Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Anne Gibson Boardroom, City Hospital **Date** 28 July 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 C Rickards	(CR)
Prof D Alderson	(DA)			
Mr G Clarke	(GC)		**Secretariat**	
Mrs O Dutton	(OD)		Mr S Grainger-Payne	(SGP) [Secretariat]
Mr J Adler	(JA)			
Mr D O'Donoghue	(DO'D)			
Mr R White	(RW)			
Miss R Overfield	(RO)			
Miss R Barlow	(RB)			

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 30 June 2011 as true and accurate records of discussions*	**SWBTB (7/11) 147**	**Chair**
5	**Update on actions arising from previous meetings**	**SWBTB (7/11) 147 (a)**	**Chair**
6	**Questions from members of the public**	**Verbal**	**Public**
	MATTERS FOR APPROVAL		
7	**Application for a Capital investment Loan**	**SWBTB (7/11) 165** **SWBTB (7/11) 165 (a)**	**RW**
8	**Sustainability update and Sustainability and Sustainability & Environment policy**	**SWBTB (7/11) 149** **SWBTB (7/11) 149 (a) -** **SWBTB (7/11) 149 (c)**	**GS**

MATTERS FOR INFORMATION/NOTING			
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)	RO
9.2	Integrated risk report	SWBTB (7/11) 162 SWBTB (7/11) 162 (a)	KD
9.3	Update on complaints handling	Hard copy paper	KD
9.3	Minutes of the Quality and Safety Committee held on 19 May 2011 and update form meeting held on 21 July 2011	SWBQS (5/11) 015	DA
10	**Performance Management**		
10.1	Monthly finance report	SWBTB (7/11) 150 SWBTB (7/11) 150 (a)	RW
10.2	Draft minutes from the Finance and Performance Management Committee meeting held on 21 July 2011	To follow	RT
10.3	Monthly performance monitoring report	SWBTB (7/11) 164 SWBTB (7/11) 164 (a)	RW
10.4	NHS Performance Framework monitoring report	SWBTB (7/11) 151 SWBTB (7/11) 151 (a)	RW
10.5	Update on progress with the delivery of the Corporate Objectives 2011/12 - Quarter 1	SWBTB (7/11) 152 SWBTB (7/11) 152 (a)	MS
11	**Strategy and Development**		
11.1	'Right Care, Right Here' programme: progress report	SWBTB (7/11) 157 SWBTB (7/11) 157 (a)	MS
11.2	Foundation Trust application programme		
▶	Programme Director's report	SWBTB (7/11) 166 SWBTB (7/11) 166 (a)	MS
▶	Draft minutes from the Foundation Trust Programme Board meeting held on 30 June 2011	SWBFT (6/11) 039	RT
11.3	Midland Metropolitan Hospital project: Programme Director's report	SWBTB (7/11) 156 SWBTB (7/11) 156 (a) SWBTB (7/11) 156 (b)	GS
11.4	Clinical Services Reconfiguration Programme		
▶	Progress Report	SWBTB (7/11) 167 SWBTB (7/11) 167 (a)	MS
▶	Draft minutes from the Clinical Services Reconfiguration Board held on 30 June 2011	SWBTB (7/11) 153	MS

12	**Minutes of the Board Committees**		
12.1	Draft minutes of the Audit Committee meeting held on 12 May 2011 and 9 June 2011	SWBAC (5/11) 037 SWBAC (6/11) 038	GH
12.2	Draft minutes of the Charitable Funds Committee held on 12 May 2011	SWBCF (5/11) 012	SS
13	**Any other business**	**Verbal**	**All**
14	**Details of next meeting** *The next public Trust Board will be held on 25 August 2011 at 1500h in the Churchvale/Hollyoak Rooms, Sandwell Hospital*	**Verbal**	**Chair**

MINUTES

Trust Board (Public Session) – Version 0.2

Venue Churchvale/Hollyoak Rooms, Sandwell Hospital **Date** 30 June 2011

Present:

Mrs Sue Davis (Chair)	Mr Roger Trotman	Prof Derek Alderson
Mr Gary Clarke	Mrs Olwen Dutton	Dr Sarindar Sahota
Mr John Adler	Mr Robert White	Mr Donal O'Donoghue
Mr Mike Sharon	Miss Rachel Overfield	Mr Matthew Dodd

In Attendance:

Mr Graham Seager Mrs Jessamy Kinghorn

Guests

Mr Amaro Pereira (Sandwell LINks) [Item 7 only]

Observers

Mrs Claire Heaney (Deloitte LLP) Mr Andrew Crawshaw (NHS West Midlands)

Secretariat:

Mr Simon Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Miss Kam Dhami.	
2 Declaration of Interests	**Verbal**
There were no declarations of interest raised.	
3 Chair's Opening Comments	**Verbal**
The Chair welcomed Mrs Claire Heaney from Deloitte LLP and Mr Andrew Crawshaw from NHS West Midlands, who were both present to observe the meeting.	

4 Minutes of the previous meeting	**SWBTB (5/11) 125** **SWBTB (6/11) 124**
The minutes of the previous meeting were presented for approval and were accepted as a true and accurate reflection of discussions held on 26 May 2011 and 9 June 2011.	
AGREEMENT: The Trust Board approved the minutes of the last meetings	
5 Update on actions arising from previous meetings	**SWBTB (5/11) 125 (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.	
7 Outcome of the Sandwell LINks discharge review	**SWBTB (6/11) 133** **SWBTB (6/11) 133 (a)**
The Chair explained that at a prior meeting of the Sandwell Health and Wellbeing Board which she had attended, she had suggested that the outcome of the discharge review that had been undertaken by the LINks would be useful to share with the Trust Board. Mr Amaro Pereira, a member of Sandwell LINks was welcomed to the Board meeting. He outlined the role of LINks and advised that a number of issues concerning discharge had been raised with the organisation, which had prompted a review of the discharge process. The Board was advised that the review had involved a survey of patients and discussions with Trust managers to present an overview of the findings of the review. Mr Pereira outlined the key findings of the review. Mr Dodd advised that having worked closely with the LINks during the review, the report of the findings was welcomed and the key issues reported were clearly recognised by the Trust. The Board was advised that since the review, much work had been undertaken including strengthening the arrangements with Social Services by introducing a link social worker onto wards. A 'Listening into Action' discharge event had also been held to generate ideas for improved discharge planning processes. The transfer of Sandwell PCT's community services staff into the Trust was also highlighted to be a measure which would assist with improving the discharge process. Mr Dodd did however flag a number of areas for improvement which had been identified, including the need to make the out of hours discharge process more efficient and improving the links with Mental Health services. The Chair remarked that there appeared to be a perception by those patients	

surveyed that To Take Out prescriptions (TTOs) was a fundamental contributory factor to delayed discharges. Mr Dodd agreed that there were issues with the TTO process in this respect. Mr Clarke asked for a summary of the main issues related to the TTO process. Mr Dodd advised that patients' drugs are not routinely prepared in readiness for a known date of discharge; orders for TTOs are in some instances, not sent to Pharmacy until the end of a ward round, whereas if the order was processed directly after the patient had been seen, this would reduce the delay with receiving the drugs. Mr Dodd advised that the opening times of Pharmacy had been extended, however it was clear that processing orders for patients due for discharge was not prioritised by Pharmacy staff at present, on the basis that in a small number of cases the order could change prior to discharge. Mr Trotman suggested that given the small number of instances in which orders are changed, this should not be regarded as a reason to delay the preparation of TTOs.

Miss Overfield advised that there was currently insufficient use of preadmission clinics to confirm that patients have adequate non-prescription drug stocks ready for arrival back home following a spell in hospital. Mrs Hunjan asked whether patients treated in the Birmingham Treatment Centre (BTC) are affected by similar issues. Miss Overfield advised that the majority of patients treated in the BTC are asked to ensure that routine drugs are available for their discharge.

Mrs Dutton asked whether a delay with transport collecting patients being discharged was a major concern. Miss Overfield advised that transport services rarely stipulate a specific time for pick up, although she acknowledged that there were further measures which could be implemented which could minimise the impact of transport on delayed transfers. Mr Dodd advised that the demand for transport in the afternoon outweighed that of other parts of the day, therefore effort should be made to ensure discharges occur more evenly throughout the day.

Mr Sharon remarked that it was encouraging to learn that 70% of patients understand the guidance issued to them on discharge. He asked whether there was feedback from the remaining 30% as to the main issues they experienced. Mr Pereira advised that there was no further information available on this matter.

Mrs Dutton commented that the process by which drug orders are provided to Pharmacy appeared to be labour intensive and suggested that greater use of IT solutions should be considered. Mr O'Donoghue advised that the current technical solutions were not sufficiently robust to provide any significant benefit, however he advised that the paper based system in place at present works well and generally once the paperwork reaches the Pharmacy that the turnaround of the order is speedy. Professor Alderson asked what the barrier was to the use of electronic prescribing. Mr O'Donoghue advised that a solution arising from the National Programme for IT had been awaited, however as this had stalled an alternative means would need to be sought.

Mr Seager suggested that if the survey was to be the main way of capturing patients' views on discharge that the exercise should be repeated again in due course. Miss Overfield advised that related feedback is requested as part of the adult inpatient satisfaction surveys that are undertaken on an ongoing basis. The Chair asked whether the LINks was planning to undertake a follow up survey. Mr Pereira advised that there was an intention to consider the review further in future, however he highlighted that there was optimism that the issues raised by the review could be rectified with reasonable ease. Mr Clarke asked how the results of the survey were fed back to those who had completed the survey. Mr Pereira advised that as the surveys had been submitted anonymously, it was not possible to feed back to the patients directly. It was however noted that the review was publicly available on the LINks website. Mrs Kinghorn asked the Board to note the welcome professional and collaborative manner with which the LINks had undertaken the review. The Chair thanked Mr Pereira for his informative and useful presentation.	
8 Application of the Trust Seal to the Deed of Variation	**SWBTB (6/11) 137**
Mr White advised that as part of finalising the contract documentation for the 2011/12 Local Delivery Plan (LDP) with Sandwell, Heart of Birmingham and other West Midlands PCTs, a National Variation Deed is prepared to capture key components of the settlement between the Trust and its commissioners. The Board was advised that specifically, the co-ordinating Commissioner and the Trust enters into a standard contract but this can be varied to reflect local nuances. Following the publication of the NHS Operating Framework for 2011/12 in December 2010, the Board was informed that it had been necessary to amend the national contract as part of the LDP process, which was now complete. It was highlighted that the Deed itself required the application of the Trust Seal and the Board was asked to support the use of the seal under signature by the Chief Executive and the Director of Finance and Performance Management. The Trust Board approved this request.	
AGREEMENT: The Trust Board approved the application of the Trust Seal to the national Deed of Variation	
9 Safety, Quality and Governance	
9.1 Same sex Accommodation declaration	**SWBTB (6/11) 143** **SWBTB (6/11) 143 (a)**
Mr Dodd reminded the Trust Board that a declaration had been approved at its March meeting which reported that that the Trust was not compliant with the same sex accommodation guidance as at 31 March 2011. The Board was advised	

that since then, the required capital works on ward D26 at City Hospital had been completed and as such a declaration was being made that the Trust was now compliant with the guidance. It was highlighted that the declaration had also been updated to report that the Leasowes community facility was also compliant with the guidance. The Board was advised that following the achievement of compliance with the national guidance, further work was planned to refine and improve the accommodation, including review the arrangements on the wards at Sandwell Hospital. The Chair remarked that it was encouraging that the number of Same Sex Accommodation breaches reported for May had reduced to four. Mr Trotman noted that the two wards arising from the capital works at City Hospital were not fully occupied and asked how the extra space would be used. Mr Dodd advised that consideration would be given to using the space for patients who were recovering from surgery. The Trust Board was asked for and gave its approval to the Same Sex Accommodation declaration.	
AGREEMENT: The Trust Board gave its approval to the Same Sex Accommodation declaration	
9.2 Transforming Community Services - Post transactional integration and benefits realisation	**SWBTB (6/11) 135** **SWBTB (6/11) 135 (a)**
Mr Dodd reminded the Trust Board that a paper had been presented at its March meeting outlining the stages of the Transforming Community Services (TCS) integration and benefits realisation plan. Having completed the initial stages of the plan, the Board was advised that work on establishing the management structures target setting, harmonisation of policies and implementing consistent communications methods were underway. Work to realise the benefits of the integration was reported to be progressing well and included measures such as transferring the management of Rowley Regis Hospital to the community services area to ensure a greater focus on community activity and closer links with GPs. As part of this work the Board was advised that a reablement ward at Rowley Regis Hospital had been established. Within the community children's area, Mr Dodd advised that there had been effort made to target resources in the community more effectively. In terms of service planning, there was reported to be a focus on improving services for Primary Care, identifying new service opportunities and better support to the 'Right Care, Right Here' trajectory. Work was highlighted to be underway to work with Sandwell Commissioners to strengthen the provision of a selection of key services, including greater patient choice within End of Life Care,	

expansion of community orthopaedic services and a holistic community diabetes services. Mrs Davis advised that the acquisition of staff who work in more efficient and effective ways was an added benefit of the transfer. She provided an example of a group of staff who used digital dictation to good effect, which had prompted consideration of the system being used more widely within the Trust. Mr Adler agreed that the transfer had brought into the Trust some enthusiastic individuals with different ways of working. Mr Dodd was asked how the benefits and transition were monitored outside of Trust Board meetings. He advised that a TCS benefits and realisation workstream had been established within the Quality and Efficiency Programme (QuEP), a report on which is considered by a number of Boards and Committees on a monthly basis. It was highlighted that this workstream mainly considers the lower level benefits however, although a greater focus on the wider and more significant benefits would be given in future. Mr Adler reported that the Atos consultants had highlighted significant potential from the community services area in respect of generation of efficiencies and savings for the Trust. Mrs Hunjan reported that at the recent meeting of the Finance and Performance Management Committee, it had been highlighted that there was a potential for significant additional costs to be incurred as a result of a difference in the policy for archiving patient records between the Trust and Sandwell PCT to which the community services staff had been working. Mr Dodd advised that this matter was being fully investigated to determine the scale of the issue (if any). Mr Sharon reminded the Board that the TCS Transfer Agreement provided for discussions to be reopened with the PCT should it be determined that there are unforeseen costs that could not otherwise have been reasonably anticipated within four months of the transfer. Dr Sahota noted that there were benefits to the local Health Economy around End of Life Care. Mr Dodd advised that new palliative care consultants had been recruited and he reported that one of the Commissioning for Quality and Innovation (CQUIN) schemes for 2011/12 concerned End of Life Care, which involved preparing a baseline assessment and developing an action plan focussed on ensuring that a greater number of patients die in the place of their choice. The Board was advised that the End of Life strategy was also being discussed with Sandwell PCT on a wider scale. It was agreed that the overlap between the palliative care service provision and End of Life care plans had the potential to generate significant efficiencies. Miss Overfield advised that the End of Life Care teams were meeting on a regular basis at present. Mr O'Donoghue advised that an IT solution was being developed to alert the Trust to End of Life Care patients in an identical way to those to which the 'Think Glucose' initiative applied.	

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. Mr Adler advised that progress with improving the output of complaints responses was good, with 97 having been issued during the period against a target of 95. It was noted in particular that there had been a fall in the number of complaints outside of the failsafe timeframe. Overall, the Board was assured that the plan to clear the backlog of complaints responses by December 2011 was on track. Mr Adler suggested that the report issued by the Care Quality Commission (CQC) as part of the responsive review into compliance with Outcome 17, complaints, should be presented to the Quality and Safety Committee at its July meeting, together with an update on the action plan to address the recommendations. Mr Grainger-Payne agreed to arrange for this report to be presented. The Board was informed that the CQC report had advised that the Trust was non-compliant with the relevant Essential Standard of Care with minor concerns. It was suggested that the Quality and Safety Committee should also see a report into any clusters or trends in themes of complaints being handled. The Chair highlighted that there had been a significant increase in the number of complaints that had been received by the Trust during the period. She asked whether there was an explanation for this increase but was advised that there was no clearly understood reason. Mr Adler offered to confirm with Miss Dhami the likely impact of this increase in complaints on the plan to address the backlog.	
ACTION: Mr Grainger-Payne to arrange for the CQC report into complaints to be presented to the Quality and Safety Committee at its meeting in July, together with an update on the action plan to address the recommendations **ACTION: Mr Adler to confirm the impact of the increase in complaints received on the plan to address the backlog with Miss Dhami**	
9.4 Briefing on 'Listening into Action'	**SWBTB (6/11) 130** **SWBTB (6/11) 130 (a)**
Mr Adler presented an update on the progress with embedding 'Listening into Action' within the Trust. He advised that there were positive signals that the approach was being embedded well and that events around discharge planning and stroke reconfiguration had been held recently or were planned shortly. The Board was advised that nine 'Listening into Action' champions had been identified and a new easy guide to 'Listening into Action' had been developed. The Chair asked whether any of the champions had been selected from the community services areas. Mr Adler advised that he was unclear on this point.	

The Chair suggested that there was a need to ensure that the 'Listening into Action' concept is rolled out to the community services areas. Mr Adler advised that this would not be problematic, given that the community areas were already engaged with the 'Owning the Future' initiative and 'Listening into Action' had been used extensively in the transfer process. Mrs Kinghorn remarked that there were staff within the community services area who could be readily identified as 'Listening into Action' champions if needed. Mr Adler asked Mrs Kinghorn to liaise with Sally Fox, 'Listening into Action' Programme Manager, to select some 'Listening into Action' champions from the community services teams. An Organisational Development Steering Group was reported to be being established, which would be co-ordinated by Mr Sharon and would bring together the plans to continue the 'Listening into Action' approach, leadership development and the 'Owning the Future' work.	
ACTION: Mrs Kinghorn to liaise with Sally Fox to identify 'Listening into Action' champions within community services teams	
9.5 Communications and Engagement Strategy update	**SWBTB (6/11) 141** **SWBTB (6/11) 141 (a)**
Mrs Kinghorn presented an update on the progress with delivering the communications and engagement strategy and a proposal for the delivery of the next steps of the strategy which the Board was asked to support and approve. The Chair noted that the 50% turnout for the 'Owning the Future' votes compared well with Local Authority elections which tended to be lower. In connection with the televisions in place across the Trust, Mr Clarke asked how these were used to communicate information about the Trust to patients. Mr Seager advised that production costs for material to be broadcast on the televisions could be costly. He also informed the Board that according to the contractual arrangements with the supplier of televisions to patients, the Trust was not permitted to broadcast television independently. Mr Clarke clarified that he was referring to televisions in communal areas, such as Accident and Emergency Departments, not those available to inpatients at their beds. It was further highlighted that work would need to be undertaken to determine what material patients would wish to be broadcast on these televisions. In terms of the information reporting the number of times that the Trust website areas had been accessed, Mrs Kinghorn was asked to what extent this information was used to improve the website and target specific information at those accessing the sites. Mrs Kinghorn advised that quick links had been arranged for those areas of the website proving most popular. Mr White asked whether the questions asked as part of the search function were captured. He was advised that this was not the case at present. Mr Trotman commented that the recent television programme concerning the	

maternity services reconfiguration had been good publicity for the Trust. The Board was asked to note that there were currently a number of smaller strategies underpinning the overarching Communications and Engagement Strategy and it was proposed that these be rationalised as part of the refresh of the overarching strategy. Mrs Dutton asked whether the Trust had considered the use of social networking technology as part of its communications plan. Mrs Kinghorn confirmed that this had been considered, however she highlighted the difficulty with maintaining up to date posts on sites such as Twitter and Facebook. The Board was advised that the Trust was embarking on a project to establish an interactive website to enable information and advice to be provided for those individuals wishing to receive information in this way. Mrs Dutton asked whether there were plans to work with libraries as part of the Communications and Engagement Strategy. Mr O'Donoghue advised that the Rheumatology speciality was pioneering an approach with libraries, with a view to gathering information from this source. The Board was asked for and gave its support and approval to the proposed process for reviewing the Communications and Engagement Strategy, including measures such as undertaking a review of the communications and engagement team's workload and priorities, conducting a communications and engagement 'Listening into Action' event and scheduling a discussion in communications and engagement and membership strategies by the FT Programme Board or Trust Board. The Board was advised that the refreshed strategy would be presented for final sign off at the meeting of the Trust Board in December 2011.	
AGREEMENT: The Trust Board approved the proposal for renewing the Communications and Engagement Strategy	
9.6 Report from Sandwell Mental Health Foundation Trust Governor	**SWBTB (6/11) 138** **SWBTB (6/11) 138 (a)**
Miss Overfield presented annual update prepared by Assistant Director of Nursing, Debbie Talbot, an appointed Governor to Sandwell Mental Health Foundation Trust. The Trust Board received and noted the update on key activities, with which Mrs Talbot had been involved in her role as a Governor. The Chair suggested when the time was appropriate, Mrs Talbot's experience as a Governor should be discussed at a meeting of the FT Programme Board. Miss Overfield agreed to make these arrangements.	
ACTION: Miss Overfield to arrange for Mrs Debbie Talbot to attend the FT Programme Board meeting to discuss her experience as a Governor of a Foundation Trust	

9.7 Freedom of Information Requests update	**SWBTB (6/11) 131** **SWBTB (6/11) 131 (a)**
Mr Grainger-Payne presented the annual update on Freedom of Information requests received by the Trust, highlighting that 229 requests had been received during 2010/11, of which 96% had been answered within the statutory 20 working day deadline. That Chair noted the trend towards individuals making requests using a private e-mail address rather than making a request clearly on behalf of a company. Mr Grainger-Payne confirmed that this was the case and Mr White provided an example of a recent request which with some research had been submitted by an individual from a recruitment company, yet had been received from a private e-mail address. Mrs Dutton asked whether much use was made of information publicly available to answer requests. Mr Grainger-Payne advised that a publication scheme was included on the Trust website, listing all documents that were publically available and therefore did not require a Freedom of Information request to be submitted. Mrs Kinghorn advised that in some cases, simple requests for information received by the local press were handled as a media enquiry rather than being treated as a Freedom of Information request. Mr Adler highlighting that the vast majority of Freedom of Information requests had been handled within the statutory timeframe, congratulated Mr Grainger-Payne on achieving the high level of compliance with the legislation.	
10 Performance Management	
10.1 Monthly finance report	**SWBTB (6/11) 131** **SWBTB (6/11) 131 (a)**
Mr White reported that during the month a surplus of £25k had been achieved, £6k better than the planned position against the Department of Health target. Year to date however, the Trust was reported to carry a deficit of £204k, £296k worse than the planned position. It was highlighted that financial pressure lay with the pay budgets particularly, and that the Medicine & Emergency Care and Surgery, Anaesthetics & Critical Care divisions' positions were causing the greatest concern at present. Given the significant deficits reported by both divisions, the Trust Board was advised that formal recovery plans and associated action plans had been developed to address the positions. The Board was advised that additionally, other areas of the Trust were being monitored closely to ensure an adequate performance is maintained. Mr Adler advised that a special measures approach had been invoked for the Medicine and Emergency Care division. As such, a batch of actions had been developed to review the division and to recover the current position. The issue in	

the Surgery, Anaesthetics and Critical Care division was highlighted to concern mainly a forecast slippage in delivery of the area's Cost Improvement Plan (CIP), therefore plans were to be put into place to stabilise the position and recover and the slippage to date. Mr Clarke asked whether there was sufficient scrutiny of CIP delivery by divisions other that the Medicine & Emergency Care and Surgery, Anaesthetics & Critical Care divisions. Mr White advised that any slippages forecast are required to be addressed by a substitution or mitigation scheme, which are considered by the Performance Management Board and approved if deemed adequate. Mr White was asked why expenditure on agency staffing had increased. He advised that this related to some degree to the change in the VAT rules on agency staff and that there had been a high level of agency use during the month. Miss Overfield advised that the use of non-clinical agency staff was currently being reviewed. The Chair suggested that it would be useful to review agency and bank staff usage broken down into staff usage due to sickness cover and that used to support a rise in activity. Miss Overfield advised that this information was available, however was not sufficiently robust as to be meaningful. The Chair asked Mrs Hunjan when Internal Audit had last reviewed the use of bank and agency staff. She was advised that this had been undertaken in 2010. Mr Adler confirmed that the use of agency medical staff needed to be reviewed as a priority given that this represented a high proportion of agency staff expenditure. Miss Overfield advised that a robust administration and facilities bank had been established which would assist with the position to some degree. She was asked whether students were employed and the Board was advised that this was the case, particularly in IT and facilities areas. Mr White reported that greater effort needed to be placed into ensuring that the use of agency staff is clearly justifiable and that greater direction needed to be given as to when agency staff may be used. In terms of the local economy, the Chair asked what impact the regional financial position may have on the Trust. Mr White advised that the Trust's principal commissioners were not citing any issues with their financial position at present. The Board was advised however, that should a cluster decide to cross subsidise its PCTs, then this might impact on the Trust, although at present no trusts were forecasting slippage against the end of year position. Mr Crawshaw advised that at present there had been a commitment from the Black Country cluster Chief Executive that cross subsidy between PCTs would not be undertaken.	
10.2 Monthly performance monitoring report	**SWBTB (6/11) 129** **SWBTB (6/11) 129 (a)**
Mr White advised that there had been an in month improvement on performance against the rate of cancelled operations, which had dropped to 0.4%. In overall terms, the number of Delayed Transfers of Care was also noted to have dropped, although the Board was advised that there was greater pressure on the City Hospital site at present.	

