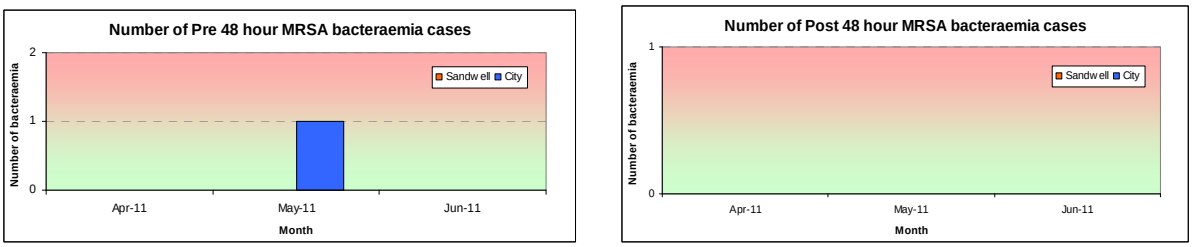

Figure 1: Number of MRSA bacteraemia cases

3.1.2 Percentage of possibly contaminated blood cultures.

The percentage of potentially contaminated blood cultures is monitored closely by the infection control team as a marker of compliance against the practice of taking blood cultures. In the event of a possible blood culture contaminant being identified the following action is taken:-

Signature on blood culture form legible

- Letter sent to practitioner concerned highlighting contaminate results and requesting person be retrained in the taking of blood cultures.
- Notification sent to IV team for retraining.
- Letter sent to consultant informing them on the blood culture result

Signature on blood culture form not legible.

- Copy of blood culture from sent to consultant with letter (Consultant identified from ICM)

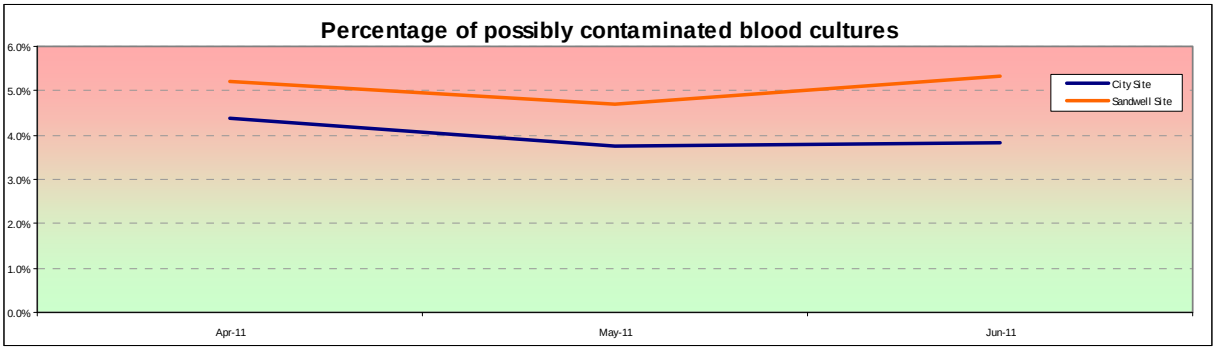

Figure 2: Percentage of possibly contaminated blood cultures

3.1.3 Number of MRSA Screening undertaken

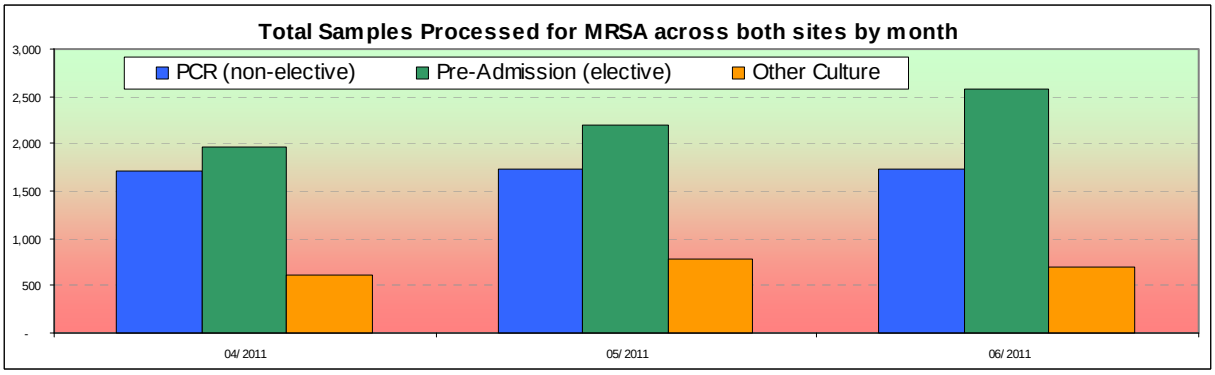

Figure 3: MRSA screening numbers

3.1.4 Graph to identify the percentage positively rate by month

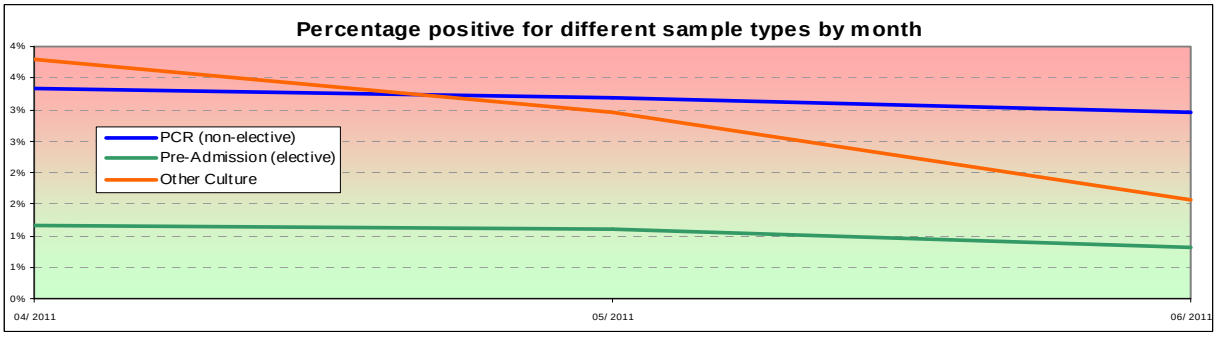

Figure 4: MRSA screening positivity rates

3.2 Clostridium difficile infections (CDI)

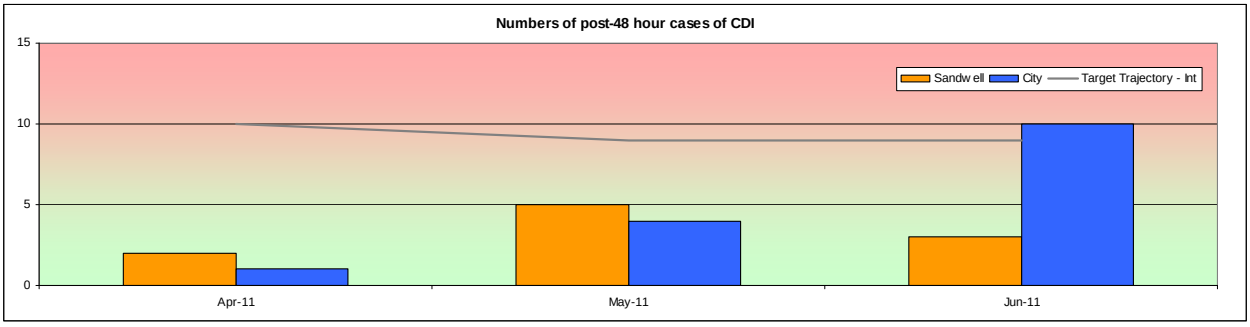

Figure 5: Numbers of post-48 hour cases of CDI

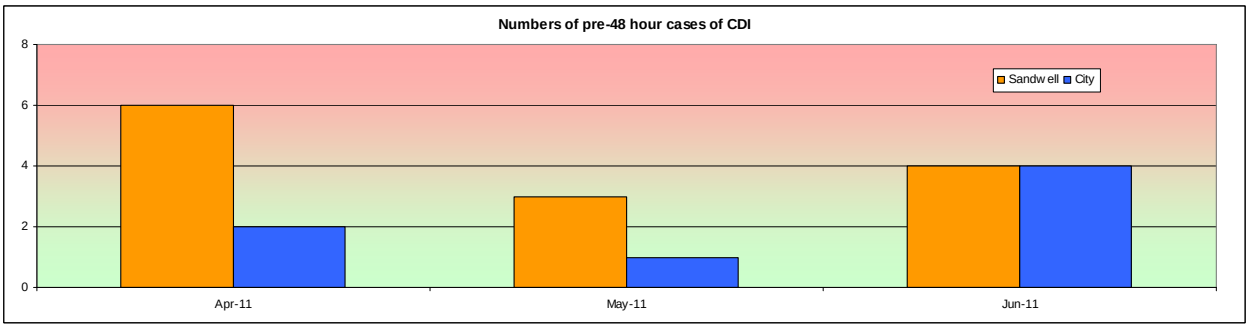

Figure 6: Numbers of pre-48 hour cases of CDI

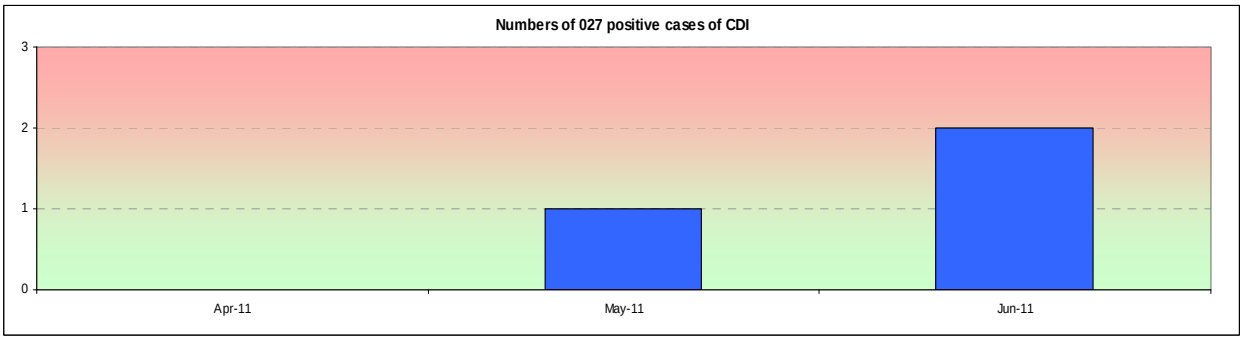

Figure 7: Number of 027 ribotype cases of CDI

3.3 Number of MSSA bacteraemia's

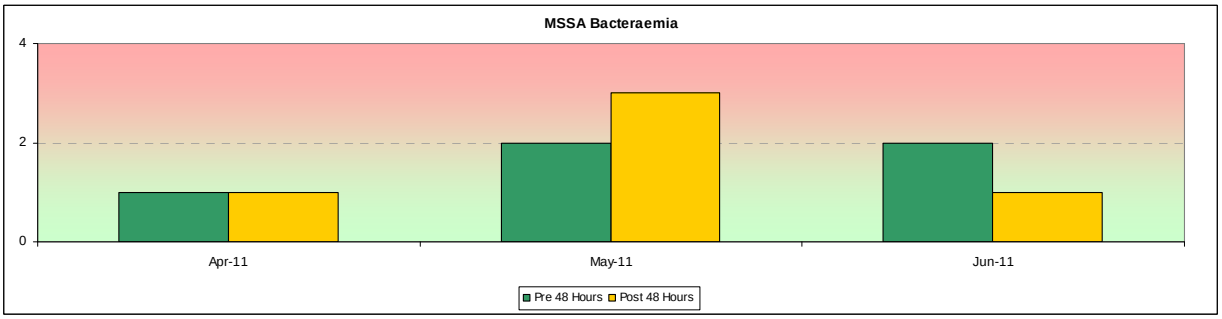

Figure 8: Numbers of MSSA bloodstream infections

3.4 Number of E.coli bacteraemia's

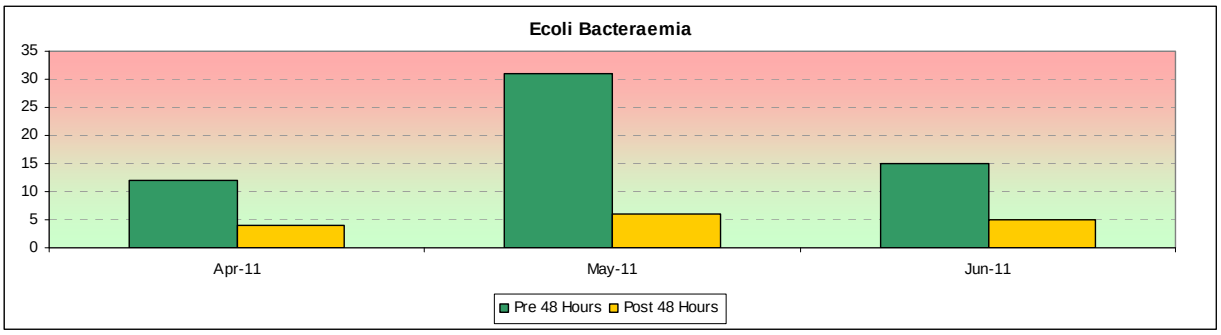

Figure 9: Numbers of E coli bloodstream infections

3.5 Tuberculosis

The West Midlands has the 2nd highest incidence of Tuberculosis (TB) in the United Kingdom (11%). SWBH is responsible for the care and management of a large proportion of those patients known to or suspected of having Tuberculosis (TB). In addition to drug sensitive TB, SWBH also sees a proportion of patients identified as Multi drug resistant tuberculosis (MDR-TB). Patients with TB are identified to the ICS from either clinical specimen received in laboratory or by clinical diagnosis at ward/departmental level (i.e. imaging) or via the community chest clinics/GP's. All patient with TB are nurse in line with respiratory and infection control guidance. All patients suspected or known to have open TB should be nursed in isolation. The trust has in place a risk assessment tool to enable staff to determine risk and isolate appropriately.

Outlined below are a series of tables identifying the number of specimens processed in the laboratory for TB and the number of positive isolates for the period April to June 2011. The number of specimens processed can be used as a marker to identify the number of patients suspected of having TB. The Multi-drug resistant figures (MDR-TB) are those patients with confirmed MDR-TB, though their initial TB diagnosis may have been some time previous to the date when MDR-TB was confirmed.

3.5.1 Total number of specimens processed for TB (including GP/OPD)

SPECIMEN TYPE	TOTAL PROCESSED
Fluids	76
Pus	17
Respiratory	756
Tissue	42
Urine	147
Total	**1038**

3.5.2 Total number of TB positive isolates

SPECIMEN TYPE	POSITIVE PATIENTS
Fluids	8
Pus	7
Respiratory	37
Tissue	4
Urine	4
Total	**60**

3.5.3 Total number of Positive TB inpatients.

All TB	Apr-11	May-11	Jun-11
Sandwell	1	4	8
City	11	8	9
Total	**12**	**12**	**17**

3.5.4 Total number of patient identified with drug sensitive pulmonary TB and MDR-TB as inpatients.

PTB & MDR TB	Apr-11	May-11	Jun-11
Sandwell	1	2	8
City	8	5	7
Total	**9**	**7**	**15**

3.5.5 Number of confirmed cases of drug Sensitive PTB as inpatients

PTB	Apr-11	May-11	Jun-11
Sandwell	1	1	6
City	8	5	6
Total	**9**	**6**	**12**

3.5.6 Number of confirmed cases of MDRTB as inpatients.

MDR TB	Apr-11	May-11	Jun-11
Sandwell	0	1	2
City	0	0	1
Total	**0**	**1**	**3**

3.5.7 Number of confirmed or clinically diagnosed Non-Pulmonary TB as inpatients.

NonPTB	Apr-11	May-11	Jun-11
Sandwell	0	2	0
City	3	3	2
Total	**3**	**5**	**2**

4. Summary of Outbreaks/ Periods of Increased incidence of infection.

The management and investigations of outbreaks, periods of increased incidence (PII) and investigation of other potential breeches in infection control practices is an intrinsic part of the Infection Control Service's. The severity of an outbreak or investigation is dependent on the type of infective organism its virulence and potential to cause harm. Small outbreaks occur frequently requiring immediate investigation and control measures. On the other hand, large or protracted outbreaks to include investigation of incidence requiring look back exercises and contact tracing can be extremely time consuming, expensive and offsetting to the hospital. All outbreaks/investigations present an increased cost to healthcare settings and thus require quick action and a structured management approach to control their impact.

	Outbreak	Summary
4.1	Diarrhoea and/or vomiting	▪ During the period April – June 2011 there were a total of 11 occasions where ward closures were required attributed to D&V. Of those 11 occasions, closures by site equated to City 5 and Sandwell 6. The outbreaks involved a total of 162 patients and 54 staff. Wards were closed for a total period of 123 days with a range of between 3 and 17 days.
4.2	Influenza	▪ During period April to June 2011 there was 1 ward closed at Rowley Regis Hospital for a total of 5 days involving 13 patients with flu like symptoms. No organism was isolated
4.3	iGAS outbreak Lyndon 5,	▪ Previously reported to Trust Board – Now Closed

5. Decontamination

Decontamination is a key function in reducing healthcare acquired infection. Each year a decontamination program is identified that is then monitored via the Infection Control operational committee and the medical device committee meetings.

Key elements of the plan are as follows:-

5.1 Decontamination of Neo-Natal medical devices was relocated to a new decontamination unit late summer 2010.

5.2 A system of tracking and tracing cots and incubators was introduced. A recent audit has been undertaken to validate monitoring processes.

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Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Tuberculosis (TB) in Sandwell and West Birmingham Hospitals NHS (SWBH) Trust.
SPONSORING DIRECTOR:	Rachel Overfield
AUTHOR:	Dr Natasha Ratnaraja
DATE OF MEETING:	25th August 2011

SUMMARY OF KEY POINTS:

TB is a common infection at SWBH, and the incidence appears to be rising again this year. Management of this infection can be improved by improving the diagnosis of TB, and improving the management by having more appropriate isolation rooms (in the new hospital), caring for our patients in our Trust, and having the resources to diagnosis latent TB and prevent active infection and transmission.

Because TB can affect a significant number of our population, as part of any new build or reconfiguration of services it is essential that operational polices and design of builds reflect the through put and flow of patients with known or suspected PTB. This should include OPD attendance, diagnostics, paediatrics and maternity.

Sufficient resources need to be allocated for the TB team to educate other staff about the diagnosis of TB as well as manage an increasing workload. Resources should be made available so that patients who require long hospital stays do not feel socially isolated. Consideration needs to be given to having all aspects of TB managed within the Trust as opposed to Trust and Birmingham Chest Clinic as this will undoubtedly improve both patient care and experience.

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

Approval	Receipt and Noting	Discussion
		x- as requested by the Board

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

Because TB can affect a significant number of our population, as part of any new build or reconfiguration of services it is essential that operational polices and design of builds reflect the through put and flow of patients with known or suspected PTB. This should include OPD attendance, diagnostics, paediatrics and maternity.

Sufficient resources need to be allocated for the TB team to educate other staff about the diagnosis of TB as well as manage an increasing workload. Consideration needs to be given to having all aspects of TB managed within the Trust as opposed to Trust and Birmingham Chest Clinic as this will undoubtedly improve both patient care and experience.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Ensure systems are in place for the prevention, diagnosis and control of tuberculosis within the Trust.
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

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

Financial		
Business and market share		
Clinical	**x**	Prompt and appropriate management of TB will reduce the morbidity and mortality associated with this infection and also prevent transmission to others.
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience	**x**	Early diagnosis and appropriate management contributes to a positive patient outcome and prevents and reduces transmission of TB within both the community and healthcare settings
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

To my knowledge not previously discussed as a separate issue

Tuberculosis (TB) in Sandwell and West Birmingham Hospitals NHS (SWBH) Trust.

Summary

TB is a common infection at SWBH, and the incidence appears to be rising again this year. Management of this infection can be improved by improving the diagnosis of TB, and improving the management by having more appropriate isolation rooms (in the new hospital), caring for our patients in our Trust, and having the resources to diagnosis latent TB and prevent active infection and transmission.

Because TB can affect a significant number of our population, as part of any new build or reconfiguration of services it is essential that operational polices and design of builds reflect the through put and flow of patients with known or suspected Pulmonary TB (PTB). This should include OPD attendance, diagnostics, paediatrics and maternity.

Sufficient resources need to be allocated for the TB team to educate other staff about the diagnosis of TB as well as manage an increasing workload. Resources should be made available so that patients who require long hospital stays do not feel socially isolated. Consideration needs to be given to having all aspects of TB within the Trust as opposed to Trust and Birmingham Chest Clinic as this will undoubtedly improve both patient care and experience.

Introduction

Tuberculosis (TB) is an infectious disease commonly affecting the lungs, but which can involve any part of the body. It is usually spread by the cough of an infected person. Prolonged close contact with a person with TB, for example, living in the same household, is usually necessary for infection to be passed on. It may take many years before someone infected with TB develops the disease.

Epidemiology

Birmingham has one of the highest rates for TB in the West Midlands region with 35 cases per 100 000 population. Rates in Birmingham generally rose until 2009. In 2010, there were 363 cases of TB in Birmingham, a fall from 472 in the previous year.

Figure 1: Graph of the TB case rate in Birmingham and England (2002-2010)

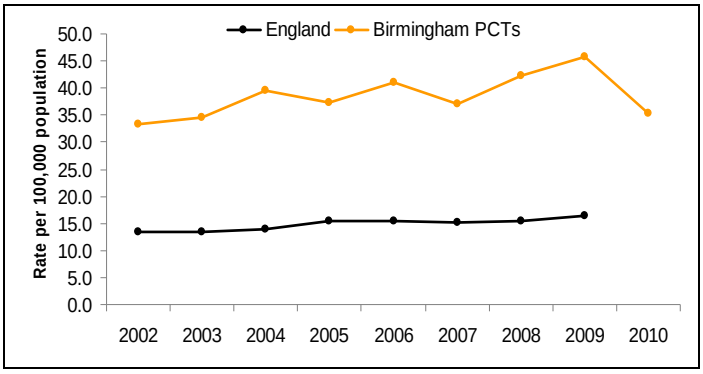


Figure 2: Numbers of notified TB cases in Sandwell 2005-2010

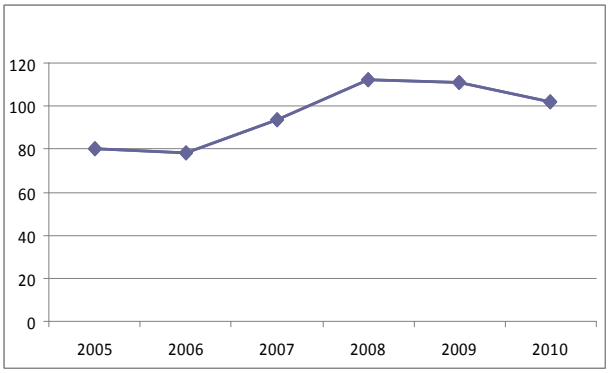
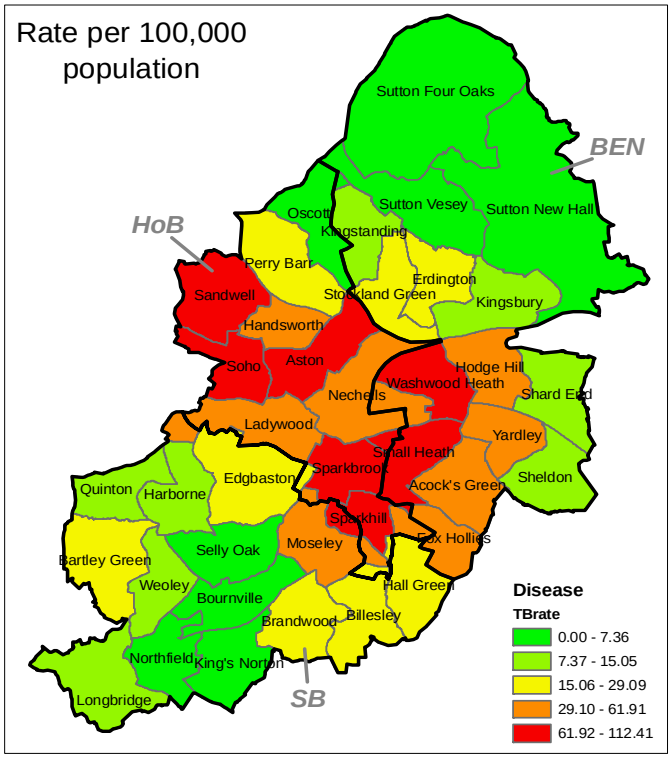


Figure 3: Map of TB rate per 100,000 population by ward and PCT in Birmingham (2010)

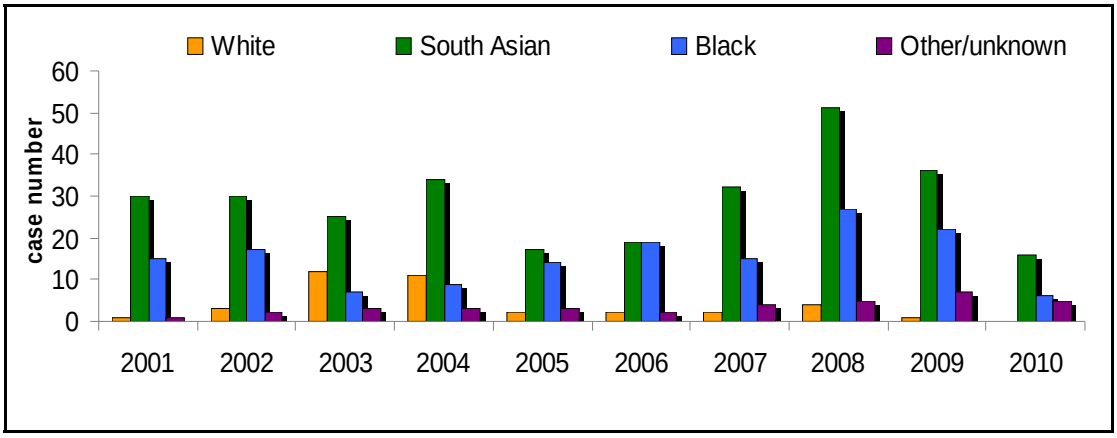


The Heart of Birmingham wards have one of the highest rates of TB in the country, along with Brent and Newham PCTs in London.

Most cases in Birmingham are concentrated in a small number of wards and 73% with TB were born overseas. The overwhelming majority of cases were in those from ethnic minorities with links to countries with high rates of TB, especially people of Pakistani, Indian or Black African ethnic origin (figure 4). The highest rates were in young adults (predominantly those born overseas) with a second peak among the elderly. Other groups at increased risk include those who are homeless, alcohol and drug misusers.