In terms of performance against the stroke care targets, the Board was asked to note the positive performance against the target to ensure that 95% or more of stroke patients spend 90% or more of their stay on stroke unit. Performance against the TIA target was noted to be poor however, and therefore an action plans was reported to have been developed to assist the position. The Chair agreed that the performance against this target was a concern. Mr Adler advised that the recent investment agreed by the Strategic Investment Review Group (SIRG) would rectify the instability in this area. Mr Dodd reported that the issue had been discussed in detail at the recent meeting of the Trust Management Board at which Dr Deva Situnayake had outlined the plan for improvement in this area. The plan was reported to include in the longer term greater cover for all seven days in the week. The Chair proposed that a review of practice in other trusts may be needed. Mr Adler suggested that a specific report on plans to address performance against the stroke care targets should be presented at a future meeting of the Finance and Performance Management Committee. It was agreed that this would be a useful addition to the agenda of the next Committee meeting. The Trust Board was advised that during the previous month, performance against the Accident and Emergency waiting times target had been good, however deterioration against this was forecast for June. Mr Dodd confirmed that there had been pressure on the Emergency Departments at both sites recently, however actions were planned to address the situation at Sandwell Hospital in particular. Performance against the *C difficile* infection rate trajectory was noted to be acceptable, although the Board was asked to note that there had been an increase in the number of cases to nine within the month. The Board was advised that communications were being issued to reinforce the need to apply basic measures that minimise infection control rates. The number of breaches against the Same Sex Accommodation guidance was noted to have reduced significantly. Performance against the PDR target was reported to be slightly behind plan, although Mr White reported that this may reflect a lag between PDR5 forms being submitted and the information systems being updated to report that the PDR had been completed. Mrs Dutton asked for clarity on the position regarding mortality information. She was advised that there are plans to ensure that by March 2012, 60% of deaths are reviewed on a systematic basis. Mr O'Donoghue advised that to achieve this level of review there had been investment in new technology and that it was anticipated that a further improvement over and above the 60% target would be made following March 2012. Dr Sahota remarked that performance against the Delayed Transfers of Care and smoking cessation targets appeared to have slipped. Mr Dodd confirmed that the	

increase in the level of Delayed Transfers of Care at City Hospital would be escalated to the Local Authority, and that internal procedures would also be tightened.	
ACTION: **Mr Dodd to arrange for a report on progress with improving the performance against the stroke target to be presented at the next meeting of the Finance and Performance Management Committee**	
10.3 NHS Performance Framework monitoring report	**SWBTB (6/11) 127** **SWBTB (6/11) 127 (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 remains classified as a 'performing' organisation. It was noted that although the position was at green status, the amber alerts included in the report were reflective of the current poor performance against the Delayed Transfers of Care target.	
10.4 Draft minutes of the Finance and Performance Management Committee meeting held on 23 June 2011	**Hard copy paper**
Mr Trotman advised that the Committee had considered a report by the Sandwell Adult Community Health Services Division, which whilst it showed a satisfactory performance, did highlight differences in the treatment of certain information. The Board was advised that this discrepancy would be corrected and the performance of the division would be considered again in six months time. The Board was informed that the Committee had received an update from Atos consultancy on their current work with the Trust. Finally, the Board was advised that the Committee had considered the financial performance of the Trust, where it was noted that the news of the surplus had been coloured by the continued adverse variances in the Medicine & Emergency Care and Surgery, Anaesthetics & Critical Care divisions. Mr Trotman reported that the Committee had reviewed the recovery plans in detail and drew the Board's attention to the section of the draft minutes of the meeting which outlined these discussions. The Board was advised that the Committee had recognised that the turnaround would not happen in the short term, however it had underlined the need that speed was of the essence in dealing with the issues.	
11 Strategy and Development	
11.1 'Right Care, Right Here' programme: progress report	**SWBTB (6/11) 144** **SWBTB (6/11) 144 (a)**
Mr Sharon presented the latest 'Right Care, Right Here' programme progress report, which the Board received and noted.	

In connection with the discussion around the revised governance arrangements for the 'Right Care, Right Here' programme, the Chair suggested that a more comprehensive explanation was needed for the Board, particularly to understand the various levels of budgetary delegations. Mr Sharon offered to circulate the proposals for these arrangements as developed by the Programme Director to the Trust Board. Dr Sahota asked whether the changes to the commissioning arrangements were impacting on the relationships between the Trust and the local PCTs. Mr Sharon reported that the Trust was experiencing a degree of frustration with engaging its commissioners. Mr Adler advised that it was anticipated that the interface between the Trust and its commissioners would be simplified in the medium term. Mr Sharon added that the recent response to the Future Forum had created further discussion on the configuration of the commissioning arrangements and that there was a possibility of further changes as a consequence.	
ACTION: Mr Sharon to circulate the proposal for the revised governance arrangements for the 'Right Care, Right Here' programme	
11.2 Foundation Trust application: progress update	
Programme Director's report	**SWBTB (6/11) 140** **SWBTB (6/11) 140 (a)** **SWBTB (6/11) 140 (b)**
Mr Sharon advised that the Foundation Trust Programme Board had considered the first draft of the Integrated Business Plan (IBP) at its meeting earlier in the day. The Board was advised that the final Tripartite Formal Agreement had been agreed and it was asked to receive and note the version presented. Mr Sharon advised that the board development work and development of the first draft Integrated Business Plan (IBP) represented significant progress for the programme. Challenges with preparation of the next version of the plan due for presentation to the Strategic Health Authority in July 2011, were highlighted to include the need to reduce the length of the document and rationalise the content.	
Draft minutes from the Foundation Trust Programme Board meeting held on 26 May 2011	**SWBTB (5/11) 027**
The tabled minutes of the FT Programme Board held on 26 May 2011 were received and noted.	
11.3 Midland Metropolitan Hospital project: progress report	**SWBTB (6/11) 139** **SWBTB (6/11) 139 (a)**
Mr Seager reported that approval of the Outline Business Case (OBC) for the Midland Metropolitan Hospital remained awaited.	

The Board was advised that a 'Time Out' session for the Board was to be arranged for September to review the key procurement documentation. Mr Seager reported that a project risk register had been developed. The Board was reminded that at the earlier private session of the Trust Board there had been an extensive discussion around the plans for land acquisition and it had been agreed to implement the General Vesting Declaration and to support the movement of businesses off the site in a structured and timely way.	
12 Any other business	
Mr Adler advised that further to earlier conversations by the Board around the involvement of patients in the incident reporting process, initial discussions had been held and it had been agreed that it would be inappropriate to invite patients to table top reviews for a variety of reasons (not least the need for maximum openness on the part of staff present). It was acknowledged that the patient's perspective was important however and therefore the new incident management process would be development in cognisance of this requirement.	
13 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 28 July 2011 and would be held in the Anne Gibson Boardroom at City Hospital.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 28 July 2011, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

30 June 2011, Churchvale/Hollyoak Rooms@ Sandwell Hospital

Members present: Mrs S Davis (SD), Mr R Trotman (RT), Dr S Sahota (SS), Mrs G Hunjan (GH), Prof D Alderson (DA), Mr G Clarke (GC), Mrs O Dutton (OD), 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), Mrs J Kinghorn (JK)

Apologies: Miss K Dhami (KD)

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 15 July 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	25/08/11	Progress to be reported at August meeting of Trust Board	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		G
SWBTBACT.202	Update on complaints handling	Hard copy paper	30-Jun-11	Arrange for the CQC report into complaints a to be presented to the Quality and Safety Committee at its meeting in July, together with an update on the action plan to address the recommendations	SG-P	21/07/11	Included as a standard agenda item on the agenda of the Quality and safety Committee	B
SWBTBACT.203	Update on complaints handling	Hard copy paper	30-Jun-11	Confirm the impact of the increase in complaints on the plan to address the backlog	JA	28/07/11	To be discussed as part of the update on complaints handling	B
SWBTBACT.204	Briefing on 'Listening into Action'	SWBTB (6/11) 130 SWBTB (6/11) 130 (a)	30-Jun-11	Liaise with Sally Fox to identify 'Listening into Action' champions within community services teams	JK	28/07/11	Discussed and agreed at the recent LiA Sponsor Group meeting	B
SWBTBACT.205	Report from Sandwell Mental Health NHS FT Governor	SWBTB (6/11) 138 SWBTB (6/11) 138 (a)	30-Jun-11	Arrange for Mrs Debbie Talbot to attend the FT Programme Board meeting to discuss her experience as a Governor of a Foundation Trust	RO	30/09/11	Arranged for September meeting of FT programme Board	B

SWBTBACT.206	Monthly performance monitoring report	SWBTB (6/11) 129 SWBTB (6/11) 129 (a)	30-Jun-11	Arrange for a report on progress with improving the performance against the stroke target to be presented at the next meeting of the Finance and Performance Management Committee	MD	21/07/11	Presented at TMB and Finance and Performance Management Committee meetings in July 2011	B
SWBTBACT.207	Right Care, Right Here' programme: progress report	SWBTB (6/11) 144 SWBTB (6/11) 144 (a)	30-Jun-11	Circulate the proposal for revised governance arrangements for the 'Right Care, Right Here' programme	MS	28/07/11	Circulated as requested	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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Application for a Capital investment Loan
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Tony Wharram, Deputy Director of Finance
DATE OF MEETING:	28 July 2011

SUMMARY OF KEY POINTS:

The paper request approval of the application for a capital investment loan for a period of 4 years to be drawn down in September 2011. This loan featured as part of the original business case and is therefore in accordance with anticipated cashflows. The CRL (capital resource limit) has been reserved by the West Midlands Strategic Health Authority.

The proposal was presented to and supported by the Finance and Performance Management Committee at its meeting on 21 July.

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 accept the Finance and Performance Management Committee's recommendation that the application for a capital investment loan for a period of 4 years be formally presented to the SHA.

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	**X**	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. Cash repayment requirements.

PREVIOUS CONSIDERATION:

Finance and Performance Management Committee on 21 July 2011.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

REPORT OF THE DIRECTOR OF FINANCE AND PERFORMANCE MANAGEMENT TO THE TRUST BOARD

Thursday 28th July 2011

APPLICATION FOR A CAPITAL INVESTMENT LOAN

1. Introduction

As part of its approved capital programme for 2011/12, the Trust included the purchase of a significant proportion of the land in Grove Lane required for the development of the Midland Metropolitan Hospital. As part of the approved capital programme for the year of £24.1m, a DoH loan of £8m was included as a source of funding for the land purchase.

2. Loan Application Process

A standardised loan application process for Capital Investment Loans is operated by the Department of Health and, on its behalf, the West Midlands Strategic Health Authority.

This process includes the submission of a business case for the approval of the loan which contains details of the purpose and period of the loan and provides supporting information on the Trust's ability to make repayments and incur interest charges. The existing business case was submitted to the StHA on 7th July 2011. This is accompanied by a calculation of the Trust's Prudential Borrowing Limit which, based on a series of financial performance measures, determines the amount the Trust will be allowed to borrow. This varies with the amount and time period of the loan required. Based on the details of the current application, Sandwell & West Birmingham Hospitals has a PBL of £26.9m in addition to existing borrowing (outstanding PFI and finance lease liabilities).

In order for the loan to be approved by the DoH, the approval of the Trust Board of the loan application is required.

By 17th August, the DoH will give their decision on approval in principle to the loan.

3. Loan Terms

The application is for a loan of £8m to be drawn down in September 2011, repayable in eight equal instalments over four years (each September and March). Interest is payable annually in March on a reducing balance basis at an interest rate to be determined at the time the loan is drawn down (on an

indicative basis, the current rate for a 5 year loan is 1.4% with a 4 year loan likely to be slightly lower).

4. Recommendation

The Trust Board is requested to:

> accept the Finance and Performance Management Committee's recommendation that the application for a capital investment loan for a period of 4 years be formally presented to the SHA.

Robert White
Director of Finance and Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Sustainable Development Management Plan Update
SPONSORING DIRECTOR:	Graham Seager, Director of Estates/New Hospital Project
AUTHOR:	Rob Banks, Head of Estates
DATE OF MEETING:	19 July 2011

SUMMARY OF KEY POINTS:

The purpose of this paper is to update the Trust Board on progress with regards to sustainability and to seek approval on the Sustainability and Environmental Policy.

KEY POINTS:

- Sustainability Champions - Uptake and training
- Carbon Management Plan
- Sustainability Event – 13th October 2011
- Sustainability and Environmental Policy – Submitted to Trust Management Board for review and approval gained (July 2011). In accordance with the 'Policy on Policies' it is now presented for ratification by the Trust Board
- Good Corporate Citizen – Submitted online with improvements across most areas (July 2011)

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

Approval	Receipt and Noting	Discussion
X	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to:

- RECEIVE AND NOTE the current progress in relation to Sustainability Champions, Carbon Management Plan, Sustainability Event, Good Corporate Citizen; and
- APPROVE the Sustainability and Environmental Policy.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Improve the environmental sustainability of the Trust's operations by responding to the national carbon reduction strategy
Annual priorities	Cost Improvement Programme Carbon Reduction Programme European Emissions Trading Scheme (EU ETS) Carbon Reduction Commitment (CRC)
NHS LA standards	
CQC Essential Standards Quality and Safety	Regulation 11
Auditors' Local Evaluation	Standard 2.3.4 – Trust can demonstrate commitment to sustainability

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

Financial	x	Potential for cost efficiencies through sustainability projects as developed through Carbon Management Plan, Sustainability Event and Sustainability Champions (increased awareness)
Business and market share		
Clinical		
Workforce	X	Promotion and link to Health and Wellbeing projects Potential for reduction in staff sickness levels Training for Sustainability Champions
Environmental	X	Reduction in SWBH carbon emissions baseline
Legal & Policy	X	Compliance with Climate Change Bill 2008 Good Corporate Citizen targets Carbon Reduction Commitment (CRC) European Emissions Trading Scheme (EU ETS) Sustainability and Environment Policy
Equality and Diversity		
Patient Experience	X	Provide patients with options for public transport
Communications & Media		
Risks		Non compliance with : Climate Change Bill 2008 Good Corporate Citizen Staff morale and engagement Carbon emission reductions affected Missed cost saving and efficiency opportunities Potential Increase in CRC allowances

PREVIOUS CONSIDERATION:

Sustainability Working Group (SWG) and the policy was considered and approved by the Trust Management Board on 19 July 2011.

Sustainability Update

Trust Board – 28 July 2011

Introduction

The purpose of this report is to update the Trust Board on progress to date with implementing the Trust's sustainability agenda and to seek approval of the Sustainability and Environment Policy.

Sustainability Champions

The number of Sustainability Champions has increased from 46 to 62 since April 2011 through a drive in internal communications (including regular updates, sustainability staff questionnaire), presentation at divisional managers meetings, and the offering of training programmes.

The Trust offers Sustainability Champions the opportunity to undertake a Level 2 Certificate in Developing Environmental Management. Six of the Sustainability Champions have passed this course, with a further twelve booked onto the training in August 2012. Two of the Sustainability Champions are currently undertaking a NEBOSH National Certificate in Environmental Management.

Carbon Management Plan (CMP)

The Trust has started work on the Carbon Management Plan to deliver savings of approx 15% of the 2008/09 baseline (22,184 tonnes of Carbon).

Key updates to date are:

- Development of local Sustainability Champion network and distribution of information (as above)
- Procurement of IT power save which is being rolled out across the Trust
- Link to Health & Well Being (cycling, walking, etc)
- Partnership and best practice collaboration with external organisations (Sandwell PCT, Hommerton University Hospital NHS Trust, University Hospital North Staffordshire NHS Trust, Wolverhampton University)
- Sustainability event planned for October 2011 (see below)
- Sustainability and Environment Policy in review (see below)
- Submission of Good Corporate Citizen report

Sustainability Event

The Estates department are organising an event for 13th October 2011 to celebrate the launch of the Carbon Management Plan and all associated strategies. The aim of this event is to gain further support across the organisation and demonstrate the successes we have achieved to date. Links with external stakeholders have been organised to provide information for attendees on energy, Cycle Scheme, cycling and health and fitness.

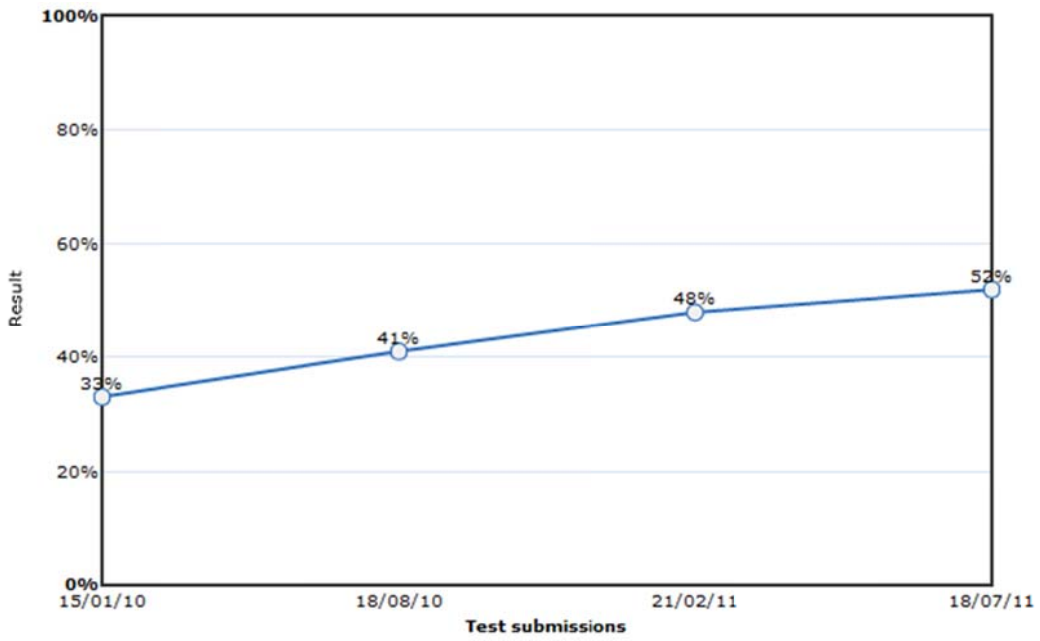
Sustainability and Environment Policy

A Sustainability and Environment Policy has been developed to co-ordinate all works being undertaken by SWBH in terms of Carbon Reduction, Carbon Management and Environmental Management. The aim is that this policy will further engage staff, emphasise the importance of sustainability and embed sustainable working practices across the organisation. The policy was reviewed by the Trust Management Board 20 July 2011 and approved and is now presented to the Trust Board as one of the small number of Trustwide policies requiring approval by this body in accordance with the Policy on the Development, Approval and Management of Policies. The policy has been linked to the Trust Carbon Management Programme and Carbon Reduction Commitment Strategy.

Good Corporate Citizen

The Good Corporate Citizen self-assessment was completed in July 2011, with improvements across most areas (see figure 1 below for progress tracker).

Figure 1: Good Corporate Citizen progress since January 2010 based on total average scores



Next Steps

- Promotion of Sustainability Champions (uptake and training opportunities), Carbon Management Plan, Sustainability and Environment Policy (once approved), and Sustainability Event (October 2011) to staff

Recommendations

The Trust Board is asked to:

- NOTE the current progress in relation to Sustainability Champions, Carbon Management Plan, Sustainability Event, and Good Corporate Citizen
- APPROVE for the Sustainability and Environment Policy
- SUPPORT the Sustainability event through attendance and promotion through staff comms / team brief and 'Hot Topics'

Rob Banks
Head of Estates

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SUSTAINABILITY AND ENVIRONMENT POLICY

Reference	*Assigned by Trust policy co-ordinator*
Category	*Assigned by Trust policy co-ordinator*
Date Approved	DD-MM-YYYY
Date of Next Review	DD-MM-YYYY

POLICY PROFILE	
Overview	
Key overall purpose of policy	*To inform Trust of action and responsibilities relating to Sustainability for the organisation*
Principal target audience	*Staff, Patients, Visitors, Contractors and external stakeholders*
Application	
Accountable Executive Director	*Graham Seager*
Author(s)	*Rob Banks / Steve Lawley / Fran Higginson*
Impact Assessment	
Resource implications	*Investment for Carbon Reduction Projects as defined in Carbon Management Programme/Carbon Reduction Commitment Strategy*
Training implications	*Staff to be informed of all policy locations at Trust induction, Investment in staff for knowledge on Sustainability to support role as champion*
Communications implications	*Regular staff communications using all media Annual/bi-annual Trust event*
Date of initial equality impact assessment	*9th June 2011*
Date of full equality impact assessment (if appropriate)	*Not Applicable*
NHSLA risk management standards/ CQC core standards	*CQC Regulation 15 – Outcome 10 Premises Assurance Model- Effectiveness*
Consultation and referencing	
Key stakeholders consulted/involved in the development of the policy	*Sustainability Champions, Sustainability Working Group, Estates, Facilities, and Health, Safety and Welfare Committee*
Complementary Trust documents for cross reference	*Carbon Management Programme, Carbon Reduction Commitment Strategy, European Union Emissions Trading Scheme Submission, Estates Maintenance Policy*
Approvals and monitoring	
Approving body	
Date of implementation	
Monitoring and audit	

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

SUSTAINABILITY AND ENVIRONMENT POLICY

Contents

1 Introduction

1.1 Introduction

Sustainability, in terms of sustainable development, is making sure that we meet the needs of today, without compromising the ability of future generations to meet needs of their own. This means stabilising, and then reducing, our impact on the environment (including reducing our carbon emissions) is essential in ensuring we live within environmental limits.

1.2 Purpose

The purpose of this policy is to set the vision for Sandwell and West Birmingham Hospitals (SWBH) NHS Trust to play a leading and innovative role at a regional and local level with regards to the environment and sustainability. Implementing a high standard of sustainable development based on the principles of Good Corporate Citizenship, the Carbon Management Plan (CMP) and the Carbon Reduction Commitment (CRC) will ensure that we move towards a low carbon organisation. This will have a positive impact on health, expenditure, and efficiency of the organisation.

For more information, see the Trust's CMP and CRC Strategy.

1.3 Scope

This policy document applies to all activities, processes and services that SWBH Trust has responsibility for or influence over.

The policy applies to all relevant stakeholders to the Trust including, but is not limited to staff, patients, visitors, local community, suppliers and contractors.

2 Objectives

We will reduce our environmental impact and implement sustainable practices throughout the Trust by committing to:

- Work towards, comply with, or exceed (where practicable) all applicable legislation, regulations and codes of practice relating to sustainability, whilst also identifying any shortfalls through the Trust Risk Register and identifying necessary investment (see references for a list of legislations that we comply with)
- Integrate sustainability and environmental considerations into all business decisions
- Ensure that all staff, contractors, suppliers and stakeholders are fully aware of the Trust's Sustainability and Environment Policy and are committed to implementing it, whilst working with clients to promote and develop sustainable outcomes
- Develop and implement a management system to help effectively manage our environmental impacts through assessment, management and control of environmental risks

- Reduce, reuse and recycle waste where possible and to dispose of all other waste responsibly, whilst working to targets as defined in our CMP
- Measure and reduce our use of resources in accordance with our CMP (including water and energy) and procure 'sustainable' goods
- Develop and implement a sustainable travel plan to reduce the impact of car travel, whilst also promoting healthy alternatives through links with the Trust's health and wellbeing department
- Report on sustainability performance and achievements
- Ensure that all Trust Management Board members are committed to delivering sustainability

3. Definitions

Term	Definition
Carbon Footprint	A carbon footprint is a measure of the impact our activities have on the environment, and in particular climate change. It relates to the amount of greenhouse gases produced in our day-to-day lives through burning fossil fuels for electricity, heating and transportation etc.
Carbon Management Plan (CMP)	The aim of this plan is to achieve a reduction in carbon emissions and to embed carbon management into the culture of the organisation. It sets out our response to the different drivers for change and will act as a routemap for achieving our carbon reduction targets.
Carbon Reduction Commitment (CRC) Energy Efficiency Scheme	The CRC is a mandatory, carbon emissions trading scheme that aims to improve energy efficiency and reduce the amount of carbon dioxide (CO_2) emitted in the UK. This is considered to be a vital component in achieving the UK's overall targets of reducing greenhouse gas emissions by at least 80% compared to the 1990 baseline by 2050. SWBH Trust is legally bound to this scheme.
Climate Change	Climate change refers to changes in the earth's temperature over the last 100 years.
Climate Change Act 2008	The Climate Change Act 2008 is a legally binding long-term framework to cut carbon emissions, creating a framework for building the UK's ability to adapt to climate change
Environmental Management System (EMS)	The management of an organisation's environmental programs in a comprehensive, systematic, planned and documented manner
European Union Emissions Trading Scheme (EU ETS)	The EU ETS is the largest multi-national emissions trading scheme in the world and is one of the key policies introduced to meet the greenhouse gas emissions targets of 8% below 1990 levels under the Kyoto Protocol. Under this scheme, large emitters of CO_2 within the EU must monitor and annually report their emissions. Each year, they must then return the amount of emissions allowances to the government that is equivalent to their CO_2 emissions in that year.
Good Corporate Citizen	Good Corporate Citizenship describes how NHS organisations can embrace sustainable development and tackle health inequalities through their day-to-day activities.
Sustainability / Sustainable Development	The goal of sustainable development is to meet the needs of today, without compromising the ability of future generations to meet their needs

4. Roles and Responsibilities

4.1 Trust Management Board

The Trust Management Board is corporately responsible for the management and implementation of the policy.

4.2 Chief Executive

The Chief Executive will have overall responsibility for the delivery of the policy.

4.3 Director of Estates and the New Hospital Project

The Director has Trust Management Board level responsibility for co-ordinating the Trust's approach to the policy and reporting progress to the Trust Management Board.

4.4 Head of Estates

The Head of Estates has delegated responsibility for leading, facilitating and ensuring that this policy is being implemented. He/she is also responsible for ensuring that the relevant legislation is being addressed within the Trust and for co-ordinating Trust-wide sustainable management policies and activities.

4.5 Compliance Manager/Deputy Heads of Estates

The Compliance Manager and Deputy Heads of Estates will assist the Head of Estates in delivery of the policy and will be responsible for monitoring emissions and identifying and implementing reduction measures.

4.6 Chief Operating Officer and Divisional Managers

These senior managers will be responsible for ensuring that sustainable management is communicated, implemented, monitored and reviewed within their areas of responsibility. They will see that systems are set up to ensure the management and communication of the policy is in place. They will provide adequate resources and time to those who have been delegated to assist in its implementation (e.g. Sustainability Champions).

4.7 Sustainability Officer

The Sustainability Officer will be the person primarily responsible for delivering this policy. Amongst their many roles, they will be responsible for raising awareness of sustainability within the Trust. The Sustainability Officer will also be responsible for identifying projects that are aligned with the Trust's sustainability agenda, facilitating with their implementation and monitoring to minimise the environmental impact.

4.8 Sustainability Working Group (SWG)

The SWG will co-ordinate the implementation of the Sustainability Action Plan and report to the Trust Management Board quarterly on progress. The SWG will set

the guiding principles for implementing the policy and identify and promote good practice throughout the Trust.

4.9 Budget Holders

All budget holders should consider the sustainability implications of their purchasing decisions. The detail of the consideration should be proportionate to the magnitude of the purchasing decision being made and the availability of sustainability /carbon footprint information.

4.10 Employees

All employees (including temporary, community, part-time and agency staff) have a duty to adhere to this Policy. In addition, they have a responsibility to:

- Co-operate with their manager in the implementation, monitoring and reviewing of this policy
- Communicate and co-operate with others on Trust premises regarding sustainability management issues
- Adhere to the Trust's sustainability 'top tips'

4.11 Contractors

The Trust Manager letting and supervising the contract will ensure that:

- Contractors are made aware of the Trust Sustainability and Environment Policy
- Use energy, water and materials in an efficient way
- Segregate waste and dispose of waste responsibly

4.12 Sustainability Champions

Sustainability champions will:

- Promote sustainability guidance in local work areas (e.g. through team meetings)
- Act as point of contact to departmental staff to link to and support sustainability officer in embedding actions
- Attend the quarterly sustainability champions update meetings
- Review and distribute communications in local area

For more information on the role of the Trust's sustainability champions, click here.

4.13 Ward/Department Manager

The Ward / Department Manager will ensure that:

- A sustainability champion is appointed for their area. Also ensure that time is allocated for sustainability champions attendance to the quarterly meetings or for training required to support the role
- Sustainability, environmental and related policies are adhered to and staff are aware of these
- Ensure that sustainability forms part of any local quality initiatives

5. Sustainability and Environmental Objectives

5.1 Policy statement

SWBH NHS Trust recognises that climate change represents a significant threat to health and that, in the delivery of its service, there are unavoidable environmental impacts. The Trust is therefore committed to mitigate this impact and demonstrate good corporate citizenship by reducing our carbon dioxide emissions 80% below the 1990 levels, by 2050. This will be achieved through our CMP and CRC strategy, and will include energy, water, transport, waste and procurement.

5.2 Governance

For the Trust to continue to operate and prosper, sustainability has to be integrated into the essence of what our health services are about: providing quality and cost effective healthcare for the local population.

The Trust will therefore incorporate sustainability and the environment into the management and operational structure of the organisation so that it becomes integrated into all functions. For more information, please see our Trust Management Board papers (available upon request).

5.3 Carbon management

The management of carbon emissions across the Trust will save resources now, improve health today and help to deliver high quality and sustainable services for the future.

The Trust is committed to operating in an energy efficient way to continually reduce carbon emissions, resources, consumption and costs. The Trust adheres to CRC (see the Trust's CRC Strategy), European Union Emissions Trading Scheme (EU ETS) and the Climate Change Act to work towards goals. For more information on the Trust's carbon emissions targets, see the CMP.

5.4 Procurement

Procurement constitutes a large portion of the Trust's carbon footprint, from the energy used to manufacture and deliver goods and the waste from packaging and disposal.

The Trust will ensure that the goods, works and services we commission or purchase are manufactured, delivered, used and managed to include the whole life cycle process so that products and services are sourced in a safe, socially and environmentally responsible manner and in accordance with the Department of Health guidance on sustainable procurement (Scope 2).

Note: Procurement is not currently a measured baseline. This will be included once greater information is available from key suppliers, such as Supply Chain and Buying Solutions.

5.5 Travel and transport

The Trust is dependant on transport systems for many of its functions and it will remain a necessary part of the access to and delivery of healthcare provision for the foreseeable future.

The Trust will reduce the environmental impact of travel associated with our activities, particularly through vehicle emissions, fuel consumption and our impact on local congestion through our Travel Plans (see City Hospital Travel Plan and Sandwell Hospital Travel Plan), Action Plan and CMP.

5.6 Water

The Trust will monitor and reduce our water consumption in accordance with water regulations, targets and actions as defined in our CMP.

5.7 Waste (clinical and non-clinical)

The Trust will minimise the production of waste through good purchasing practice, reuse and economic recycling as defined in the SWBH Trust Waste Management Policy and is working towards targets and actions as identified in our CMP.

5.8 Designing the built environment

A large proportion of the Trust's carbon emissions come from the use of fossil fuels to heat, light and ventilate the buildings. Every effort will be taken to ensure that new buildings are constructed sustainably and that renovations employ the highest possible standards available (e.g. BREEAM Excellent).

The Trust will design the built environment to encourage sustainable development and low carbon usage in every aspect of their fabric and function.

5.9 People

Everyone involved in the Trust - staff, patients, visitors, suppliers, and contractors - will have an impact on the energy, waste and transport requirements and so each person has a role to play in ensuring that this is kept to a minimum.

The Trust will raise awareness by informing and motivating people at all levels, so that sustainability is communicated and integrated throughout the organisation.

5.10 External stakeholders

The Trust will develop strong partnerships to promote the changes required for a more sustainable society (e.g. other public authorities and Trust governors).

6. Equality

The Trust recognises the diversity of the local community and those in its employment. Our aim is, therefore, to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and

appropriately to their need. The Trust recognises that equality impacts on all aspects of its day-to-day operations and has produced and Equality Policy Statement to reflect this. All policies are assessed in accordance with the SWBH Equality Impact Assessment Toolkit, the results for which are monitored centrally.

7. Training and Awareness

The Trust will raise awareness by informing and motivating people at all levels, so that the environment and sustainability are communicated and integrated throughout the organisation.

8. Key Performance Indicators/Monitoring Effectiveness

This policy will be reviewed in three years time by the authors and Sustainability Working Group. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation of guidance.

Trust Management Board reports will be submitted quarterly on progress with an annual update

9. Discipline

Breaches of this policy will be investigated and may result in the matter being treated as a disciplinary offence under the Trust's disciplinary procedure.

10. References

Saving Carbon, Improving Health	NHS Sustainable Development Unit
HTM 07-02 EnCO2de	Department of Health
Procure for Carbon Reduction (Scope 2)	Department of Health
Good Corporate Citizen	Sustainability Development Commission
Climate Change Act 2008	HM Government
Carbon Management Plan (CMP)	SWBH Trust
Carbon Reduction Commitment (CRC)	Environment Agency
European Union Emissions Trading Scheme (EU ETS)	Environment Agency
SWBH Trust Waste Management Policy	SWBH Trust
Sustainability Action Plan	SWBH Trust

11. Further enquiries

For further information and guidance regarding this policy please contact the Director of Estates.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

POLICY IMPLEMENTATION PLAN

POLICY TITLE:	Sustainability and Environment Policy
ACCOUNTABLE DIRECTOR:	Graham Seager
POLICY AUTHOR:	Steve Lawley / Francesca Higginson
APPROVED BY:	Trust Board
DATE OF APPROVAL:	28 July 2011

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

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

IMPLEMENTATION PLAN OWNER: Steve Lawley / Francesca Higginson

KEY ACTIVITY	RESPONSIBLE	PLANNED COMPLETION DATE	EVIDENCE AVAILABLE
Communications and engagement			
Communications plan included in Trust approved Carbon Management Plan which included a launch event to promote all work on Sustainability	SL/FH	October 2011	
Promotion of policy through Trust Champion network and via Sustainability Working Group	SL/FH	August 2011	
Continued use of internal media to promote success of Sustainability and use of case studies	SL/FH	Ongoing	
Links to PCT and other external agencies such as Local Authority to provide and share best practice	SL/FH	Ongoing	
Training			
Develop opportunity to be part of Trust Induction to promote policy	SL/FH	Jan 12	
Continue staff development through providing Level 2 qualification to Sustainability Champions	SL /FH	Ongoing	
Provide opportunity for further formal qualifications in Sustainability to enhance corporate knowledge at various levels	SL/FH	Ongoing	
Resources			
Funding through SIRG for capital invest to save projects as defined in Carbon Management Programme and Carbon Reduction Committment Strategy (£500k approved for 2011/12)	RB/SL/FH	April 2014	
Time for Champions to attend meetings and training to be updated on Trust outcomes and goals going	Local Managers	Ongoing	

KEY ACTIVITY	RESPONSIBLE	PLANNED COMPLETION DATE	EVIDENCE AVAILABLE
forward			
Monitoring Effectiveness and Evaluation			
Quarterly Reports to Trust Board	RB/GS	Ongoing	
Management of Corporate Carbon Data to evaluate and inform of position against targets for CRC and CMP	SL/FH	Ongoing	
Monthly Sustainability Working Group	GS/RB		

Final date when plan is expected to be fully implemented: April 2014

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	CQC Dignity and Nutrition Reports
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Rachel Overfield, Chief Nurse
DATE OF MEETING:	28 July 2011

SUMMARY OF KEY POINTS:

The Care Quality Commission (CQC) has undertaken Dignity and Nutrition visits to 100 trusts in response to public concerns about basic levels of care.

Sandwell Hospital was visited on 28th March and City Hospital on 4th May 2011. The reports detailing the findings of the visits are attached. Two wards were visited on each site and most of the significant concerns centred around one ward at Sandwell.

Sandwell - Moderate concerns Privacy and Dignity
- Major concerns Nutrition/hydration

City - Fully compliant Privacy and Dignity
- Minor concerns nutrition/hydration (compliant)

Attached are the action plans for the Trust in response to the reports that have been submitted to the CQC.

Newton 4 has also been put into special measures in response to issues identified as part of the visit and also internal concerns.

A Privacy, Dignity and Nutrition Task and Finish Group has been established to drive through the actions ahead of further unannounced visits.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to note the contents of the attached reports and to approve the action plans attached.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

The Governance Board has been previously verbally appraised of the outcome of the visits.

The action plans and reports were reviewed by the Quality and Safety Committee at its meeting on 21 July 2011.

Dignity and nutrition for older people

Review of compliance

Sandwell and West Birmingham Hospitals NHS Trust **Sandwell General Hospital**	
Region:	West Midlands.
Location address:	Sandwell General Hospital Lyndon West Bromwich West Midlands B71 4HJ
Type of service:	Acute Services
Publication date:	July 2011
Overview of the service:	Sandwell General Hospital is part of Sandwell and West Birmingham Hospitals NHS Trust. It is a busy acute hospital with 470 beds. The Office of National Statistics information shows that Sandwell General Hospital serves a population of around 290,000.

	Sandwell General Hospital provides many specialist services including maternity and accident and emergency provision.

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

What we found overall

We found that Sandwell General Hospital was not meeting either of the essential standards we reviewed. Improvements are needed.

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

Why we carried out this review

This review was part of a targeted inspection programme in acute (National Health Service) NHS hospitals to assess how well older people are treated during their hospital stay. In particular, we focused on whether they were treated with dignity and respect and whether their nutritional needs were met.

How we carried out this review

We reviewed all the information we held about this provider, carried out a visit on 28 March 2011 which involved two wards priory 4 and Newton 4, observed how people were being cared for, talked with patients, talked with staff, checked the provider's records and looked at patients' records.

The inspection teams were led by CQC inspectors joined by a practising, experienced nurse. The inspection team also included an 'expert by experience' – a person who has experience of using services (either first hand or as a carer) and who can provide the patient perspective.

What people told us

Patients we spoke with gave mixed views about their experiences of care and treatment. A number stated that they were kept informed and were involved in making decisions about treatment. Some patients told us that they had their care needs met and had been treated respectfully. One patient told us that their experience could not have been better. They described one ward as being 'marvellous'. They said; "Staff come and talk to you, have time and give you a hug if you are feeling down". Other comments made by patients were; "Not really listened to. Some staff just seem to do their own thing regardless of what I say". Staff can be gruff and miserable. Doctors talk down to you. Nursing staff are rushed when caring because there are not enough". One patient told us; "not very nice" being placed in a bay, on a ward with patients of opposite gender.

'NHS choices' is a NHS national and local information giving website which also enables people to make comments about NHS services they have received. There were six positive comments submitted to NHS choices between March 2010 and January 2011 for Sandwell and West Birmingham Hospitals NHS Trust (the trust) overall. These detailed encounters with attentive, caring staff who treated patients with respect. There were also six negative comments three of which made reference to rude or disrespectful behaviour by some staff.

Some patients we spoke with were happy about their experiences of mealtimes. They commented that there was a good choice of food. However, some were not happy with the quality of food provided and felt that it could be improved. A patient commented "give you menu food, horrible. Good food wasted. I feel sorry for those who have to be fed".

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

Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

A number of patients feel positive about their experiences of care and treatment at Sandwell General Hospital. They stated that they were kept informed and were involved in making decisions. Others commented that they were not listened to and gave examples of how their dignity and privacy needs were not met.

Our observations and evidence from records showed that people do not always receive the information they require and do not have sufficient attention to ensure their privacy and dignity. Our observations on the second ward particularly, highlighted that patients privacy and dignity needs are not being met.

Overall we found that Sandwell General Hospital is not meeting this essential standard and improvements are needed.

- Overall, we found that improvements were needed for this essential standard.

Outcome 5: Food and drink should meet people's individual dietary needs

Sandwell General Hospital is not ensuring that all patients receive a full and thorough assessment of their nutritional requirements or that nutritional needs are addressed and regularly reviewed. Systems in place to support patients who are at risk from malnutrition and dehydration are not being used on all wards. Adherence with protected mealtimes is not being practiced resulting in interruptions and unnecessary noise levels whilst people are trying to eat.
Patients had mixed views about the quality of food. Observations showed that food availability is limited after tea time and special diets not always available at the specified mealtimes.
Recording of patients' food and fluid intake is patchy to the extent that these records could not be used as a tool to determine if patients had eaten enough or if they had drunk enough to prevent dehydration.
Observations showed that staff supporting patients to eat, were caring and attentive but there were not enough staff available for the number of people who needed this support.

- Overall, we found that improvements were needed for this essential standard.

Action we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns, we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

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

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

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

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

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

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

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

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

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

Outcome 1:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are moderate concerns

with outcome 1: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us

We spoke to nine patients, eleven members of staff and observed the care given to people during our visit to the hospital. We also used information provided by patients on NHS choices web site and Patient Environmental Action Team (PEAT) assessment and patient survey results. (PEAT undertakes annual assessments of inpatient healthcare sites in England).

Patients we spoke with gave mixed views about their experiences of care and treatment. A number stated that they were kept informed and were involved in making decisions about treatment. Some patients told us that they had their care needs met and had been treated respectfully. One patient told us that their experience could not have been better. They described the ward as being ‘marvellous’. They said; “Staff come and talk to you, have time and give you a hug if you are feeling down”. Other comments made by patients were; “Not really listened

to. Some staff just seem to do their own thing regardless of what I say". Staff can be gruff and miserable. Doctors talk down to you. Nursing staff are rushed when caring because there are not enough". One patient told us; "not very nice" being placed in a bay, on a ward with patients of opposite gender a third patient commented".

Other evidence

The information we held about Sandwell General Hospital prior to our visit showed that there was a low risk that they were not meeting this standard.

The trust has a procedure on patient privacy and dignity. Staff we spoke with confirmed that they had attended annual mandatory privacy and dignity training.

During our visit to Sandwell General Hospital staff outlined that they try to involve patients and their relatives in decision making about their care. A number of patients told us that they were treated with respect by staff and involved in decision making about their care whilst other patients felt that they were not listened to.

Our observations on the first ward showed that staff did treat patients with respect in the way that they spoke to them. However, the second ward we went onto was extremely busy resulting in insufficient attention being given to patients and minimal interaction between staff and patients. On the first ward we observed that call bells were within easy reach and were mostly answered promptly. On the second ward call bells were audible but staff were slow to respond.