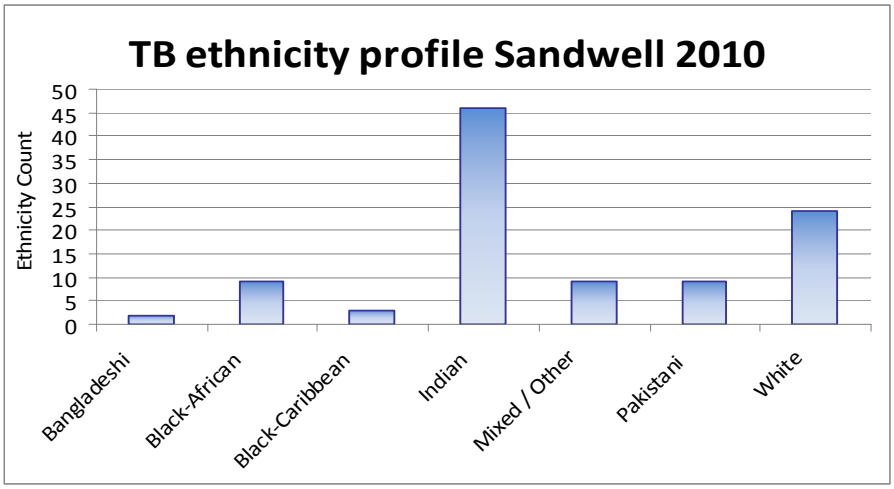
There were 27 cases of TB in children (aged 0-18) in Birmingham in 2010, a fall from the previous year. TB in children overwhelmingly affects those from ethnic minorities, in particular Pakistani or Black African ethnicity.

Figure 4: Graph of TB cases by Ethnicity in Birmingham (2010)



Sandwell is an ethnically diverse borough with an estimated 22% from black and minority ethnic (BME) backgrounds, compared to 12% nationally (JSNA 2010. The majority of notified TB cases during 2010 were in individuals who were born outside of the UK (61%).

Figure 5: The ethnicity profile of notified TB cases in Sandwell 2010



SWBH is responsible for the care and management of a large proportion of those patients known to or suspected of having Tuberculosis (TB). In addition to drug sensitive TB, SWBH also sees a proportion of patients identified as Multi drug resistant tuberculosis (MDR-TB). Patients with TB are identified to the Infection Control Service from either clinical specimens received in laboratory or by clinical diagnosis at ward/departmental level (i.e. imaging) or via the community chest clinics/GP's. All patient with TB are nurse in line with respiratory and infection control guidance. All patients suspected or known to have open TB should be nursed in isolation. The Trust has in place a risk assessment tool to enable staff to determine risk and isolate appropriately.

Outlined below are a series of tables identifying the number of specimens processed in the laboratory for TB and the number of positive isolates for the period April 2010 to March 2011. Although numbers of samples processed are quite high, it should be recognised that not every patient suspected of having TB has a sample taken for culture because of difficulty of obtaining specimens or missed diagnosis by healthcare workers.

Table 1: Total numbers of samples processed (may includes more than one sample per patient)

SPECIMEN TYPE	TOTAL PROCESSED
Fluids	280
Pus	55
Respiratory	2684
Tissue	192
Urine	462
Total	**3691**

Table 2: Total numbers of positive samples (may includes more than one positive sample per patient)

SPECIMEN TYPE	POSITIVE SAMPLES
Fluids	16
Pus	13
Respiratory	265
Tissue	39
Urine	9
Swab	2
Total	**344**

Table 3: Total number of TB positive patients

SPECIMEN TYPE	POSITIVE PATIENTS
Fluids	7
Pus	10
Respiratory	127
Tissue	34
Urine	4
Swab	2
Total	**184**

Figure 6: Number of TB culture positive patients per month from January 2008 to May 2011

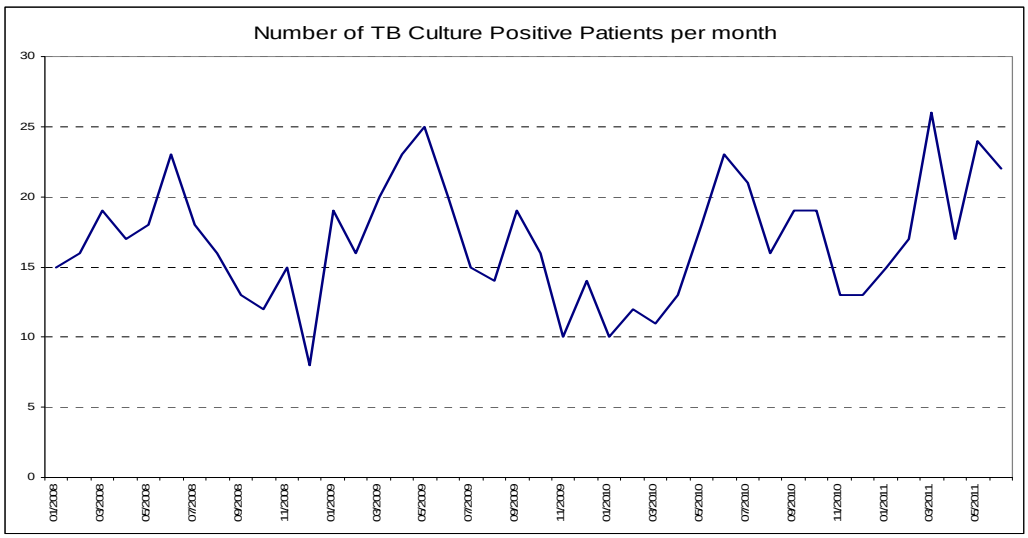
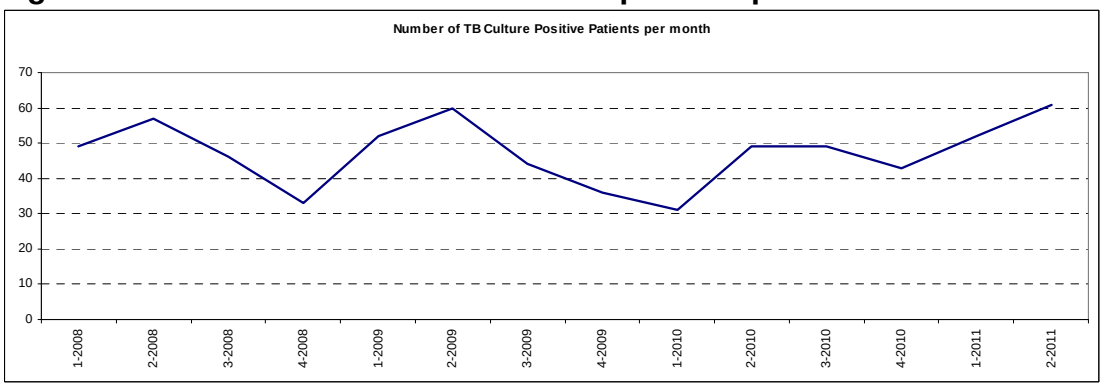


Figure 7: Number of Positive TB culture patients per month.



Managing TB at SWBH

The fundamentals of TB control as recommended internationally by WHO and nationally by the Department of Health are:

- Early recognition of possible cases
- Early and reliable diagnosis
- Effective treatment (especially supporting all those diagnosed to complete treatment)
- Identification and treatment of people with latent infection
- Prevention through infection control and BCG

Early diagnosis and effective treatment of those with TB is vital in the control of TB as this reduces onward transmission.

The majority of cases of TB are diagnosed and managed within the community, with patients attending specialised TB clinics and being cared for by a specialised multidisciplinary team.

However, there are a substantial number of patients who present with symptoms of TB, often in the later stages of infection, to SWBH. There are a number of reasons why this may happen which include:

1. GPs do not always consider TB as a diagnosis in patients. This means that patients may be infectious within the community for longer than they need to be, further increasing spread of infection.

2. Patients may not seek Primary care services for symptoms of TB. This often means that patients may present late in their infection, with increased mortality and morbidity as a result. This is seen especially at City Hospital, where the diagnosis of TB is often made in the ITU.

   Reasons why patients present late include:
   - Lack of understanding of their condition – this is not common in people from countries where TB incidence is high
   - Fear of TB diagnosis due to cultural stigma
   - Protean and insidious symptoms
   - Reluctance to attend Primary Care for illness

3. Fear of diagnosis of other conditions e.g. HIV infection.

Diagnosis of TB in hospital can be hampered by:

- Lack of awareness of possibility of TB amongst clinical teams and healthcare workers

- TB may be only one of many possible diagnoses for a condition e.g. discitis, meningitis

- Difficulty in obtaining the right specimens

Although many samples are processed for TB culture at SWBH, there are many missed opportunities for diagnosis and this contributes to the high rates of TB within our catchment area.

Not recognising the possibility of TB in an inpatient means that if that patient is nursed on an open ward and is subsequently found to be infectious with TB, the Infection Control team need to co-ordinate contact tracing for all patients and staff who may have been exposed to infection. Not only is this resource consuming, it could also cause unnecessary distress for patients who may have been exposed.

Multi-drug resistant TB

Since 2007 there have been 11 cases of MDRTB diagnosed and managed at SWBH. 1 case was a child and another a young woman aged 16 years. The remaining 9 cases were all adults.

Managing patients with MDRTB

NICE guidance on the diagnosis and management of TB uses risk assessment guidance for patients at risk of acquiring MDRTB. The risk factors include:

- Male gender
- Age 25-44 years
- Birth in a high incidence country (includes Indian sub continent and Sub-Saharan Africa)
- Previous TB

This means that many patients who present to SWBH are at risk of acquisition of MDRTB. Although actual numbers of MDRTB remain low in comparison to drug sensitive TB, the proportion of cases is higher than that seen in other Trusts within the region.

Patients with MDRTB are not usually more infectious than patients with drug sensitive TB, but their infection is much more difficult to treat. Therefore it is vital that their infection doesn't spread to other people. For this reason all patients with confirmed/suspected MDRTB should be cared for in a negative pressure isolation room, with full barrier precautions and personal protective equipment, including FFP3 masks, worn by everyone who enters the room.

In practice this is incredibly difficult as there are no negative pressure isolation rooms on the Sandwell site and only five negative pressure rooms on the City site, two on MAU, two on D12 and one on ITU. Patients nursed in silver side rooms still need the same precautions as if there were in a negative pressure one.

Patients with MDRTB need injectable drugs at least for the first part of their treatment. They often need to stay in hospital until they are stabilised on their medication as some of these second line TB drugs can be quite toxic. Problems encountered as part of the management of patients with MDRTB include them having to be kept in their side room during their stay, which can last several weeks. Because the majority of these patients are from low socioeconomic backgrounds and do not speak English as a first language, issues include:

- Lack of entertainment for them whilst isolated (cannot afford PatientLine, do not own portable TVs or laptops, cannot read English books, cannot communicate with nursing and medical staff)
- Social isolation (relatives unable to visit because have to look after children, cannot afford to visit them)

There is often a delay in sending these patients home because of difficulties arranging intravenous antibiotic injections within the community.

At SWBH, whenever a patient is found to have MDRTB, a multidisciplinary team meeting is convened so that the patient journey can be mapped out as far as possible and any possible barriers to getting the patient home and managed within the community identified and addressed as soon as possible.

Screening for Latent TB infection

The 2011 update of the NICE guidance for the diagnosis and management of TB recommends the use of interferon gamma release assays (IGRAs) for the diagnosis of latent TB in healthcare workers, immunosuppressed patients and new entrants to the country. The assays are more sensitive than Mantoux tests and results are not affected by BCG vaccination, unlike the Mantoux.

Patients diagnosed with latent TB are started on chemoprophylaxis with the intention of preventing these patients developing active TB.

Currently, Sandwell PCT funds IGRAs for the diagnosis of latent TB in Sandwell residents. There is no funding available for this test in Birmingham residents.

SWBH Occupational Health is due to start screening new starters to the Trust who have been born or have spent a significant amount of time in countries with an incidence of 150/100,000 using the IGRA test. This is currently unfunded but the intention is to prevent incidents of active TB in healthcare workers as this is not a rare occurrence within this trust and results in widespread contact tracing.

The Microbiology Department is currently working on a pilot with Sandwell PCT to undertake IGRA screening of new entrants at Cape Hill Medical Centre. We will also be performing blood borne virus screening as these residents will come from countries with high incidences of these.

Multidisciplinary Team Working at SWBH

The TB team at SWBH comprises the Respiratory and Paediatric teams (especially Dr McLeod, Dr Nathani, Dr Makwana, Dr Akbar and Dr Atkinson), the Sandwell TB nurses (who work on site), the Birmingham Chest Clinic TB nurses (who are based at the Chest Clinic), Microbiology and Infection Control, and the antibiotic pharmacists.

Regular operational meetings are held every 3 months and we are moving towards a comprehensive MDT meeting to augment Dr Nathani's current weekly meeting.

Other regular multidisciplinary meetings are:

- Sandwell PCT TB stakeholders meeting (quarterly)

- Birmingham PCT commissioning group meetings (quarterly)
- Birmingham PCT clinical reference group meetings (quarterly)

There are also plans in place to develop a Birmingham and Sandwell Cohort Review, as in London. This review discusses all cases of TB managed within the previous quarter, with the aim of identifying operational issues and rectifying them.

Having the Sandwell TB nurses on site streamlines the process for contact tracing, as well as reviewing patients with possible TB on the wards. Although there are now both Adult and Paediatric TB clinics on both sites, contact tracing for Birmingham residents still happens at Birmingham Chest Clinic, which means that there is a lack of continuity for them and patients often have to attend two different centres if they have to take relatives for contact tracing. This goes against the DH guidance of treating the patients within their own community wherever possible.

Recommendations

Because TB can affect a significant number of our population, as part of any new build or reconfiguration of services it is essential that operational polices and design of builds reflect the through put and flow of patients with known or suspected PTB. This should include OPD attendance, diagnostics, paediatrics and maternity.

Sufficient resources need to be allocated for the TB team to educate other staff about the diagnosis of TB as well as manage an increasing workload. Resources should be made available so that patients who require long hospital stays do not feel socially isolated. Consideration needs to be given to having all aspects of TB within the Trust as opposed to Trust and Birmingham Chest Clinic as this will undoubtedly improve both patient care and experience.

References

1. Tuberculosis. Clinical diagnosis and management of tuberculosis, and measures for its prevention and control. NICE guidance update March 2011
2. Health Protection Strategy for Birmingham March 2011
3. Tuberculosis prevention and treatment: a toolkit for planning, commissioning and delivering high-quality services in England. DH 2007

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Cleanliness/PEAT Report
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Steve Clarke, Deputy Director - Facilities
DATE OF MEETING:	25 August 2011

SUMMARY OF KEY POINTS:

The report provides an update to the Trust Board regarding the results from the National Standards of Cleanliness, PEAT audits and inspections from April to June 2011/12.

The report provides an overview of the:

- National Standards of Cleanliness (NSoC) Guidelines
- Patient Environment Action Teams (PEAT) Assessments
- Environmental Issues

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 report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Continue to reduce hospital infection rates achieving national and local targets for MRSA and clostridium difficile including introducing MRSA screening in line with national guidance.
Annual priorities	
NHS LA standards	
CQC Essential Standards of Quality and Safety	To meet the National Standards of Cleanliness Guidelines.
Auditors' Local Evaluation	

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

Financial		
Business and market share		
Clinical	**X**	
Workforce		
Environmental	**X**	To help and assist in maintaining the patient environment.
Legal & Policy		
Equality and Diversity		
Patient Experience	**X**	To help and assist in maintaining the patient experience.
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Routine quarterly update.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

TRUST BOARD REPORT

CLEANLINESS & PEAT

25TH AUGUST 2011

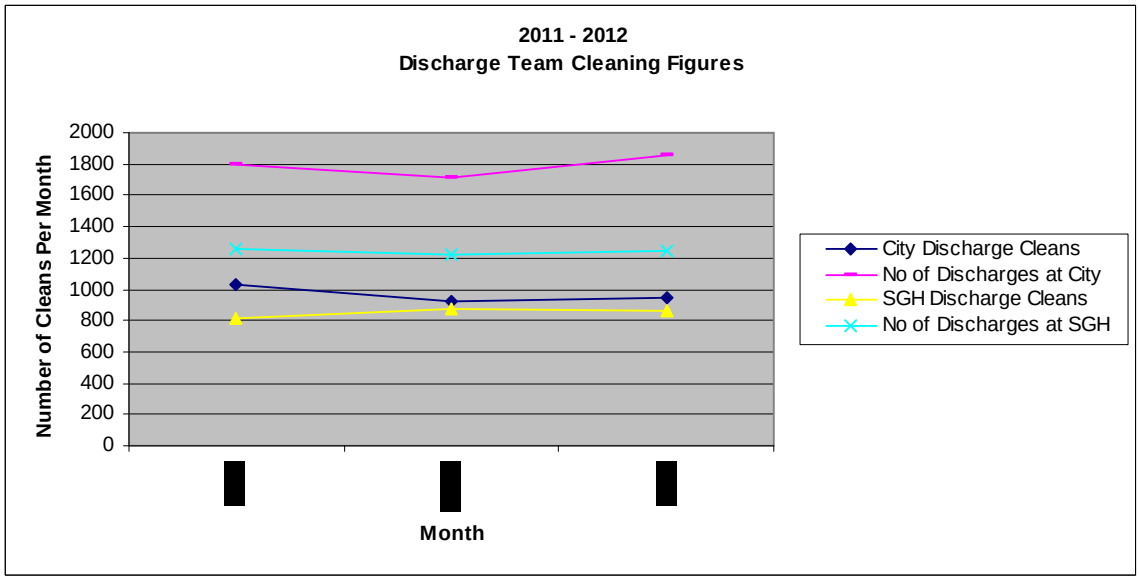
The report provides an update to the Trust Board regarding the results from the National Standards of Cleanliness, PEAT audits and inspections and summary for the year to date April – June 2011.

NATIONAL STANDARDS OF CLEANLINESS AUDITS

The Trust is continuing to maintain its performance from last year with the first quarter figures consistent with the previous year.

	April 11		May 11		June 11	
	V High %	High %	V High %	High %	V High %	High %
City	96	95	96	96	96	95
Sandwell	96	97	97	96	97	93
Rowley	N/A	99	N/A	99	N/A	99
BTC	97	98	97	96	97	97
Target	98	95	98	95	98	95
Overall Average	**96**	**97**	**97**	**97**	**97**	**96**

- **Discharge Cleaning Team – Performance 2011/12**



- % of cleans undertaken at City against the number of discharges 51%.
- % of cleans undertaken at Sandwell against the number of discharges 69%.

A review of the discharge cleaning teams work schedules is being undertaken in conjunction with bed management to increase the number of cleans, this is

following changes to their weekend working, the introduction of protected mealtimes etc. which has affected performance.

PEAT

- **PEAT Audits (Internal)**
  The internal PEAT programme is continuing, however the programme has been alternated to ensure the patient lunchtime meal service is reviewed at both City and Sandwell on a monthly basis.

- **PEAT Expenditure 2011/12**
  The PEAT environmental programme is to continue throughout 2011/12. The planned improvements include upgrades to visitor waiting areas and the refurbishment of storage facilities and sluice rooms in the wards. The PEAT budget will also be used to fund the:

  - Replacement flooring.
  - Signage.
  - Redecoration programme.
  - Replacing/refurbishing patient seating/waiting areas.
  - General ward refurbishments (bathrooms, storerooms etc).

EXPENDITURE TO DATE	PEAT £000's	BED REPLACEMENT £000's	WARD EQUIPMENT £000's	TOTAL EXPENDITURE £000's
Budget	626	150	145	**921**
Expenditure	354	58	45	**457**

HOSPITAL SERVICES INITIATIVES

- **Cleaning Procedures Manual**
  The cleaning procedures manual has been published and distributed. The manual will be a guide for all cleaning procedures undertaken with a definitive explanation on method and equipment. The books will be available in all the ward's domestic cleaning cupboards, stores and offices.

- **Bottled Water**
  A trial of using bottled water as opposed to offering water in jugs for patients has been implemented at Sandwell. The major benefits are the time released for ward service officers to undertake alternative duties and the hydration measurement of patients.

  The time released will enable ward service officers to undertake a further two drinks rounds (releasing nursing time), introduce a third toilet clean per day on all wards and take responsibility for washing patient mugs following their introduction in August.

  An implementation plan is currently being formulated to plan the introduction of bottled water at City Hospital.

- **Laundry Project Update**
  The work has started to deliver the 'On Premises Laundry' (OPL) at Sandwell. There are a series of relocations that have had to be actioned in order to finally vacate an area suitable to house the OPL

  - Staff female locker room relocated (actioned).
  - Male locker room relocated temporarily (actioned).
  - Laundry equipment purchased (actioned).
  - Tendering for the installation of utility services and refurbishment re bed store/wash area (actioned).
  - Date of installation August).
  - Samples of nightwear received, options being discussed at the next Senior Nurses Forum (8th August).

  On completion the OPL will have capacity to process baby wear, slings and hoists and all of the Trust curtains, the benefits are better control, reduced losses and significant cost savings.

  However the first phase of the operation is to purchase and process patient's nightwear, this will address both the privacy and dignity problems associated with nightwear as well as improving the overall quality issues.

- **Dishwashers – Patient Mugs**
  Dishwashers are currently being installed at Sandwell Hospital. Mugs will be introduced on all wards for patient use when the installation is complete (Mid August).

  Hotel Services are currently undertaking a review of City Hospital kitchens to ascertain the method of service delivery and potential costs for equipment prior to introducing the mugs.

STEVE CLARKE
DEPUTY DIRECTOR - FACILITIES

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Newton 4 Progress Report and Future Plans
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Rachel Overfield, Chief Nurse
DATE OF MEETING:	25th August 2011

SUMMARY OF KEY POINTS:

As the Trust Board is aware, Newton 4 has been struggling to maintain satisfactory standards for some time – predominantly as a result of additional unfunded capacity being open on the ward and an increasingly demoralised staff group. The CQC visited the ward at the end of March and judged the ward (Sandwell site) to have major concerns around nutrition and moderate concerns around privacy and dignity. Since then the ward has been put into special measures and has been subject to considerable support to improve. Attached is a progress report against key metrics and other key developments.

The CQC visited the ward again on 3rd August. We have yet to receive their report but this visit prompted discussions about the way stroke services are configured at Sandwell which may be affecting our ability to improve the ward as quickly as we would like and to consistently sustain quality standards. The second paper describes this issue in more detail and sets out the outline of the way forward. This is subject to further detailed discussion and further progress will be reported verbally to the meeting.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

To note the contents of the report and outline plans to reconfigure stroke ward configuration at Sandwell.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High Quality Care
Annual priorities	Improve Stroke Services Maintain compliance with CQC standards
NHS LA standards	
CQC Essential Standards Quality and Safety	Core nursing 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	**x**	
Environmental		
Legal & Policy	**x**	
Equality and Diversity		
Patient Experience	**x**	
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Executive Team

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Progress summary Newton 4 against key metrics – August 2011

Establishment

	February/March 2011 (22 beds but flexed to 34)	July 2011 (34 beds)
WTE	29.87	40.5 (44.5 post 1st September)
Bank/agency use % of actuals	32%	18%
Sickness absence	14.78%	2.35 %
Trained/untrained ratio	62:38	62:38
WTE:bed ratio	.82 (when beds flexed) – 1.23 with bank mitigation	1.34 going to 1.4 post 1st September

Shift staffing

	March 20 beds	March 34 beds	July 34 beds
early	3 + 3	3 + 3 plus bank	6 + 4
Late	3 + 2	3 + 2 plus bank	4 + 4
Night	2 + 2	2 + 2 plus bank	2 + 3

Specialling budget also agreed additional to funded WTE since 1st June

Other staff

Volunteer feeders/dinner ladies have also been recruited for N4 and commenced on 1st august to cover every lunch time.

Ward Review

October 10 – 2 red, 4 amber, 2 green
March 11 - no reds, 5 amber, 3 green. (change of reviewer to HoN)
July 11 – no reds, 5 amber, 3 green

Patient care Quality audits

Mean compliance against all standards (positive responses)

- November 2010 – 86%
- April 2011 – 88.3%
- June 2011 – 92.2%

Improvements mainly seen in following areas:

- Pressure damage – 97%
- Falls prevention – 91%
- Bladder and bowel care – 94%
- Nutrition and fluid balance – 91%

Falls

Number of falls over the year as follows:

- March 2011 – 12 (4 fractures)
- April 2011 – 6 (1 fracture)
- May 2011 – 5 (no fractures)
- June 2011 – 4 (no fractures)

Pressure damage

There have been 4 hospital acquired grade 3 or 4 pressure sores in the period Jan – July 2011

For the period August 2010 – Jan 2011 there had been 6 cases.

For the cases Jan – July this year all have been reviewed at table top meetings and of the 4, 2 cases were considered to be unavoidable ie all preventative strategies had been taken. The other 2 cases were considered to have avoidable factors.

Nutrition

	April	July
MUST assessment complete	27%	70%
Food diary complete	51%	85%
Fluid balance chart complete	74%	90%

Plus

- Weekly and daily checks on mealtimes demonstrate protected meal times is now embedded and working well.
- Red tray system is working well.
- Red mugs are now on ward for at risk patients and beakers are on order.
- Range of snacks and out of hours hot and cold food available and being accessed.

(audit evidence is available)

Complaints

There have been 3 formal complaints since January 2011 relating to nursing care standards or attitude on the ward; this compares to 5 in same period last year.

Patient views

The Trust surveys every patient on discharge and also offers surveys for carers/easy read and different languages.

N4 does not have a particularly good rate of returns – 30%. However, there has been a shift in positive responses received in June compared to April 2011.

Overall rating	April 2011 %	June 2011 %
Excellent		42.9
Good	36.5	14.3
Fair	37.5	28.5
Poor	26	14.3

End of life Care (supportive care pathway - SCP)

There have been 20 deaths (expected) on N4 in period April – June 2011 of these 13 patients were on the SCP ie on a pathway that is intended to make sure patients die with dignity, symptom free and well supported.

In the same period in 2010 there were a similar number of patient deaths – no patients were on the SCP.

Safeguarding

In period April 2010 – April 2011, there were no referrals made to the adult safeguarding team from N4.

Since April 2011 there have been 9 referrals made from N4 (6 safeguarding/mental health, 3 Deprivation of Liberty DOL)

This suggests greater awareness of safeguarding issues.

Infection control

There have been no cases of CDiff or MRSA on N4 since March 2011.
Hand hygiene results in June 2011 were 100%

<u>Optimal Wards (productive wards)</u>

N4 joined the programme in April 2011 as part of special measures process. As a result:

- Bathrooms cleared of all clutter – access now for patients
- All non ward associated offices cleared – converted to:
    - Therapy room./gym
    - Patient activity room
    - Quiet room for patients/relatives
    - Training/ resource room
    - Storage space

- Walkabout handover introduced
- SBAR tool introduced
- Safety briefings introduced
- Second nursing station commissioned for part way on ward.
- Meal coordinator role established
- Drug round tabards in use.
- Measures boards in place

Training/competency

- N4 education programme established and in place.
- Weekly sessions delivered
- Clinical MOT in place – essential skills
- Stroke internal programme in place with competency framework attached.
- On the job training being provided in addition by safeguarding team, older persons nurse and stroke coordinator.

Privacy and dignity – in general

- There is now an available stock of Trust purchased bariatric pyjamas
- On site laundry has been tendered which will enable trust own PJs
- Trust PJs designed and ordered
- No sleeping SSA breeches on in patient wards for past two months
- P+D trust action plan in place and progressing.

Nutrition – in general

- Full range of snacks now available in high risk areas
- Hot and cold meals available 24/7
- Over 47 choices of meal available for lunch and dinner. Hot breakfasts available on request
- Special meals access reviewed and proved satisfactory.
- Protected meal times robustly enforced across the trust and working well in most areas.
- Nutrition action plan in place and progressing

Areas of slow progress

- Documentation and care planning – the Trust's current method of care planning and our combined medical records requires a complete review. This work has commenced but we do not expect to have a new system in place before October.
- Laundry./Nightwear – the trust is tied into a contract with Sunlight who provide an unsatisfactory quality of nightwear and no bariatric provision.l. We therefore took the decision in 6 months ago to re provide our own on site laundry so that we can provide and launder our own nightwear. This is on target to be operational by October.

Other external sources of assurance

- PCT have visited N4 twice since the CQC visit and were satisfied at progress.

- CQC have re-visited the ward (and EAU) and their report is awaited. Initial feedback was that some concerns remained in respect of N4 but this has not yet been confirmed

- Cluster nurse has visited once.

- WMQRS assessment of safeguarding on 13th July (included N4) – feedback very positive awaiting report.

- SHA director of nursing visit

Internal audits/support

- Special measures process – led by Chief nurse/AND
- Matron daily rounds
- ADN and HON x 2 clinical shifts per week
- Safeguarding and older peoples nurse twice weekly visits
- Daily senior nursing audits throughout April/May
- Weekly audit mealtimes/charting
- Weekly training sessions

Conclusion

Utilising the various sources of information available on ward performance and key metrics it is apparent that progress has been made with N4 over recent weeks. There continues to be work to be done to ensure that these improvements are sustainable and we also need to consider whether the pace of improvement is sufficient. These two points are considered in the supplementary paper attached, that proposes changes to the configuration of stroke services on the Sandwell site.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Newton 4 Progress Report and Future Plans

The whole stroke pathway is currently managed on Newton 4 (i.e. from hyperacute → discharge/end of life). This requires the nursing staff to have a wider skill set than on most wards and these skills are not necessarily complementary i.e.:

- Acute nursing observation and assessment
- Ability to identify and act on deterioration
- Ability to work at speed and make rapid judgments
- Ability to risk assess clinically and take appropriate courses of action

↓

- Ability to support a patient at end of life
- Ability to plan complex discharges
- Ability to rehabilitate patients after stroke

The ward staff is made up of acute stroke nurses and nurses transferred from Rowley Hospital and part of our work has been to try to skill both groups of staff up to the same level across the whole pathway. This is something that will inevitably take time and does not necessarily reflect the specialist preferences of individual staff.

In addition ward environments need to support the clinical needs of patients. The size of Newton 4 and the variety of patient needs has made the ward very noisy and busy for large parts of the day. Acute stroke patients need periods of quiet to rest their injured brain. Rehabilitation patients need activity and stimulation to prepare them for discharge home. End of life patients need peace and calm.

It is therefore the considered opinion of the stroke team and Executive Team that we should progress plans as quickly as possible to separate acute stroke from rehabilitation. This is the model already in place at City Hospital. Plans have been developed and are being progressed within the division with an anticipated implementation completion of end September.

Newton 4 and its subsequent component parts will continue to be in special measures until we are satisfied that standards are being continuously met. In addition management changes have also been introduced.

Rachel Overfield
Chief Nurse

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Annual Risk Report – 2010/11
SPONSORING DIRECTOR:	Kam Dhami – Director of Governance
AUTHOR:	Allison Binns, Head of Risk Management Dally Masaun, Head of Health and Safety
DATE OF MEETING:	25 August 2011

SUMMARY OF KEY POINTS:

This report highlights key risk activity undertaken during 2010/11:

- Risk Assessment and Register process
- NHSLA assessment
- Health and Safety
- Electronic Incident Reporting
- Policy Review
- Analysis of 2010/11 incident data

Key incident data points:

- Total incidents: 9490 (8798 in 2009/10), an increase of 8% (Graph 1)
- Clinical incidents: 6458 (5564 in 2009/10), an increase of 10%
- Health and safety incidents: 3032 (3234 in 2009/10), an decrease of 2%
- Red incidents: 446 (170 in 2009/10) an increase of 162%
- Top incident type: aspects of clinical care (1620)

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High quality of care
Annual priorities	
NHS LA standards	Standard 5 'Learning from Experience'
Core Standards	SfBH Core Standard C1a
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Routine annual report.

SWBTB (8/11) 172 (a)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Annual Risk Management Report.

2010 - 11

Where EVERYONE Matters

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Risk Management Report – Annual

2010/11

1. Introduction

This report highlights key risk activity undertaken during 2010/11:

- Risk Assessment/Register process
- NHSLA Assessment
- Health and Safety
- Electronic incident reporting
- Policy review
- Analysis of 2010/11 incident data

2. Risk Register process

The Trust continued in its achievement of Level 3 in ALE KLOE scores. Throughout the year there was continued divisional compliance with the requirement to produce quarterly divisional risk registers.

New red risks for escalation to the Trust Risk Register were discussed at Risk Management Group, were accepted and proposed to Governance Board for inclusion on the Trust Risk Register.

Red risks were then reported and discussed on a quarterly basis at Governance Board, Governance and Risk Management Committee and Trust Board, together with the Assurance Framework.

Wards and departments continue to undertake the generic risk assessments as laid out in the Health and Safety Starter Pack. This was evident during the build-up to the NHSLA Assessment in February 2011. Local risk registers were also evident within the Starter Pack files.

3. NHSLA Assessment

In February 2011 the Trust underwent its NHSLA Level 2 assessment. The Trust was successful in attaining Level 2 with a pass of 43 criteria out of 50. The assessor in her overall round up suggested a review of our policies and processes as they were often over complex.

No assessment was undertaken against the Maternity CNST standards, however, work commenced on reviewing Maternity service guidelines in preparation for commencement of evidence collection for a Level 2 assessment in March 2012.

4. Health and Safety

Risk Assessment & Risk Register Audit – in preparation for NHSLA Assessment all wards & departments, prioritised by division size, were audited and given reports to aid compliance with current standards.

Following a formal audit of the Trust (Nov 2010) by the HSE on contact dermatitis a action plan was produced and agreed by the visiting Inspector. The three key issues addressed are:

- Improvements in skin surveillance
- Introducing a specific COSHH risk assessment training programme
- Addressing concerns expressed by staff about vinyl gloves

Bariatric folders were introduced to all clinical areas. The folders contain;

- Laminated instruction leaflets which can be used in the bed space
- Detailed instructions including Decontamination leaflets

They also contain clear instructions on how to order equipment and the safe working load of all equipment. A Bariatric Hotline was introduced, for the ordering of equipment, training or help with assessing the patients needs.

A range of leaflets on Ergonomics were produced and made available on the intranet. These offer advice from the office to the computer through to load handling.

The Chief Nurse launched the Trust's Health & Well-Being Committee in response to the Boorman Report into health & well-being in the NHS. The Committee comprises key management and staff side stakeholders alongside experts (e.g. Occ Health, Human Resources) and reports to the HSWC which will in turn report to the Governance Board.

The Committee's promotes and monitor health & well-being amongst the workforce. The Group comprises a representative cross-section of staff and receive and comment on initiatives created by the Committee. A LiA event was held in June. The Committee has agreed a strategy and action plan which is progressing to schedule.

5. Security

There is now a security team at Sandwell working 12 hrs rotating shifts. An article has been published in Heartbeat highlighting their role and the fact that they have a dedicated security role.

Security Awareness Month took place in November members of the security team and the Trust's Security Adviser arranged a number of publicising events.

New digital radio equipment costing £27k have been installed in each of the Security Control. The system is 'secure' and will improve patient confidentiality.
A number of Security capital projects have been completed this year. These are related to Hospital "Lock-down", Ward security and improved surveillance technology.

6. Electronic Incident Reporting

The Risk Management Team, with assistance from colleagues in IM&T has developed an electronic incident reporting process which largely mirrors the paper-based system. A select group of areas began testing the system during Q3, allowing the reporting structures and forms to be amended in light of staff feedback. The conversion of the Trust to NHS.NET delayed the rollout for a few months. However, Maternity volunteered to go live with the system in February 2011 and have been reporting successfully ever since.

7. Policy review

A number of policies were reviewed and a few small amendments were made to aid in the NHSLA assessment. Some policies were due for review in Q3 and Q4 of 2010/11. These reviews were rescheduled for the financial year 2011/12 to take account of the NHSLA assessment.

8. Analysis of 2010/11 Incident data

Incident data analysis
Incident data and comment on issues raised/steps taken is attached (appendix 1).

Key issues highlighted within appendix 1
Total incidents: 9490 (8798 in 2009/10) an increase of 8% (Graph 1)
Clinical incidents: 6458 (5564 in 2009/10), an increase of 10%
Health and Safety incidents: 3032 (3234 in 2009/10), a decrease of 2%
Red incidents: 446 (170 in 2009/10) an increase of 162%
Top incident type: Aspects of Clinical Care (1620)

9. 2011/12 Objectives

- Raise awareness of incident report to facilitate an increase in reporting numbers
- Improve position in the NRLS benchmarking of incident reporting against similar Trusts
- Support CNST Maternity Level 2 assessment
- Review, amend and develop policies required for NHSLA Level 2 reassessment
- Prepare processes and evidence collection methods ahead of NHSLA Level 2 reassessment in 2013
- Align community and hospital processes and policies
- Undertake LiA, with one focus to be feedback from incidents.
- Improve communication regarding Health and Safety
- Amend process for risks to be escalated to Trust risk register
- Redefine risk assessment and register processes and data collection.
- Define one risk database for use within the Trust

10. Recommendations

The Trust Board is recommended to NOTE this report.

Appendix 1

Incident Data Analysis
2010/11

The Trust has established an organisation-wide culture of incident reporting. On receipt of a completed incident form, information is centrally inputted onto Safeguard, an electronic database, against 1 of 28 categories (cause groups). Incidents reported via the electronic system are quality assured prior to merging into the "live" Safeguard system.

This report is based on data from Safeguard and looks at incident trends from key cause groups and associated sub-cause groups over 4 years since 2007/08.

Key indicators are shown in the following pages and more detailed information is provided on a regular basis (generally quarterly) to divisional meetings and to key corporate committees.

All incidents are investigated in accordance with the grade of severity assigned to each incident. Green/Yellow incidents are followed up locally. Amber incidents are investigated and the resulting action plans monitored at divisional level. Red incidents are investigated and monitored centrally, with action plans being ratified, monitored and closed at the Adverse Events Committee, chaired by the Chief Executive.

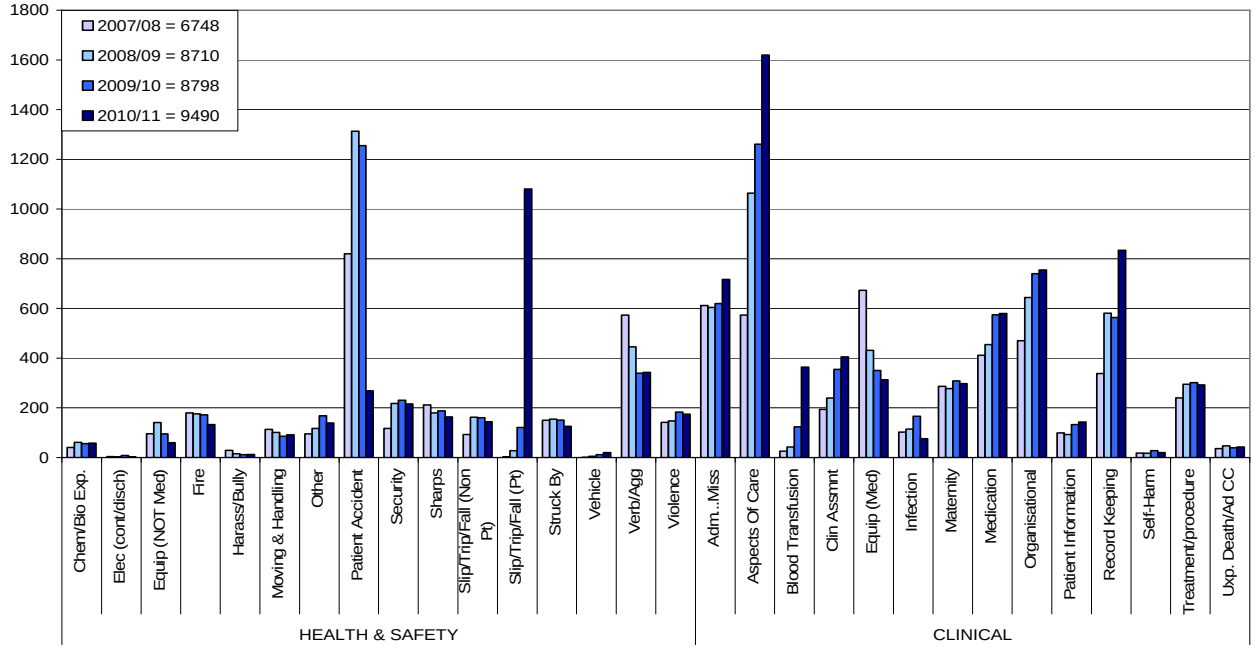
Clinical Incidents are reported to the National Reporting and Learning System (NRLS) and data is benchmarked on a 6 monthly basis against Trusts of a similar size. This Trust is generally in the lower quarter or third for reporting under the identified cause groups.

Performance Monitoring Data

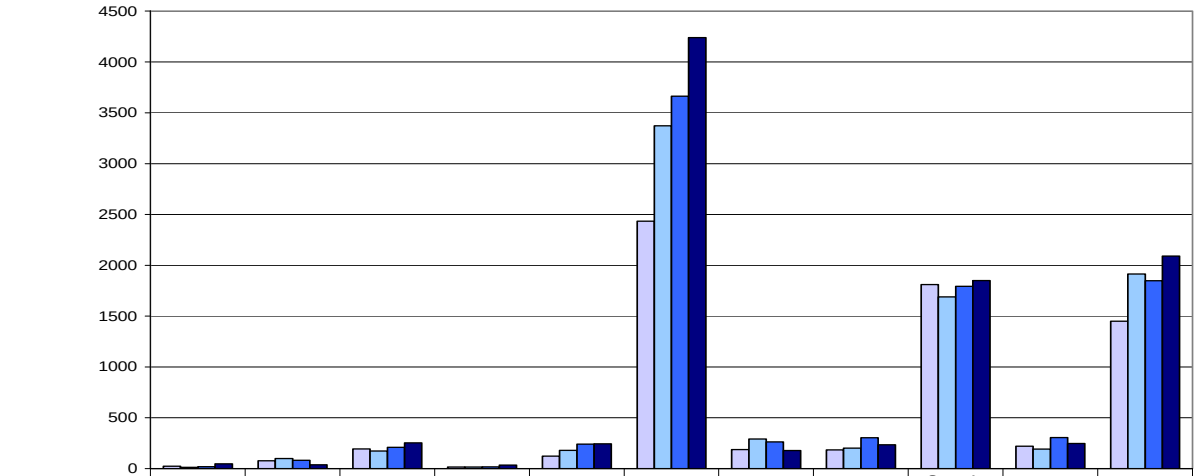
1. Overview of incident data (Graphs 1 and 2 and Table 1)

The total number of incidents recorded for 2010/11 is 9490 (8798 in 2009/10), an 8% increase (Graph 1). Numbers of reported Clinical incidents increased from 5564 in 2009/10 to 6458 in 20010/11, an increase of 10%. Numbers of reported Health & Safety incidents decreased from 3234 in 2009/10 to 3032 in 2010/11, a decrease of 2%.

Graph 1: **Incident Trends (Trust) 2007/08 – 2010/11**



Graph 2: **Incidents by Division 2007/08-2010/11**



	Dev/Stra	Est	FNM&T	IM&T	Imaging	Medicine	Ops	Path	Surg A, A&CC	Surg B	W&C Hlth
2007/08 = 6748	25	78	195	16	124	2434	187	185	1810	221	1449
2008/09 = 8170	14	100	174	16	180	3372	291	202	1690	193	1914
2009/10 = 8798	20	83	211	18	242	3663	264	305	1794	307	1848
2010/11 = 9490	48	38	254	34	246	4239	178	235	1849	247	2090

Table 1: **Reported Incidents (Cause Group & Risk Rating by Division) 2010/11**

	Dev/Strat	Est	FN&T	Imag	IM&T	Med	Ops	Path	Surg A	Surg B	W&C Hlth	WF/Fin	
Adm, Disch			4	8		362	4	2	177	18	142		**717**
Aspects of Care	2		8	27		802	1	7	325	27	421		**1620**
Blood Transfusion	3		1		2	185	1	21	79		72		**364**
Chemical/Bio	1	2	3	5		18	5	4	14	1	5		**58**
Clinical Assess	1		6	16		122		105	44	12	99		**405**
Elec (Cont/Disch)			1				1		1				**3**
Equip (Med)			2	12		55	3	4	137	22	78		**313**
Equip (NOT Med)		2	1	1	1	19	2	1	12	2	14	5	**60**
Fire	1	7	35	4	3	35	4		16	1	25	2	**133**
Harass/Bully			2			5	2		1	1	1		**12**
Infection				3		25		4	35	1	8		**76**
Maternity			1			2					294		**297**
Medication	5		2	1	5	255	78	2	125	4	103		**580**
Moving & Handling		1	23	5		32	3		17	2	8		**91**
Needlestick	1	2	3	4		62		2	55	8	27		**164**
Organisational	5		6	52	1	196	11	20	188	32	244		**755**
Other		2	22	4	4	30	9	14	24	3	23	5	**139**
Patient Accident	2			7		190	1	1	40	8	10		**260**
Patient Info Incident	6		5	5	1	21	3	4	28	28	42		**143**
Recordkeeping	1		4	14	11	290	23	21	184	40	244	2	**834**
Security	12	2	29	4	4	87	6	5	28	2	34	3	**216**
Self-Harming						18			2				**20**
STF (Non-Pt)	3	8	27	4		36	7	6	22	2	24	5	**144**
STF (Pt)	1		6	9		898	3		148	8	17		**1090**
Struck By	2	9	29	6	2	34	5	5	16	3	12	2	**125**
Treatment/Procedure	2		3	50		97		5	50	10	75		**292**
Uxp Death\Adm CC			1			17			9		15		**42**
Vehicle		1	11			1					6	1	**20**
Verbal/Aggression			16	5		204	6	2	55	11	38	6	**343**
Violence			5			142			17	1	9		**174**
TOTAL	**48**	**36**	**256**	**246**	**34**	**4240**	**178**	**235**	**1849**	**247**	**2090**	**31**	**9490**
Red			3			310		2	80	3	48		**446**
Amber	7	4	30	10	7	522	10	28	375	77	354	3	**1427**
Yellow	28	11	86	136	13	1770	93	126	785	76	1020	12	**4156**
Green	13	21	137	100	14	1638	75	79	609	91	668	16	**3461**
TOTAL	**48**	**36**	**256**	**246**	**34**	**4240**	**178**	**235**	**1849**	**247**	**2090**	**31**	**9490**

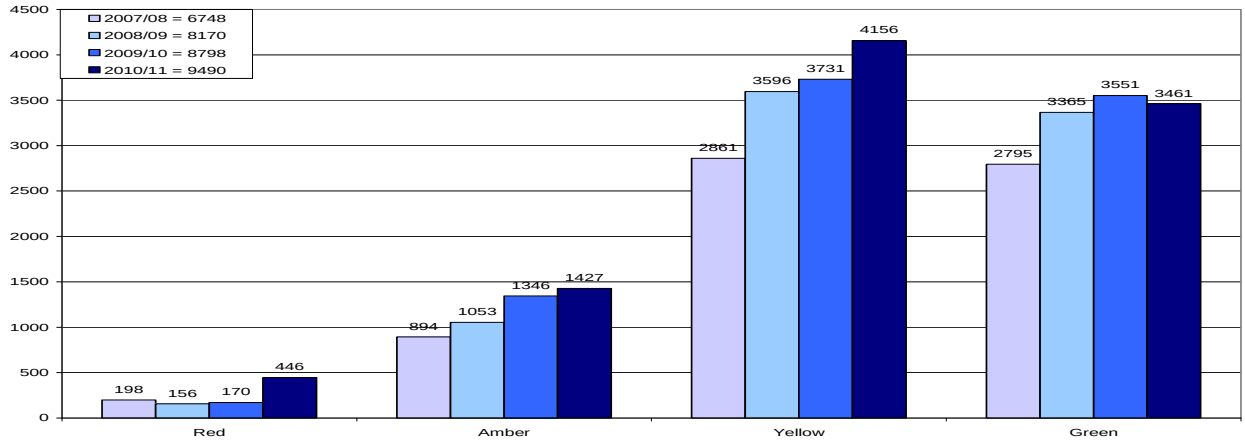
2. Risk ratings and red incidents (Graphs 3 and 3a and Table 1)

Whilst overall levels of numbers of incidents give information about patient safety activity, a breakdown by grade (graphs 3 and 3a) indicates whether staff are managing risks proactively. The most desirable trend is for high numbers of green/yellow incidents, with lower numbers of amber incidents and relatively few red incidents.

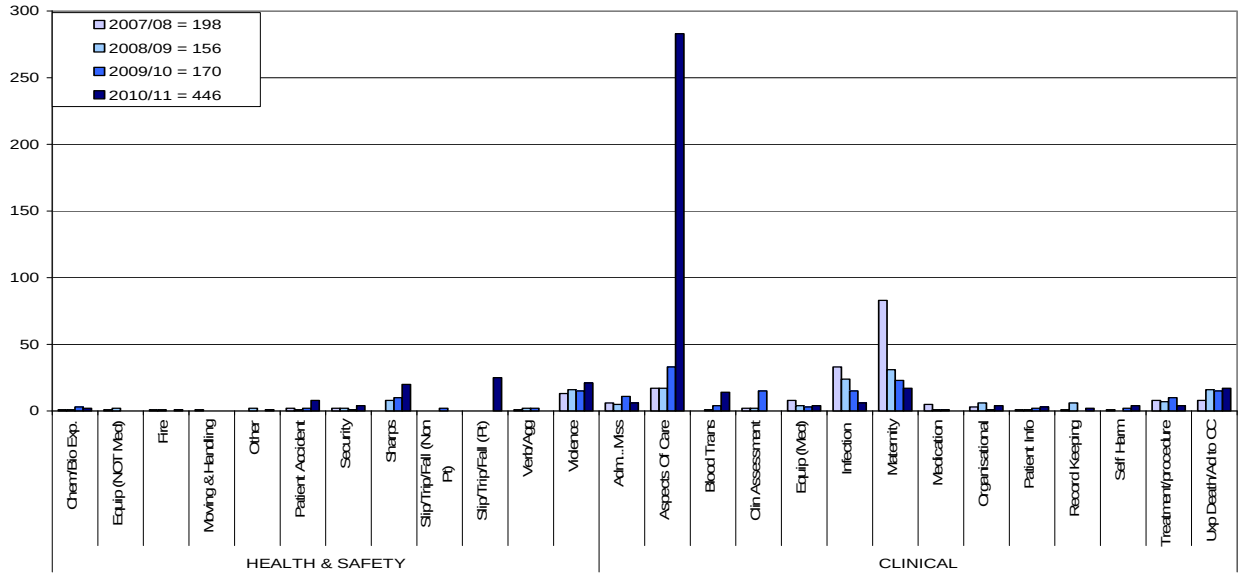
The overall number of reported red incidents in 2010/11 was 446 (Graph 3a). This is an increase of 162% from 170 in 2009/10. This increase reflects the requirement to report grade three and four pressure sores and fractures following a fall as red incidents. The number of red incidents as a proportion of total incidents is 5%, compared with 2% in 2009/10.

Not all red incidents result in generation of an incident form, although areas are reminded to provide forms. Reviews are still held and action plans developed irrespective of whether a form is received or not.

Graph 3: **Risk Rating Trends 2007/08-2010/11**

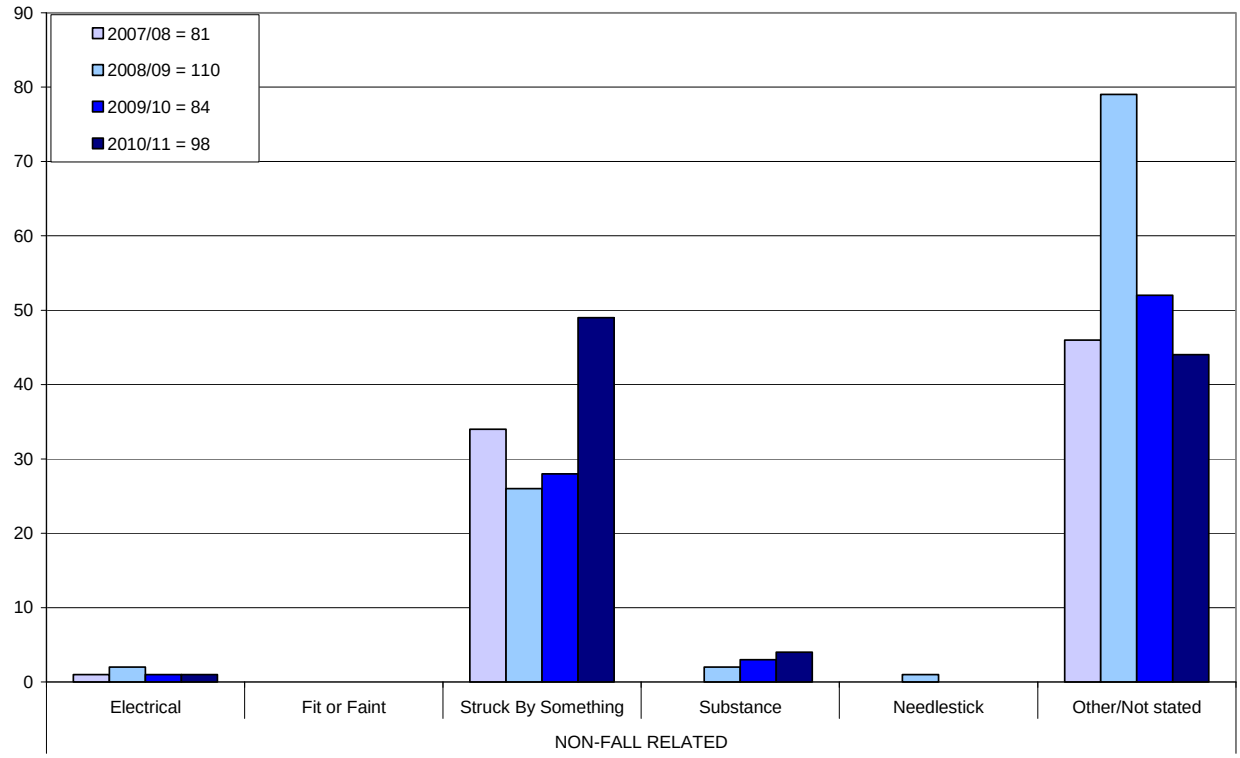


Graph 3a: **Red Incidents (Trust) 2007/08-2010/11**

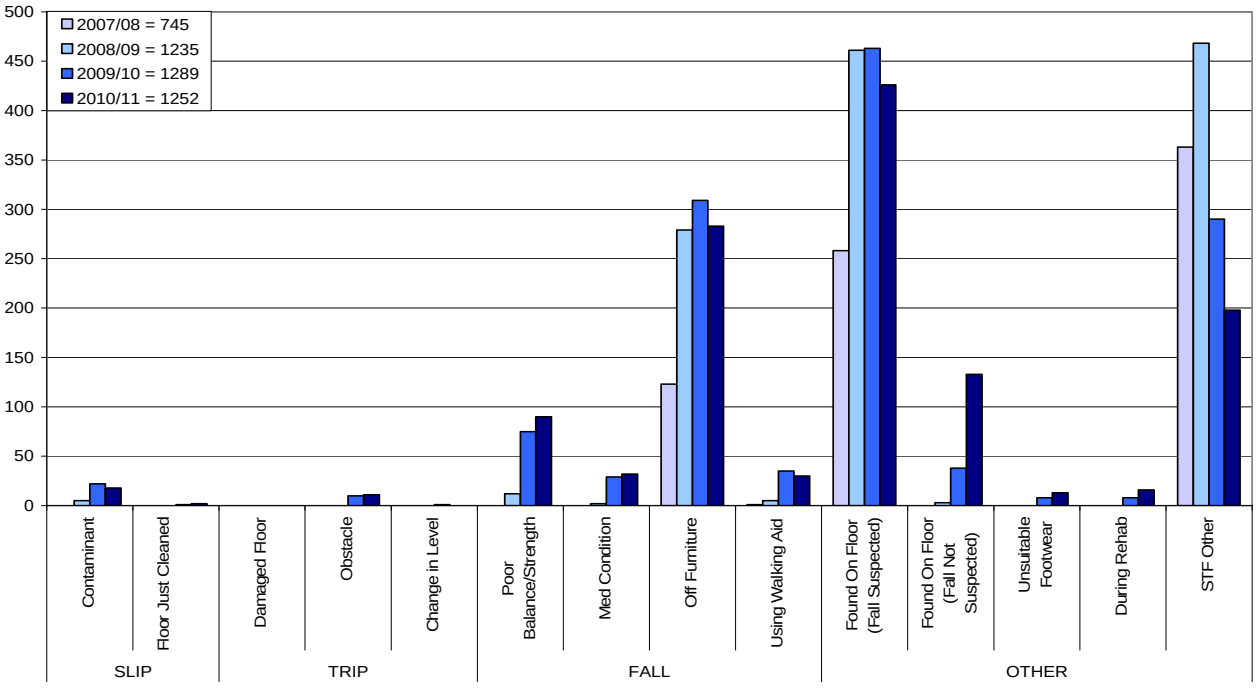


3. Analysis of specific cause groups

Graph 4: **Patient Accident – excluding falls (Trust) 2007/08 – 2010/11**



Graph 4a: **Patient Accident – Slip Trips and Falls (Trust) 2007/08 – 2010/11**



Patient Accidents are the non-clinical incidents that happen to patients. The dominant type of non-clinical events that occur to patients are falls. The Trust has a named lead nurse working on implementing strategies to reduce patient falls and investigating those with serious outcomes. This lead nurse reports directly to an Assistant Director of Nursing. The Risk Team are currently re-examining all patient falls recorded on the incident database to re-categorise the incidents so that the information gathered can be used to inform and help to assess the effectiveness the future intervention strategies.