All staff we spoke with highlighted the importance of closing curtains around the bed when undertaking personal care tasks and examinations to promote privacy and dignity. In most cases we saw that this was done, but not all.
We observed times when patients' privacy and dignity was not maintained. We saw a staff member taking a female patient to the toilet. The patient's clothing was above their knees and exposed their underwear. The staff member assisted them to the toilet in full view of other patients on the ward, only closing the door when they left the toilet room. We also observed two male patients lying on their beds wearing hospital gowns which did not cover them adequately. This resulted in one man's genitals being exposed and the other's incontinence pad being visible.

The trust's annual public declaration on "same sex accommodation" states that Sandwell General Hospital is compliant with this standard. On both wards we observed patients in side rooms in bays allocated to the opposite gender. On the second ward a patient told us that their experience was "not very nice" as the night before they had been put in a bay on a ward where the rest of the patients were of the opposite gender.

Our judgement

A number of patients feel positive about their experiences of care and treatment at Sandwell General Hospital. They stated that they were kept informed and were involved in making decisions. Others commented that they were not listened to and

gave examples of how their dignity and privacy needs were not met.

Our observations and evidence from records showed that people do not always receive the information they require and do not have sufficient attention to ensure their privacy and dignity. Our observations on the second ward particularly, highlighted that patients privacy and dignity needs are not being met.

Overall we found that Sandwell General Hospital is not meeting this essential standard and improvements are needed.

Outcome 5:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are major concerns

with outcome 5: Meeting nutritional needs

Our findings

What people who use the service experienced and told us

Some patients were happy about their experiences of mealtimes. They commented that there was a good choice of food. However, some were not happy with the quality of food provided and felt that it could be improved. A patient commented “give you menu food, horrible. Good food wasted. I feel sorry for those who have to be fed”.

Other evidence

Some information we held about Sandwell General Hospital prior to our visit showed that there was a risk that they were not meeting this standard.

The PEAT survey for Sandwell General Hospital scored ‘much better than expected’ for food, menu, choice, availability, quality, quantity, temperatures, presentation, service and beverages. However, a proportion of the adult inpatient surveyed across the trust rated the hospital food as poor which had been scored as better than expected. The proportion of respondents across the trust who stated that they did not get enough help from staff to eat their meals was scored as ‘Worse than expected’.

The trust has a process in place to determine patients medical, dietary and hydration requirements. A review of patients' case notes showed that a majority of these had not received a thorough nutritional assessment and for those who had been identified as being at risk, care, goal and action planning was inadequate. Although dieticians visit the wards regularly, records and our observations showed that their instructions are not always followed.

Sandwell General Hospital uses a red tray and blue beaker system to identify patients who require support to eat and drink. Our observations and interviews with staff on the second ward showed that this is not working. Staff were not able to confirm how many patients required red trays and there were no blue beakers at all available on one ward. Staff confirmed to us that they had never been any blue beakers on the ward although there are a number of people who should have them.

We asked a member of staff on one ward how they monitor those people considered to be at risk of dehydration, we were told "we take a daily blood test to confirm this". We asked the staff member about other methods of recording or monitoring fluid intake for people, we were told "only if they have a catheter or are on IV (intravenous) fluids".

On the first ward we observed enough staff to support patients to eat. On the second ward although we did observe staff supporting patients to eat and this was done in a caring way there were not enough staff to support all the patients who needed assistance. Staff told us that this was not an unusual situation. One said; "Sometimes I am the only staff member to feed on the ward. How can I feed all these people? Sometimes by the time I get to the last bay either the food is cold, or it has been taken away".

Observations on the second ward showed that some patients did not eat their lunchtime meal. Staff told us that they did not ask patients why they did not eat their meal or offer an alternative. A staff member told us that at that lunchtime two patients should have had pureed diets but these had not been ordered. Pureed food was ordered when it was discovered none was available, but we were told that it would take 45 minutes to arrive.

A review of patients' records found that there was patchy recording of both food and fluid intake to the extent that these records could not be used as a tool to determine if patients had eaten enough or if they had drunk enough to prevent dehydration. We found that there is no provision for recording meals or food eaten after tea time such as supper on any given day apart from an 'extras' column. Staff we spoke with confirmed that they did not ask patients on admission if they would like to eat later than the set tea time and that there was no provision for regular, substantial food between tea time (5pm) and breakfast (8am) except for biscuits or toast. None of the staff we spoke to were aware that there is provision for them to be able to obtain food for patients within these hours.

Sandwell General Hospital has a protected mealtime policy. Notices are displayed on ward doors making everyone aware that there are protected mealtimes. However, our observations on both wards showed that staff are not adhering to this policy resulting in support time being interrupted and unnecessary noise while people were eating.

Our judgement

Sandwell General Hospital is not ensuring that all patients receive a full and thorough assessment of their nutritional requirements or that nutritional needs are addressed and regularly reviewed. Systems in place to support patients who are at risk from malnutrition and dehydration are not being used on all wards. Adherence with protected mealtimes is not being practiced resulting in interruptions and unnecessary noise levels whilst people are trying to eat.
Patients had mixed views about the quality of food. Observations showed that food availability is limited after tea time and special diets not always available at the specified mealtimes.
Recording of patients' food and fluid intake is patchy to the extent that these records could not be used as a tool to determine if patients had eaten enough or if they had drunk enough to prevent dehydration.
Observations showed that staff supporting patients to eat, were caring and attentive but there were not enough staff available for the number of people who needed this support.

Overall we found that Sandwell General Hospital is not meeting this essential standard and improvements are needed.

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury.	**17**	**1**
	How the regulation is not being met: A number of patients feel positive about their experiences of care and treatment at Sandwell General Hospital. They stated that they were kept informed and were involved in making decisions. Others commented that they were not listened to and gave examples of how their dignity and privacy needs were not met. Our observations and evidence from records showed that people do not always receive the information they require and do not have sufficient attention to ensure their privacy and dignity. Our observations on the second ward particularly, highlighted that patients privacy and dignity needs are not being met. Overall we found that Sandwell General Hospital is not meeting this essential standard and improvements are needed.	
Treatment of disease, disorder or injury.	**14**	**5**
	How the regulation is not being met: Sandwell General Hospital is not ensuring that all patients receive a full and thorough assessment of their nutritional requirements or that nutritional needs are addressed and regularly reviewed. Systems in place to support patients who are at risk from malnutrition and dehydration are not being used on all wards. Adherence with protected mealtimes is not being practiced resulting in interruptions and unnecessary noise levels whilst people are trying to eat. Patients had mixed views about the quality of food. Observations showed that food availability is limited	

	after tea time and special diets not always available at the specified mealtimes. Recording of patients' food and fluid intake is patchy to the extent that these records could not be used as a tool to determine if patients had eaten enough or if they had drunk enough to prevent dehydration. Observations showed that staff supporting patients to eat, were caring and attentive but there were not enough staff available for the number of people who needed this support. Overall we found that Sandwell General Hospital is not meeting this essential standard and improvements are needed.

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 28 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

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

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

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

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

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

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

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

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

Dignity and nutrition reviews of compliance

The Secretary of State for Health proposed a review of the quality of care for older people in the NHS, to be delivered by CQC. A targeted inspection programme has been developed to take place in acute NHS hospitals, assessing how well older people are treated during their hospital stay. In particular, we focus on whether they are treated with dignity and respect and whether their nutritional needs are met. The inspection teams are led by CQC inspectors joined by a practising, experienced nurse. The inspection team also includes an ‘expert by experience’ – a person who has experience of using services (either first hand or as a carer) and who can provide the patient perspective.

This review involves the inspection of selected wards in 100 acute NHS hospitals. We have chosen the hospitals to visit partly on a risk assessment using the information we already hold on organisations. Some trusts have also been selected at random.

The inspection programme follows the existing CQC methods and systems for compliance reviews of organisations using specific interview and observation tools. These have been developed to gain an in-depth understanding of how care is delivered to patients during their hospital stay. The reviews focus on two main outcomes of the essential standards of quality and safety:

- Outcome 1 - Respecting and involving people who use the services
- Outcome 5 - Meeting nutritional needs.

Information for the reader

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

Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA

Dignity and nutrition for older people

Review of compliance

Sandwell and West Birmingham Hospitals NHS Trust **City Hospital**	
Region:	West Midlands
Location address:	City Hospital Dudley Road Birmingham B18 7QH
Type of service:	Acute Services
Publication date:	July 2011
Overview of the service:	City Hospital is a busy acute hospital providing specialist services and a broad range of emergency services including Accident and Emergency. The hospital provides a total number of 504 beds. Acute Hospital services are provided for approximately 500,000 people living in and around the Sandwell and Birmingham area.

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

What we found overall

We found that City Hospital was meeting both of the essential standards we reviewed but to maintain this, we suggested that some improvements were made.

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

Why we carried out this review

This review was part of a targeted inspection programme in acute NHS hospitals to assess how well older people are treated during their hospital stay. In particular, we focused on whether they were treated with dignity and respect and whether their nutritional needs were met.

How we carried out this review

We reviewed all the information we held about this provider, carried out a visit on 4 May 2011, observed how people were being cared for, talked with people who use services, talked with staff, checked the provider's records, and looked at records of people who use services.

The inspection teams were led by CQC inspectors joined by a practising, experienced nurse. The inspection team also included an 'expert by experience' – a person who has experience of using services (either first hand or as a carer) and who can provide the patient experience. During our visit to the hospital the team spoke to people on the wards, staff who were supporting them, we looked at people's care records and observed practices on two wards.

What people told us

The majority of people told us that they were satisfied with the care and treatment they received at City Hospital. They said they have been treated with respect and that their privacy and dignity had been well protected. They said they were given information and had been involved in decisions about their care and treatment.

People told us that their nutritional needs and dietary preferences were mostly met. They gave mixed feedback about the quality and range of food. Those people, who required assistance with eating or drinking, were complimentary about the way staff

supported them. Observations on the two wards we visited showed that staff were attentive when assisting people and they mostly did this in a patient and professional way.

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

Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

- Overall, we found that City Hospital was meeting this essential standard.

Outcome 5: Food and drink should meet people's individual dietary needs

- Overall, we found that City Hospital was meeting this essential standard but to maintain this, we suggested that some improvements were made.

Action we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

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

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

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

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

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

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

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

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

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

Outcome 1:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is compliant

with outcome 1: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us

We were given a mixed response to how people were involved in their care on the wards. They told us “they tell me what’s what and ask me things but sometimes I don’t really understand, my husband could tell you he is always asking things the staff are very nice” and “all of the staff show respect and I have no complaints at all about the hospital or the nurses”.

When we asked people if staff called them by their preferred name one person said “I have had no problems with this at all”. Another person said staff did not ask their preferred name so they had told staff what they wanted to be called.

We spoke to people about how staff respond to their individual needs, some people told us that when they pressed their call bell staff were quick to respond to them. One person said call bells were not accessible at all times and another person commented “sometimes they make the bed and move the bell and forget to give it

you back but fortunately there's always someone around to help you".

We asked people about the information they received when they came into hospital. Most of the people we spoke to said that they were not given any information when they arrived at the hospital. One person who had been a patient for two weeks told us "I have made my own discharge plans no one has talked to me about it have arranged for my own frozen meals and cleaners when I get home, I am concerned about the cost of this but there is no one to talk to about it".

People also told us "When the phlebotomist takes your blood they cannot explain why I am having a test done".

Other evidence

The trust's website has a section devoted to privacy and dignity outlining the trust's commitment to patients. The page refers to both equality and diversity information and has details of the 9 Customer Care Promises. The policy applies to all trust employees and makes it clear that lead clinicians, matrons, ward and departmental managers are responsible for ensuring compliance with policy. The customer care promises are included in personal development plans for all staff and staff recruitment.

We spoke to the staff on both wards about how they make sure people are treated with respect and dignity. They told us "we always make sure that the curtains are closed when we do any personal care. There are also signs that we attach to the curtains asking people not to enter. I try to make sure that people's modesty is preserved, I'll use sheets and blankets to avoid over exposure". One nurse told us "if I found someone was not being treated with respect or dignity I would stop them there and then, I would report it".

During our observations we saw and heard numerous examples of staff caring for patients in a way that respected their privacy and dignity, with bedside curtains being drawn when personal care was being delivered or private conversations being held and staff talking to people in a warm and appropriate manner.

Annual Patient Environment Action Team (PEAT), inspections are carried out. The trust received a "good" rating for privacy and dignity in April 2011. (PEAT undertakes annual assessments of inpatient healthcare sites in England).

We also reviewed the 2010 National Inpatient Survey results, some of the results indicated the trust needs to "improve the quality and simplicity of the information available to patients on the ward". We saw very little information available to people on the wards. Staff told us "it's all gone away to be laminated. We did used to have some". None of the staff we spoke to were clear about how they would address people's concerns or complaints about their care. One nurse told us "I'd refer them to matron". There was no information on either of the wards we visited about how to make a complaint or who to refer to if you were unhappy about any aspect of your care.

We requested a Provider Compliance Assessment from the trust on the day of our visit. This is a self assessment tool the trust uses to monitor its own compliance with the essential standards of quality and safety. The trust has acknowledged in it a shortfall in the amount of information that is available to people who are using the service. They have already begun to take steps in order to rectify this. They have told us information for people will be available so that they are able to make their concerns or complaints known. Information on key health care conditions will also be available on the wards for people to read. This will be done by July 2011.

Our judgement

People have an understanding about their care and treatment and are being treated with respect and dignity.

Outcome 5:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are minor concerns

with outcome 5: Meeting nutritional needs

Our findings

What people who use the service experienced and told us

The comments from people about the food provision were mixed. People said “they give us a menu and we can choose, I always enjoy the meals here”, “since I have been in here I’ve had so much food, it’s offered all of the time and I eat it, the food’s always nice”.

Other people told us “I am a vegetarian, I want some mayonnaise and vinegar with my dinners but they only have sachets here and they all contain fish, I would like them to do something about this”, another person said “there is no food after teatime (5pm) if you want something you have to rely on your visitors bringing you something in” and “I moved beds yesterday and my meal was allocated to that bed so now I have to wait to see what’s left for me”.

None of the people we spoke to said they were offered the opportunity to wash their hands before eating their meals.

Other evidence

The PEAT survey for City Hospital scored “excellent” for food, menu, choice, availability, quality, quantity, temperatures, presentation, service and beverages.

However, a proportion of the adult inpatients surveyed across the trust rated the hospital food as “fair” which had been scored as better than expected. The proportion of respondents across the trust who stated that they did not get enough help from staff to eat their meals was scored as ‘Worse than expected’.

The Trust operates a “red tray and blue beaker policy”. This is designed to identify those people who fall into the “at risk” category and direct staff how to manage their needs. Those people who are assessed as being at risk of having insufficient fluid or food are then served their meals on a red tray. This alerts staff to those people who need extra supervision or assistance during meal times.

We spoke to staff about how they assess people’s needs in relation to nutrition. They told us “we do the MUST, [Malnutrition Universal Screening Tool], then we weigh patients weekly and they have the red trays”. We have handover every day so when we get to the patients bed we know what’s happening with them”. People also have access to other professionals such as the Speech and Language Therapist and the dietitian when a specialised assessment is needed.

We looked at the case notes of five people during this visit, we found that none of these people had been screened using the MUST and none had been weighed on admission or thereafter. Four of these people were given red trays at lunchtime. We asked staff how they had made an assessment of these people’s needs when no recording of information had taken place, they told us “we get a handover and I keep it on a sheet in my pocket”.

We spoke to a member of the medical team who said that for those people who can eat and drink independently there are no issues, but for those that need support they added “I don’t think that the charts are always filled in. I do extra checks myself when doing the ward round.”

We looked at how the staff record the amount of food and fluids people eat and drink. We found documents were inadequately completed, in some cases fluid balance charts were blank. This gave us no indication of how much fluid people had had. These concerns that we identified with record keeping relate to other essential standards and will be followed up separately.

Our observations during meal times showed us that people do generally get the support they need to eat and drink. We saw that staff were not always consistent in the way they offered support to people. We saw some staff that were very attentive to people, who made sure people were positioned in a comfortable way that enabled them to eat their meal. Those people who needed assistance to eat were helped and were in the majority of cases supported sensitively and were engaged by the staff. We did observe a couple of members of staff trying to feed people in bed without talking to them and without repositioning them prior to assisting them.

We saw dinner plates were not cleared away after one person had finished eating; they had to eat their pudding over the top of the dirty dinner plate.

The trust operates a “protected mealtime policy”. This means that people will have the opportunity to eat their meals without interruption and more staff will be available to assist them. Generally this was observed but we did see one person persistently

disturbed during their meal time. They were visited by four members of staff all asking questions about treatment, all the while this person was attempting to eat an ice cream by the time they were left alone to do this the ice cream had melted and the person commented “I suppose I didn’t need it anyway but I don’t know what they were saying to me”.

We asked staff what happened if people miss meals or they came to the ward after 5pm when tea had already been served. They told us “we give people biscuits and we can make toast. You can go to the canteen but there’s nothing hot for people to eat”. The trust operates a system that enables staff to access food for people out of hours. This includes hot meals and snacks but none of the staff we spoke to knew about this. The trust is taking action to make sure this scheme’s profile is raised and that more staff are made aware of its existence.

Our judgement

People are supported during meal times, but this is not consistent. A lack of record keeping could place people at increased risk of malnourishment and dehydration.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury	Regulation 14	Outcome 5 Meeting Nutritional Needs.
	Why we have concerns: People are supported during meal times but this is not consistent. A lack of record keeping could place people at increased risk of malnourishment and dehydration.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent within 28 days of this report being received.

CQC should be informed in writing when these improvement actions are complete.

What is a review of compliance?

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

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

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

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

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

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

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

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

Dignity and nutrition reviews of compliance

The Secretary of State for Health proposed a review of the quality of care for older people in the NHS, to be delivered by CQC. A targeted inspection programme has been developed to take place in acute NHS hospitals, assessing how well older people are treated during their hospital stay. In particular, we focus on whether they are treated with dignity and respect and whether their nutritional needs are met. The inspection teams are led by CQC inspectors joined by a practising, experienced nurse. The inspection team also includes an ‘expert by experience’ – a person who has experience of using services (either first hand or as a carer) and who can provide the patient perspective.

This review involves the inspection of selected wards in 100 acute NHS hospitals. We have chosen the hospitals to visit partly on a risk assessment using the information we already hold on organisations. Some trusts have also been selected at random.

The inspection programme follows the existing CQC methods and systems for compliance reviews of organisations using specific interview and observation tools. These have been developed to gain an in-depth understanding of how care is delivered to patients during their hospital stay. The reviews focus on two main outcomes of the essential standards of quality and safety:

- Outcome 1 - Respecting and involving people who use the services
- Outcome 5 - Meeting nutritional needs.

Information for the reader

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

Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Corporate actions in response to CQC unannounced visits (Sandwell 28.03.11 and City 04.05.11) v2
CQC Outcome Measures 1 + 5 (Nutrition and Dignity)

Key

Rachel Overfield	**RO**	**Linda Pascall**	**LP**
Matthew Dodd	**MD**	**Helen Shoker**	**HS**
Helen Jenkinson	**HJ**	**Fiona Shorney**	**FS**
Jessamy Kinghorn	**JKi**	**Debbie Talbot**	**DT**

Executive and Operational Lead	RO

Status Key:

	Complete.
	On track.
	Slight delay/expect to complete on time.
	Significant delay/unlikely to be completed as planned.
	Not yet commenced.

Board Approved:
Governance Board – 08.07.11
Trust Board – to be approved 28.07.11

Ref	Action	Progress	By Whom	Timeframe	Status
1.1	Share CQC reports with Trust Board and wider organisation. Share CQC reports with OSC, PCT, MPs and Patient reps.	Complete. Going to Public Trust Board July 28th.	**RO**	**June**	
1.2	Cross reference CQC findings with internal intelligence and PCT ward visits and share findings with TB/PCT/SHA.	Complete	**RO**	**June**	
1.3	Review patient survey results and cross reference to CQC findings.	Complete – some correlation noted.	**RO**	**June**	
1.4	Ensure staff on relevant wards are briefed on CQC findings and appropriately supported.	In place.	**HJ**	**May**	
1.5	Advise Unions of CQC visit and plans for N4.	Complete.	**RO**	**June**	
1.6	Prepare press handling strategy for when reports published.	Complete.	**JKi**	**June**	
1.7	Produce appropriate Communication Strategy for publishing CQC findings.	In place.	**JKi**	**June**	
1.8	Brief Matrons/Ward Managers/medical staff re CQC findings.	Complete.	**RO**	**May/June**	
2.1	Encourage alternative means of seeking patient views.	Progressing through HoN.	**HJ/HS**	**August**	
2.2	Continue with TB safety visits that include observation of mealtime, dignity etc.	In place since February.	**RO**	**Ongoing**	
2.3	Establish a 'Patient User Group'.	Progressing.	**DT**	**September**	
3.1	Commence weekly Matron 'rounds'/audit across the Trust.	Complete.	**HJ/HS**	**June**	
3.2	Commence weekly Head of Nursing 'rounds'	Complete.	**HJ/HS**	**June**	
3.3	Invite LINKS/PCT to do unannounced visits over meal times.	Complete.	**RO**		
3.4	Ensure 'worry wards' are on the Trust Risk Register.	Complete.	**HS/HJ**	**May**	
3.5	Commence unannounced visit of other elderly care/rehab/stroke areas to ensure similar issues not there.	Complete.	**ADN's**	**June**	
3.6	Review ward level documentation and audits to produce streamlined and less resource intensive processes.	Work commenced. Plan in place.	**RO/DT**	**September**	

3.7	Establish 'coaching' support for challenged wards via ADN's and L&D.	In place.	**RO**	**June**	
4.1	Exec Team to agree immediate ceasing of bed 'flexing' on N4.	Complete.	**Exec Team**	**April**	
4.2	N4 to be put into 'special measures' as a result of this and previous concerns.	Complete – 25/5/11	**RO**	**May**	
4.3	Special measures action plan and condition report to be completed.	Complete.	**HJ**	**June**	
4.4	TB/Exec Team alerted to special measures status N4.	Complete – 25/5/11	**RO**	**May**	
4.5	Special measures turnaround meetings established.	Complete.	**RO**	**May**	
4.6	N4 staff meeting to advise on process to 'turnaround'.	Complete.	**RO**	**May**	
5.1	Exec Team to agree bed capacity plan to avoid unstaffed bed risk in future.	For PMB discussion 19/7/11.	**Exec Team**	**July**	
5.2	Staff:bed ratio to be discussed monthly at Exec Team, TMB and Trust Board	System in place since April.	**RO**	**April**	
5.3	Develop a bed escalation policy to avoid the indiscriminate opening of additional beds.	In place.	**MD**	**July**	

Sandwell and West Birmingham Hospitals NHS Trust

Sandwell & West Birmingham Hospitals NHS Trust
CQC Essential Standards for Quality and Safety
Outcome Measure 1 – Respecting and Involving People Who Use Services
Improvement Plan v5

Compiled post CQC unannounced visits to Sandwell – 28th March 2011 and City – 4th May 2011.
The Action Plan incorporates part or all of the existing Trust Action Plans for Privacy, Dignity and Respect and Nutrition.