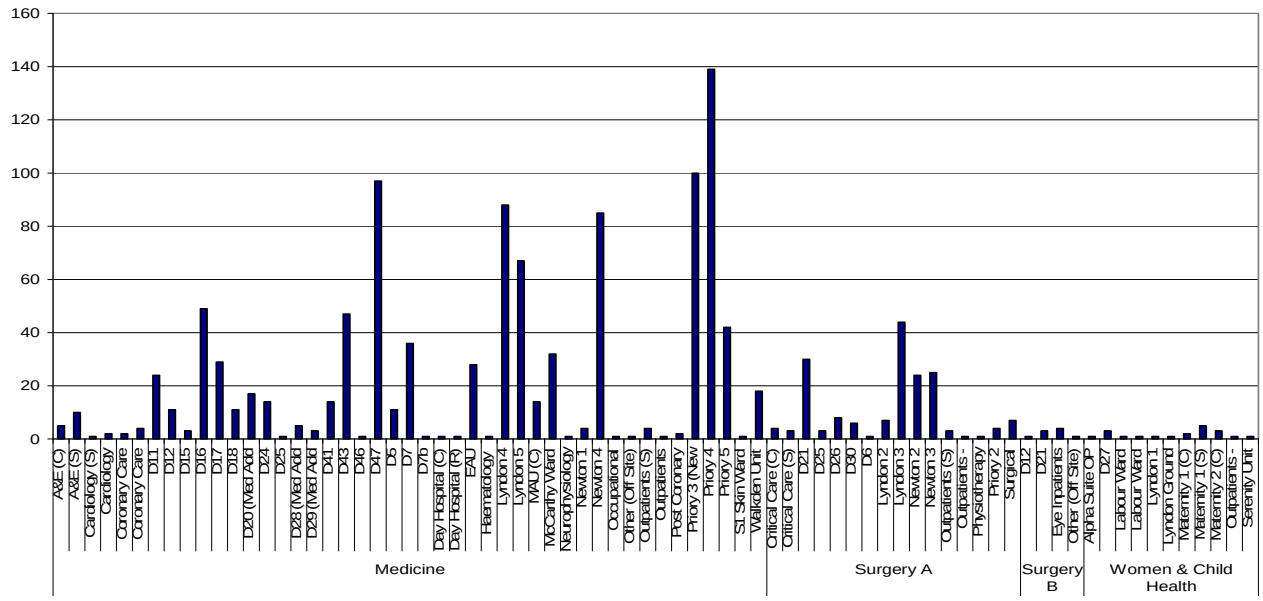
37% (459 of 1252) of the patents reported in this category were found on the floor, and 31% (133) of these were deemed not to be falls but more likely patients who had sat on the floor for some other reason. From the current descriptions in the reported incidents it is not possible to ascertain how many of the patients found on the floor fell off their beds.

The data suggest the condition of the floors is relatively good and well maintained. Fall due to contamination tend to be patients slipping on their own body fluid and the obstacles tend to be bags brought in by visitors.

Falls due to medical condition or lack of physical strength/balance manifest themselves through sudden fainting or patients legs giving way.

Occasionally falls occur when patients are mobilising using walking aids or being rehabilitated by clinical staff.

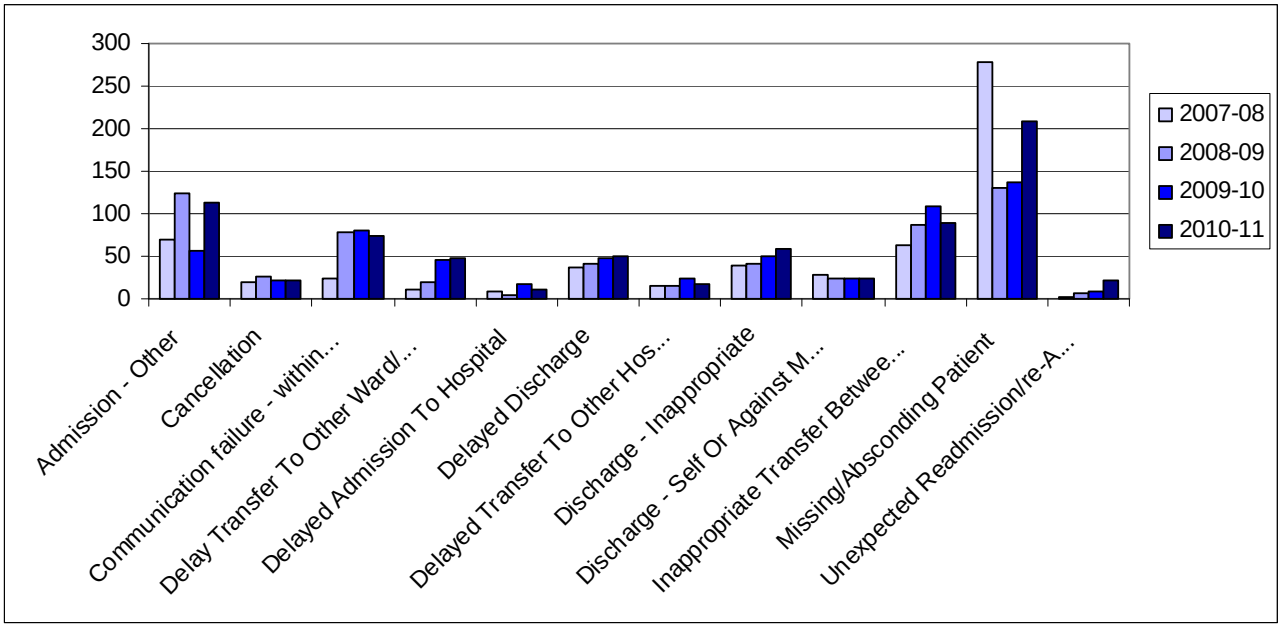
Graph 4b: **Patient Accident – Slip Trips and Falls by Inpatient Divisions (Trust) 2007/08 – 2010/11**



The following, D47, Lyndon 4, Newton 4, Priory 3 and Priory 4 have reported over 80 fall incidents this year.

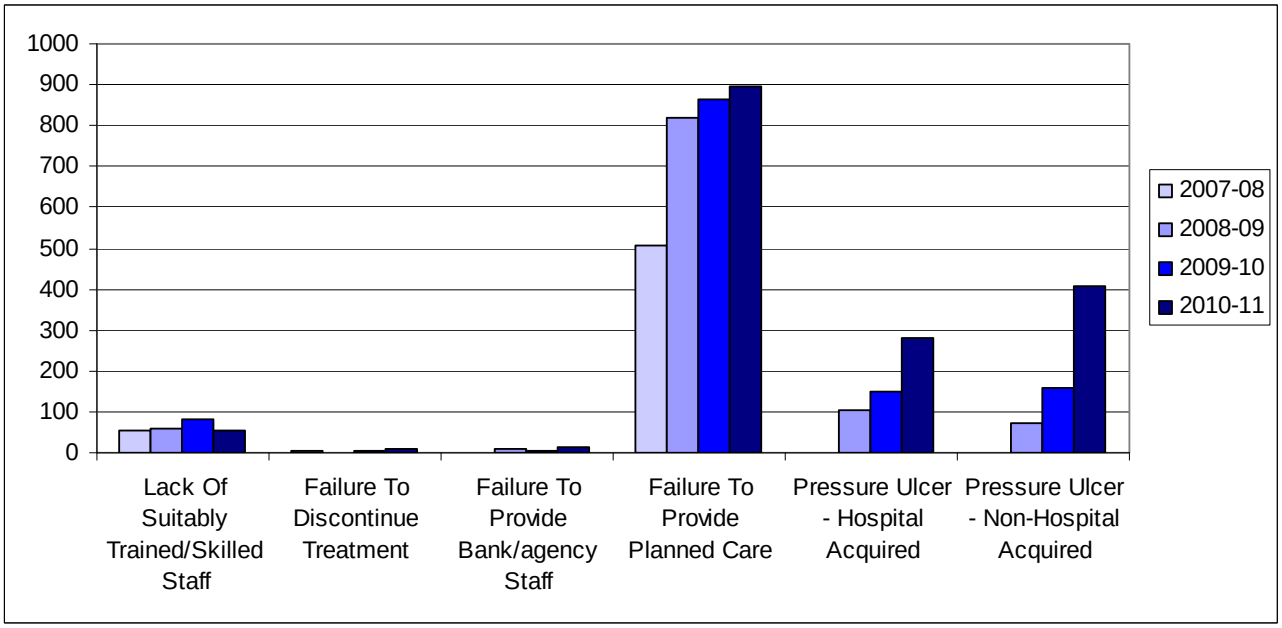
Twenty falls resulted in fractured hips and were investigated as Red incidents. No clusters on any particular ward.

Graph 5: **Admission/discharge/transfer/missing patients 2007/08-2010/11**



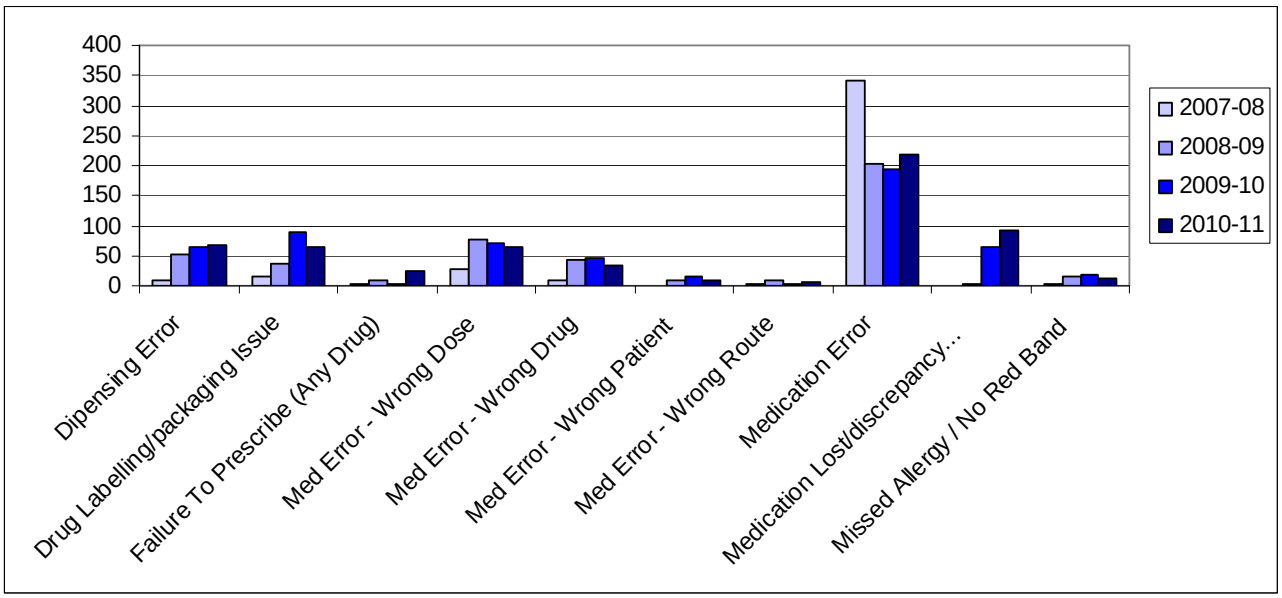
Graph 5 shows an increase in the number of **missing patients together with other admission issues**. There has been a slight decrease in reported **communication** failures and **inappropriate transfer**.

Graph 6: **Aspects of clinical care 2007/08-2010/11**



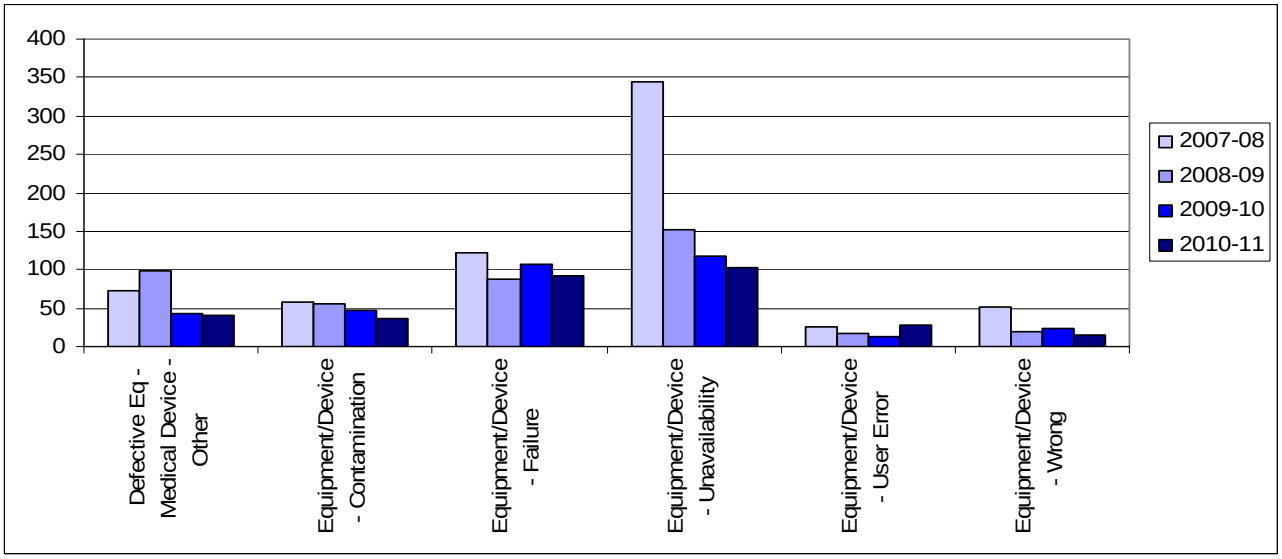
Aspect of clinical care incidents (graph 6) showed an increase in reported instances of failures to provide planned care. The categories around pressure sores have also shown a marked increase in reporting.

Graph 7: **Medication Errors 2007/08-2010/11**



Graph 7 shows reported **medication errors**. There have been slight increases in incidents around lost medication and medication error. The reporting trend continues to be low for the size of Trust. In particular omitted medications has been seen as a problem continuing to medication errors and is to be recommended as CQUIN target for next year.

Graph 8: **Medical Equipment 2007/08-2010/11**



Medical Equipment (Graph 8). There was a fall in incidents generally, with continued decrease in reported unavailability of equipment.

Graph 9: **Maternity incidents by trigger list category 2007/08-2010/11**

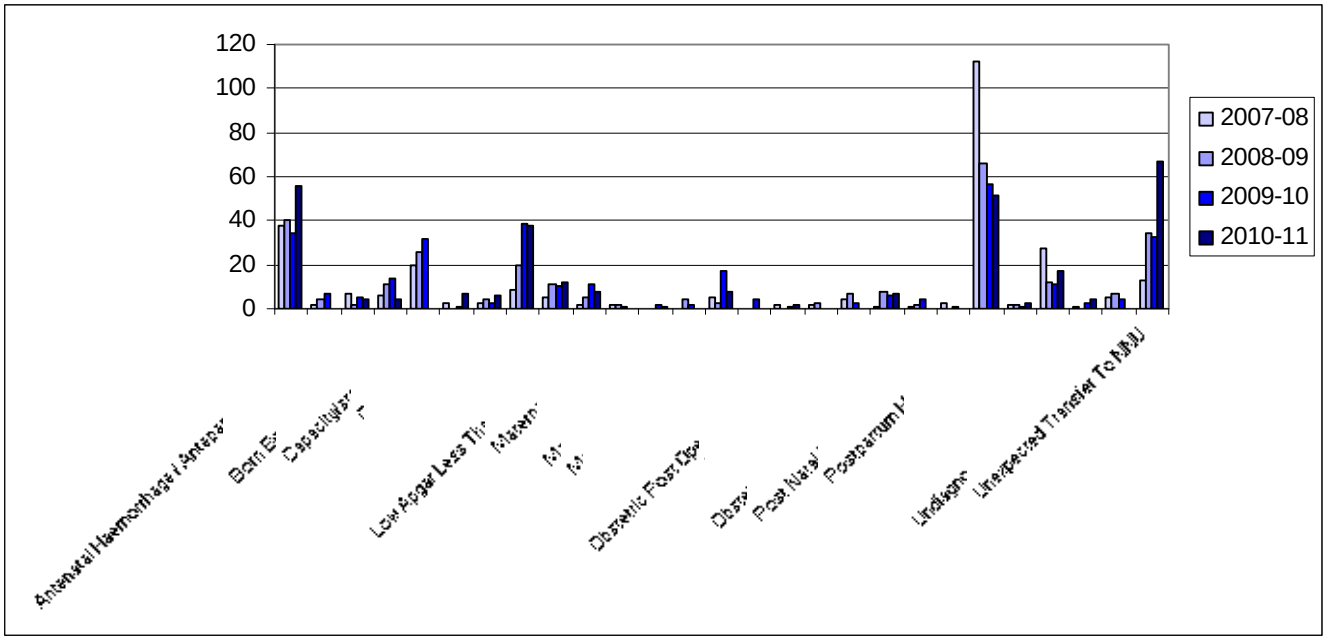
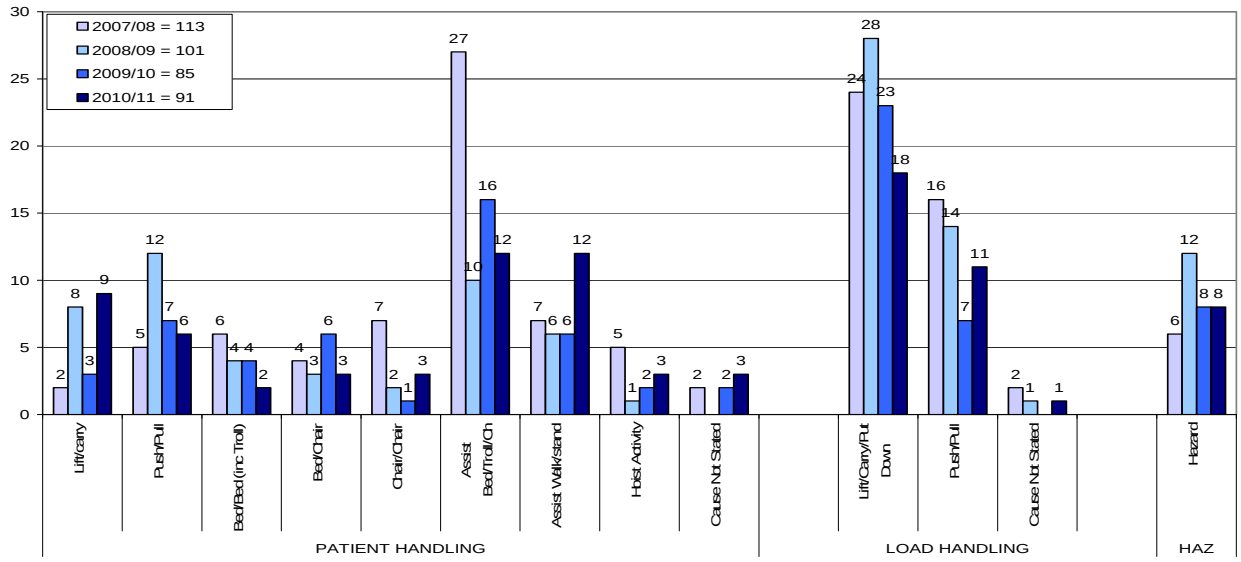


Table 2: **Maternity incidents by location 2007/08 – 2010/11**

Department	2007-08	2008-09	2009-10	2010-11
*Community	2			
Admin Suite - Maternity Bk (C		4		
Ante-Natal (C)	66	141	59	74
Ante-Natal (S)	30	41	28	31
Community - Womens (C)	10	49	36	8
Community - Womens (S)		26	23	
Labour Ward (C)	382	552	374	381
Labour Ward (S)	194	352	385	253
Lyndon 1				
Lyndon Ground				
Maternity 1 (C)	77	38	40	99
Maternity 1 (S)	64	66	96	58
Maternity 2 (C)	73	71	40	124
Maternity 2 (S)		2	1	2
Maternity Theatres (C)	56	27	21	52
Maternity Theatres (S)	35	10	11	25
Midwifery (C)*	1	2		
Midwifery (S)*	2			
Neonatal Unit (C)				8
Neonatal Unit (S)			1	2
Obstetrics (C)*	12	2	2	2
Obstetrics (S)*	16		6	1
Paediatric Medicine (C)*				
Paediatric Medicine (S)*				
Paediatric OPD City				
Serenity Unit				75

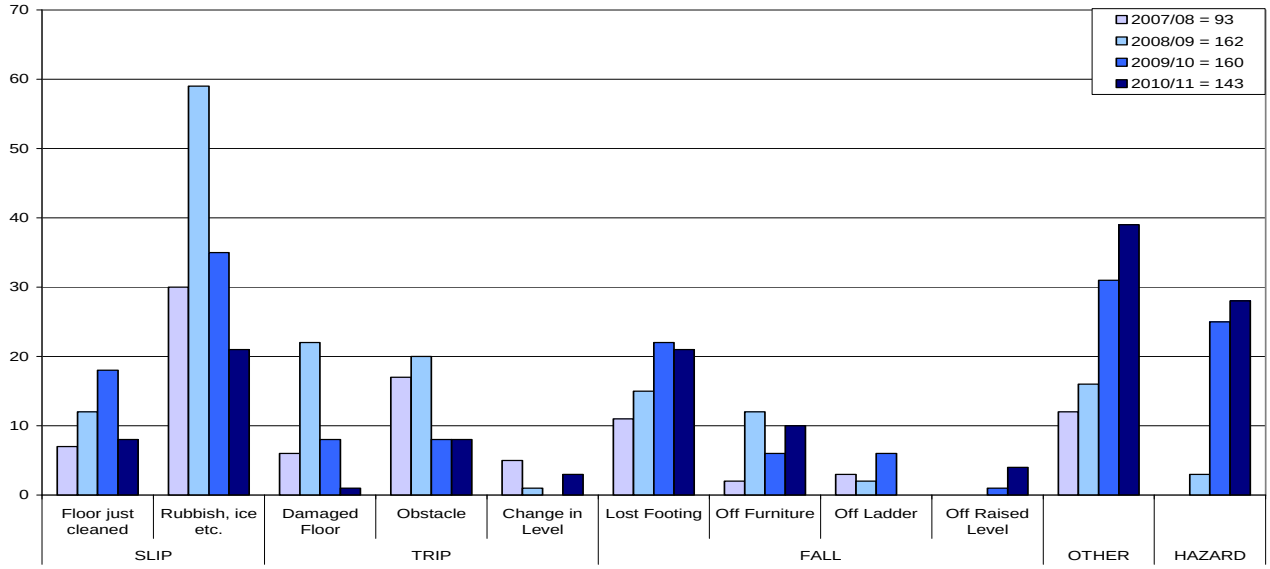
Maternity incidents by area reporting and by trigger list category (graph 9 and table 2) are included to acknowledge the high risk nature of maternity care. Although Maternity report relatively high numbers of incidents compared with some other specialities there are still trigger list categories that appear underused and areas of the service that are not reporting regularly. This data is presented at the Perinatal Risk Group where representatives are expected to feed back these issues locally.

Graph 10: **Moving & Handling (Trust) 2007/08-2010/11**.



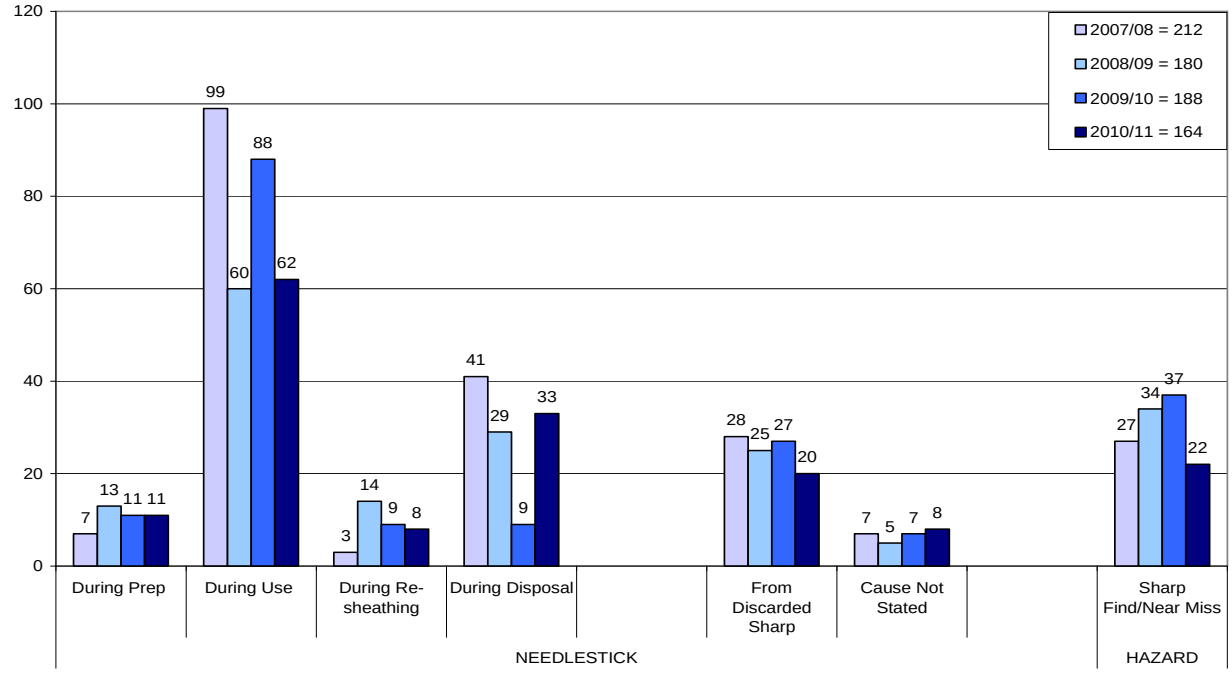
Moving & Handling (Graph 10) 91 incidents were reported under this Health & Safety category (*previous year: 85; 7% **increase***).

Graph 11: **Slip, Trip, Fall (Trust) 2007/08-2010/11**.



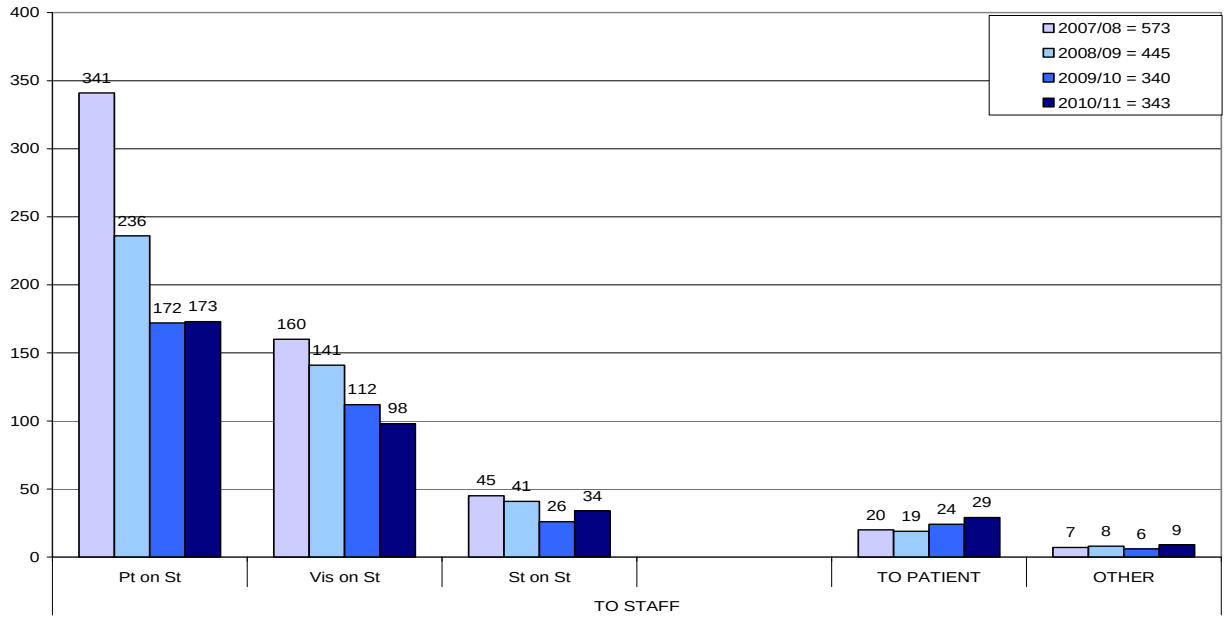
Slip, Trip, Fall (Graph 11) 143 incidents were reported under this Health & Safety category (*previous year: 160; 11% **decrease***).

Graph 12: **Sharps (Trust) 2007/08-2010/11**



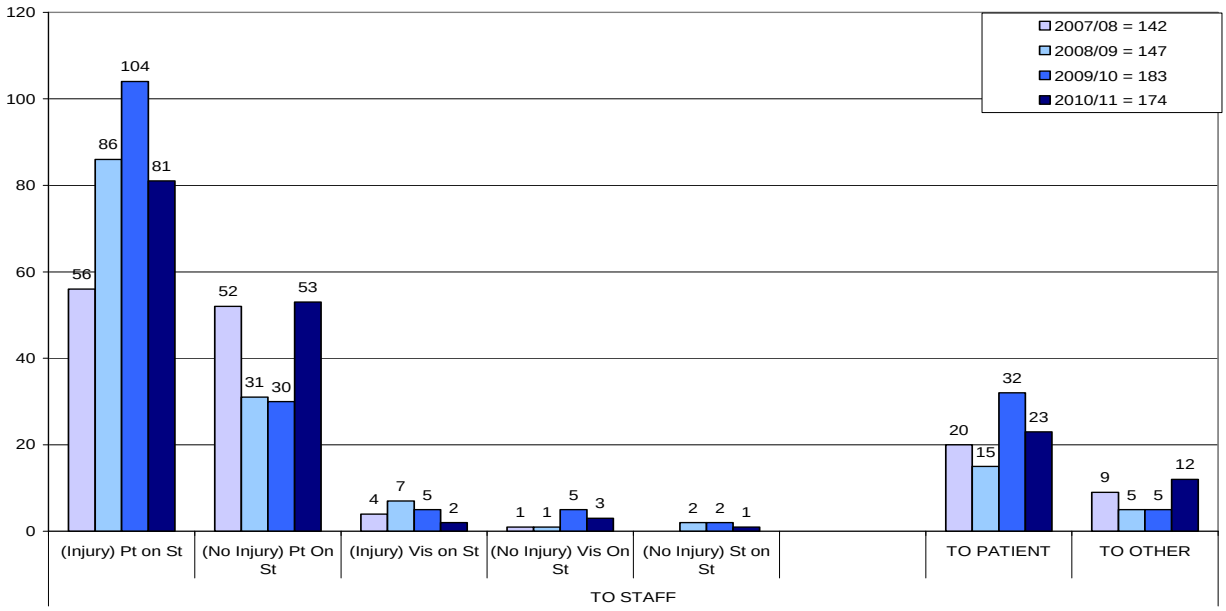
Sharps (Graph 12) 164 sharp injuries were reported under this Health & Safety category (*previous year: 188; 13%* ***decrease***). Increase in "During Disposal due to better differentiation of "During Use" incidents, i.e. avoidable incidents.

Graph 13: **Verbal/Aggression (Trust) 2007/08-2010/11**



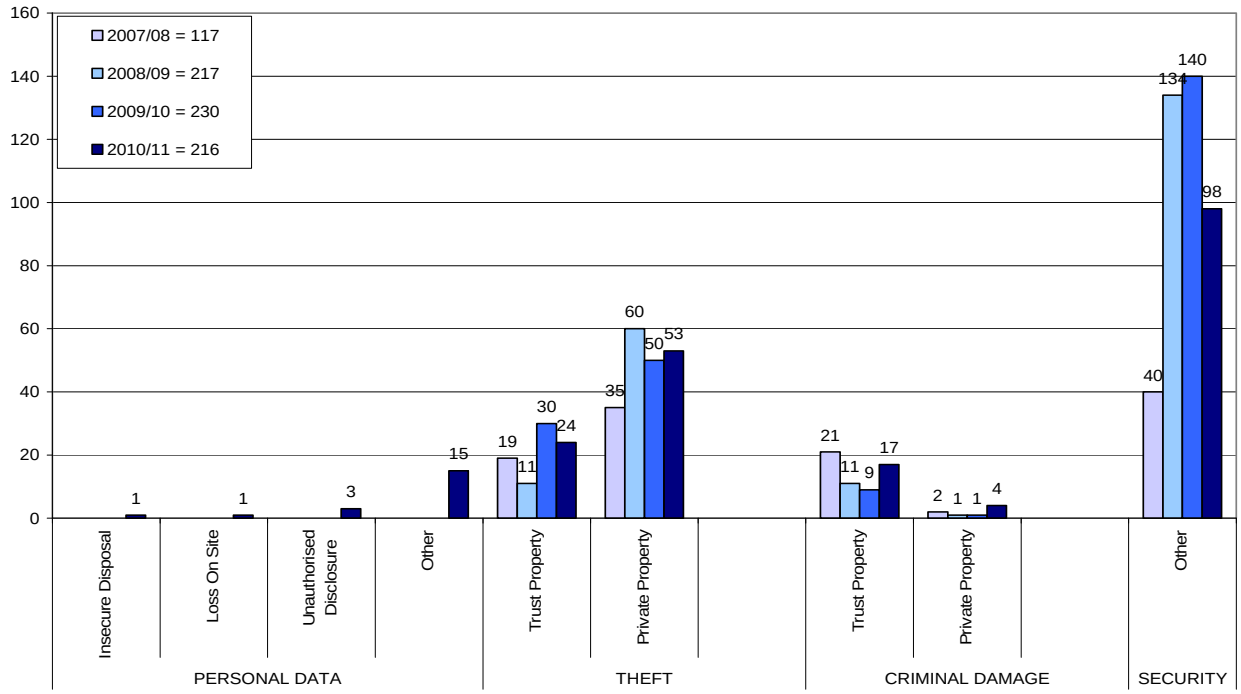
Verbal/Aggression (Graph 13) 343 incidents were reported under this Health & Safety category (*previous year: 340; 1%* ***increase***). Overall all decrease (284 to 271; 5%) in patient and visitor aggression on staff.

Graph 14: **Violence (Trust) 2007/08-2010/11**



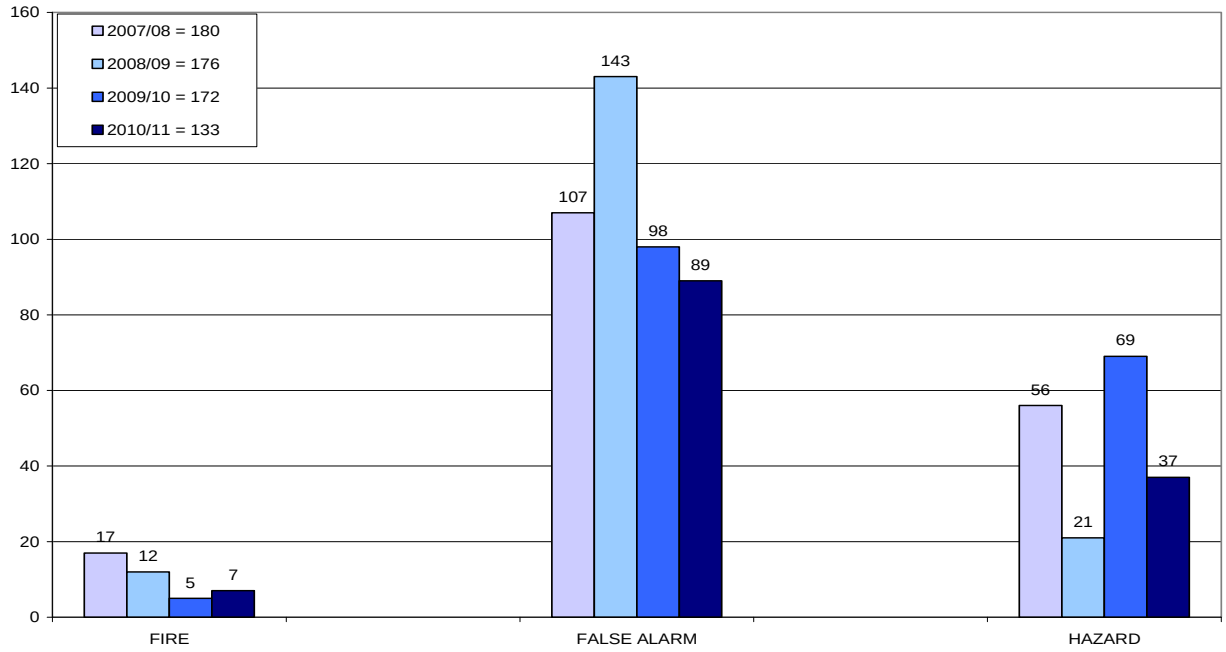
Violence (Graph 14) 174 incidents were reported under this Health & Safety category (*previous year: 183; 5%* ***decrease***). Injurious assaults against staff have decreased by 24% (111 to 84)

Graph 15: **Security - including Personal Data (Trust) 2007/08-2010/11**.



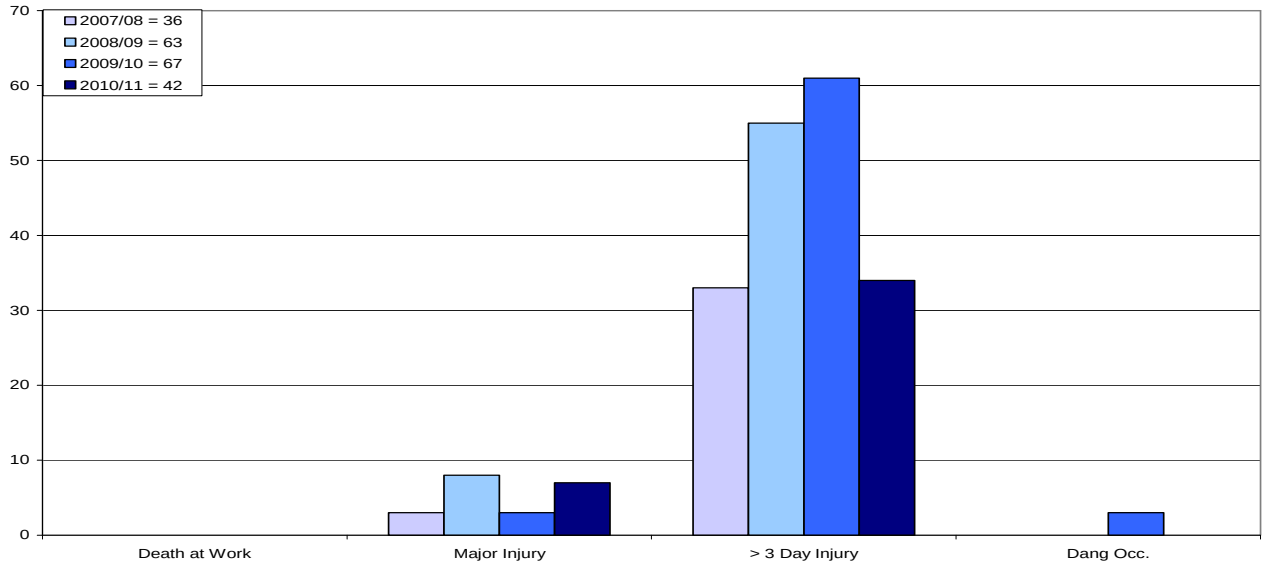
Security (Graph 15) 216 incidents were reported under this Health & Safety category (*previous year: 230; 6%* ***decrease***). NB: This cause group now features detail on incidents involving information/data.

Graph 16: **Fire (Trust) 2007/08-2010/11**.



Fire (Graph 16) 133 incidents were reported under this Health & Safety category (*previous year: 172; 23%* ***decrease***).

Graph 17: **RIDDOR (Trust) 2007/08-2010/11**



Marked decrease in Over Three Day Injuries. NB: improved reporting procedures within the Trust now ensure that occupational diseases (e.g. contact dermatitis) now feature.

ABBREVIATIONS

DIVISIONS

D/S	Development/Strategy/CEO
Est	Estates & Capital Projects
FNM&T	Facilities, Nursing, Midwifery & Therapies
Imag	Imaging
IM&T	Information Management & Technology
Medicine	Medicine & Emergency Care
Ops	Operations
Path	Pathology
Surgery, A&CC	Surgery A, Anaesthetics & Critical Care
Surg B	Surgery B
W&CH	Women's & Child Health
WF&F	Workforce & Finance

CAUSE GROUPS

Admission	Admission, Discharge, Transfer, Miss. Patient
Asp. Clinical Care	Aspects of Clinical Care
Blood Transfusion	Blood Transfusion
Chemical/Bio Exposure	Chemical/Biological Exposure
Clinical Assessment	Clinical Assessments (Diag, Scans, tests)
Electrical	Contact with electricity
Equipment (Medical)	Equipment – Medical
Equipment (Other)	Equipment – Non Medical
Fire	Fire
Harassment/bullying	Harassment\bullying
Infection Control	Infection Control Incident
Maternity	Maternity
Medication	Medication
Moving & Handling	Moving and Handling
Needlestick	Needlestick/Sharp
Organisational	Organisational Issues
Other Incident/Haz	Other incident/hazard
Patient Accident	Patient Accident
Patient Information	Patient Information Incident
Record Keeping	Recordkeeping\filing\missing notes
Security	Security (inc. information/data)
Self-Harming	Self harming behaviour
Slip/Trip/Fall (Non Pt)	Slips, trips and falls affecting non-patients
Slip/Trip/Fall (Pt)	Slips, trips and falls affecting patients
Struck by Something	Struck by something
Treatment/procedure	Treatment procedure
Unexpect Death\CC	Unexpected Death\Admit to Critical\Neonatal
Vehicle	Vehicle\Driving Offence\Accident
Verbal Abuse	Verbal Abuse\Aggression
Violence	Physical assault

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Staff Health and Well-Being - Update
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse (Executive Lead for Workforce)
AUTHOR:	Gayna Deakin, Deputy Director of Workforce
DATE OF MEETING:	25th August 2011

SUMMARY OF KEY POINTS:

This paper provides a summary position for the Trust Board. Progress can be summarised as follows:

- The Trust ended the 2010/11 financial year with a year to date sickness absence figure of 4.11 %. This improvement of 0.36 % against the previous years YTD figure of 4.47 % ensured that the Regional sickness absence target of 4.11% was achieved whilst falling slightly short of the Trust's internally set target of 4%. We continue to compare favorably when benchmarked against other large acute Trust's regionally.

- The Trust has undertaken a significant programme of activities to promote and improve staff health and well being. This programme is communicated to staff using the staff communications email and regular articles in Hot-Topics and Heartbeat.

- The key findings from the national staff survey specific health and well being questions in 2010 (completed by staff at the end of 2010) show a mixed performance

- The Trust's on-going priorities include:

  - A continued focus on the on-going management performance of sickness absence to ensure the achievement of reducing the level of sickness absence further to achieve the Trust's internal target of 3.5% by March 2012.

  - A particular focus on improving healthy eating options for staff to compliment the work undertaken on weight management and increasing physical activity and reviewing the Trust's approach to stress management.

  - Introducing a web based staff health and well-being communications package

  - Developing a set of actions to take participate in the NHS sports challenge to coincide with the publicity and profiling of the 2012 Olympics.

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** this paper.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	An Effective Organisation
Annual priorities	Make improvements to the health and well-being of staff, including reducing sickness absence (6.11)
NHS LA standards	Sickness Absence (3.2)
CQC Essential Standards Quality and Safety	Regulation 22: Outcome 13 (Staffing) Regulation 23: Outcome 14 (Supporting Workers)
Auditors' Local Evaluation	

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

Financial		
Business and market share		
Clinical		
Workforce	**X**	Staff Health and Well-Being is a key element of the Trust's Workforce strategy and organisational development plans.
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Progress towards the implementation of the Staff Health and Well-Being Strategy and Action Plan is monitored by the Staff Health and Well-being Committee and reported to the Health, Safety and Welfare Committee and Governance Board.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

STAFF HEALTH AND WELL-BEING

Trust Board Update

August 2011

1. Introduction

1.1 The purpose of this paper is to inform the Trust Board of the actions taken and progress made to reduce levels of sickness absence and improve staff health and well-being.

2. Background

2.1 The Boorman Review, published in 2009, called for staff health and wellbeing to be embedded in the core business of NHS organisations and set out a strategic business case for employee health and wellbeing as follows:

- Improved quality of care and patient safety through the reduction in sickness absence
- Increasing productivity in line with the Quality, Innovation, Productivity and Prevention (QIPP) agenda
- Improved staff satisfaction as measured by the NHS staff survey (linked to the Care Quality Commission registration)
- Commitment to provide support and opportunities for staff to maintain their health, well-being and safety as laid out by the NHS Constitution
- Supports equality, diversity and inclusion within the workplace
- Adapting to an ageing workforce

2.2 The Trust's staff health and well-being agenda is an integral part of the workforce strategy, building a high quality workforce. It compliments and supports the Trust's wider organisation development plans and the Quality and Efficiency Programme (QuEP). It relies upon a more preventative approach to managing sickness absence with the aim of leading to further reduction in sickness absence levels and improved staff satisfaction.

3. Progress to date

3.1 The Staff Health and Well-Being Committee is responsible for overseeing the implementation and action plan and reports to the Trust Governance Board through the Trust's Health, Safety and Welfare Committee. The Chief Nurse (Executive Lead for Workforce) is the Board level staff health and well-being champion.

3.2 A robust sickness absence management plan has been developed to achieve the reductions in sickness absence required and progress against this is monitored by the Workforce Utilisation QuEP workstream. The plan includes a range of interventions e.g.

- A monthly programme of sickness absence management training, with a focus on improving staff health and well-being, for line managers

- Increasing the profile of the importance of effective sickness absence management, e.g. monthly updates in Hot-Topics, reports to TMB each month, KPIs included in the HR dashboard produced quarterly

- Robust monitoring of sickness absence levels against internally agreed targets from improvement (2010/2011 - 4% and 2011/2012 - 3.5%)

- Provision of timely sickness absence data through the Trust's CDA reporting system or ESR/Manager Self-Service

- Monitoring compliance with requirement to conduct the 'return to work' interview in the quarterly HR dashboard

3.3 The Trust ended the 2010/11 financial year with a year to date sickness absence figure of 4.11 %. This improvement of 0.36 % against the previous years YTD figure of 4.47 % ensured that the Regional sickness absence target of 4.11% was achieved whilst falling slightly short of the Trust's internally set target of 4%. We continue to compare favorably when benchmarked against other large acute Trust's regionally.

The overall sickness percentage does, however, mask some significant variations across the divisions where sickness absence levels in some departments are running at unacceptably high levels. Each of these areas was reviewed during March and April 2011 by the Chief Nurse, Chief Operating Officer and Deputy Director of Workforce.

3.4 The Trust has undertaken a significant programme of activities to promote and improve staff health and well being (Appendix1). This programme is communicated to staff using the staff communications email and regular articles in Hot-Topics and Heartbeat.

3.5 The key findings from the national staff survey specific health and well being questions (completed by staff at the end of 2010) shows a mixed performance and are set out in the table below:

	2009	**2010**	**Average for acute trusts**	**!**
% saying they have access to counselling services at their Trust	74	75	66	☺
% saying they have access to occupational health services at their Trust	94	95	96	☺
% saying they have felt unwell in the last 12 months as a result of work-related stress	29	30	28	😐
% agreeing/strongly agreeing that "in general, my job is good for my health"	44	39	44	😐
% agreeing/strongly agreeing that "my immediate manager takes a positive interest in my health and well-being"	45	44	50	☹
% saying that in the last 3 months they had gone to work despite not feeling well enough to perform their duties: ▪ ….had felt pressure from their manager to come to work ▪ ….had felt pressure from their colleagues to come to work ▪ ….had put themselves under pressure to come to work	73 36 21 88	70 39 27 91	66 33 24 91	😐

These indicators and a selection of other key findings from the survey will be used as one of the measures to gauge the effectiveness of the initiatives, including the healthy lifestyle programme, that have been introduced from January 2011.

4. Staff Health and Well-Being Priorities

4.1 To continue to improve the health and well-being of the workforce and encouraging staff to look after their health is a key strategic priority within the Trust's Workforce Strategy. Our plan of work includes:

- A continued focus on the on-going management performance of sickness absence to ensure the achievement of reducing the level of sickness absence further to achieve the Trust's internal target of 3.5% by March 2012.

  This includes a schedule of meetings, chaired by the Chief Executive, to review sickness absence management by division, an increased focus on the accuracy of sickness absence recording (reasons for absence and confirmation that return to work interview has been undertaken), greater involvement of occupational health nurses supporting the managers to deal with individual sickness absence cases and a continuous review of the effectiveness of the Trust's sickness absence policy and processes.

- The continued delivery of the Trust's staff health and well-being action plan and healthy lifestyle programme, with a particular focus on improving healthy eating options for staff to compliment the work undertaken on weight management and increasing physical activity and reviewing the Trust's approach to stress management.

- Introducing a web based staff health and well-being communications package

- Developing a set of actions to take participate in the NHS sports challenge to coincide with the publicity and profiling of the 2012 Olympics.

5. Conclusion

5.1 Good progress is being made against the Sickness Absence Management Plan and steady progress is being made in implementing the Staff Health and Well-Being Strategy. It is essential that the factors affecting staff attendance and well-being continue to maintain a high profile and that links continue to be made with improving workforce productivity by reducing sickness absence, plans for staff satisfaction (national staff survey findings), leadership development (leadership framework) and staff engagement (Listening into Action).

5.2 To maintain the current profile and focus on staff health and well-being will require support for the continued funding of the staff health and well-being facilitators role and the on-going effort of the staff health and well-being committee to ensure that the initiatives introduced are embedded and that the improvements that are made are sustainable.