Key

Rachel Overfield	**RO**	**Donal O'Donoghue**	**DO'D**
Steve Clarke	**SC**	**Linda Pascall**	**LP**
Anita Cupper	**AC**	**James Pollitt**	**JP**
Kam Dhami	**KD**	**Helen Shoker**	**HS**
Matthew Dodd	**MD**	**Debbie Talbot**	**DT**
Helen Jenkinson	**HJ**	**Ward Managers**	**WMs**
Jessamy Kinghorn	**JKi**		

Executive Lead	RO
Implementation Leads	Outcome 1 – DT
Divisional Leads	HS and HJ

Status Key:

	Complete.
	On track.
	Slight delay/expect to complete on time.
	Significant delay/unlikely to be completed as planned.
	Not yet commenced.

Board Approved:
Governance Board – 08.07.11
Trust Board – to be approved 28.07.11

Ref	Action	By Who	When	Evidence	Status
1	***1A*** ***People understand the care, treatment and support choices available to them.***				
1.1	Ensure Consent Policy is up to date and robustly in place.	DO'D	In place.	NHSLA evidence.	
1.2	Ensure information is available to patients in all settings regarding treatment choices.	JKi	Sept 2011	Visits Space utilisation Patient surveys	
1.3	Ensure information is accessible to patients, ie language format etc.	JKi	Sept 2011	Visits Space utilisation Patient surveys	
1.4	Ensure appropriate areas exist to enable private conversations with patients.	MD	Sept 2011	Visits Space utilisation Patient surveys	
1.5	Ensure training/awareness raising re privacy, dignity and respect available and delivered.	DT	August 2011	Training programme and lesson plan.	
1.6	Ensure Trust is compliant with Equality Act.	LP	In place.	Action Plan. Minutes of E&D Steering Group.	
1.7	Ensure SES up to date and captures actions required to ensure patients human rights are respected.	LP	In place.	SES. Action Plan.	
1.8	Provide MT training on E&D.	JP	June 2011	MT records.	
1.9	Ensure patients confidentiality is protected.	DO'D/ Matrons/ WMs	Oct 2011	Policy. Audits. Data Protection.	
1.11	Observe care to ensure privacy, dignity and respect are maintained.	DT	In place.	Observation of care results. Patient surveys. Unannounced visits.	
1.12	Ensure staff aware of and use independent advocacy services	DT	July 2011	Poster. Referral to MCA.	
1.13	All wards/departments record in the patients/nursing notes any information given to patients regarding their planned care/treatment.	WMs/ Matrons	September 2011	Notes audit. Ward reviews.	
1.14	All wards/departments understand how to access services to promote communication for service users that are: - Deaf - Visually impaired	LP	August 2011	Ward info leaflet. Pre-admission info. Disabled Go website.	

	- Cannot speak English as first language - Require Easy Read/translated information				
1.15	All wards to have copies of bedside directory.	JKi	In place.	Matrons round. Observation of Care Team	
1.16	All wards to have information re complaints process and advocacy services.	KD	See complaints action plan.		
1.17	All wards have patient information to support DSSA and privacy and dignity.	DT/LP	Sept 2011	Evidence in bedside directory.	
1.18	All wards to document patient choice re: - Choice to get dressed - Choice of meals - Choice to self-medicate - Choices re discharge	Matrons/ WMs	August 2011	In house unannounced visits. Notes audits. Ward Reviews. Nutrition audits.	
1.19	Trust to be fully compliant with SSA guidance.	MD	In place.	Fully compliant.	
1.20	Patient experience Ward → Board reports to continue monthly.	RO	In place.	Trust Board papers.	
1.21	Continue to develop Trust privacy and dignity website.	DT	Sept 2011	Website. Patient views.	
2	***1B*** ***People who use services have their care, treatment and support needs met.***				
2.1	The process for assessing and planning care is clearly described.	DT/RO	Sept 2011	Notes audits. Ward reviews	
2.2	All patients have plans of care relevant to their assessment needs.	DT	Sept 2011	Notes audits. Ward reviews	
2.3	All patients have completed documentation.	Matrons/ WMs	Sept 2011	Notes audits. Ward reviews	
2.4	Records are concise, legible and signed/dated.	Matrons/ WMs	Sept 2011	Notes audits. Ward reviews	
2.5	Patient views are sought regarding their care.	Matrons/ WMs	Sept 2011	Notes audits. Ward reviews Satisfaction Surveyrs	
2.6	Patients have access to a variety of support sources including: - Chaplaincy - Advocacy - Interpreter Services	RO/DT/LP	In place.	PALS posters.	
2.7	Tools such as the SAP are used to ensure specific care	DT	In place.	Patient Assessment Record (PAR/SAP)	

	needs are passed on and understood.				
2.8	Staff demonstrate respect and kindness at all times.	Matrons/ WMs	Ongoing.	Patient survey visits.	
3	***1C*** ***People who use services receive care, treatment and support where clear procedures are followed in practice, monitored and reviewed.***				
3.1	All Clinicians adhere to the Consent Policy.	DO'D	Via consent NHSLA Action Plan.		
3.2	The following Acts/requirements are understood by staff and discussions and plans of care/treatment documented - Deprivation of Liberty - Mental Capacity - Safeguarding - Decisions relating to religious beliefs	DT	In place.	Programme – Safeguarding training NHSLA assessment. Care plans WMQRS peer group- review 13th July	
3.3	Access to advocacy services is in place and understood by staff.	DT	In place.	Programme – Safeguarding training NHSLA assessment. Care plans WMQRS peer group- review 13th July	
3.4	Access to Chaplaincy and spiritual care is available and understood by staff.	RO/LP	In place.	Patient Surveys.	
3.5	The Trust is DDA compliant.	LP	In place.	The Trust is fully compliant.	
3.6	All wards/departments involve patients in decision making about care/treatment.	DT	Sept 2011	Audit data – not yet available. Patient Satisfaction Surveys	
3.7	Discharge arrangements ensure involvement of patients in planning and choices.	HJ	October 2011	Discharge records. Readmissions. LINK audit. Patient surveys.	
4	***1E*** ***People who use services are supported to make informed choice about their care, treatment and support.***				
4.1	All wards/departments have relevant up to date condition specific information.	JKi	Sept 2011	Patient surveys. Observation of Care Team.	
4.2	All clinical teams ensure patients have the opportunity to discuss care and treatment.	Matrons/ WMs		Patient Satisfaction Surveys	
4.3	All wards/departments have access to quiet areas for private conversations.	MD	See action 1.4	See action 1.4	
5	***1F*** ***People who use services receive care, treatment and support that is provided in a way that ensures independence.***				
5.1	Wards/departments ensure patients are involved in care	Matrons/ WMs	Part of action 2.1		

	planning and treatment choices.				
5.2	Self-care is encouraged wherever possible.	DT	Sept 2011	PAR Quality Audits	
5.3	All nursing staff encourage the following as the norm: - Use of bathrooms/toilets - Use of dayrooms - Occupational activities - Protected mealtimes - Self-administration of drugs	Matrons/ WMs	Sept 2011	Dayroom use. Protected meal times audits. Medicines management audits. Patient surveys. Volunteer strategy.	
5.4	Environments are managed to promote 'normality', eg: - Reduced noise at night - Access to TV/radio - Relaxed visiting where possible - Protected mealtimes - Own clothes - Choice of food - Access to food/snacks/drinks 'round the clock'.	Matrons/ WMs	Sept 2011	Dayroom use. Protected meal times audits. Medicines management audits. Patient surveys. Volunteer strategy.	
6	***1G*** ***People who use services receive care, treatment and support that is provided in a way that ensures human rights and diversity are respected.***				
6.1	The interpreting services will be accessible and clearly understood by staff.	LP	In place.	All actions in place via E&D Steering Group and Action Plan.	
6.2	Telephone and staff interpreting will be clearly defined and accessible.	LP	In place.	All actions in place via E&D Steering Group and Action Plan.	
6.3	Written information where appropriate will be available in other languages/formats.	JKi	In place.	All actions in place via E&D Steering Group and Action Plan.	
6.4	Devices to assist deaf/blind patients will be available.	LP	In place.	All actions in place via E&D Steering Group and Action Plan.	
6.5	Chaplaincy/spiritual care will be sufficiently diverse to meet the needs of patients.	RO	In place.	All actions in place via E&D Steering Group and Action Plan.	
6.6	E&D training will be part of MT.	JP	In place.	All actions in place via E&D Steering Group and Action Plan.	
7	***1H*** ***People who use services are provided with information.***				
7.1	All wards/departments/services will have information on the service.	JKi	See previous action notes.	See previous action notes.	
7.2	All wards/departments will have a meet and greet pack that describes the service, care, treatment and staff.	HoN	Sept 2011	Patient surveys. Ward reviews.	

7.3	All wards will have measures boards in place.	DT	In place.	Completed – up to date boards.	
7.4	All other departments will 'publish' key quality/performance measures.	RO/MD	Oct 2011	Audits.	
7.5	All wards/departments will have information about how to raise a concern/complaints.	KD	See complaints action plan.		
7.6	All wards/departments will have information about advocacy services.	DT			
8	***1I*** ***People who use services are given encouragement, support and opportunity to describe their needs and raise concerns.***				
8.1	All wards/departments have clear assessment/admission processes in place.		See action 2.1	See action 2.1	
8.2	All wards/departments have information about Complaints/PALS in place.		See above re complaints action plan.		
8.3	All in patients have the opportunity to complete a patient survey.	DT	In place.	Survey statistics.	
9	***1J*** ***People who use services can influence how the service is run.***				
9.1	Regular FT member forums are in place.	JKi	In place.	Evidence of forums/timetables/ minutes.	
9.2	Patient views are sought via patient surveys.	DT	In place.	Surveys	
9.3	Establish a user group/forums.	DT	Oct 2011	User group minutes.	
9.4	Develop productive relationships with LINKS and other local networks.	JKi/DT	Sept 2011		
9.5	E&D roadshows to local community groups.	LP	In place.	Reports to E&D Steering Group.	
9.6	Engagement plan in place.	JKi	In place.	Reports to E&D Steering Group.	
9.7	All wards to have a 'dignity' champion – clearly identifiable to patients/visitors and responsible for local dignity initiatives.	RO	August 2011	Displayed on ward.	
10	***All staff treating patients, carers and families do so with respect.***				
10.1	All staff do not use inappropriate 'terms of endearment'. Staff will ensure tone and volume of voice is respectful.	Matrons/ WMs	August 2011	Observations of care quarterly	
10.2	All wards to document preferred name the person would	Matrons/ WMs	July 2011	PAR/SAP- need to audit as part of	

	like to be called.			quality audits	
10.3	Call bells should always be in easy reach and are answered responsively.	Matrons/ WMs	Ongoing.	Audit. Patient surveys. Matron rounds. Patient surveys.	
10.4	All wards/departments to have appropriate patient nightwear available including footwear and provision for bariatric patients.	Matrons/ WMs	Oct 2011	Matron rounds. Patient surveys.	
10.5	All ward staff to provide timely assistance to meet comfort needs, eg toileting, pain relief.	Matrons/ WMs	August 2011	Patient surveys. Matron rounds.	
10.6	Permission should be sought and documented before every intervention by staff.	Matrons/ WMs	August 2011	Patient surveys.	
10.7	All wards to use Privacy signs.	Matrons/ WMs	In place.	Quality Audits	
10.8	All ward rounds/handovers to be carried out without breaching patient confidentiality.	Matrons/ WMs	In place.	Optimal Ward	
10.9	DSSA toilet signage to be in place.	Estates	In place.		
10.10	Patients confidentiality to be maintained when answering the phone/IT.	DT	In place but requires regular audits.	Quality Audits	
10.11	Laundry development to be completed.	SC	Oct 2011		
10.12	Purchase of new Trust nightwear.	SC	Oct 2011		

Sandwell and West Birmingham Hospitals NHS Trust

Sandwell & West Birmingham Hospitals NHS Trust
CQC Essential Standards for Quality and Safety
Outcome Measure 5 – Keeping Nourished and Hydrated
Improvement Plan v4

Compiled post CQC unannounced visits to Sandwell – 28th March 2011 and City – 4th May 2011.
The Action Plan incorporates part or all of the existing Trust Action Plans for Privacy, Dignity and Respect and Nutrition.

Key

Rachel Overfield	**RO**	**Linda Pascall**	**LP**
Luke Banfield	**LB**	**Helen Shoker**	**HS**
Steve Clarke	**SC**	**Fiona Shorney**	**FS**
Helen Jenkinson	**HJ**	**Ward Managers**	**WMs**

Executive Lead	RO
Implementation Leads	Outcome 5 – FS
Divisional Leads	HS and HJ

Status Key:

	Complete.
	On track.
	Slight delay/expect to complete on time.
	Significant delay/unlikely to be completed as planned.
	Not yet commenced.

Board Approved:
Governance Board – 08.07.11
Trust Board – to be approved 28.07.11

Ref	Action	By Who	When	Evidence	Status
1	5A and 5B Where the service provides food and drink, people who use services have their care, treatment and support needs met.				
1.1	All in patients will be assessed for nutritional risk using the MUST tool within 12 hours of admission to base ward.	Matrons/ Ward Managers	August 2011	In nursing records. Monthly audits.	
1.2	All in patients will be reassessed for risk every 7 days as a minimum	Matrons/ Ward Managers	August 2011	In nursing records. Monthly audits.	
1.3	Weight will be monitored via the MUST process.	Matrons/ Ward Managers	August 2011	In nursing records. Monthly audits.	
1.4	Monthly audits of every ward for compliance.	FS	June 2011	PEPAG minutes. Audit results.	
1.5	All wards will have access to SALT for swallow assessments.	FS	June 2011	Patient records.	
1.6	Matron/Ward Manager weekly checks introduced.	HoN	June 2011	Records of checks undertaken.	
1.7	All patients assessed as being at risk will have an appropriate Nutritional care plan.	Matrons/ Ward Managers	August 2011	Patient records. Monthly audits.	
1.8	Nutritional needs will be discussed with patients./rels/carers	Matrons/ Ward Managers	August 2011	Patient records. Patient surveys.	
1.9	All nursing staff in In patient areas will be trained in the use of MUST tool and nutrition/hydration.	FS	September 2011	Training records.	
1.10	Meal diaries will be kept for all 'at risk' patients. i.e those patients with a score of 1 or more	Matrons/ Ward Managers	August 2011	Patient records. Monthly audits.	
1.11	Launch new INPUT only chart	FS	July 2011	Monthly audits	
1.12	All Patients will have FBC unless identified as exception through risk assessment. This to be fully documented.	Matrons/ Ward Managers	July 2011	Patient records. Monthly audits.	
1.13	All wards will have appropriate weighing/measuring equipment.	FS	July 2011	Audit required.	
1.14	Nutrition Policy to be produced and implemented to clearly identify what is expected.	FS	August 2011	Policy to be approved at Governance Board in August.	
1.15	Menus to be reviewed by Dieticians for Nutrition content on a minimum of once a month	LB/SC	July 2011	Evidence of review.	

1.16	All menus to be reviewed for suitability and cultural requirements on a minimum of once a month	SC	Aug 2011	Audits. Patient surveys.	
1.17	Ensure patients can gain access to special diets	SC	July 2011	Audits. Patient surveys.	
1.18	Access to hot/cold food out of hours to be re-launched and all staff made aware.	SC	July 2011	Audits. Matrons rounds	
1.19	Protected meal times will be enforced on all wards.	Matrons/ Ward Managers	July 2011	Revised PMT audit form. Patient surveys. Matrons spot checks	
1.20	Appropriate cutlery and food aids will be provided to assist independence.	Matrons/ Ward Managers	July 2011	Observation. Patient views.	
1.21	Staff will be trained in how to feed patients and flexible workforce will be identified for wards with highly dependent patients.	LP	Oct 2011	Training records. MOT	
1.22	Relatives/carers will be encouraged to come in at mealtimes to assist with feeding where appropriate.	Matrons/ Ward Managers	June 2011	Patient surveys. Visual evidence/ observations. Measures boards. Visitors policy Pt information	
1.23	Members of MDT working with patients during Protected Meal Times as part of their therapy will be identified by wearing tabards.	FS	Aug 2011	Observations.	
1.24	Pre meal time routines will be established in all wards to ensure patients are/have: - Positioned - Clean Hands - Toilet needs met - Cleared table	Matrons/ Ward Managers	August 2011	Monthly audits. Patient surveys. Weekly Ward Manager rounds. Spot checks.	
1.25	Red trays and beakers will be used to identify patients who need assistance.	Matrons/ Ward Managers	July 2011	Monthly audits. Observation of care.	
1.26	The meal plan will reflect patient's special needs.	Matrons/ Ward Managers	June 2011	Monthly audits. Observation of care.	
1.27	Meal times will be supervised by an identified member of nursing staff.	Matrons/ Ward Managers	July 2011	Monthly audits. Observation of care.	

1.28	Roll out bottled water to all wards.	SC	August 2011	Supplies orders.	
1.29	Relaunch the Nutrition champions and develop a Nutrition resource folder for each area	FS	August 2011	Clearly visible on wards. Folder in place.	
2	***5C*** ***Where the service provides food and drink people who use services can make decisions about their food and drink.***				
2.1	Menu cards are available equitably for all patients	SC	Sept 2011	Patient Survey	
2.2	Menus include cultural meals, special diets and soft/pureed options	SC	In place.	Patient Survey. Mealtime audits. Patient groups.	
2.3	Snacks (hot and cold) will be available day/night.	SC	In place.	Patient Survey. Mealtime audits. Patient groups. Matrons rounds	
2.4	Information regarding diet/nutrition will be provided to patients routinely.	Matrons/ Ward Managers	Sept 2011	Patient Survey. Mealtime audits. Patient groups.	
3	***5D*** ***People who use services benefit from clear procedures that are followed in practice, monitored and reviewed.***				
3.1	Develop a Trust Fasting Policy that reflects Enhanced Recovery recommendations.	HS	Oct 2011	Policy in place.	
3.2	Audit Fasting arrangements as a baseline and then quarterly thereafter.	HS	Aug 2011	Audit reports.	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Risk Management Report – Q4 2010/11
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Allison Binns, Head of Risk Management Hillary Mottishaw, Head of Complaints, Litigation & PALS Dally Masaun, Head of Health and Safety
DATE OF MEETING:	28 July 2011

SUMMARY OF KEY POINTS:

This report combines information on incidents (both clinical and Health & Safety), complaints, PALS and claims.

Key incident statistics:

- There were 2155 reported incidents (2286 in Q4 2009/10)
- Reported clinical incidents increased from 1482 in Q4 2009/10 to 1488 in Q4 2010/11
- Reported health & safety incidents fell from 804 in Q4 2009/10 to 667 in Q4 2010/11
- There were 128 incident forms received relating to red incidents (5.9% of the total), compared with 120 in Q4 2009/10 (5.2% of the total),

Key complaints statistics:

- Total complaints: 231 (257 in Q4 2009/10), an decrease of 11%

Key claims statistics:

- Total claims: 39 (42 in Q4 2009/10).

Key PALS statistics:

- Total enquiries to PALS team: 901compared with 1066 in the previous quarter

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High quality of care
Annual priorities	
NHS LA standards	Standard 1 'Governance'
Core Standards	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Governance Board on 3 June 2011 and Quality and Safety Committee on 21 July 2011

SWBTB (7/11) 162 (a)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Risk Management Report

Quarter 4 - 2010-2011

An Integrated report from Clinical Risk, Health & Safety, PALS, Complaints & Claims

Where EVERYONE Matters

Integrated Risk, Complaints and Claims Report: Quarter 4 2010/11

1. Overview

This report highlights key risk activity including:

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

2. Introduction

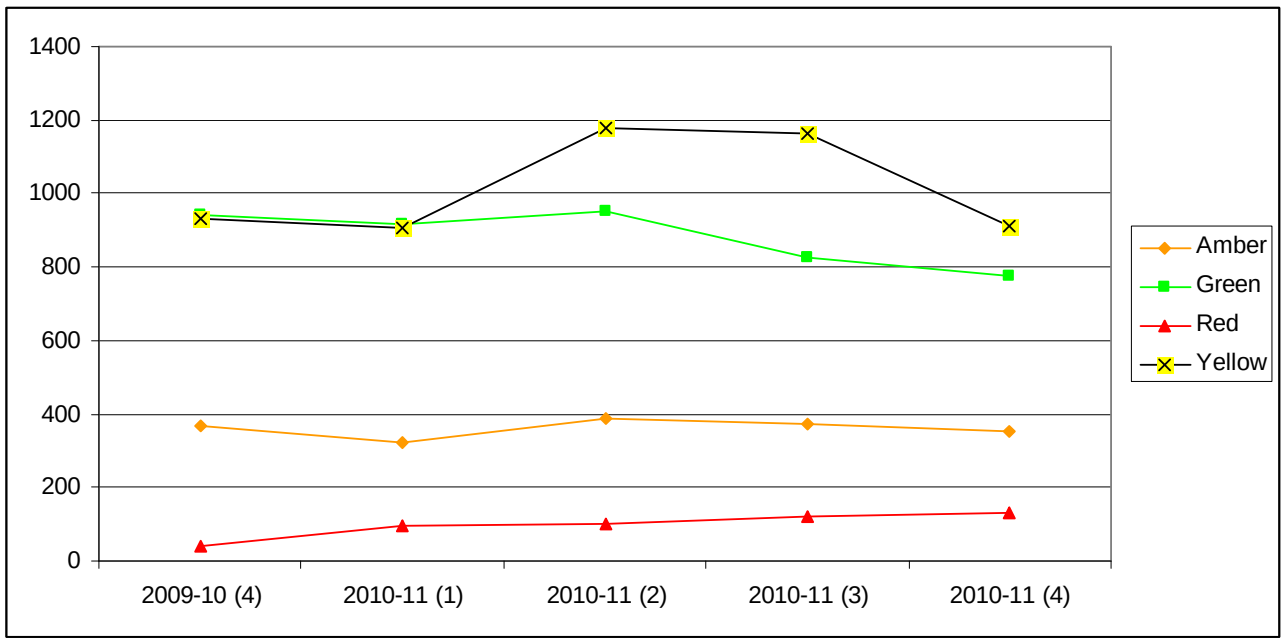
This report combines previous quarterly reports on incident/risk and complaints to implement the Policy for the Investigation, Analysis and Learning of Lessons from Adverse Events and meet NHS Litigation Authority assessment requirements. Where possible, comparisons across these areas of activity will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

3. Key Issues

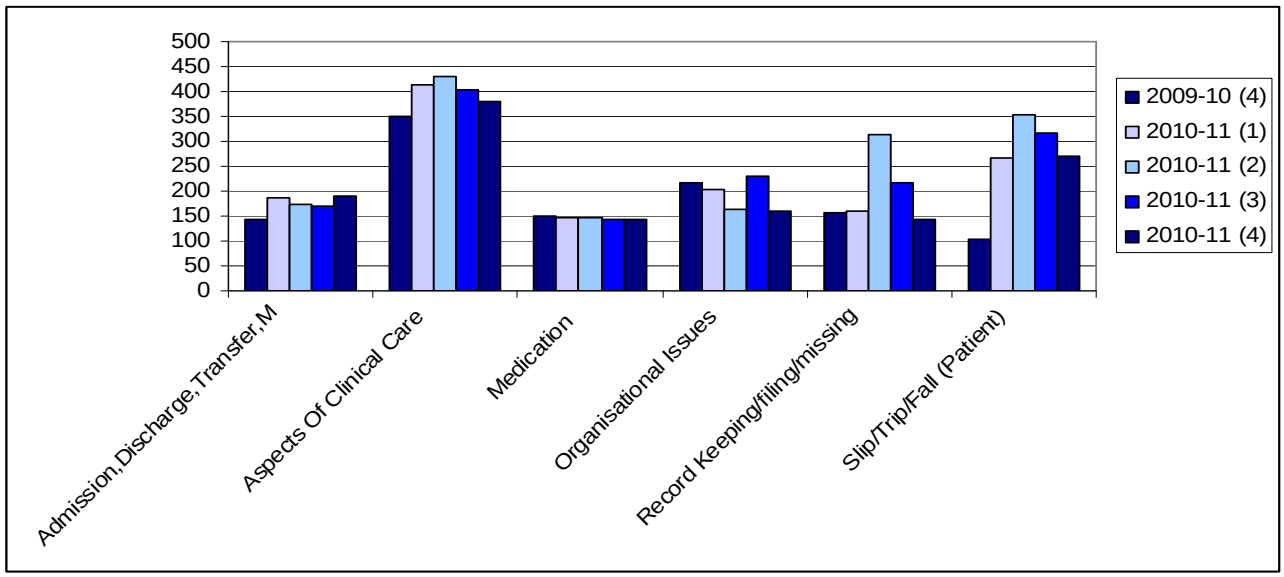
3.1 Review of Quarter 4 Incident Data

- There were 2155 reported incidents (2286 in Q4 2009/10)
- Reported clinical incidents increased from 1482 in Q4 2009/10 to 1488 in Q4 2010/11
- Reported health & safety incidents fell from 804 in Q4 2009/10 to 667 in Q4 2010/11
- There were 128 incident forms received relating to red incidents (5.9% of the total), compared with 120 in Q4 2009/10 (5.2% of the total),

Graph 3.1a - **Incident Trends** by risk score Q4 2009/10 – Q4 2010/11

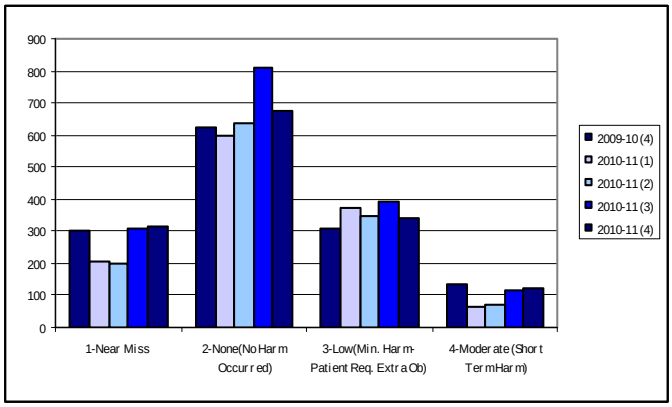


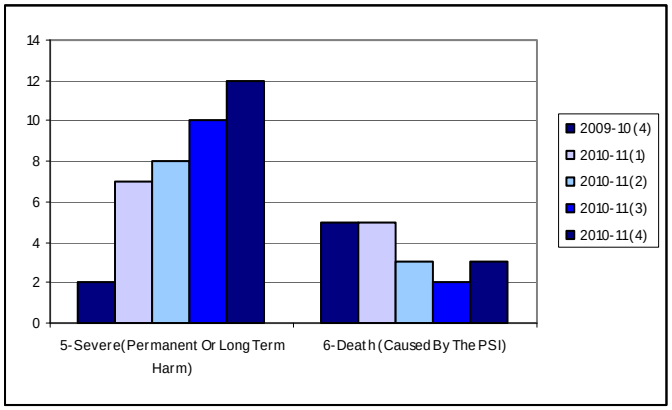
Graph 3.1b – Top 6 reported **clinical incidents** by quarter (Q4 2009/10 – Q4 2010/11)



The top 6 most frequently reported categories remain the same as Q3 2010/11. Compared to the last quarter, there has been either a fall or no change in all cause groups with the exception of admission, discharge, transfers. Patient accident has been re-categorised into Slips/Trips/Falls (patient)

Graph 3.1c & d **Patient Safety incidents** by reported impact by quarter (Q4 2009/10 – Q4 2010/11)





Graphs 3.1c and 3.1d look at reported "actual harm" suffered by the patient and allows benchmarking against the six monthly feedback reports provided by the National Patient Safety Agency (NPSA) from its National Reporting and Learning System (NRLS). Further work is required to improve the accuracy of recording of the true impact of incidents rather than the outcome to the patient.

As we learn lessons and amend our systems to promote safety we should see a decrease in incidents that report death, serious or moderate harm as the patient outcome with a corresponding increase in near misses.

Table 3.1 **Patient Safety incidents** by reported impact by division within Q4 2010/11

	Near Miss	None(No Harm Occurred)	Low(Min. Harm- Patient Req. Extra Ob)	Moderate (Short Term Harm)	Severe(Perm Or Long Term Harm)	Death (Caused By The PSI)
Medicine	110	326	162	55	6	2
Women & Child Health	96	169	74	27	6	1
Surgery A	68	122	67	27		
Pathology	14	20	4	1		
Imaging	10	12	10	5		
Operations	8	8	7			
Surgery B	5	8	9	3		
Facilities/Nurs & Therapy	5	7	4	2		
Development/Cancer	1	2				

3.2 Complaints

During the reporting period the complaints team dealt with 231 new complaint contacts, which is a reduction (-11%) over the same quarter for the previous year (257).

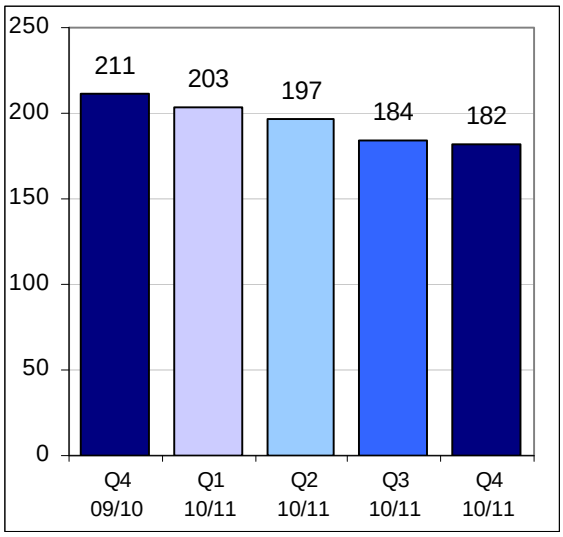
First contact complaint: where the Trust's substantive (i.e. initial) response has not yet been made.
Link complaint: the complainant has received the substantive response to their complaint but has returned as they remain dissatisfied/or require additional clarification.

Table 3.2a Types of **Contact** during Q4 2010-11

Types of Contact	No	
Formal Complaints	182	Formal complaints with negotiated timescales
Can't Accept	1	Concerns not addressed (due to time elapsed since incident etc)
General Query/Feedback	18	Not dealt with formally (concerns/query addressed via letter)
GP/intra NHS Concerns	0	Concerns raised by GPs or other NHS organisations/staff members
Dealt with informally	2	Not dealt with formally (concerns/query addressed via phone or meeting)
Under Review	0	Pathway not finalised (e.g. reviewing records to establish whether a complaint can still be reviewed given time elapsed)
Withdrawn	28	Complaints are typically withdrawn if a relative has made the complaint, but patient consent cannot be obtained. Occasionally complaints are withdrawn as the complainant changes their mind about taking their concerns forward.

The Trust dealt with 182 formal complaints, compared with 211 in the same quarter in 2009/10.

Graph 3.2a – Number of **formal complaints** received by quarter



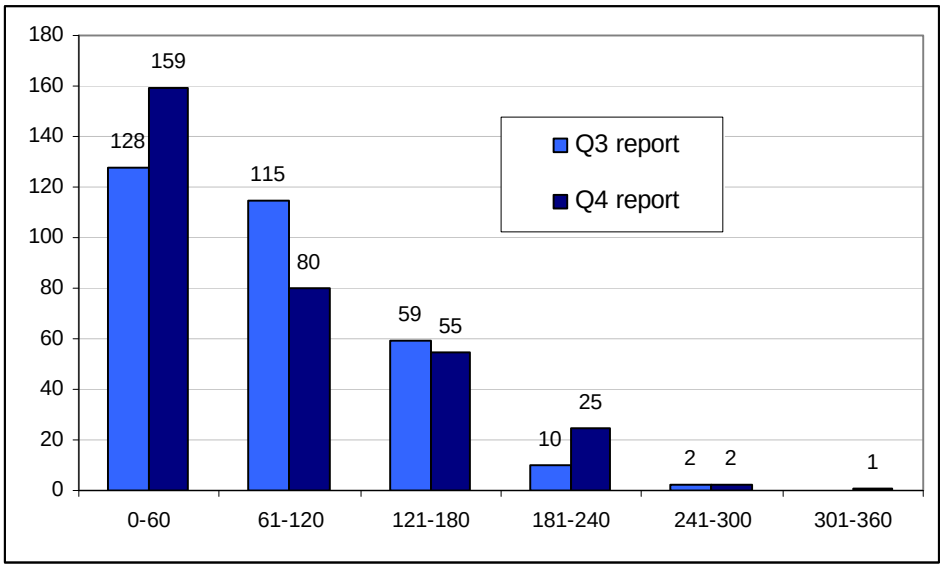
The Trust received 22 “link” (follow-up) contacts during the quarter. Of these, 18 complainants raised concerns about the Trust’s previous complaint investigation; 3 wished to attend a local resolution meeting and 1 asked for some further information. All “link” contacts are now tracked and categorised from receipt. However, this feature was not available for the same quarter last year.

Negotiated target times are an important feature of the new NHS Complaints Procedure that was introduced from 1 April 2009. Details of how often negotiated target times have been changed are included below.

So far the deadlines for 44% (80 cases) of complaints have been re-negotiated. Some of these timescales have had to be extended more than once. In total there have been 100 recorded date changes. This compares with a finalised figure of 50% (107 cases, 196 changes) for the same reporting period last year. However, as 70% of cases received during the present reporting period are still open (and thus potentially subject to further renegotiation), it would not be appropriate to directly compare the figures.

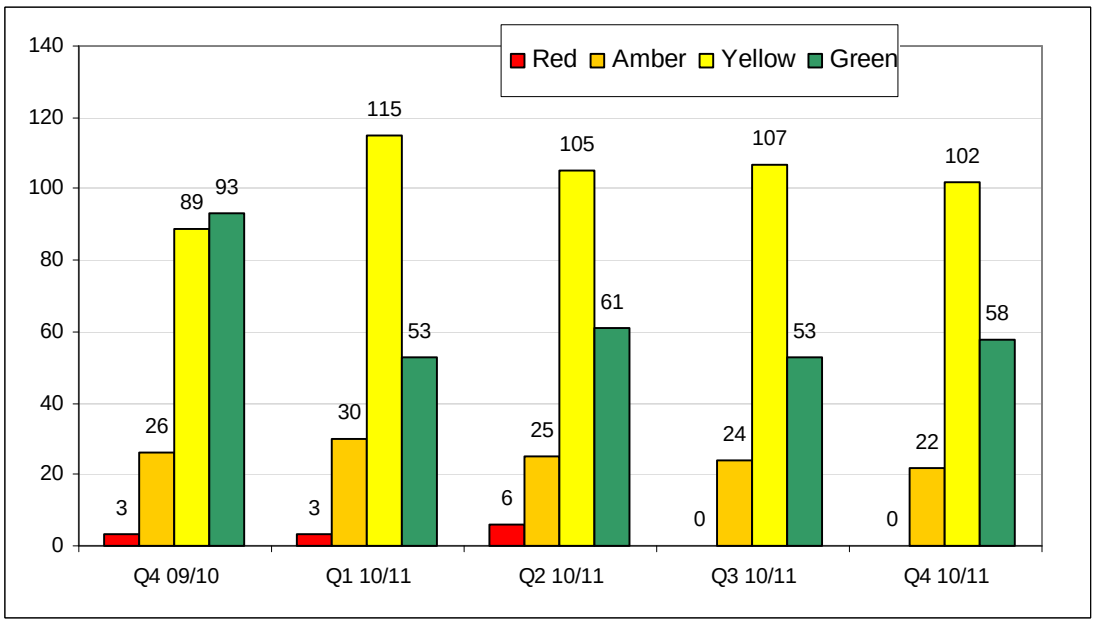
Overall response timings have remained unsatisfactory due to pressures within the complaints team. Response handling capacity has been boosted to ensure response times are appropriate and agreed timescales are met wherever possible. It is very difficult to assess divisional response time performance against this picture.

Graph 3.2b **Active** complaints grouped by 60 day intervals at the end of Q3 and Q4 2010/11



The complaints were graded as below. The severity of the grading remains broadly consistent with previous quarters.

Graph 3.2c **Grading** of formal complaints (Q4 2009/10 – Q4 2010/11)



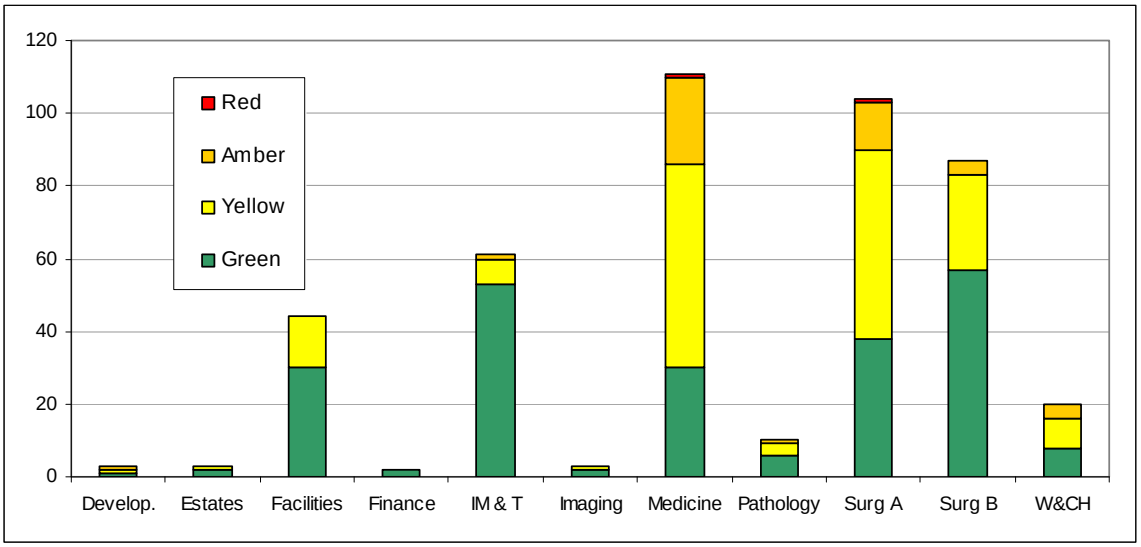
Key lessons learned for complaints during Q4 are attached at **Appendix 1**.

Action Plan Completion

All divisions are required to submit a copy of a completed action plan to the Complaints Department following the finalising of the Trust's investigation and response to the complainant. Monthly reports are being issued to relevant divisional managers containing details of any action plans yet to be submitted.

The graph below is a breakdown by division of action plans currently outstanding for complaints responded to up until the end of March 2011. The chart shows how many of each grade is outstanding.

Graph 3.2d Number of **action plans outstanding** by divisional lead (responses to end of Q4 2010/11)



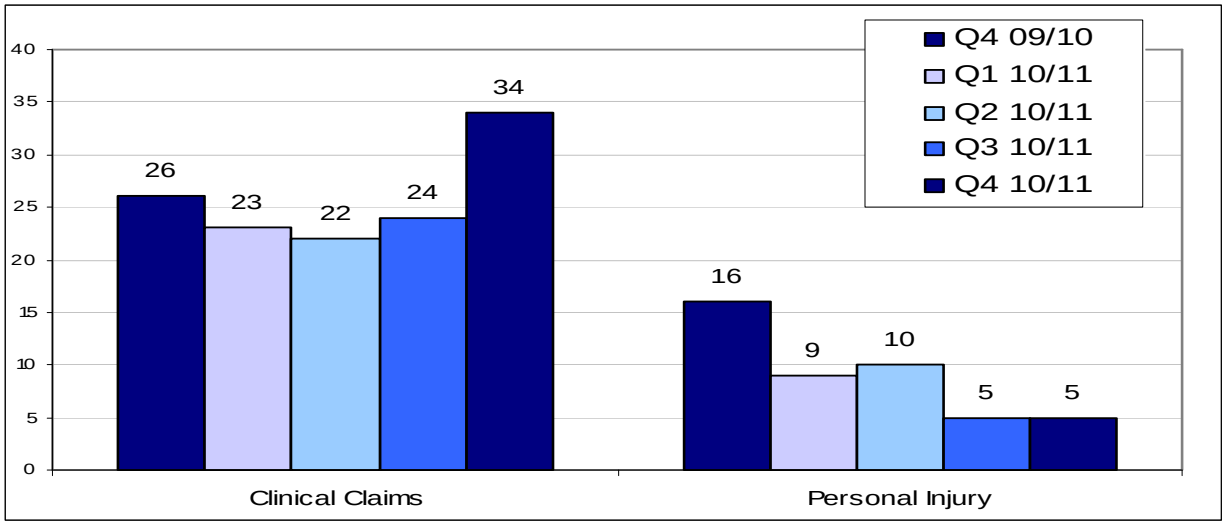
Referral of Complaints to the Health Service Ombudsman

Two cases were referred to the Ombudsman during the reporting period.

3.3 Claims

The claims received are as follows:

Graph 3.3a – **Claims** received by quarter



Of the 34 clinical claims received, there were 4 that had a reported clinical incident related to the case. 12 claimants had already raised their concerns via the complaints procedure.

Of the 5 personal injury claims received, there were 2 that had a reported clinical incident related to the case. No claimants had previously raised their concerns via the complaints procedure. However, personal injury claims typically relate to staff injuries (this applies to all 5 claims here) and staff are not able to raise their concerns via the NHS complaints procedure.

Table 3.3a **Categories** of claims

Allegation Category	Clinical Claims	Personal Injury Claims
Not clear	2	-
Burns/scalds/reactions	1	-
Delay In Treatment	2	-
Dissatisfied With Treatment	12	-
Failure Or Delay In Diagnosis	7	-
Failure To Recognise Complications	1	-
Fall/slip	1	2
Lacerations/sores	-	1
Moving/falling Objects	-	1
Operation Carried Out Negligently	4	-
Treatment Carried Out Negligently	4	-
Violence & Aggression	-	1

At present the Trust has 279 Clinical claims and 90 personal injury claims at various stages of the legal process.

Table 3.3b **Status** of all active claims

Status Type	Clinical Claims	Personal Injury Claims
Defence Served	2	-
Disclosure Of Records*	189	3
Early Stages	1	1
Letter Of Claim	21	58
Letter Of Response	3	-
Liability Admitted	6	13
Liability Being Assessed	9	5
Liability Denied	5	-
Negotiate Settlement	12	5
Part 36 Offer	8	1
Proceedings Issued/served	5	1
Settlement Made	18	3

* It is worth noting that not all requests for disclosure of records progress into a claim.

Table 3.3c Claims by **Directorate/Division** (*excludes records disclosure*)

Directorate	Clinical Claims	Personal Injury Claims
Unclear	2	4
Estates	-	20
Facilities/Nurs & Therapy	-	24
IM & T	-	1
Imaging	1	3
Medicine	24	18
Pathology	1	1
Surgery A	27	9
Surgery B	9	3
Women & Child Health	26	4

Table 3.3d **Ongoing** claims by category

Directorate	Clinical Claims	Personal Injury Claims
Burns/scalds/reactions	7	5
Defective Equipment	1	3
Delay In Treatment	15	-
Dissatisfied With Treatment	64	-
Failure Or Delay In Diagnosis	83	-
Failure To Obtain Consent	1	-
Failure To Recognise Complications	13	-
Failure To Warn Of Risk	-	1
Fall/slip	6	37
Head Injury	-	1
Infection - MRSA	1	-
Infection - Other	-	1
Lacerations/sores	4	1
Lack Of Care	3	-
Late Diagnosis And Treatment	3	-
Lifting/moving/handling	2	12
Moving/falling Objects	-	13
Needlestick	-	10
Not Known	1	0
Operation Carried Out Negligently	35	
Stress		1
Violence & Aggression		5
Treatment Carried Out Negligently	40	

3.3 Aggregated analysis

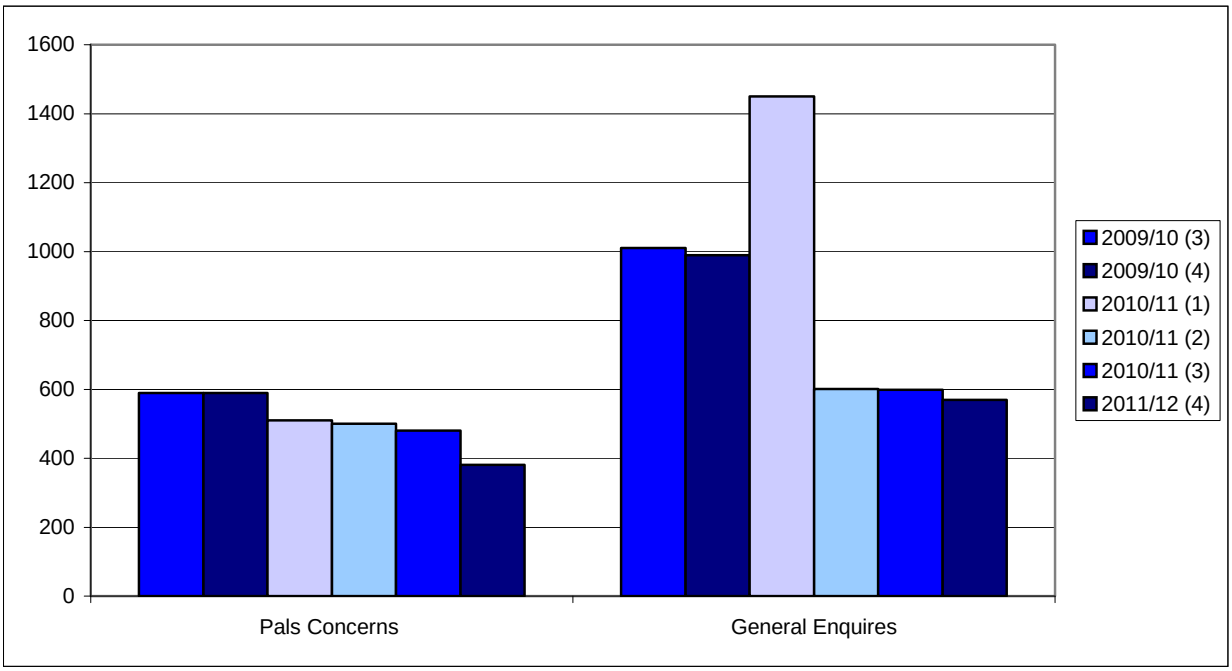
Details of key lessons learned are included at **Appendix 1**.