6. Recommendations

6.1 The Trust Board is asked to **receive** and **note** this paper.

STAFF HEALTH AND WELLBEING

HEALTHY LIFESTYLE PROGRAMME 2011-12

	Quarter One	Quarter Two	Quarter Three	Quarter Four
Key Topics	**Physical Activity**	**Smoking cessation**	**Mental Health**	**Obesity**
References / Rationale	"Increasing physical activity levels will help prevent and manage over 20 conditions and diseases including cancer, coronary heart disease, diabetes and obesity and help to promote mental wellbeing" http://www.nice.org.uk/nicemedia/live/11981/40678/40678.pdf	"Employers that (do) provide cessation support could reduce the risk of non-compliance with the law, as well as promoting healthy living and no smoking within society, as well as benefiting from reduced sickness absence and increased productivity." http://www.nice.org.uk/nicemedia/live/11381/31972/31972.pdf	"Promoting the mental wellbeing of employees can yield economic benefits in terms of increased commitment and job satisfaction, staff retention, improved productivity and performance, and reduced staff absenteeism" http://www.nice.org.uk/nicemedia/live/12331/45895/45895.pdf	"Staying a healthy weight improves health and reduces the risk of diseases, such as coronary heart disease, type 2 diabetes, osteoarthritis and some cancers." http://www.nice.org.uk/nicemedia/live/11000/30364/30364.pdf
Aims	To raise awareness of health benefits of exercise To raise the numbers of staff participating To increase the diversity of staff participating To promote the facilities offered in the Trust and ensure its stairs are used where possible To improve the health of staff, contributing to reducing sickness absence	To reduce the numbers of staff that smoke To ensure the health effects of smoking are publicized to high risk groups in particular To provide or signpost a full range of smoking cessation resources to all staff		
Sub committee members	P Verow TBC TBC			
Outcome measurement	Awareness improved by survey			

	Feedback from participants Increased gym membership / use NICE NHS Trust re-audit		
Activities	Touch rugby scheme Link in with 2012 scheme (national) Zumba classes Bikes for rehabilitation scheme Walk to work week Trust cycle ride promotion Slimwell promotion TBA – targeted intervention for high risk / low participation groups Review of staircases within the Trust ?Roadshow event	TBC	Depression Awareness Exercise Program Slimwell

National Weeks and promotions	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	mar	apr
Branded H&W communications with consistent format "What is the issue?" "Why is it relevant to us?" "What can the Trust do to help me?" "What can I do to help myself?" Links to local and national resources	9/5 walk to work week 10/5 stroke awareness day 17/5 world hypertension day	Male cancer awareness month Cervical cancer awareness week National bike week	Dementia awareness week Samaritans awareness day	Skin sun safety awareness	Migraine awareness week World suicide prevention day	TBC						

Quality and Safety Committee – Version 0.1

Venue Executive Meeting Room, City Hospital **Date** 21 July 2011; 0900h – 1100h

Members Present

Prof D Alderson [Chair]
Mrs S Davis
Dr S Sahota
Mr J Adler
Mr R White
Miss K Dhami

In Attendance

Mrs D Talbot
Mr S Parker
Mr D Masaun

Observers

Mrs C Heaney [Deloitte LLP]
Prof D Nicolini [Warwick University]

Guests

Ms S White Browne-Jacobson
Mr O Pritchard Browne-Jacobson

Secretariat

Mr S Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received apologies for absence from Olwen Dutton, Rachel Overfield, Rachel Barlow, Donal O'Donoghue, Allison Binns and Hillary Mottishaw. It was noted that Mrs Talbot was present on behalf of Miss Overfield. No deputy for the Medical Director was present, therefore Mr Grainger-Payne was asked to remind Mr O'Donoghue of the importance of tendering a deputy in cases where he was unable to attend.	
ACTION: Mr Grainger-Payne to remind Mr O'Donoghue of the importance of tendering a deputy to meetings of the Quality and Safety Committee in cases where he is unable to attend	
2 Minutes of the previous meeting	**SWBGR (5/11) 015**
The minutes of the Quality and Safety Committee Committee meeting held on 19 May 2011 were approved as a true and accurate reflection of discussions held.	
AGREEMENT: The minutes of the previous meeting were approved	
3 Matters arising from the previous meeting	**SWBGR (5/11) 015 (a)**

The updated actions list was noted by the Committee. In connection with action SWBGRACT.065, Professor Alderson asked against how many NICE Quality Standards the Trust's position remained to be assessed. Mr Parker reported that baseline assessments and progress against the actions plans was considered by the NICE and Clinical Effectiveness Groups. Regarding the VTE standard, the Committee was advised that an action plan was yet to be developed. Mr Parker reported that there was a delay assessing the Trust's position against the Neonatology standards, however a meeting had been convened between the Deputy Medical Director and the Clinical Director for Neonates to discuss this. An assessment against the Glaucoma standards was reported to be planned, although the clinical lead for this standard remained to be agreed. The Committee was advised that the baseline assessment against the chronic kidney disease had been undertaken. Professor Alderson noted that the number of targets and indicators against which the Trust would be measured would increase with the introduction of the new standards. He asked whether the VTE action plan was on track to be delivered by September 2011. Mr Parker advised that this was the case, with a major focus being on ensuring an assessment is completed within 24 hours of admission. Miss Dhami reported that the relevant Trust governance committee would be approached to take on the work required within the Quality Standards action plan. Mrs Davis asked whether the Trust's assessment and performance against the Quality Standards was behind that of other organisations regionally. She also asked what the impact of compliance with then standards was having on patient. Mr Parker advised that the impact of compliance on patients had not been considered specifically, however this would be built into the considerations of the Thrombosis Committee in future. In relation to Mrs Davis' first question, Mr Adler advised that there was no deadline for compliance against the standards, however there was an expectation that the Trust would make every effort to achieve compliance with them. He highlighted that in terms of the work required and resources needed to deliver full compliance, at present there was insufficient support available.	
4 Legal Services Update – Browne Jacobson	**SWBQS (7/11) 023** **SWBQS (7/11) 023 (a)**
Ms White advised that Browne Jacobson had completed its first full year of support to the Trust and that spend on legal services had totalled £261k including VAT and disbursements. It was noted that this was a higher than planned level of expenditure, mainly due to the requirements of the Transforming Community Services (TCS) project and the expense associated with the secondments into the Complaints and Litigation Team. The Committee was informed that the Trust could anticipate a higher level of complaints and litigation cases over the coming months in line with that seen by other trusts in the region, where a 30% increase year on year has been experienced. It was highlighted that this trend was driven by the recession and a	

change to the regulations covering legal aid and insurance policies. It was suggested that the Trust needed to consider the resourcing implications associated with this increase in work. In terms of complaints, the Committee was advised that a Health Select Committee report had been recently released, which recommended that the complaints system needed to be more robustly managed and that Trust Boards needed to be more greatly involved with the complaints system. The report was also advised to recommend that complaints data should be lodged with trusts' commissioning bodies. Ms White advised that overall, it was likely that there would be greater scrutiny of how complaints are handled. Regarding data security, the Committee was advised that there was greater interest at present in the policies and procedures relating to security of data. In line with this, Ms White advised that the Information Commissioner would be more active in terms of making recommendations and levying fines where appropriate. The Committee was advised that the changes to the Employment Act, including the impact of the alteration of the retirement age were likely to impact on the Trust in future. Mrs Talbot asked whether there was an opportunity to cover Safeguarding and Deprivation of Liberties issues within one of the training sessions offered by Browne Jacobson. Ms White agreed that this was a potential training option for the Trust, particularly as she advised that the advice to be provided in connection with Deprivation of Liberties matters was complex. Mrs Davis asked whether the number of instances that the provisions of the Mental Capacity Act are invoked was monitored. Mrs Talbot confirmed that this oversight was given through the Safeguarding Steering Group. It was agreed that this information would be useful to the Board. Mr Grainger-Payne suggested that this could be included as part of the biyearly update on Safeguarding that was presented to the Board, which was agreed. Mrs Talbot asked what key themes had been raised as part of the twenty minute free advice helpline. Ms White reported that many of the enquiries covered miscellaneous matters, many of which ask for clarity or confirmation of an issue. Mr Pritchard advised that on commercial matters, a significant event for the Trust which had required legal support had been the Transforming Community Services (TCS) event in April 2011. It was highlighted that the estate from which the community services was delivered had been retained as part of the TCS plans and that there was a possibility that there were some tenancies in these premises, the terms of which might not be clearly understood. Mr Pritchard suggested that the Trust might wish to consider formalising the occupancy terms within the buildings, although he cautioned that there were benefits and disadvantages to this approach where there exists a stable relationship with tenants at present, including the possibility of service interruption. Dr Sahota asked what the legal implications were if the landlord wished to terminate a tenancy and how much notice was required.	

Mr Pritchard advised that this was dependent on a number of matters as statutory tenancy rights may have been assumed in some instances where a tenant had been in situ for a considerable time. In this case, the Committee was advised that a formal procedure for eviction needed to be followed. When occupying premises on a licence, however, Mr Pritchard advised that the tenant would have less rights and the process for termination would be different. Mr Adler asked for some examples of tenancies to which this situation would relate. He was advised that delivery of service from church halls or community centres was likely to fall within this category of tenancy.

The Committee was advised that reconfiguration of the commissioning arrangements presented a risk to the delivery of community services, particularly if the commissioning bodies decided to tender for services differently. It was highlighted that in the case of a service being awarded to another organisation, TUPE might apply to prevent significant redundancies.

In terms of risks associated with the Trust's Foundation Trust (FT) application, Mr Pritchard advised that care needed to be taken to ensure that the operations of the Trust were maintained in the face of the distraction presented by the demands of the FT application process. The Committee was informed that care needed to be taken to ensure that appropriate resources were made available to support the FT application process, backfilling those taken from elsewhere in the Trust where necessary.

The Committee was advised that competition laws were due to enter the health economy, therefore there was a need to ensure that robust procurement processes were in place within the Trust. Mr White reported that the impact of the Bribery and Corruption Act on the Trust's policies was being considered. It was noted that in some trusts representatives from medical and pharmaceutical companies were not permitted to meet with consultants for this reason. Mr Pritchard offered to provide assistance where needed to ensuring that the relevant policies incorporated the requirements of the Bribery and Corruption Act.

Dr Sahota observed that the Equality Act 2010 included a section concerning public procurement rules. Mr Pritchard advised that as a result of these stipulations, this was an area of growth for lawyers, including the need to provide training and support individuals involved in this process. Dr Sahota suggested that a briefing for the Trust Board on these matters would be useful. Ms White agreed that this would be considered as part of the discussions on training requirements provided within the terms of the contract. Mrs Davis added that a session on procurement would be useful in advance of the planned Trust Board 'Time Out' to review the procurement documentation for the Midland Metropolitan Hospital.

It was agreed that the risk management issues presented within the Legal Services update should be discussed with the Executive Team at one of its forthcoming meetings.

Professor Alderson remarked that the rise in medical negligence claims was

surprising. Ms white advised that the greatest rise related to clinical negligence claims, the data for which was reported to be published on the NHS LA website. The number of claims concerning obstetric treatment was highlighted as a particular area of increase. It was noted that the increasing number of claims had the potential to impact on the insurance premiums levied by the NHSLA. Ms White and Mr Pritchard were thanked for their informative presentation.	
ACTION: **Mr Grainger-Payne to ensure that the risks identified within the legal services update are considered by the Executive Team**	
5 Complaints	
5.1 Complaints referred for independent review	**SWBQS (7/11) 023** **SWBQS (7/11) 023 (a)**
Miss Dhami presented the list of complaints that had been referred for independent review by the Public and Health Service Ombudsman (PHSO) as at 11 July 2011. The Committee was advised that during the period, four new complaints had been referred to the Ombudsman, meaning that 16 cases in total had been referred for independent review. Miss Dhami advised that in all cases, there was little further local resolution that could be pursued. Miss Dhami reported that the Ombudsman had made the Care Quality Commission (CQC) aware of the high number of cases related to the Trust that were being referred and that this had been the principal reason for the responsive review into complaints that had been initiated. Mrs Davis asked, in terms of the number of cases, how the Trust was positioned relative to other organisations. She was advised that the Trust was within the set of twenty organisations with the highest number of complaints referred to the Ombudsman. Miss Dhami was asked to include this league table and append a report presenting the benchmarked information as part of the next update to the Committee. It was agreed however, that this information needed to be contextualised in terms of the Trust's turnover and number of patients treated.	
ACTION: **Miss Dhami to present the list of the organisations having the highest number of complaints referred to the Ombudsman, together with benchmark information at the next meeting**	
5.2 Action plan to the CQC regarding registration: Outcome 17	**SWBQS (7/11) 024** **SWBQS (7/11) 024 (a)**
Miss Dhami presented the updated action plan that had been developed in response to the responsive review of complaints undertaken by the Care Quality Commission (CQC). It was highlighted that the majority of actions were on track to be delivered as planned.	

Professor Alderson asked whether the plan to address the backlog of complaints by December 2011 remained a realistic target. Miss Dhami advised that there had been confidence that the target could be met until the dramatic increase in complaints received in June. As a result, the Committee was advised that it would be a challenge to meet the deadline set. It was highlighted that there were now fewer simple complaints to handle, as the majority of these had already been processed, leaving the more complex cases to be answered. Professor Alderson asked what issues were limiting the rate at which the complaints could be answered. He was advised that available capacity was a principal issue. Mr Adler reported that the quality of the responses and the output of the team was excellent, however consideration might need to be given to deploying more resources from within the Trust to assist with handling the complaints in order to meet the December 2011 deadline.	
5.3 Complaints trend analysis	**SWBQS (7/11) 025** **SWBQS (7/11) 025 (a)**
Miss Dhami presented a report showing the various categories to which the complaints had been assigned which had been produced in response to a request from the Trust's commissioners. It was highlighted that there were no obvious trends in the reasons for the complaints, although the majority were noted to concern clinical care matters. Most of the complaints were noted to be related to issues in the Medicine & Emergency Care, Surgery, Anaesthetics & Critical Care and the Women & Child Health divisions, which the Committee was informed was expected, given that the majority of patients are treated in one of the three areas. Professor Alderson remarked that care needed to be given to ensuring that the quality of the complaints handling process is not compromised as a result of the large number of incoming complaints. Mr Adler noted that it was pleasing to see that the number of complaints related to nursing care and staffing levels had declined. It was agreed that the long-term trend in complaints associated with the Trust's maternity service would be useful to review. It was further agreed that an analysis of the uncategorised complaints should be presented at the next meeting, together with a separate report on complaints related to the wards in 'special measures'.	
ACTION: Miss Dhami to organise for the long-term trend in complaints associated with the Trust's maternity services, an analysis of the uncategorised complaints and a separate report on complaints related to the wards in 'special measures' to be presented at the next meeting	
6 CQC Privacy, Dignity and Nutrition reports and action plans	**SWBQS (7/11) 026** **SWBQS (7/11) 026 (a) - SWBQS (7/11) 026 (d)**

Mrs Talbot presented the reports that had been received from the Care Quality Commission (CQC) following its recent inspections into the Trust's compliance with the essential standards concerning Privacy, Dignity and Nutrition.

It was reported that at Sandwell Hospital, the CQC had raised moderate concerns in relation to compliance with the Privacy and Dignity standards and major concerns related to compliance with nutrition and hydration standards. The Committee was advised that the inspection at City Hospital had presented a more encouraging picture, with minor concerns being raised in relation to privacy and dignity.

The Committee was asked to review the action plans that had been developed in response to the CQC reports, including a joint corporate strategic action plan. Mrs Talbot reported that a nutrition 'task and finish' group had been established, alongside a privacy and dignity 'task and finish' group, which were noted to be making good progress on delivering key actions. It was highlighted that the nutrition action plan was a key focus, delivery of which was reported to be being led by the Head of Therapies. Actions within the nutrition plan were noted to include improved access to snacks during out of hours; potentially introducing the use of bottled water to replace water jugs; ensuring greater visibility of patients needing assistance with eating and drinking; enforcement of protected mealtimes; purchase of additional scales to weigh non-ambulatory patients; and a review of food available at mealtimes.

It was reported that a recent visit by the West Midlands Quality Review Group concerning safeguarding, had reviewed a number of areas covered within the CQC inspections and no significant concerns had been expressed.

Professor Alderson noted that the reports and action plans presented a significant number of complex issues and asked whether the proposed action plans were realistic and on track at present. Mrs Talbot advised that the plans were on track to be delivered as planned and that some of the individual actions were simple to complete. She highlighted however, that the profile of patients being treated on the wards that had been inspected was a challenge however, given that individually many of them require significant assistance to eat and drink.

Professor Alderson asked when the effect of the action plans would be reported. It was agreed that this would be incorporated into the nursing updates that are presented to the Trust Board. It was noted that the ward audits also cover many of the areas which were being addressed as part of the CQC action plans.

Dr Sahota reported that he had recently participated in the ward walkabout and advised that it had been clear that some patients were not aware of the name of the doctors responsible for their care. He asked whether measures had been put into place to address this issue. Mrs Talbot reported that on the majority of wards, a place for the name of the responsible consultant was available above the patients' bed. The Committee was advised however, that there was potential for

confusion should the consultant handling the patient on admission change during the period of care. Mr Parker asked whether the action plans introduced a patient rest period. Mrs Talbot advised that this was not specifically included, however agreed to consider this as part of the plans. Mr Adler remarked that because of the high dependency of patients during mealtimes, good nurse staffing support was needed at these times. Mrs Talbot advised that particular issues, such as this would be highlighted when the Safe Nursing Tool was introduced. It was noted that the Trust treats a high number of patients with some form of mental health issue. Miss Dhami reported that the CQC would undertake a further unannounced visit at which there would be a clear expectation that improvements would be seen. Mr Adler suggested that the progress with the action plans needed to continue to be monitored by the Quality and Safety Committee.	
7 Quarterly Integrated Risk report	**SWBQS (7/11) 018** **SWBQS (7/11) 018 (a)**
Miss Dhami presented the quarterly integrated risk report, which highlighted a 6% reduction in the number of incidents reported. It was noted in particular that incidents related to Health and Safety matters had declined. 'Aspects of care' was noted to be the principal category into which incidents fell. It was highlighted that the incidents related to patient accidents had been reviewed in some detail and those incidents related to falls had been identified separately. From this information, the Committee was advised that it had been possible to identify the wards on which a higher number of patient falls occur. In terms of the incidents related to information security, Miss Dhami reported that the Information Governance Manager was responsible for investigating these matters. Regarding the PALS contacts, the Committee was advised that a number of complaints were received which related to the appointments process, therefore investigations were planned, particularly given that there had been an understanding that the situation had been improving. It was agreed that the 'aspects of care' incident category should be broken down into subcategories, while remaining within the confines of the National Patient Safety Agency (NPSA) definitions. It was noted that maternity incident information would be presented differently in future reports. Failure to provide planned care was highlighted to be cited as an issue on a regular basis, although the Committee was informed that the work being led by the Medical Director on improving clinical systems would address these issues.	
8 NPSA safety alerts update	**SWBQS (7/11) 019**

	SWBQS (7/11) 019 (a)
Miss Dhami presented the latest progress on actions to address the NPSA safety alerts, which the Committee received and noted.	
9 Patient Related Outcome Measures (PROMs) update	**SWBQS (7/11) 020** **SWBQS (7/11) 020 (a)**
Mr Parker presented the latest set of Patient Related Outcome Measures (PROMs) information , which he advised covered the period April 2009 – December 2010. In terms of preoperative questionnaire return rates, it was highlighted that the Trust performed below the national average for groin hernia and varicose veins. Post operative questionnaire return rates were noted to be outside the control of the Trust, however again it was noted that the Trust received a lower number of returned questionnaires than the national average. Regarding the outcomes data, Mr Parker reported that the health gain reported was below the national position, both for adjusted and unadjusted information, with 23.45% of patients reporting that they felt worse after varicose vein procedures and 17% of patients reporting that they felt worse after a knee replacement. The Committee was advised that the information had been circulated to the Governance Board and the relevant directorates. It was highlighted that detailed review of the situation regarding groin hernia outcomes was planned. The Committee was informed that likewise the situation regarding hip and knee replacement was due to be reviewed to understand the results. It was noted that undertaking a survey three months following a varicose vein procedure, was not likely to be sufficient time to be able to fully assess the health gain as a result of the operation. Mrs Davis suggested that it would be sensible to compare the Trust's position regarding hip and knee replacements with that of the Royal Orthopaedic Hospital NHS Foundation Trust. Mr Adler agreed that this would be a useful comparison and asked Mr Parker to circulate the information. It was suggested that it should be determined whether the information related solely to elective patients. Professor Alderson observed that the questionnaire return rate was low and therefore the results should be reviewed with a degree of caution, given the limited statistical significance that could be applied to the results. Where a higher return rate was evident, in knee and hip replacements, the Trust was noted to appear to perform better.	
ACTION: Mr Parker to circulate a comparison of the Trust's PROMs outcomes for hip and knee replacements with that of the Royal Orthopaedic Hospital NHS Foundation Trust	

10 Clinical Audit forward plan: monitoring report	**SWBQS (7/11) 021** **SWBQS (7/11) 021 (a)**
Mr Parker reported that the Clinical Audit forward plan had been amended to incorporate some of the nursing audits that cut across the organisation. Of the audits in the plan, three were noted to be experiencing significant delay: TARN, ICNARC and SINAP, although plans were noted to be in place to commence participation in the audits shortly. It was highlighted that the profile of the SINAP audit had been raised by the Royal College of Physicians, with trusts' submissions being published. A discussion was reported to have been held with the Deputy Medical Director to ensure that a minimum data set is submitted covering Quarter 2 of the year. It was reported that participation in some of the key audits needed to be evidenced within the annual Quality Account. It was agreed that the progress with the audit would be monitored by the Governance Board. Dr Sahota asked whether the possibility of grants to support the audit work had been considered. Professor Alderson advised that clinical audit work was unlikely to attract funding set aside for research.	
11.1 – 11.3 Minutes from Governance Board	**SWBGB (5/11) 094** **SWBGB (6/11) 107** **SWBGB (6/11) 107 (a)**
The Quality and Safety Committee received and noted the minutes from the Governance Board meetings held on 6 May 2011 and 3 June 2011. The Committee also noted the actions list that was discussed at the meeting held on 8 July 2011.	
12.1 Minutes from Clinical Quality Review Group	**SWBQS (7/11) 022**
The Quality and Safety Committee received and noted the minutes from the Clinical Quality Review Group meeting held on 4 May 2011.	
13 Any other business	**Verbal**
There was none.	
14 Details of the next meeting	**Verbal**
The date of the next meeting of the Quality and Safety Committee was reported to be 22 September 2011 at 0900h in the Executive Meeting Room, City Hospital.	

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – July 2011
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Management
AUTHOR:	Robert White/Tony Wharram
DATE OF MEETING:	18th August 2011

SUMMARY OF KEY POINTS:

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

For July, the Trust generated a "bottom line" surplus of £72,000 which is £22,000 better than the planned position (as measured against the DoH performance target).

For the year to date, the Trust has a surplus of £79,000 which is £84,000 worse than the planned position

Capital expenditure for the year to date is £1,395,000 and the cash balance at 31st July remained £7.7m above the plan.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Performance Management Board and Trust Management Board on 16 August 2011; Finance and Performance Management Committee on 18 August 2011

Sandwell and West Birmingham Hospitals NHS

NHS Trust SWBTB (8/11) 180 (a)

Financial Performance Report – July 2011

EXECUTIVE SUMMARY

• For the month of July 2011, the Trust delivered a "bottom line" surplus of £72,000 compared to a planned surplus of £50,000 (as measured against the DoH performance target).

• For the year to date, the Trust has a surplus of £79,000 compared with a planned surplus of £163,000 so generating a £84,000 adverse variance from plan.

•At month end, WTE's (whole time equivalents), excluding the impact of agency staff, were approximately 230 below plan. After taking into account the impact of agency staff, actual wte numbers are 85 below planned levels. This compares with a position last month of 46 below plan. Total pay expenditure for the month, inclusive of agency costs, was £24,000 above plan.

• The month-end cash balance remains approximately £7.7m above the plan.

Financial Performance Indicators - Variances

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	22	(84)	>= Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	15	(111)	>= Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	(24)	(313)	<=Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	(349)	(300)	<= Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	85	6	<= Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	7,698	7,698	>= Plan	> = 95% of plan	< 95% of plan

Note: positive variances are favourable, negative variances unfavourable

Performance Against Key Financial Targets

Target	Year to Date Plan £000	Year to Date Actual £000
Income and Expenditure	163	79
Capital Resource Limit	13,986	1,395
External Financing Limit	---	7,698
Return on Assets Employed	3.50%	3.50%

2010/2011 Summary Income & Expenditure Performance at July 2011	Annual Plan £000's	CP Plan £000's	CP Actual £000's	CP Variance £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's	Forecast Outturn £000's
Income from Activities	373,732	31,256	31,509	253	124,490	124,522	32	373,732
Other Income	39,487	3,317	3,452	135	12,892	13,362	470	40,487
Operating Expenses	(389,653)	(32,709)	(33,082)	(373)	(129,966)	(130,579)	(613)	(390,653)
EBITDA	23,566	1,864	1,879	15	7,416	7,305	(111)	23,566
Interest Receivable	25	2	9	7	8	35	27	25
Depreciation & Amortisation	(13,269)	(1,106)	(1,106)	0	(4,423)	(4,423)	0	(13,269)
PDC Dividend	(5,803)	(484)	(484)	0	(1,934)	(1,934)	0	(5,803)
Interest Payable	(2,156)	(180)	(180)	0	(719)	(719)	0	(2,156)
Net Surplus/(Deficit)	**2,363**	**96**	**118**	**22**	**348**	**264**	**(84)**	**2,363**
IFRS/Impairment Related Adjustments	(557)	(46)	(46)	0	(185)	(185)	0	(557)
SURPLUS/(DEFICIT) FOR DOH TARGET	**1,806**	**50**	**72**	**22**	**163**	**79**	**(84)**	**1,806**

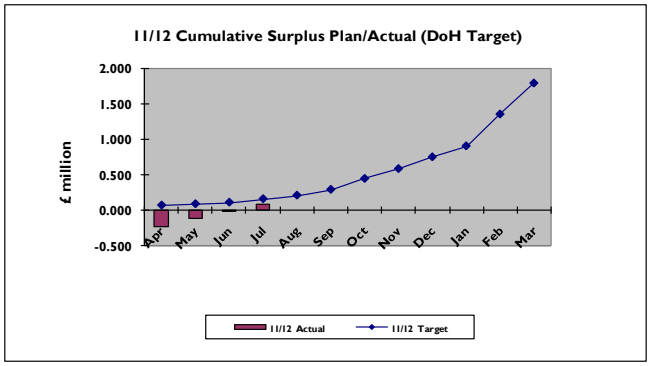
The Trust's financial performance is monitored against the DoH target shown in the bottom line of the above table. IFRS and impairment adjustments are technical, non cash related items which are discounted when assessing performance against this target.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – July 2011

Overall Performance Against Plan

• The overall performance of the Trust against the DoH planned position is shown in the adjacent graph. Overall bottom-line performance in July improved thus reducing the level of deficit reported at the end of June. Specifically in July, the performance was £22,000 better than plan lowering the year to date shortfall to £84,000.

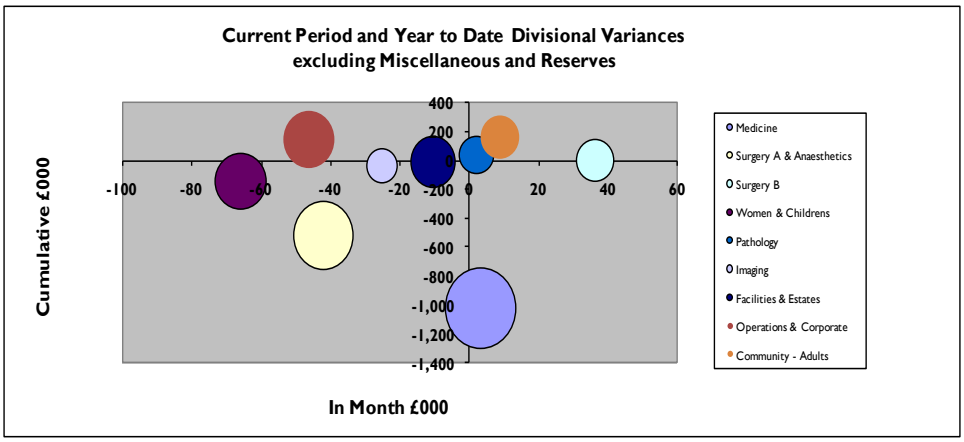


Divisional Performance

• For July, a number of deficits were posted by divisions, the biggest ones being Womens & Childrens at (£66,000), Corporate (primarily Operations/Strategy and IM&T) at (£46,000) and Surgery A, Anaesthetics & Critical Care at (£42,000). This level of adverse performance is, generally, significantly lower than has been experienced in earlier months although, for Medicine, it does reflect a number of significant budget adjustments implemented as part of the special measures programme.

• In month performance of Miscellaneous and Reserves was better than planned with a surplus of £153,000.

• There are some positive signs of improvement in month, for example the significant reduction in the level of bank and agency use. However, significant pressures still exist within the Trust on capacity and the ability to deliver against performance targets and maintain levels of quality while sustaining tight control on expenditure. Close management of performance will need to be maintained for the remainder of the year and development and implementation of a long term sustainable cost reduction programme (reflective of the expected economic climate for the next few years) needs to be rapidly progressed as part of the Trust's work on its strategic efficiency programme.



The tables adjacent and overleaf show significant year to date adverse performance for Medicine and Surgery A and in month adverse performance particularly for Womens & Childrens and Corporate Services.