4. PALS

The Patient Advice and Liaison Service (PALS) provides a one stop service for patient's/relatives and their carers to speak to someone who will listen to their issue of concern, provide support, information and advice. PALS work in partnership with Trust staff to improve patient experience.

The enquiries detailed within this report have been dealt with by the PALS team.

Graph 4.1a Trends of number of **enquiries** received (Q4 January-March 2011)



The following methods identify ways in which patient's, their relatives and carers can access the PALS service:

- Telephone (calls are centralised at City Hospital via a direct line)
- Email
- Fax
- Appointment to meet PALS Lead
- Face to face contact at the Patient Support Centre BTC
- Completing a 'have your say form' and posting it in red boxes provided at main reception areas on 3 sites
- Dedicated phone line for direct access to PALS for Rowley Regis Hospital patients/relatives/carers.

Table 4.1a **Top 11 categories** of issues raised with PALS Q4 2010-11

Category breakdown	Number of contacts
APPOINTMENTS	
Appointment Cancellation	33
Appointment Delay	19
Appointment Notification	11
Appointment time	14
Appointment Booking (Choose and Book)	5
ATTITUDE OF STAFF	
Admin	2
AHP	0
Ancillary	2
Doctor/Consultant	8
Nurse	7
CLINICAL TREATMENT	
Clinical Care	10
Clinical Treatment	10
Delay in Investigations	2
Delay in Results	1
Delay in Surgery	3
Delay in Treatment	9
Delay in X-ray/Scan	4
Information – Condition	1
Medicines	4
Waiting time	3
COMMUNICATION	
Written	20
Verbal	9
COMPLIMENTS	
Staff	6
Wards/Departments	4
ADMISSION/DISCHARGE/TRANSFER	
Admission Arrangements	
Discharge Arrangements	1
Transfer arrangements	11
	1
FORMAL COMPLAINTS	
Complaint advice	31
Complaint process	11
Complaint referral	20
Complaint Handling	5
Complaint response time	1

TRANSPORT		
	Patient Transport Service	6
	Car Park Charges	6
ESSENCE OF CARE		
	Continence	5
	Hygiene	3
	Nutrition	2
	Privacy and Dignity	2
	Safety	3
PERSONAL RECORDS		
	Access	6
	Content	3
GENERAL ENQUIRY		
	General Advice	40
	Information	16
	Referral	3
	Support Other	3

Compliments

During quarter 4, ten compliments were received in the following areas:

Neurophysiology (c)	1
Day Treatment Unit (s)	1
Accident & Emergency (s)	2
Newton 3 (s)	1
Newton 4 (s)	1
Paediatric Surgical Unit BTC	1
D11 (c)	1
PALS	1
Lyndon 2 (s)	1

5. Recommendations

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

Appendix 1

Lessons Learned Q4 2010/11

1. Incidents

127 red incidents were reported via incident forms during this period. Table top reviews are held for each and action plans developed, which are monitored through the Adverse Events Committee, chaired by the Chief Executive.

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

Examples of some of the red incidents and some key actions planned/lessons learned/actions completed are set out below:

Learning from Experience: Case Examples	
Incident	Action Taken / Good practice noted
A G1P0 was booked for low risk midwifery led care and had an uneventful antenatal period. The patient attended Serenity Suite with contractions. The patient progressed rapidly in the birthing pool with a compound delivery where the baby was born in poor condition (apgars 3:1, 1:5, 4:10). Extensive resuscitation was performed and the baby was intubated and transferred to NNU.	Develop a programme of regular rotation of midwives between Labour Ward/Delivery Suite and Serenity Suite
Pressure sores being identified on heels of patients who have plaster casts on.	Review of technique for application of POP
Bomb threat at City ED	Accident and Emergency Department evacuation managed very well and very orderly

Lessons Learned Q4 2010/11

1. Complaints

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

Learning from Experience: Case Examples	
Complaint	Action Taken
A lady was concerned about her maternity care and her overall experience with the birth of her baby, including the poor attitude of some staff and a lack of pillows on the post-natal ward.	The investigation identified that the lady's antenatal care was appropriate and her labour was induced in accordance with the local guidance. With respect to the poor attitude of some individuals, customer care workshops are continuing and relevant staff have been allocated to attend. The Trust has also had all pillows replaced and has increased stocks.
A gentleman was concerned about the re-organisation of the anti-coagulation clinic in that every patient is now required to see the "dosing officer" regardless of the result of their INR (International Normalised Ratio). He felt this resulted in chaotic overcrowding of the clinic and unnecessary waiting. Concerns were also raised about car-parking charges.	The system in the anticoagulant clinics is designed to ensure that all patients now undergo a consultation prior to discharge. This has lengthened attendance times, but does reflect best clinical practice. However, the transition from the old to the current system may have been smoother for patients had the Trust informed patients of the changes in good time to receive and consider any feedback. Better consultation will be adopted for any future clinic changes. The gentleman in question has been advised of 25 other locations within the community for INR checks where there are no parking charges.
A daughter of a lady with dementia felt that her mother's ward care had been poor and staff had not understood how to deal with her care.	The ward staff are being enrolled on the dementia training pathway. The review also identified some issues relating to documentation. The ward manager has discussed this with staff and has commenced a monthly audit.

2. Claims

The practice has been that solicitors instructed by the NHS Litigation Authority (NHSLA) to act on behalf of the Trust would prepare a formal report for each claim, which would include a number of specific risk management recommendations (if applicable).

- Due to the overall slower progression of litigation cases, no actions have yet been identified for this quarter.

MINUTES

Sandwell and West Birmingham Hospitals NHS Trust

Quality and Safety Committee – Version 0.1

Venue Executive Meeting Room, City Hospital **Date** 19 May 2011; 0915h – 1115h

Members Present

Mr R Trotman [Chair]
Mrs G Hunjan
Mr J Adler
Mr D O'Donoghue
Miss R Overfield
Miss K Dhami
Mr R White

In Attendance

Mr S Parker
Ms A Binns
Mrs H Mottishaw

Guests

Mr P Finch [Item 5 only]

Secretariat

Mr S Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received apologies for absence from Professor Derek Alderson.	
2 Minutes of the previous meeting	**SWBGR (3/11) 023**
Subject to minor amendment, the Quality and Safety Committee approved the minutes of the Governance and Risk Management Committee meeting held on 24 March 2011 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 (3/11) 023 (a)**
The updated actions list was noted by the Committee.	
4 Governance and Risk Management Committee Chair's annual report for 2010/11	**SWBGR (5/11) 008** **SWBGR (5/11) 008 (a)**
The Committee was asked to receive and note the Governance and Risk Management Committee Chair's annual report for 2010/11, which it was reported would be presented to the Trust Board at its next meeting.	

5 Local Security Management Specialist annual report 2010/11 and forward plan for 2011/12	**SWBGR (5/11) 006** **SWBGR (5/11) 006 (a) - SWBGR (5/11) 006 (c)**
Mr Finch joined the meeting to present the Local Security Management Specialist (LSMS) annual report 2010/11 and forward plan for 2011/12. The Committee was asked to note that of significance was that the Police response to calls made by the Trust was likely to be downgraded. Mr Finch advised that the Police were planning to respond to a 999 call within thirty minutes and routine responses would be met within 24 hours or not at all, depending on the nature of the request. As such, the Committee was advised that there was less support for security team to deal with incidents of violence and aggression. To mitigate this change, Mr Finch reported that he was investigating the use of tools which would assist the security teams with meeting the response to incidents in the most appropriate way. Miss Overfield advised that the way in which the Fire Service handles emergency calls made was also planned to change to provide a downgraded response, although negotiations with the Fire Service were reported to be underway to ensure that changes made impact minimally.	
6 Complaints	
6.1 Complaints referred for independent review	**SWBQS (5/11) 010** **SWBQS (5/11) 010 (a)**
Mrs Mottishaw presented the list of complaints that had been referred for independent review by the Parliamentary and Health Service Ombudsman (PHSO) as at 10 May 2011. In terms of complaint A4, concerning issues regarding the use of a contrast dye in an imaging procedure for a cardiac condition which had resulted in renal problems, Mr O'Donoghue advised that the issues were well understood on a national level and the dyes causing complications were being replaced with ones that presented less risk. Miss Binns remarked that it should be standard practice to seek consent from patients in this situation given that this matter related to an interventional procedure and therefore the risks associated with the treatment would have been explained to the patient. Mr Adler highlighted that there had been difficulty with communications with the PHSO on some occasions, including reports that had been sent by the Trust not appearing to be received. He asked whether this was an issue frequently encountered. Mrs Mottishaw advised that this was the case, however measures had been put into place to manage the issue.	
6.2 Action plan to the CQC regarding registration: Outcome 17	**SWBQS (5/11) 013** **SWBQS (5/11) 013 (a)**

Mrs Mottishaw presented the updated action plan that had been developed in response to the responsive review of complaints undertaken by the Care Quality Commission (CQC). One of the key pieces of work underway was reported to be updating the complaints and PALS leaflets. Miss Dhami confirmed that this activity was required in accordance with the provider compliance self-assessment tool. Mr Adler asked for confirmation that the complaints leaflet had been out of circulation for some time. Mrs Mottishaw advised that this was the case, although she highlighted that 'Your Views Matter' leaflets had been available for patients and visitors to complete. Mr Adler suggested that a composite leaflet should be developed, which captured information concerning complaints, concerns and compliments and asked to see the revised complaints form prior to publication. It was agreed that an update be given as part of the next discussion of the action plan as a specific point. In terms of complaints being handled by the Trust, the Committee was advised that there were 336 open matters, 32 of which required revised completion dates to be set. Mr Trotman asked how the secondment from the Trust's solicitors was working. Mrs Mottishaw advised that the work handled by these individuals mainly related to litigation, however this released some of the time previously spent by one of the complaints managers on litigation to now handle complaints. Other work in progress was reported to concern establishing systems to ensure that the process for handling inquests was made more robust. Templates were reported to be being developed for complaints responses with a view to streamlining them. In terms of staffing, the Committee was advised that the job specification for the Band 7 complaints manager had been agreed and that the post would be advertised shortly. Mrs Mottishaw reported that a Band 6 complaints manger would be recruited to cover the maternity leave of one of the existing substantive complaints managers. Mr Adler asked for confirmation that securing the Band 7 position was progressing without delay. Miss Dhami assured the Committee that as Mrs Mottishaw had advised, the position would be advertised shortly. Miss Overfield asked whether the planned level of staffing in the complaints department would be sufficient to handle the backlog. Miss Dhami advised that the backlog would be handled as planned.	
6.3 Summary profile of complaints	**SWBQS (3/11) 015** **SWBQS (3/11) 015 (a)** **SWBQS (3/11) 015 (b)**
Mrs Mottishaw presented the latest summary profile of complaints. The Committee was asked to note that there had been 13 more complaints received during April than responses issued. It was highlighted that the current number of complaints being handled was significantly higher than would be expected for an	

organisation of the size of the Trust and that a lower caseload per complaints manager would normally be expected. The Committee was advised that many of the complaints presented complex matters for investigation. Mrs Mottishaw reported that the focus on the complaints backlog had not necessarily concentrated on the older complaints in the system and that a trajectory to clear the backlog by December 2011 had been agreed, which required 25 or more complaints responses to be issued above the 70 per month being received. Mr Trotman asked whether the target was realistic. Miss Dhami confirmed that the trajectory was challenging. Miss Overfield highlighted that this plan required 25% more work per head than would be expected. It was highlighted that a reporting period of 21 working days had been set for the backlog clearance plan. Mr O'Donoghue asked whether there had been any consideration given to handling complaints in ways other than through the current process used. Miss Dhami advised that an investigatory report would not be issued in cases where the complaints do not require such a response; instead a proportionate response would be issued. Mr O'Donoghue asked whether consideration had been given to the use of clinics to handle complaints. Mrs Mottishaw advised that complainants appear to prefer receiving a written response before engaging in a meeting with relevant clinicians. Mr Adler asked for assurance that the staffing plans would be sufficient to handle the plans for handling the complaints backlog. Miss Dhami advised that deliverability would be tested in the forthcoming months. She acknowledged however that there was a risk to the achievement of the trajectory, should staff take leave or need to take a period of sickness absence. Miss Overfield asked whether thought had been given to whether any other members of staff in the Trust could assist with preparing complaints responses. She asked that any delays with issuing responses concerning nursing and medical staff matters be escalated as a priority. Mr Adler agreed that it was a sensible approach to consider whether internal resources could be deployed to assist with the preparation of complaints responses where possible. Miss Dhami advised that at the recent meeting of the Clinical Quality Review Group (CQRG) some of the PCT's Non Executive Directors had expressed concern at the complaints situation. As such, the Committee was advised that further information on the situation and remedial actions underway would be presented to the CQRG at its next meeting.	
7 NPSA safety alerts update	**SWBQS (5/11) 002** **SWBQS (5/11) 002 (a)**
Ms Binns reported that there had been a reduction in the number of safety alerts issued. Of those outstanding, one was highlighted to concern radiological imaging, however the Committee was advised that based on the actions planned, sign off of	

the alert was planned for September 2011. Miss Binns advised that the proposed actions had been discussed with PCT colleagues who were reported to be comfortable with the plans and the deadline set. Mr O'Donoghue advised that progress with the plans was dependent in part on IT and in particular iCM. In terms of the laparoscopic surgery alert, the Committee was advised that sign off by Urology and General Surgery remained awaited. Mr O'Donoghue offered to raise this matter with clinicians should the need arise.	
8 Trust Risk Register – 2010/11 Quarter 4 update	**SWBQS (5/11) 003** **SWBQS (5/11) 003 (a)**
Ms Binns presented the updated Trust Risk Register, reflecting the position for Quarter 4 of 2010/11. The Committee was asked to note that there had been little change since the previous version, although a risk concerning the lack of Mental Health liaison resources at Sandwell Hospital had been added, in line with an agreement made at the recent meeting of the Governance Board. Ms Binns advised that a risk concerning infant mortality at Sandwell Hospital had been removed from the risk register, given that this matter had been addressed by the reconfiguration of maternity services. The Committee was advised that there was difficulty with identifying the appropriate ownership of some of the risks, which was a contributory factor to the paucity of updates obtained. At future meetings, Ms Binns reported that the Committee would be presented with exceptions reports and an overview of risks rather than the full risk register. It was suggested that the decisions as to whether to tolerate the risk or mitigate against it, together with the financial implications of the actions if appropriate should be included within the reports. Mr White agreed that this would be a sensible inclusion and suggested that the risk score should take into account the financial exposure presented by the risk. It was further suggested that there should be a clear link between the expenditure decisions detailed in the annual plan and the nature of the risks identified on the risk register. Ms Binns reported that greater effort would be made to ensure that staff prepare more robust treatment plans and perform better risk assessments. Work was reported to be planned to improve the risk management process more generally at a divisional level.	
9 Assurance Framework – 2010/11 Quarter 4 update	**SWBQS (5/11) 009** **SWBQS (5/11) 009 (a)**
Mr Grainger-Payne presented the updated Assurance Framework, reflecting the position for Quarter 4 of 2010/11 which the Committee received and noted.	
10 Infection Control	
10.1 Quarterly Infection Control update	**SWBQS (5/11) 004**

	SWBQS (5/11) 004 (a)
Miss Overfield presented the quarterly update on Infection Control and advised that progress with minimising infection control rates was good, with the Trust performing within the regional and internal stretch targets. The Committee was advised that surveillance of infections associated with target organisms and MSSA infection rates was now required. Mr O'Donoghue asked whether table top reviews for incidents involving Infection Control issues were being undertaken. Miss Overfield advised that this was the case and were conducted in batches where appropriate.	
10.2 Annual Infection Control report	**SWBQS (5/11) 005** **SWBQS (5/11) 005 (a)**
Miss Overfield presented the annual Infection Control report, which the Committee received and noted. She advised that overall, 2010/11 had been a good year for controlling infection control rates. The Committee was informed that more recently there had been a Norovirus outbreak across City and Sandwell Hospitals which had been resolved and had been well contained.	
11 Clinical Audit Outturn report: 2010/11	**SWBQS (5/11) 012** **SWBQS (5/11) 012 (a)**
Mr Parker presented the end of year position with delivery of the Clinical Audit forward plan for 2010/11. It was highlighted that the plan comprised 66 audits, a number of which required ongoing data collection rather than being a finite piece of work. In just under 30% of cases, an action plan arising from the audit had been presented to an appropriate board or group. The Committee was advised that there had been a good level of participation (83%) in nationally mandated audits, however further work was required to ensure adequate involvement with the SINAP audit and PROMS data collection. Some specific areas of shortfall against some of the particular standards within the audits was noted, although Mr Parker advised that the Trust had not been notified to date that it was an overall outlier in any cases. A number of areas for development were highlighted, which had arisen from some internal audits, including the need to make some improvements to patient safety within the Trust. Mr O'Donoghue asked whether measures were in place to ensure that all audits undertaken across the Trust are captured centrally and are not undertaken without due authorisation. Mr Parker advised that it was a requirement of the policy governing clinical audit that all audits are undertaken with appropriate approval. It	

was agreed that audits recorded needed to be extended to those undertaken within nursing areas and Mr Parker was asked to liaise with Mrs Debbie Talbot, ADN for Quality and Patient Experience for this purpose.	
12 Clinical Audit Forward Plan: 2011/12	**SWBQS (5/11) 011** **SWBQS (5/11) 011 (a)**
Mr Parker presented the portfolio of audits that was due to be undertaken during 2011/12 and highlighted that the number of national audits in which the Trust was expected to participate had increased from that in 2010/11. Many of the additional audits were noted to concern NICE guidance, patient safety and NHSLA requirements. Miss Overfield asked that all audits related to CQuIN targets be captured within the Clinical Audit forward plan. It was noted that TCS audits were identified separately at present, however work would be undertaken shortly to harmonise systems and templates.	
13.1 – 13.3 Minutes from Governance Board	**SWBGB (3/11) 065** **SWBGB (4/10) 082** **SWBGB (4/10) 082 (a)**
The Quality and Safety Committee received and noted the minutes from the Governance Board meeting held on 4 March 2011 and 8 April 2011. The Committee also noted the actions list that was discussed at the meeting held on 6 May 2011.	
14.1 Minutes from Clinical Quality Review Group	**SWBQS (5/11) 007**
The Quality and Safety Committee received and noted the minutes from the Clinical Quality Review Group meeting held on 6 April 2011.	
15 Any other business	**Verbal**
There was none.	
16 Details of the next meeting	**Verbal**
The date of the next meeting of the Quality and Safety Committee was reported to be 21 July 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 – June 2011
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Robert White/Tony Wharram
DATE OF MEETING:	28 July 2011

SUMMARY OF KEY POINTS:

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

For June, the Trust generated a "bottom line" surplus of £216,000 which is £194,000 better than the planned position (as measured against the DoH performance target).

For the year to date, the Trust has a surplus of £6,000 which is £107,000 worse than the planned position

Capital expenditure for the year to date is £1,097,000 and the cash balance at 30th June was £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	**x**	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 19 July 2011; Finance and Performance Management Committee on 21 July 2011

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – June 2011

EXECUTIVE SUMMARY

• For the month of June 2011, the Trust delivered a "bottom line" surplus of £216,000 compared to a planned surplus of £22,000 (as measured against the DoH performance target).

• For the year to date, the Trust has a surplus of £6,000 compared with a planned surplus of £113,000 so generating a £107,000 adverse variance from plan.

•At month end, WTE's (whole time equivalents), excluding the impact of agency staff, were approximately 213 below plan. After taking into account the impact of agency staff, actual wte numbers are 46 below planned levels. Total pay expenditure for the month, inclusive of agency costs, was £7,000 below plan.

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

• Staged capital expenditure for the month was very low.

Financial Performance Indicators - Variances

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	194	(107)	>= Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	186	(127)	>= Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	7	(288)	<=Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	3	51	<= Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	46	(104)	<= Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	7,686	7,686	>= 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	113	6
Capital Resource Limit	9,448	1,097
External Financing Limit	---	7,686
Return on Assets Employed	3.50%	3.50%

2010/2011 Summary Income & Expenditure Performance at June 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	373,905	30,862	30,890	28	93,235	93,013	(222)	373,905
Other Income	39,200	3,170	3,318	148	9,577	9,909	332	39,200
Operating Expenses	(389,538)	(32,196)	(32,186)	10	(97,306)	(97,543)	(237)	(389,538)
EBITDA	23,567	1,836	2,022	186	5,506	5,379	(127)	23,567
Interest Receivable	25	2	10	8	6	26	20	25
Depreciation & Amortisation	(13,269)	(1,106)	(1,106)	0	(3,317)	(3,317)	0	(13,269)
PDC Dividend	(5,803)	(484)	(484)	0	(1,451)	(1,451)	0	(5,803)
Interest Payable	(2,156)	(180)	(180)	0	(539)	(539)	0	(2,156)
Net Surplus/(Deficit)	**2,364**	**68**	**262**	**194**	**205**	**98**	**(107)**	**2,364**
IFRS/Impairment Related Adjustments	(557)	(46)	(46)	0	(92)	(92)	0	(557)
SURPLUS/(DEFICIT) FOR DOH TARGET	**1,807**	**22**	**216**	**194**	**113**	**6**	**(107)**	**1,807**

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

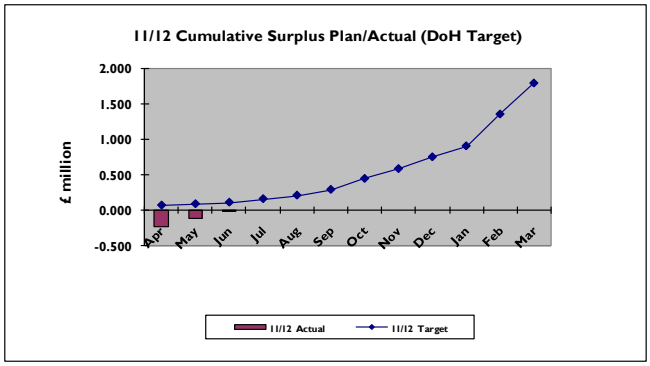
Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – June 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 June improved thus reducing the level of deficit reported at the end of May. Specifically in June, the performance was £194,000 better than plan lowering the year to date shortfall to £107,000.