Sandwell and West Birmingham Hospitals NHS

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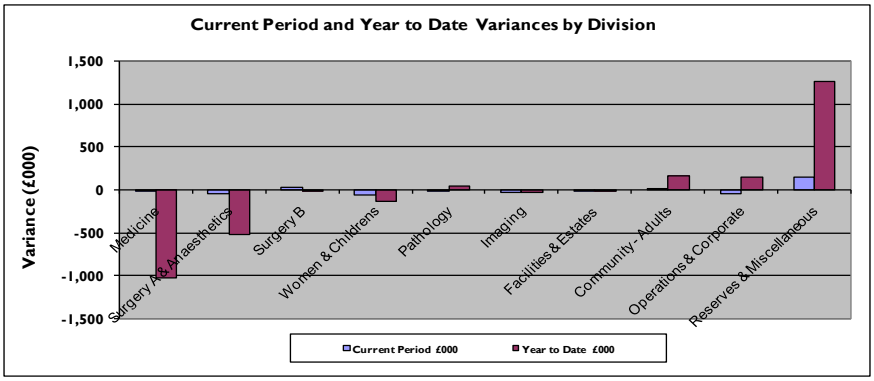
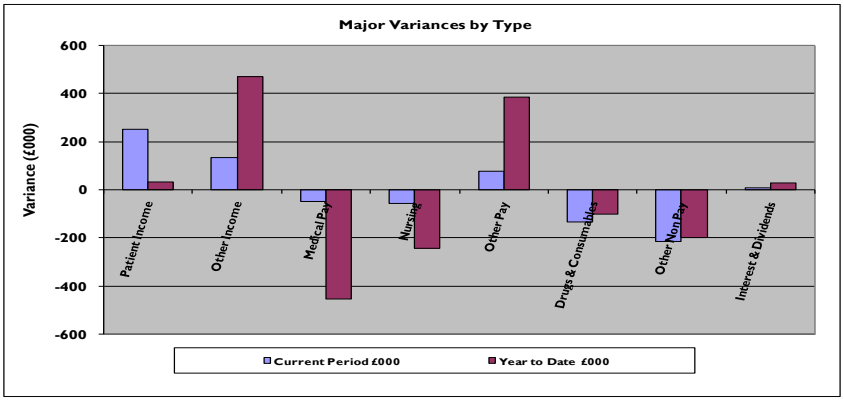
Financial Performance Report – July 2011

Divisional Variances from Plan	Current Period £000	Year to Date £000
Medicine	3	-1,021
Surgery A & Anaesthetics	-42	-516
Surgery B	36	1
Women & Childrens	-66	-138
Pathology	2	42
Imaging	-25	-35
Facilities & Estates	-10	-9
Community - Adults	9	161
Operations & Corporate	-46	149
Reserves & Miscellaneous	153	1,258



For July, the table and graph below show the positive in month performance in patient related and other income and for other pay with adverse performances primarily for drugs and consumables and other non pay.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
Patient Income	253	32
Other Income	135	470
Medical Pay	-47	-453
Nursing	-55	-244
Other Pay	78	384
Drugs & Consumables	-133	-103
Other Non Pay	-216	-197
Interest & Dividends	7	27

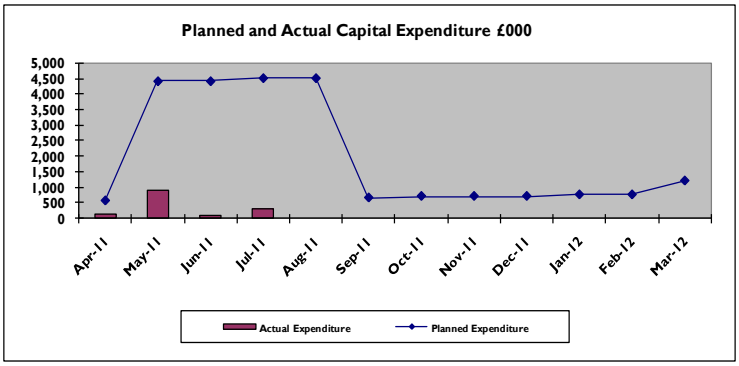


Capital Expenditure

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

• The profile (particularly the high level of planned expenditure between May and August) reflects the original expected pattern of Grove Lane land transactions. No expenditure has yet been incurred for the year to date although progress is being made on acquisitions and expenditure will then flow through to the capital programme.

• July expenditure was at very low levels, even after taking into account the delay in land purchases.



Sandwell and West Birmingham Hospitals NHS
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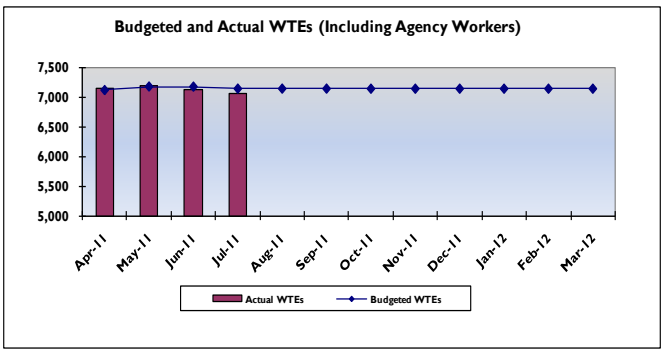
Financial Performance Report – July 2011

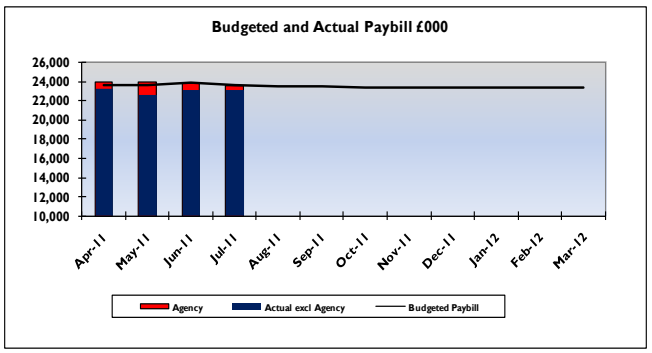
Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are approximately 85 below plan for July. Excluding the impact of agency staff, wte numbers are around 230 below plan. Actual wtes have fallen by 70 since June, primarily the result of a lower level of bank and agency usage.

• Total pay costs (including agency workers) are £24,000 below budgeted levels for the month with higher than planned levels of spend being incurred for HCAs and support staff offset by lower than planned spend in other pay groups.

• Expenditure for agency staff in July was £590,000 compared with £741,000 in June, an average of £703,000 for the year to date and a July 2010 spend of £538,000. The biggest single group accounting for agency expenditure remains medical staffing.





Pay Variance by Pay Group

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

Analysis of Total Pay Costs by Staff Group

	Year to Date to July					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	25,262	24,272		1,443	25,715	(453)
Management	5,244	4,954		0	4,954	290
Administration & Estates	10,861	9,979	340	392	10,711	150
Healthcare Assistants & Support Staff	9,948	9,410	804	127	10,341	(393)
Nursing and Midwifery	29,072	27,651	1,073	592	29,316	(244)
Scientific, Therapeutic & Technical	14,702	14,139		257	14,396	306
Other Pay	(20)	(51)			(51)	31
Total Pay Costs	95,069	90,354	2,217	2,811	95,382	(313)

NOTE: Minor variations may occur as a result of roundings

Financial Performance Report – July 2011

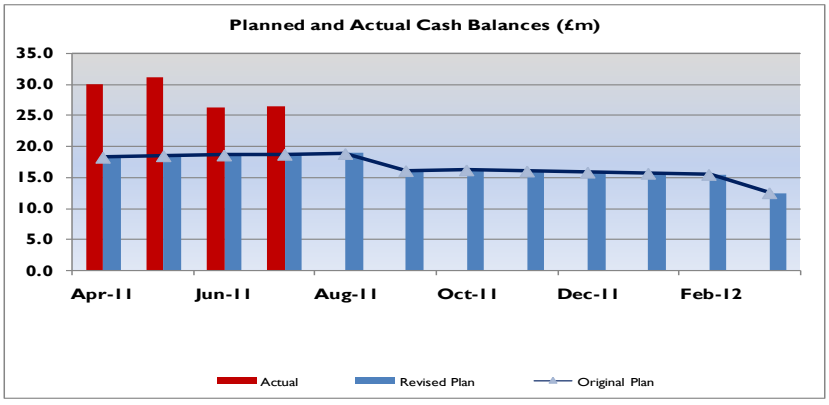
Balance Sheet

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

• Cash balances at 31st July are approximately £26.3m which is a similar level to that held at 30th June.

Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION

		Opening Balance as at 1st April 2011 £000	Balance at 31st July 2011 £000
Non Current Assets	Intangible Assets	1,077	1,037
	Tangible Assets	216,199	213,171
	Investments	0	0
	Receivables	649	650
Current Assets	Inventories	3,531	3,637
	Receivables and Accrued Income	12,652	17,320
	Investments	0	0
	Cash	20,666	26,390
Current Liabilities	Payables and Accrued Expenditure	(33,513)	(41,467)
	Loans	0	0
	Borrowings	(1,262)	(1,240)
	Provisions	(4,943)	(4,511)
Non Current Liabilities	Payables and Accrued Expenditure	0	0
	Loans	0	0
	Borrowings	(31,271)	(30,938)
	Provisions	(2,237)	(2,237)
		181,548	181,812
Financed By			
Taxpayers Equity	Public Dividend Capital	160,231	160,231
	Revaluation Reserve	36,573	36,573
	Donated Asset Reserve	2,099	2,099
	Government Grant Reserve	1,662	1,662
	Other Reserves	9,058	9,058
	Income and Expenditure Reserve	(28,075)	(27,811)
		181,548	181,812



Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – July 2011

Cash Forecast

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

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW

12 MONTH ROLLING FORECAST AT July 2011

ACTUAL/FORECAST	Jul-11 £000s	Aug-11 £000s	Sep-11 £000s	Oct-11 £000s	Nov-11 £000s	Dec-11 £000s	Jan-12 £000s	Feb-12 £000s	Mar-12 £000s	Apr-12 £000s	May-12 £000s	Jun-12 £000s	Jul-12 £000s
Receipts													
SLAs: Sandwell PCT	**14,867**	14,729	14,729	14,729	14,729	14,729	14,729	14,729	14,729	14,434	14,434	14,434	14,434
HoB PCT	**7,315**	7,314	7,314	7,314	7,314	7,314	7,314	7,314	7,314	7,168	7,168	7,168	7,168
Associated PCTs	**6,315**	5,425	5,425	5,425	5,425	5,425	5,425	5,425	5,425	5,317	5,317	5,317	5,317
Pan Birmingham LSCG	**1,376**	1,376	1,376	1,376	1,376	1,376	1,376	1,376	1,376	1,348	1,348	1,348	1,348
Other SLAs	**462**	462	462	462	462	462	462	462	462	453	453	453	453
Over Performance Payments	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Education & Training	**1,247**	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255
Loans			8,000										
Other Receipts	**3,995**	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500
Total Receipts	**35,577**	33,061	41,061	33,061	33,061	33,061	33,061	33,061	33,061	32,475	32,475	32,475	32,475
Payments													
Payroll	**13,727**	13,700	13,700	13,500	13,500	13,500	13,250	13,250	13,250	12,985	12,985	12,985	12,985
Tax, NI and Pensions	**9,328**	9,340	9,340	9,310	9,310	9,310	9,250	9,250	9,250	9,065	9,065	9,065	9,065
Non Pay - NHS	**2,110**	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,715	1,715	1,715	1,715
Non Pay - Trade	**9,202**	7,050	6,550	7,050	7,050	5,550	7,050	6,550	8,392	8,224	7,224	7,224	7,224
Non Pay - Capital	**432**	4,750	4,750	4,750	500	500	750	750	3,750	500	500	500	500
PDC Dividend			2,928						2,928				
Repayment of Loans									1,000				
Interest									70				
BTC Unitary Charge	**396**	400	400	400	400	400	400	400	800	415	415	415	415
Other Payments	**250**	200	200	200	200	200	200	200	200	200	200	200	200
Total Payments	**35,445**	37,190	39,618	36,960	32,710	31,210	32,650	32,150	41,390	33,104	32,104	32,104	32,104
Cash Brought Forward	**26,258**	26,390	22,261	23,704	19,805	20,156	22,007	22,418	23,329	15,000	14,371	14,741	15,112
Net Receipts/(Payments)	**132**	(4,129)	1,443	(3,899)	351	1,851	411	911	(8,329)	(629)	371	371	371
Cash Carried Forward	**26,390**	22,261	23,704	19,805	20,156	22,007	22,418	23,329	15,000	14,371	14,741	15,112	15,483

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

Risk Ratings

Measure	Description	Value	Score
EBITDA Margin	Excess of income over operational costs	5.6%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	98.5%	4
Return on Assets	Surplus before dividends over average assets employed	1.5%	2
I&E Surplus Margin	I&E Surplus as % of total income	0.2%	2
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	25.5	4
Overall Rating			**2.8**

Risk Ratings

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

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

• Return on Assets and I&E Surplus Margin are lower than would normally be expected due to performance just above break-even

Financial Performance Report – July 2011

External Focus

• There are an increasing number of indicators being published of both potential and actual deterioration in the financial performance of some NHS organisations.

• Although it covers the final quarter of the last financial year, David Flory's (Deputy NHS Chief Executive) report published on 30th June reported surpluses for the year ended 31st March 2011 of £1,375m for PCTs and StHAs and £121m for trusts (excluding foundation trusts). However, it also reported a number of organisations which performed poorly with 2 PCTs and 7 NHS trusts posting deficits for the year.

• Monitor's publication on 4th August *Review of NHS Foundation Trust Annual Plans 2011/12* reported an increasingly challenging environment in a number of areas including the following:

  • an increase in the number of foundation trusts forecasting the lowest financial risk ratings (FRR), with 11 forecasting an FRR of 1 or 2 at the year end

  • foundation trusts planning to deliver cost improvement plans of 4.4% in 2011/12 and similar levels during the following two years

  • from 2012 onwards income is forecast to decline by around 1% per year for the following two years

• Although only reporting to 31st May, the West Midlands StHA performance report identified 2 PCTs and 6 NHS Trusts in year to date deficit (4 of the trusts had a planned deficit and actual performance was in line with or better than plan) although none were forecasting a deficit at year end. Analysis of reported performance as at 30th June (Q1) is expected to be released shortly.

• The Trust's main commissioners (Sandwell Primary Care Trust and Heart of Birmingham teaching Primary Care Trust) both continue to forecast achievement of their start of year plans and consequently are not reporting significant financial pressures to the end of July 2011.

Conclusions

• The Trust generated an actual surplus of £72,000 during July bring its financial performance for the first four months of the year to an overall surplus of £79,000

•The Trust's year to date performance against both its Department of Health control total (i.e. the bottom line budget position it must meet) and the statutory accounts target shows a shortfall of (£84,000) against the planned position although an absolute surplus of £79,000.

• The £72,000 surplus in July is £22,000 ahead of the plan for the month.

• Year to date capital expenditure was £1,395,000 which is significantly lower than plan, the bulk of which relates to the later than originally expected acquisition of land in Grove Lane although expenditure on other capital items is also relatively slow.

Financial Performance Report – July 2011

Conclusions (cont)

•At 31st July, cash balances are approximately £7.7m higher than the cash plan which is similar to the position reported at 30th June.

• Performance in main clinical divisions is generally better than has been seen for the first three months of the year although the performance of the Medicine Division is significantly affected by adjustments made to budgets linked with the implementation of special measures. The highest in month deficits were posted by Womens & Childrens, Corporate Services and Surgery A, Anaesthetics & Critical Care Divisions, although the performance of the last is significantly improved on previous months.

• Monitoring and review of the special measures implemented in Medicine along with the targeted recovery actions within Surgery A, Anaesthetics & Critical Care continues on a regular basis. The previously proposed trust wide measures, including the additional 1% CIP for non clinical areas, have been implemented to generate additional headroom in meeting year end financial targets. The current situation will be kept under review and further action taken when and if this is deemed necessary.

Recommendations

The Finance & Performance Management Committee is asked to:

i. NOTE the contents of the report; and

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

Robert White

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Monthly Performance Monitoring Report
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of planning & Performance Management
DATE OF MEETING:	25 August 2011

SUMMARY OF KEY POINTS:

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

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

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

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

SANDWELL AND WEST BIRMINGHAM HOSPITALS CORPORATE QUALITY & PERFORMANCE MONITORING REPORT - JULY 2011

SWBTB (8/11) 183 (a)

EXECUTIVE SUMMARY

Note	Comments
	A colour coded Key identifies which Indicators which comprise the NHS Performance Framework, Monitor's FT Compliance Framework and the SHA Performance Framework.
a	The overall number and percentage of **Cancelled Operations** on both sites reduced considerably during the month of July.
b	**Delayed Transfers of Care** increased significantly on both Sandwell and City sites to 8.1% and 8.5% respectively, 8.3% overall, further increasing the year to date level to 5.9%. Census date (31 July 2011) data indicates that of 55 delays, 41 relate to Sandwell Local Authority and 14 to Birmingham Local Authority, with 32 of the 55 delays attributable to Social Care and 23 attributable to the NHS. An all day multi-agency workshop has been set up to meet on 19 August 2011 to agree and implement appropriate actions to resolve. Internally NHS delays are being closely monitored as well as the adherance to agreed discharge policies.
C	**Stroke Care** - provisional data for the month of July indicates that the percentage of patients who spent at least 90% of their hospital stay on a Stroke Unit improved to 82.93%, which improves year to date performance to 80.0%. **TIA** outpatient performance (the percentage of High Risk patients who were treated within 24 hours from initial presentation to the medical profession) also remained stable at 50.0%. Following further recent additional investment in Stroke Services the improvement plan has been updated with trajectories identified to deliver improved performance by the end of the calendar year.
d	**Accident & Emergency Clinical Quality Indicators** - performance against the 5 Headline Clinical Quality Indicators is indicated. For the purpose of performance monitoring, which is effective for Quarter 2 onwards, the indicators are grouped into two groups, timeliness and patient impact. Organisations will be regarded as achieving the required minimum level of performance where robust data shows they have achieved the thresholds for at least one indicator in each of the two groups, which for the month has been achieved. It is however acknowledged that further work is required to improve data recording and enhance staff awareness of the new indicators. Additionally, escalation processes where performance is sub-optimal are being developed. Regular meetings to review performance are taking place. Performance will also continue to be assessed against the 4-hour wait target, which during the month of July improved to 96.8% (year to date 96.28%).
e	There were 4 cases of **C Diff** reported across the Trust during the month of July, well within the trajectory for the month and the year to date. There remain no cases of **MRSA Bacteraemia** reported for the year to date. Data for MSSA Bacteraemia and E Coli Bacteraemia is also included in the report.
f	There were no Breaches of **Same Sex Accommodation** reported during the month of July.
g	**Readmission** data aligned to the national (2011/2012 Operating Framework) definition is included within the report. Readmission numbers and rates following either an initial Elective admission or an initial Non Elective admission are indicated. Data excludes any readmisisons to another provider, where the initial admission was to this Trust within the preceeding 28 days.
h	A total of 1915 **PDRs** are reported for the year to date, this is equivalent to a rate of 76.5%. **Mandatory Training** compliance at the end of July decreased slightly to 83.4%.
i	**CQUIN -** The range of schemes agreed with commissioners and their financial values are included within the report.
	VTE (Venous Thromboembolism) Risk Assessment - this CQUIN continues from 2010 / 2011. Performance of at least 90% each month is required to trigger payment. During the month of July 92.2% of eligible patients were ssessed.
	Patient Experience Acute Services (Personal Needs) - this CQUIN also continues from 2010 / 2011. Composite of response to 5 inpatient survey questions. Goal to improve responsiveness to personal needs of patients. Survey to be conducted between October and January, for patients who had an inpatient episode between July and August. Target is an improvement (increase) of 2 percentage points on 2010 / 11 baseline.
	Smoking Cessation (training) Acute Services - the target is to train 90% of frontline staff in key specialties (Oral Surgery, Gastroenterology, MAU, Respiratory Medicine, A/E, Cardiology and pre-op assessment to identify smoking and provide brief advice. A training action plan will be circulated by the end of August, with trained scheduled to commence mid September. Approximately 500 frontline staff have been identified to require training.
	Smoking Cessation (delivery) Acute Services - a target of 2000 referrals to the smoking cessation service within the year. A total of 603 referrals have been recorded year to date, with a month on month improvement.
	End Of Life Care (Acute Services) - The Acute and Community schemes are harmonised to deliver an Increase (by 10% on baseline (56%)) in people on a supportive care pathway dying in the place of their choice by Quarter 4. Performance for the most recent month (June) for which data is available is 76%.
	Medicines Management (Missed Doses) - Decrease (by 10% on Q1 baseline) in avoidable medicines ommissions. Baseline data now available. The detail of the CQUIN target is under consideration.
	Nutritional Assessment - target is for 75% adults reported as having had a nutritional assessment within 12 hours of admission (not in assessment units) using a validated tool (e.g. MUST). Data for Q1 indicates 81% patients assessed.
	Enhanced Recovery - the implementation of an enhanced recovery model for 4 specified procedures in 4 surgical specialties. Specific details of this scheme are currently being finalised.
	Stroke Discharge - 90% of patients discharged meet 5 set criteria such as discharge information, clinical contact within 48 hours and community contact details. A process to capture and report data is being set up with an anticipation that it is operational with effect from July. The Adult Community Division is now leading on this CQUIN indicator.
	Mortality Review - target to review 60% of all qualifying (adult) deaths within hospital during March 2012. During the month of June 35.8% of deaths were reviewed compared with a target for the month of 25%, with a straight line trajectory to the final target of 60%.
	Alcohol Screening - 80% (throughout Q4) of patients (aged 16+) within agreed groups (Emergency Department, EAU, MAU and Gastroenterology OP to have an alcolohol assessment and be offered advice. Implementation scheduled for July.

	Comments
i	**Patient Experience Community Services (Personal Needs)** - comprises composite of response to 6 national patient survey questions of patients receiving care at home by the district nursing service. Composite score of 69 required.
	End Of Life Care (Community Services) - The Acute and Community schemes are harmonised to deliver an Increase (by 10% on Q1 baseline) in people on a supportive care pathway dying in the place of their choice by Quarter 4. Baseline identified as 26.73%, target is 36.73%.
	Health Visiting - Children on the Health Visitor Case List who have had a full developmental review at 2 years and 6 months. Target 70% during Q4. Performance during June was 48.6%.
	Falls Assessment - Increase (by 30% on baseline of 25% (determined by manual audit)) in the percentage of patients on the district nursing caseload who have a falls assessment. Performance during the month of June improved to 20.0%.
	Smoking Cessation (training) Community Services - the target is to train 80% of frontline staff (by end Quarter 2) in District Nursing, Diabetes, Community Heart Failure and Chiropody services. 86.7% of staff are reported to have received training to date.
	Smoking Cessation (delivery) Community Services - a target of 90% smokers seen by agreed services (Musculo-Skeletal, Diabetes, Heart Failure and COS) will have received an offer of brief intervention and onward referral to cessation services. 50.0% of patients were referred during the month of June.
	Access to Chemotherapy Out of Hospital is aimed at increasing the volume of chemotherapy / anti-cancer drug deliveries made either at the patient's home or in a community setting closer to the patient's home. The targets are to increase the number of patients in receipt of Herceptin at Home by 15 during 2011 / 2012, and to provide a total of 500 (non-Herceptin) deliveries (drugs, not patients) by year end.
	Improving Access to Organs for Transplant comprises 5 separate measures (each with a specific target) which relate to improving the availability of organs for transplant based upon the recommendations of the Organs for Donation Task Force. The Trust will collect and collate data in conjunction with the NHS Blood and Transplant special health authority. Data has been captured internally for the three months year to date. The Trust met each of the measures for each month.
	Screening for Retinopathy of Prematurity. The CQUIN will establish a baseline for screening babies at risk of severe Retinopathy of Prematurity and then move towards a 95% screening rate by Q4 2011 / 2012. Data for April indicates that 100% of babies who required screening were screened. As screening of some babies born within one month is not required until the following month data will be in arrears.
	Auditing Neonatal Pathways requires the Trust to complete a audit template designed to identify where, why and how often transfers occur which fall outside the agreed newborn network pathways. The audit has been completed for the three months indicated.
j	**Quality and Efficiency Programme** - performance relative to a number of QuEP schemes is included in the report. The majority of indicators which comprise the various schemes have identified performance targets, trajectories and thresholds identified. Some of the indicators feature elsewhere in the report, but are also included in this section for completeness.
k	Detailed analysis of **Financial Performance** is contained within a separate paper to this meeting.
l	**Activity** (trust-wide) to date is compared with the contracted activity plan for **2011 / 2012** - Month and Year to Date.

	Month			
	Actual	Plan	Variance	%
IP Elective	989	1058	-69	-6.5
Day case	4523	4175	348	8.3
IPE plus DC	5512	5233	279	5.3
IP Non-Elective	4538	5233	-695	-13.3
OP New	13250	13125	125	1.0
OP Review	33987	34202	-215	-0.6
OP Review:New	2.57	2.61	-0.04	-1.5
AE Type I	15153	15605	-452	-2.9
AE Type II	3224	3099	125	4.0

	Year to Date			
	Actual	Plan	Variance	%
IP Elective	3686	3902	-216	-5.5
Day case	17703	15400	2303	15.0
IPE plus DC	21389	19302	2087	10.8
IP Non-Elective	18159	20159	-2000	-9.9
OP New	52963	48417	4546	9.4
OP Review	139189	126168	13021	10.3
OP Review:New	2.63	2.61	0.02	0.8
AE Type I	60974	63298	-2324	-3.7
AE Type II	13168	12568	600	4.8

Activity to date is compared with **2010 / 11** for the corresponding period

	2010 / 11	2011 / 12	Variance	%
IP Elective	4028	3686	-342	-8.5
Day case	18159	17703	-456	-2.5
IPE plus DC	22187	19302	-2885	-13.0
IP Non-Elective	20712	18159	-2553	-12.3
OP New	55094	52963	-2131	-3.9
OP Review	149038	139189	-9849	-6.6
OP Review:New	2.71	2.63	-0.08	-3.0
AE Type I	63241	60974	-2267	-3.6
AE Type II	12128	13168	1040	8.6

Overall Elective activity for the month and year to date continues to be in excess of the plans for the respective periods, by 5.3% and 10.8% respectively. Non elective activity is 13.3% less than plan for the month and 9.9% less than plan for the first 4 months of the year. Outpatient New and Review activity both reduced during the month, although continues to exceed the plan for the year to date by 9.4% and 10.3% respectively. The Follow Up to New Outpatient Ratio improved during the month to 2.57. Activity across all categories reported is less than that delivered during the corresponding period last year (as indicated) with the exception of Type II (BMEC) A&E attendances.

m	**Bank and Agency -** overall use of Nurse Bank & Nurse Agency staff reduced by approximately 700 shifts (approximately 13%) in month.

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:	25 August 2011

SUMMARY OF KEY POINTS:

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

Service Performance (July):
The indicators which comprise the Service Performance assessment of the framework have been revised with effect from July to those indicated in the attached report. 4 of the A&E Headline Clinical Indicators are incorporated, with the long established A&E 4-hour wait target retained. The various aspects of A&E performance now attract a weighting of 3.0 out of an overall weighting of 14.0. There are 2 groupings of the A&E Clinical Indicators, Patient Impact and Timeliness, each comprising 2 indicators. The threshold of at least 1 indicator in each of the 2 groups must be met to attract the maximum score of 3. Formal assessment of A&E Clinical Indicator performance for Quarter 2 will be based upon the performance during July, with Quarter 3 performance based upon the aggregate of August, September and October.

There is 1 area of underperformance during the month of July; Delayed Transfers of Care. For the month overall performance attracts a score of 2.80 with the Trust classified as Performing.

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

Foundation Trust Compliance Summary report:
There was 1 area of underperformance reported within the framework during the month of July which relates to the A&E Clinical Indicator 'Total time to Assessment'. Performance thresholds of the remaining 4 A&E Clinical Indicators were met and as such the overall score for the month is 0.0, with a GREEN Governance Rating.

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

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Finance and Performance Management Committee.

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

SWBTB (8/11) 184 (a)

Operational Standards and Targets

Indicator		Weight	Thresholds		July 2011	Score	Weight x Score	August 2011	Score	Weight x Score
			Performing	Underperforming						
A/E Waits less than 4-hours		1.00	95.00%	94.00%	96.80%	3	3.00			
A/E Unplanned re-attendance rate	{Patient Impact Group}	2.00	=<5.00%	>5.00%	1.70%	3	6.00			
A/E Left Department without being seen rate			=<5.00%	>5.00%	4.58%					
A/E Time to Initial Assessment - 95th centile	{Timeliness Group}		=<15mins	>15mins	23.00					
A/E Time to treatment in department (median)			=<60mins	>60mins	60.00					
Cancelled Operations - 28 day breaches		1.00	5.0%	15.0%	0%	3	3.00			
MRSA Bacteraemia		1.00	0	>1.0SD	0	3	3.00			
Clostridium Difficile		1.00	0	>1.0SD	4	3	3.00			
18-weeks RTT Admitted 95 Percentile(weeks)		0.50	<=23.0	>27.7	<=23.0*	3	1.50			
18-weeks RTT Non Admitted 95 Percentile(weeks)		0.50	<=18.3	>18.3	<=18.3*	3	1.50			
18-weeks RTT Incomplete Pathway 95 percentile (weeks)		0.50	<=28.0	>36.0	<=28.0*	3	1.50			
18-weeks RTT 90% Admitted		0.75	=>90.0%	85.0%	=>90.0%*	3	2.25			
18-weeks RTT 95% Non -Admitted		0.75	=>95.0%	90.0%	=>95.0%*	3	2.50			
Cancer - 2 week GP Referral to 1st OP Appointment		0.50	93.0%	88.0%	>93.0%*	3	1.50			
Cancer - 2 week GP Referral to 1st OP Appointment - breast symptoms		0.50	93.0%	88.0%	>93.0%*	3	1.50			
Cancer - 31 day diagnosis to treatment for all cancers		0.25	96.0%	91.0%	>96.0%*	3	0.75			
Cancer - 31 day second or subsequent treatment (surgery)		0.25	94.0%	89.0%	>94.0%*	3	0.75			
Cancer - 31 day second or subsequent treatment (drug)		0.25	98.0%	93.0%	>98.0%*	3	0.75			
Cancer - 31 Day second/subsequent treat (radiotherapy)		0.25	94.0%	89.0%	>94.0%*	3	0.75			
Cancer - 62 day urgent referral to treatment for all cancers		0.50	85.0%	80.0%	>85.0%*	3	1.50			
Cancer - 62 day referral to treatment from screening		0.50	90.0%	85.0%	>90.0%*	3	1.50			
Stroke (Stay on Stroke Unit)		1.00	80.0%	60.0%	82.93%	3	3.00			
Delayed Transfers of Care		1.00	3.5%	5.0%	8.30%	0	0.00			
Sum		**14.00**								
Average Score					* projected		**2.80**			

Scoring:	
Underperforming	**0**
Performance Under Review	**2**
Performing	**3**

Assessment Thresholds	
Underperforming if less than	**2.1**
Performance Under Review if between	**2.1 and 2.4**
Performing if greater than	**2.4**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Right Care Right Here Progress Report
SPONSORING DIRECTOR:	Mike Sharon, Director of Organisational Development and Strategy
AUTHOR:	Jayne Dunn, Redesign Director – RCRH
DATE OF MEETING:	25th August, 2011

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 July 2011.

It covers:

- Progress of the Programme.

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: • Deliver the agreed changes in activity required as part of the Right Care Right Here programme. • Make fuller use of the facilities at Rowley Regis Community Hospital to provide care closer to home.
Annual priorities	
NHS LA standards	
CQC Essential Standards of Quality and Safety	
Auditors' Local Evaluation	

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

Financial	**X**	The Right Care Right Here Programme sets out the future activity model for the local health economy including the transfer of activity into the community and to new PBC provider services.
Business and market share		
Clinical	**X**	The Right Care Right Here Programme sets the context for future clinical service models.
Workforce	**X**	The service redesign within the Right Care Right Here Programme will require development of the workforce to deliver redesigned services in a new way and in alternative locations. This will be overseen by the Workforce work stream 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 work stream.
Risks		

PREVIOUS CONSIDERATION:

Monthly progress reports to Trust Board

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

RIGHT CARE RIGHT HERE PROGRAMME: PROGRESS REPORT
AUGUST 2011

INTRODUCTION

The Right Care Right Here Programme is the partnership of SWBH, HoB tPCT, Sandwell PCT and Birmingham and Sandwell local authorities leading the development of health services within Sandwell and Western Birmingham. This brief paper provides a progress report for the Trust Board on the work of the Programme as at the end of August 2011. The Right Care Right Here Programme Director's report as presented to the Right Care Right Here Partnership Board at the end of July is included as 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.

PROJECT PERFORMANCE

It has not been possible to provide the usual activity update by work stream in this report as the analysis of month 1 (April 2011) data is still not complete. This is due to a number of factors, but most significantly the re-structuring of some of the information received, which has meant that this does not key into the reporting structure used for the Programme and has required some additional work to re-format the information.

Overall, the activity trends observed in April are in line with those reported throughout last year (2010/11) and year-on-year movements are much as expected.

CARE PATHWAY AND SPECIALITY REVIEWS

The Care Pathway Reviews continue with plans to publish the 13 approved localised pathways on the Map of Medicine within the new month. The Speciality Review work for Rheumatology continues to make progress.

TRANSFER OF ACTIVITY

There have been ongoing discussions across the local health economy regarding implementation of the LDP agreement to transfer a range of services, activity and related income from secondary care to community and primary care during 2011/12 in line with the RCRH Programme. The Trust and GP commissioners have identified a number of specific schemes which have now been agreed and for which implementation plans are now being developed. Examples include undertaking review appointments following planned hip and knee surgery in community locations, physiotherapists undertaking planned joint injections that do not require specialist x-ray equipment in community locations etc. Work is ongoing to identify additional schemes.

PROGRAMME GOVERNANCE

The Programme Director has facilitated ongoing discussions across the local health economy about the proposed revised governance arrangements intended to streamline the decision making processes in order to tie decision making within the Programme more closely to annual contracting decisions, performance management and to deliver much more rapid decisions on service redesign and its implementation. It has been proposed that a joint event should be held in September between the Partnership Board and Clinical Commissioning Groups to agree the way forward.

RECOMMENDATIONS

The Trust Board is recommended to:

1. NOTE the progress made with the Right Care Right Here Programme.

Jayne Dunn
Redesign Director – Right Care Right Here

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, 25th July 2011**

1. Summary and Recommendations

This paper summarises the main issues and developments in the Programme since the previous report.

The Partnership Board is recommended to:

- Debate the proposed alternative day and time for meeting (Section 2)
- Debate and agree the proposal to hold a joint event in September on governance between the Board and Clinical Commissioning Groups to agree the way forward (Section 3)
- Note the content of the remainder of the report in Section 4.

2. Day and Time of Partnership Board meeting

Following the discussion at the last meeting, a further canvass of members has been undertaken. Members will recall that it was suggested that we should look at the first or second Thursday of the month between 1pm and 3pm. The outcome of this will be reported to the meeting for decision.

The Partnership Board is recommended to:

- Debate the proposed alternative day and time for meeting (Section 2)

3. Combined Governance Arrangements

The paper proposing the change to governance arrangements to deliver much more rapid decisions on service redesign and its implementation was discussed in detail last month. At the meeting, it was agreed that I would review the responses with Sohaib Khalid and Martin Stevens and make a recommendation to the Board this month.

The overall conclusion from responses received seems to be that there is general and broad support for the proposals, although some amendments are needed and it will be necessary to define what the fine detail looks like. My only concern is the comparative lack of views from Clinical Commissioning Groups.

The responses received are as follows:

SWBH RCRH Implementation Board

The discussion centred on the need to include Finance Directors in both the Combined Governance Group and the Contract Management Group, the need to include the re-affirmation of the principle of the Transitional Finance Funding and the annual re-negotiation of the amount pre-LDP in the brief of the Combined Governance Group, and the need to maintain the Clinical Quality Group as separate from the Contract Management Group. Mike Sharon has helpfully provided a more detailed statement of their views following further discussions within their Executive Team and Trust Board.

Sandwell PCT RCRH Programme Board

The proposals were described as being in the right direction, and basically sound. It was suggested that the Clinical Quality Group should remain separate as it has a detailed and important agenda to deliver. There was concern that this type of arrangement might not fit with the developing governance of Clinical Commissioning Groups and that there remained a disjoint between the understanding and committed support of senior clinicians in the acute trust and their Consultant colleagues. This led on to a debate about similar issues in commissioning consortia and a concern that those colleagues may not understand both the extent of what the Programme does and the extent of their responsibility for it. It was suggested that it would be sensible to look at putting in place an event in September to ensure Clinical Commissioning Groups achieve this understanding and that this could then operate as a formal transfer of commissioning responsibility for the Programme from the PCTs to the Clinical Commissioning Groups.

Programme Delivery Group

Broadly supported, with the need to include Finance Directors being raised and the need for a formal arrangement to be in place for referral of issues requiring resolution to CEOs, potentially on a quarterly basis

Transport and Access Group

Received, no comments made

Engagement and Communications Group

Received, no comments made

Clinical Group

Received, comment made that effective decision-making was required. It was agreed that the paper needed discussion in individual organisations, and further comments may be made at the next meeting.

Strategic Workforce Group, Finance and Capacity Group, Strategy Group

No meeting in the period (Strategy Group cancelled) so not discussed.

Partnership Board last meeting

It was suggested that a minor tweak was needed on one of the appendices which shows CEOs as a group when this is not currently the case. SWBH (Mike Sharon) agreed with the proposals, and confirmed that it is important that the members involved from the various organisations have the authority to make decisions and that the Combined Governance Group has Finance Director involvement. Andy Williams supported this as the right direction and structure, based essentially on accountable officers reaching agreement, but it is really important to get strong support from Clinical Commissioning Groups.

It was suggested that the Partnership Board role will continue to be necessary, particularly through this period of continuing change. It was also agreed that we may be in danger of losing contact and involvement from mental health and social care if we disband the Partnership Board. It was thought necessary to ensure we continue to make progress on service redesign and improvement rather than being paralysed by structural discussions again.

In discussing allowing Clinical Commissioning Groups to make decisions about service change, it was noted that in Sandwell, funding for commissioning programmes is £2.8million for clinical changes in year so Commissioning Consortia have hypothecated development funding to spend this year. From a clinical commissioning perspective, it was thought to be important to make sure that the Combined Governance Group defines and understands what pathways they want to address and that when a way forward has been determined there needs to be an analysis of the cost of implementation these. It was

acknowledged that it will be necessary to flesh out how the proposed arrangements work in detail. It was agreed by the Board to receive a firm proposal at the July meeting.

Commissioning Groups

I have raised these issues at the Pioneers for Health meeting, the Sandwell Health Alliance, and the Vitality Partnership, but received no comments back. Martin Stevens attended the Black Country Commissioning Group and informs me that the proposals were broadly agreed but they were concerned about the following issues:

- Will there be patient engagement in the Combined Governance Group?
- Management influence over the process should not be king
- The group does not look balanced between clinicians and managers
- Need to consider including two acute trust Medical Directors (to include Dudley Group of Hospitals)

Discussion

While these comments could be interpreted as supportive of the need to make changes, I do not believe that we have yet reached the point of full support from Clinical Commissioning Groups. This is in part due to pressures on their agenda and time and may also be in part due to a lack of full understanding about what the Programme does and how it operates. As it is critical that any change has the full and active support of Clinical Commissioning Groups going forward, I support the suggestion that we should hold an event in September between the Board and the Clinical Commissioning Groups which allows all these issues to be aired and a way forward agreed upon, with that being the point of transfer of responsibility for the Programme from PCT commissioners to clinical commissioners.

The Partnership Board is recommended to:

- Debate and agree the proposal to hold a joint event in September between the Board and Clinical Commissioning Groups to agree the way forward

4. Items for Information

Telecare Steering Group

This group has met again, on 14th July 2011. Following Glynn Dixon's departure, it is now chaired by Chris Guest, Divisional Manager, Sandwell MBC.

At the latest meeting, it was agreed to hold an event in September with all stakeholders to develop a strategy for telecare and telehealth across the LHE, and agree a series of actions. The event will review current services in place, current plans, evidence from the national Whole Systems Demonstrator sites for telehealth care and the opportunity to develop a strategic vision for the application of technology to care processes in health and social care. The first major deliverable will be to develop a business case for investment, and realisation of savings, for consideration by this Board and partner organisation boards. This will need to be a clear and cogent argument which proves that investment at scale can generate significant savings to achieve changed services and a contribution to QIPP plans.

The Group also agreed to add representation from Birmingham City University to the group to represent the faculties of Health and Social Care, Technology, Engineering and the Environment and Birmingham Institute of Art and Design. This will enable us to explore many wider aspects of the potential application of new and emerging technologies.

Within the Programme, we will be reviewing how the Specialty Review and Care Pathway Review planning processes can take account of how telecare could benefit specific service redesign changes.

5. Recommendations

The Partnership Board is recommended to:

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Les Williams
Programme Director

2011-07-15 – prog dir report - lnw

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

RIGHT CARE RIGHT HERE PROGRAMME: PROGRESS REPORT
AUGUST 2011

INTRODUCTION

The Right Care Right Here Programme is the partnership of SWBH, HoB tPCT, Sandwell PCT and Birmingham and Sandwell local authorities leading the development of health services within Sandwell and Western Birmingham. This brief paper provides a progress report for the Trust Board on the work of the Programme as at the end of August 2011. The Right Care Right Here Programme Director's report as presented to the Right Care Right Here Partnership Board at the end of July is included as 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.

PROJECT PERFORMANCE

It has not been possible to provide the usual activity update by work stream in this report as the analysis of month 1 (April 2011) data is still not complete. This is due to a number of factors, but most significantly the re-structuring of some of the information received, which has meant that this does not key into the reporting structure used for the Programme and has required some additional work to re-format the information.

Overall, the activity trends observed in April are in line with those reported throughout last year (2010/11) and year-on-year movements are much as expected.

CARE PATHWAY AND SPECIALITY REVIEWS

The Care Pathway Reviews continue with plans to publish the 13 approved localised pathways on the Map of Medicine within the new month. The Speciality Review work for Rheumatology continues to make progress.

TRANSFER OF ACTIVITY

There have been ongoing discussions across the local health economy regarding implementation of the LDP agreement to transfer a range of services, activity and related income from secondary care to community and primary care during 2011/12 in line with the RCRH Programme. The Trust and GP commissioners have identified a number of specific schemes which have now been agreed and for which implementation plans are now being developed. Examples include undertaking review appointments following planned hip and knee surgery in community locations, physiotherapists undertaking planned joint injections that do not require specialist x-ray equipment in community locations etc. Work is ongoing to identify additional schemes.

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Les Williams
Programme Director

2011-07-15 – prog dir report - lnw

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Foundation Trust Programme: Project Director's Report
SPONSORING DIRECTOR:	Mike Sharon, Director of Strategy & Organisational Development
AUTHOR:	Neetu Sharma, Senior Programme Manager
DATE OF MEETING:	25th August 2011

SUMMARY OF KEY POINTS:

The Project Director's report provides an update on:

- Activities this period
- Activities next period
- Issues for resolution and risks in next period

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The FT Programme Board is asked to **receive** and **note** the update.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	An Effective Organisation
Annual priorities	Make Significant progress towards becoming a Foundation Trust
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Routine monthly update.

FT Programme Director Report August 2011 – Overall status - Amber

Activities this period

- Draft IBP and LTFM submitted to SHA on 12/08/11 for first review
- Deloitte to also review updated IBP/LTFM
- Strategic risks reviewed and risk assessments included in draft IBP
- Board effectiveness, staff surveys and staff focus groups completed – findings to be fedback to Chair and CE by Deloitte (September)
- Trust Board and committee review observations held (3 conducted to date, Audit Committee planned for 08/09/11)
- 15 of the 20 External stakeholder surveys completed
- Board Member 1-1 sessions followed by Board Member 1-1 feedback sessions scheduled for September / early October 2011
- SHA/Exec to Exec discussion planned for 20/09/11

Activities next period

- Complete external stakeholder survey for remaining 5 stakeholders
- Provide more detail on milestones for the remainder of the programme
- SHA to provide feedback on first draft iteration
- SHA to produce Board Observation feedback and provide verbal and written feedback to Chair and CE
- Deloitte to prepare IBP/LTFM review feedback
- Mckinsey feedback on PFI review awaited

Issues for resolution and risks in next period

- DH has not signed the TFA
- Outputs from McKinsey review of our PFI position expected

MINUTES

Sandwell and West Birmingham Hospitals NHS
NHS Trust

FT Programme Board – Version 0.1

Venue Anne Gibson Boardroom, City Hospital **Date** 28 July 2011

Present:	Mr Roger Trotman	[Chair]	Mr Robert White
	Dr Sarindar Sahota		Miss Rachel Overfield
	Mrs Gianjeet Hunjan		Mr Donal O'Donoghue
	Prof Derek Alderson		Mr Graham Seager
	Mr Gary Clarke		Miss Kam Dhami
	Mr John Adler		Mrs Jessamy Kinghorn
	Mr Mike Sharon		Miss Neetu Sharma

Observers: Prof D Nicolini

Secretariat: Mr Simon Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Mrs Sue Davis, Mrs Olwen Dutton and Miss Rachel Barlow.	
2 Minutes of the previous meeting	**SWBFT (6/11) 039**
The minutes of the previous meeting were accepted as a true and accurate record of the discussions held on 30 June 2011.	
AGREEMENT: The minutes of the previous meeting were approved.	
3 Update on actions arising from previous meetings	**Verbal**
It was noted that there were no overdue actions or actions that required escalating for attention.	
4 FT Programme Critical Path	**SWBFT (7/11) 041** **SWBFT (7/11) 041 (a)**
Miss Sharma advised that Critical Path had been updated to reflect that the second draft of the Integrated Business Plan (IBP) had been completed. It was reported that the planned Board to Board exercise with the Strategic	

Health Authority on 20 September 2011 was now to be replaced with a discussion with a number of the Executive Team around the new hospital plans. Mr Adler reported that it appeared that the Private Finance Initiative (PFI) Deed of Safeguard issue had been resolved. It was noted that as the resource limit for the land purchase had now been agreed, the status of this action should be changed from red.	
5 FT workstream high level milestone plan	**SWBFT (7/11) 042** **SWBFT (7/11) 042 (a)**
Mr Sharon presented the high level milestone plan for the FT Programme, which he highlighted had been amended to show where any slippage had occurred. It was reported that in the course of the next month, greater details concerning the key activities required as part of the next phase of the programme would be developed. Mr Adler asked what impact the ongoing delays with the approval of the Outline Business Case (OBC) were having on the programme. Mr Sharon advised that the Tripartite Formal Agreement had not yet been approved by the Department of Health, which it was suggested may be reflective of the need for the new hospital OBC to be approved as part of the agreement. The Board was advised that should there be a continued delay with the approval of the OBC, there would come a point where the FT application process would need to be paused. It was highlighted that this point would be reached in October 2011, when the planned public engagement phase was due to commence. It was agreed that there was a need to discuss the position with the Strategic Health Authority at the meeting planned for 20 September 2011. Mrs Kinghorn reported that the Overview and Scrutiny Committee had asked for details of the public engagement activities, which was difficult to articulate in the light of the delay. Mr Seager reported that a fresh individual in the Department of Health had been assigned to review the OBC and that as part of this, requests for additional information had been received which had been provided. It was noted that the review of the OBC was due to be completed by 29 July 2011. The Board was advised that the GP commissioning leads had been approached to seek their renewed support for the new hospital plans and that a number of responses had been received to date, all of which provided positive support.	
6 Programme Director's report	**SWBFT (7/11) 043** **SWBFT (7/11) 043 (a)**
The Board considered a report by the Programme Director which outlined the progress of all key activities. The Board members was thanked for their contributions to the Integrated Business Plan (IBP). It was reported that the Long Term Financial Model (LTFM)	

had been completed. A market assessment and validation event were also noted to have been undertaken. The Board was advised that the Overview and Scrutiny Committee had agreed to the planned approach for engagement. Mr Sharon informed the Board that a 'soft' mock Board to Board event was planned for 15 September 2011, although it was highlighted that further thought was being given to whether the event should remain to be held given that key members of Deloitte LLP would be unavailable. It was reported that the staff survey had been completed and focus groups had been held, the outcome from which was highlighted would be reported to the Chair and Chief Executive in due course. The Board was advised that the final changes to the IBP would be undertaken shortly, with submission to the Strategic Health Authority planned for 12 August 2011. The outcome of the McKinsey review into the impact of a Private Finance Initiative (PFI) on FT applicants' plans was reported to remain awaited. Mr Adler reported that OBC approval could not be given until this work had concluded. Miss Dhami reported that one to one meetings between Board members and Deloitte LLP would be arranged shortly.	
7 Programme risk register	**SWBFT (7/11) 044** **SWBFT (7/11) 044 (a)**
Miss Sharma presented the FT Programme risk register. In terms of risk 14, to ensure that quality stems throughout the IBP, it was reported that Miss Dhami was to review the entire IBP to ensure that there is sufficient reference to quality in all pertinent places. In terms of engagement, it was emphasised that there was much work to do both internally and externally.	
8 Integrated Business Plan (IBP) – Version 0.2	**SWBTB (7/11) 163** **SWBTB (7/11) 163 (a)**
Mr Trotman advised that the IBP needed to present a cogent picture and show consistency throughout the various chapters. He highlighted that there needed to be adequate assurance that the IBP incorporated adequately, aspects of quality, safety, patient care and strategy and was able to demonstrate that the Cost Improvement Plans (CIPs) were realistic and achievable. The Board was asked to comment on the version of the IBP planned for submission to the Strategic Health Authority on 12 August 2011. Mr Adler remarked that quality and safety did not appear to be strongly enough represented at present, although he suggested that this may be reflective of the	

imposed structure of the IBP. It was suggested that the chapter dealing with governance arrangements could be reordered to bring quality further to the fore. Miss Dhami reported that the IBP would be considered chapter by chapter to ensure that quality and safety were incorporated where relevant.

Mr Adler suggested that the Atos view concerning Organisational Development and transformation needed to be built into the document, which would provide the coherence needed.

Mrs Kinghorn suggested that in terms of organisational strategy, greater detail needed to be included regarding the reasons for deciding to develop some specialities over and above others. The plan for the Leasowes facility was highlighted to also need inclusion. Mr Sharon reported that a piece of work was underway around the community estate strategy, which would capture the plan for Leasowes. In terms of the decisions to expand certain services, Miss Sharma advised that the service development plans needed to be consistent with market assessment. It was suggested that a patient story could be included to illustrate the success of service development or to articulate why the plans are required. Mr Adler advised that as reconfiguration is a strength of the Trust, this should be included within the IBP, particularly as this demonstrates practically that the Trust embraces the quality and safety agenda. Dr Sahota suggested that quality and safety should also be mentioned in the context of the local health economy.

Professor Alderson recommended that further evidence of the Trust's research and education work needed to be included in the IBP, particularly to demonstrate a commitment to this and to emphasise the good performance in this area at present. It was suggested that some aspects of this element could be incorporated into the Trust Profile section.

The key questions posed at the beginning of each chapter of the IBP were discussed. Comments raised during the discussion of the questions, included a suggestion that in Chapter 3 that the annual objectives should be redefined to make them more measurable, perhaps by identifying additional high level measures of progress to assess delivery. The rationale for each of the strategic objectives was reviewed and comments noted. Another comment raised during the review included that within Chapter 4, there is a need to clearly identify that the population served by the Trust does not include the whole of Birmingham, but a select number of wards having a similar demographic, level of deprivation and health issues to those in Sandwell. In terms of the risks in Chapter 7, it was suggested that there is not a need to discuss infection control as a separate matter, but to broaden this to include compliance with a wider set of standards to ensure quality targets are met. It was agreed that the risks and their respective assessments should be considered further by the Executive Team. It was suggested that the downside scenario section in Chapter 7 should be reworked to add in further detail. In terms of Chapter 9, the Board agreed that it was content with age eleven being set as the minimum age for members. It was further agreed

that the Board committees in place were sufficient and appropriate. Subject to the amendments suggested as part of the review, the FT Programme Board was asked for and gave its support to the IBP and it agreed to recommend to the Trust Board that it should be approved for submission to the Strategic Health Authority on 12 August 2011.	
AGREEMENT: Subject to the amendments suggested as part of its review, the FT Programme Board gave its support to the IBP and it agreed to recommend to the Trust Board that it should be approved for submission to the Strategic Health Authority on 12 August 2011	
10 Proposal to establish a Transformation Programme Management Office	**Hard copy papers**
Mr Sharon advised that a proposal had been developed by the Atos consultants to establish a transformation programme and Transformation Support Office (TSO). The proposal was reported to have been discussed by the Executive Team at its meeting on 26 July 2011. The Board was advised that to achieve the Trust's strategic objectives, a large number of projects would need to be managed coherently, however at present there was a difference in the approach adopted to management of these according to where and by whom they are delivered. It was suggested that to address this inconsistency that the projects should be managed using a transformation plan and TSO approach. It was highlighted that the transformation plan would cover the delivery of the CIP, Quality and Efficiency Programme (QuEP) workstream plans, 'Right Care, Right Here' plans, Service Line Management and the elements of the IM & T strategy. It was proposed that the transformation plan should fall within the remit of the Chief Operating Officer, who would ensure that the projects meet their objectives, with the progress of the principal projects being reported to the Organisational Development Steering Group (ODSG). It was proposed that the ODSG should report to the Trust Management Board and should act as a subcommittee of the FT programme Board. The Board was advised that the resourcing of the plans would need to be discussed further. Mr Trotman agreed that the remit of the Chief Operating Officer appeared to be the most sensible place to oversee the transformation programme and TSO. He reminded the Board however, that the Atos consultants had recommended the establishment of circa thirty individuals who were equipped with LEAN management experience and could act as the core of the TSO. As such, he asked that the plans to secure these individuals be expedited. Mr O'Donoghue suggested that a representative from the Finance area needed to	

be included on the membership of the ODSG, given that as part of the remit of the transformation plan, there was a possibility that cost centres would need to be moved, established and changed. Mr Adler reported that the internal resources to support the plans needed to be determined and he advised that the cost attached to the plan was likely to be significant. The Board was informed that further detail would be presented at a future meeting of the FT Programme Board. The Board was asked for and gave its approval to the principle and establishment of a transformation plan and TSO.	
AGREEMENT: The Board gave its approval to the principle and establishment of a transformation plan and Transformation Support Office	
11 Summary of NHS Commissioning Board arrangements	**Hard copy paper**
The Board was asked to receive and note the summary of NHS Commissioning Board arrangements. Mr Sharon advised that as a consequence of the arrangements, a more directive approach was expected.	
12 Matters for information	**SWBFT (7/11) 045** **SWBFT (7/11) 046**
The Board received and noted the minutes from the meeting of the Monitor Board held in May 2011 and Monitor's FT bulletin published in July 2011.	
13 Any other business	**Verbal**
There was none.	
14 Details of next meeting	**Verbal**
The next FT Programme Board meeting will be held on 25 August 2011 at 1300h in the Boardroom at Sandwell Hospital.	

Signed ……..

Print ……

Date ……..