Divisional Performance

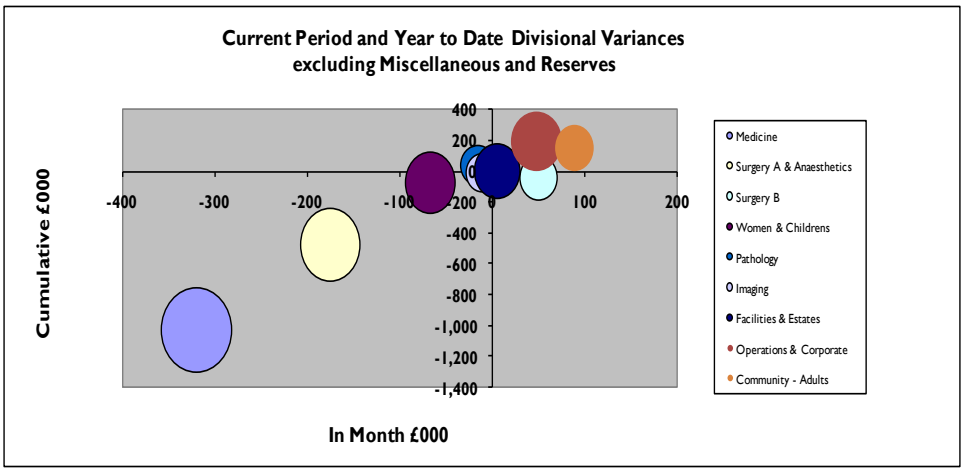
• For June, significant deficits persisted within a number of major clinical divisions, primarily Medicine at (£320,000) and Surgery A, Anaesthetics & Critical Care at (£175,000). This broadly continues the bottom line level of performance being delivered by these divisions in May. There are also a number of other, smaller, adverse performances particularly in clinical areas.

• In month performance of corporate divisions and Miscellaneous and Reserves was better than planned with surpluses of £48,000 and £582,000 respectively.

• Community – Adult Services has generated a further surplus in month.

• The pressures within Medicine (mainly seen through high staffing costs) are linked with the maintenance of high levels of capacity, in part linked with the need for additional bed capacity to be opened as well as the need to maintain throughput in A&E to ensure acceptable waiting times for patients. For Surgery A, significant levels of bank and agency staff have been used to cover vacancies and sickness as well as high demand in critical care. Waiting List initiatives have also continued to make a significant contribution to the adverse position.

• Although overall performance is better than plan for June, the financial performance of key clinical divisions worsened. Therefore, the actions being taken to mitigate pressures in these areas must begin to show positive gains in the remainder of the year in order to manage risk to the achievement of yearend financial targets.



The tables adjacent and overleaf shows adverse performance particularly within Medicine and Surgery A, offset by better than planned performance corporate divisions and reserves and miscellaneous.

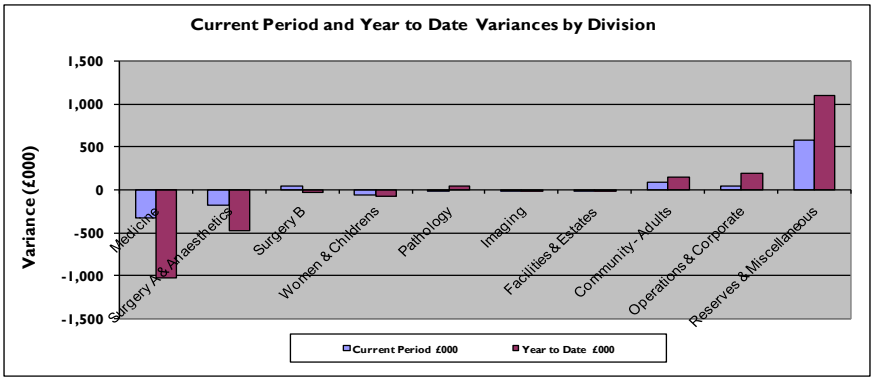
Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – June 2011

Divisional Variances from Plan

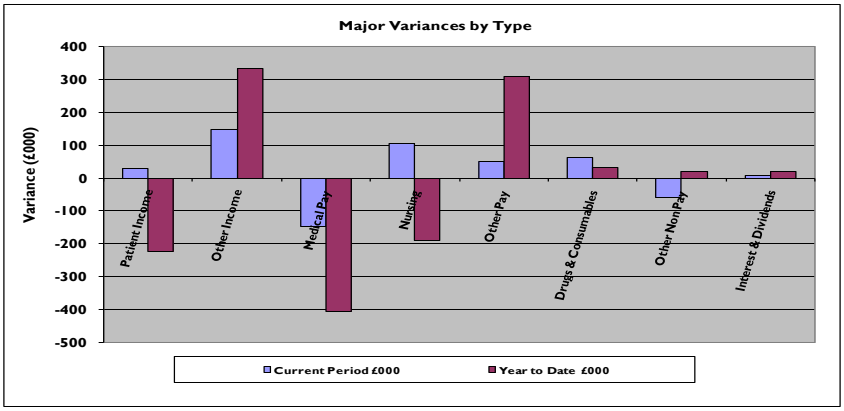
	Current Period £000	Year to Date £000
Medicine	-320	-1,025
Surgery A & Anaesthetics	-175	-474
Surgery B	50	-36
Women & Childrens	-67	-73
Pathology	-15	40
Imaging	-11	-10
Facilities & Estates	5	2
Community - Adults	89	150
Operations & Corporate	48	195
Reserves & Miscellaneous	582	1,105



For June, the table and graph below show the positive in month performance in other income and for nursing pay with adverse performances primarily for medical pay and other non pay.

Variance From Plan by Expenditure Type

	Current Period £000	Year to Date £000
Patient Income	28	-222
Other Income	148	332
Medical Pay	-146	-407
Nursing	104	-189
Other Pay	49	308
Drugs & Consumables	62	31
Other Non Pay	-59	20
Interest & Dividends	8	20

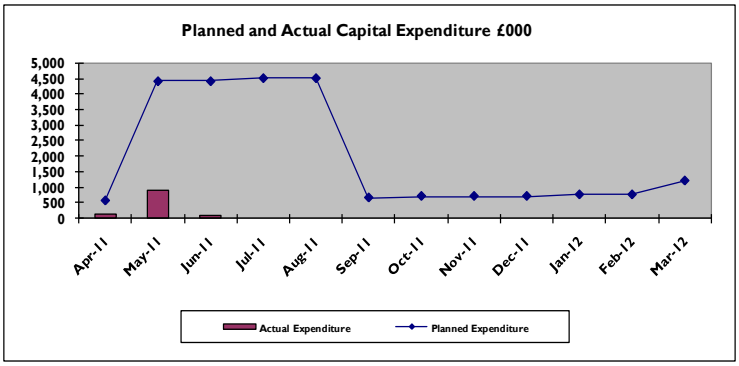


Capital Expenditure

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

• The profile (particularly the high level of expenditure between June and August, reflects the expected pattern of expenditure on Grove Lane land although this area is more volatile than others and no expenditure has yet been incurred for the year to date. Matters are however progressing.

• June expenditure was negligible.



Sandwell and West Birmingham Hospitals NHS

NHS Trust

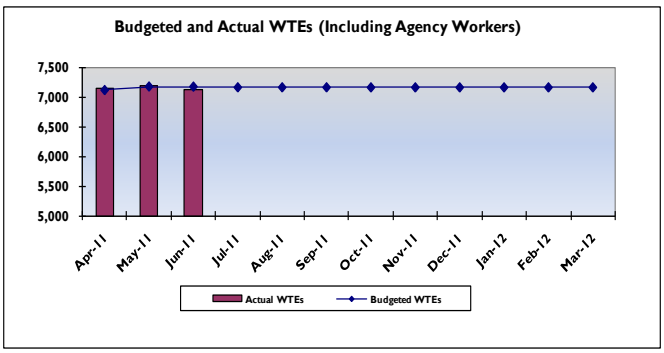
Financial Performance Report – June 2011

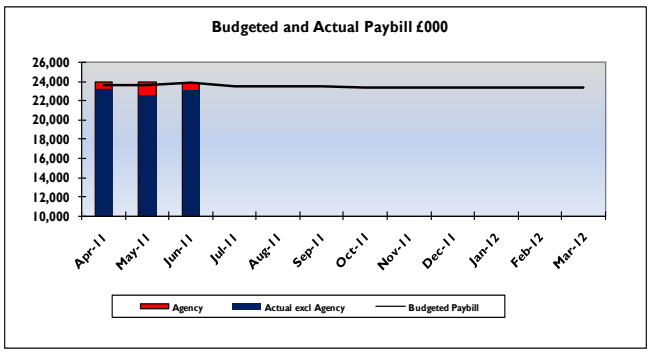
Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are approximately 46 below plan for June. Excluding the impact of agency staff, wte numbers are around 213 below plan. Actual wtes has fallen by 65 since May, primarily the result of a lower level of bank usage.

• Total pay costs (including agency workers) are £7,000 below budgeted levels for the month with higher than planned levels of spend being incurred for medical staff and HCAs and support staff offset by lower than planned spend in other pay groups .

• Expenditure for agency staff in June was £741,000 compared with £782,000 in May, an average of £673,000 for 2010/11 and a 'June 2010' spend of £413,000. 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 June					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	19,010	18,267		1,150	19,417	(407)
Management	3,964	3,732		0	3,732	232
Administration & Estates	8,173	7,476	243	330	8,050	123
Healthcare Assistants & Support Staff	7,423	7,039	670	57	7,765	(342)
Nursing and Midwifery	21,883	20,729	862	481	22,072	(189)
Scientific, Therapeutic & Technical	11,053	10,580		202	10,782	271
Other Pay	(13)	(37)			(37)	24
Total Pay Costs	71,493	67,785	1,775	2,221	71,781	(288)

NOTE: Minor variations may occur as a result of roundings

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – June 2011

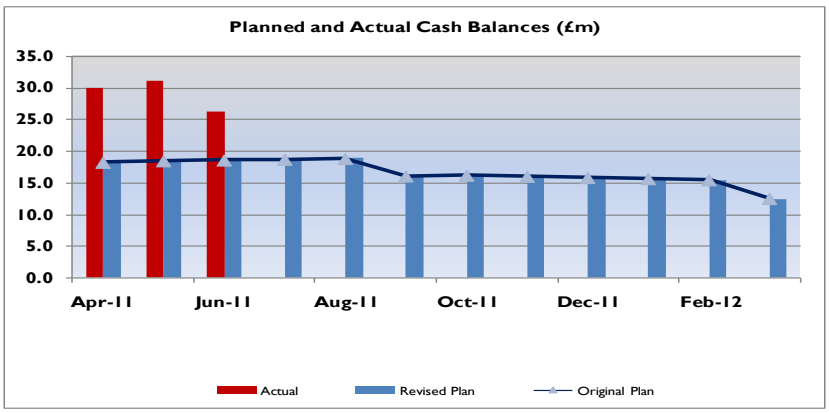
Balance Sheet

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

• Cash balances at 30th June are approximately £26.3m (£4.8m lower than at 31st May).

Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION

		Opening Balance as at 1st April 2011 £000	Balance at 30th June 2011 £000
Non Current Assets	Intangible Assets	1,077	1,052
	Tangible Assets	216,199	213,979
	Investments	0	0
	Receivables	649	650
Current Assets	Inventories	3,531	3,783
	Receivables and Accrued Income	12,652	16,690
	Investments	0	0
	Cash	20,666	26,258
Current Liabilities	Payables and Accrued Expenditure	(33,513)	(42,250)
	Loans	0	0
	Borrowings	(1,262)	(1,250)
	Provisions	(4,943)	(4,508)
Non Current Liabilities	Payables and Accrued Expenditure	0	0
	Loans	0	0
	Borrowings	(31,271)	(30,521)
	Provisions	(2,237)	(2,237)
		181,548	181,646
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)	(27,977)
		181,548	181,646



Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – June 2011

Risk Ratings			
Measure	**Description**	**Value**	**Score**
EBITDA Margin	Excess of income over operational costs	5.5%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	97.7%	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	0.1%	2
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	24.1	3
Overall Rating			**2.6**

Risk Ratings

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

• 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 1 to 3.

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

External Focus

• The West Midlands StHA collects performance data for all PCTs and non Foundation Trusts in its area. The data for Month 2 (May) performance has been published and limited sanctions announced for organisations not achieving at least a break even bottom line position. Monitoring of performance has been amended slightly to consider the absolute bottom line figure (i.e. whether an organisation has achieved an actual break even position or better) rather than performance relative to a planned position.

• For M2, the StHA reported that 2 PCTs and 6 NHS Trusts were in year to date deficit (4 of the trusts had a planned deficit and actual performance was in line with or better than plan) but none were forecasting a deficit at year end.

• The StHA reported that they were expecting greater DoH scrutiny of reported performance at Q1 (30th June) and the introduction of enhanced monitoring arrangements for those organisations.

• 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 financial pressures to the end of May 2011.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – June 2011

Conclusions

• The Trust generated an actual surplus of £216,000 during June bring its financial performance for the first three months of the year to an overall surplus of £6,000

•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 (£107,000) against the planned position although an absolute surplus of £6,000.

• The £216,000 surplus in June is £194,000 ahead of plan (for the month).

• Year to date capital expenditure was £1,097,000 which is significantly lower than plan but this is the result of actual land acquisition in Grove Lane being later than originally expected.

•At 30th June, cash balances are approximately £7.7m higher than the cash plan.

• Once again, significant in month shortfalls against plan have been generated by Medicine and, to a lesser extent, Surgery A, Anaesthetics & Critical Care. High levels of cost are primarily being driven by increased staffing levels in these divisions, manifested particularly through bank and agency spend and reflecting additional ward capacity being opened and the continuation of out of hours working and waiting list initiatives.

• The adverse performance in key clinical divisions is offset by better than planned performance in corporate services along with a release of reserves and miscellaneous divisions.

• Special measures have been implemented in Medicine together with targeted recovery actions within Surgery A, Anaesthetics & Critical Care to rectify the current adverse performance. Regular reviews of financial, activity, capacity and operational issues are being undertaken with the Executive Team and the Divisional management teams. In addition, trust wide measures have been implemented to generate greater headroom in order to ensure that the Trust is able to deliver its financial targets at the year end. The current situation will be kept under review and further action taken when and if this is deemed necessary.

Recommendations

The Trust Board 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:	28 July 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 – June 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 on 19 July 2011 and Finance and Performance Management Committee on 21 July 2011.

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

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	**Cancer Waits** - Performance (92.9%) against the 2-week wait for patients with Breast Symptoms during the month of May was mariginally short of the 93.0% threshold, performance for the year to date is 93.7%. Thresholds for all other cancer waits indicators during the month were met.
b	The overall number and percentage of **Cancelled Operations** at Sandwell remains low, an increase at City increased the overall rate to 0.7% for the month.
c	**Delayed Transfers of Care** increased on both sites, particularly at Sandwell to an overall rate of 6.3% across the Trust for the month, and 5.1% for the year to date. This compares with a rate of 4.3% for the corresponding period last year.
d	**Stroke Care** - provisional data for the month of June indicates that the percentage of patients who spent at least 90% of their hospital stay on a Stroke Unit reduced to 71.7%. **TIA** outpatient performance (the percentage of High Risk patients who were treated within 24 hours from initial presentation to the medical profession) improved to 50.0%, but remains below the 60% target.
e	**Accident & Emergency Clinical Quality Indicators** - provisional performance against the 5 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. Performance will also continue to be assessed against the 4-hour wait target, which during the month of June fell to 94.4% (year to date 96.00%).
f	The overall number of cases of **C Diff** reported across the Trust during the month of June increased to 13, of these 10 were at City. The trajectory for the month was 9. For the period to date a total of 25 cases are reported compared with a trajectory of 28. There are no cases of **MRSA Bacteraemia** reported during the month or year to date. Data for MSSA Bacteraemia and E Coli Bacteraemia is also included in the report.
g	**Referral to Treatment Time** - data for June was not available for inclusion within this report.
h	There were no Breaches of **Same Sex Accommodation** reported during the month of June.
i	A total of 1377 **PDRs** are reported for the year to date, this is equivalent to a rate of 73.4%. **Mandatory Training** compliance at the end of June is 86.6%.
j	**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 June 91.2% 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. Training scheduled to commence this month.
	Smoking Cessation (delivery) Acute Services - a target of 2000 referrals to the smoking cessation service within the year. A total of 401 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 (May) for which data is available is 71%.
	Medicines Management (Missed Doses) - Decrease (by 10% on Q1 baseline) in avoidable medicines ommissions.
	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.
	Mortality Review - target to review 60% of all qualifying (adult) deaths within hospital during March 2012. During the month of May 24.4% of deaths were reviewed compared with a target for the month of 20%, 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
j	**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.
	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 May was 46.2%.
	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. Electronic recording of performance for each of the 2 months to date is less than 10%.
	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. 71% 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. 58.5% of patients were referred during the month of May.
	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 (tbc) deliveries above the current baseline plus an additional 15 patients above 2010 / 11 outturn receiving herceptin at home. Targets to be fully achieved by Q4 2011 / 2012. Final details of this CQUIN are yet to be confirmed by Specialised Commissioners, internal monitoring indicates an increasing percentage of patients in receipt of home therapy with a cumulative increase in the number of patients for the first 2 months of 3
	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. 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 year to date.
k	**Ward Staffing** - The number of wards (of 39 in total) with a Trained : Untrained Staff Skill Mix Ratio of less than 60:40 and the number of wards where the Nurse : Bed Ratio is less than 1:1 are indicated. Data is split into 3 categories; Nursing Budgetted Posts & Funded Beds, Nursing Budgetted Posts and Actual Beds Open and Nursing Actual in Post & Actual Beds Open.
l	**Complaints** - a revised set of complaints indicators, which will be populated monthly has been incorporated into the report. Historical data is included where available.
m	**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.
n	Detailed analysis of **Financial Performance** is contained within a separate paper to this meeting.
o	**Activity** (trust-wide) to date is compared with the contracted activity plan for **2011 / 2012** - Month and Year to Date.

	Month				Year to Date			
	Actual	Plan	Variance	%	Actual	Plan	Variance	%
IP Elective	963	976	-13	-1.3	2702	2844	-142	-5.0
Day case	4894	3851	1043	27.1	13169	11226	1943	17.3
IPE plus DC	5857	4827	1030	21.3	15871	14070	1801	12.8
IP Non-Elective	4682	4995	-313	-6.3	13630	14926	-1296	-8.7
OP New	14416	12105	2311	19.1	39543	35292	4251	12.0
OP Review	36920	31542	5378	17.1	104420	91966	12454	13.5
OP Review:New	2.56	2.61	-0.05	-1.9	2.64	2.61	0.03	1.1
AE Type I	15121	16482	-1361	-8.3	45820	47692	-1872	-3.9
AE Type II	3258	3273	-15	-0.5	9935	9470	465	4.9

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

	2010 / 11	2011 / 12	Variance	%
IP Elective	2995	2702	-293	-9.8
Day case	13476	13169	-307	-2.3
IPE plus DC	16471	15871	-600	-3.6
IP Non-Elective	15366	13630	-1736	-11.3
OP New	40787	39543	-1244	-3.0
OP Review	110494	104420	-6074	-5.5
OP Review:New	2.71	2.64	-0.07	-2.6
AE Type I	47569	45820	-1749	-3.7
AE Type II	9106	9935	829	9.1

Overall Elective activity for the month and year to date continues to be in excess of the plans for the respective periods, although 3.6% less than that delivered during the corresponding period last year. Non elective activity is 6.3% less than plan for the month and 8.7% less than plan for the first 3 months of the year. Outpatient New and Review activity, month and year to date, continues to exceed plan. The Outpatient Follow Up : New attendance ratio reduced during the month to 2.56.

p	**Bank and Agency -** with the exception of 'Other Agency Costs' the use of Bank, Agency and Locum staff, and associated costs, exceed trajectories for the period.

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:	28 July 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 - There are 4 areas of underperformance during the month of June; A&E 4-hour waits, C. Diff cases (13) compared with trajectory (9), Stay (90%) on Stroke Unit and Delayed Transfers of Care. For the month this attracts a score of 2.33 (Performance Under Review).

Formal assessment by the DH is Quarterly. During this period there are 2 areas of underperformance; Stay on Stroke Unit and Delayed Transfers of Care. This attracts an overall score of 2.67 with the Trust classified as Performing.

Financial Performance (June) - The weighted overall score is 2.85 and is classified as Performing. Underperformance is indicated June in 4 areas; Better Payment Practice Code (Value), Better Payment Practice Code (Volume), Current Ratio and Creditor Days.

Foundation Trust Compliance Summary report:
There were 2 areas of underperformance reported during the month ofJune 2011, these were the number of reported cases of C. Diff compared with trajectory and A/E 4-hour waits. Monitor's assessment of Foundation Trust's is quarterly. During Quarter 1 there are no areas of underperformance reported. This attracts an Overall Score of 0.0 and a Green Governance Rating.

Performance in areas where no data are currently available for the month are expected to meet operational performance thresholds.

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:

Performance Management Board on 19 July 2011 and Finance and Performance Management Committee on 21 July 2011.

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

Operational Standards and Targets

Indicator	Weight	Thresholds		April 2011	Score	Weight x Score	May 2011	Score	Weight x Score	June 2011	Score	Weight x Score	Quarter 1 2011	Score	Weight x Score
		Performing	Underperforming												
A/E Waits less than 4-hours	1.00	95.00%	94.00%	96.70%	3	3.00	96.80%	3	3.00	94.40%	2	2.00	96.00%	3	3.00
A/E Unplanned re-attendance rate	0.50	Data Completeness / Data Quality Measures for Q1													
A/E Left Department without being seen rate	0.50														
A/E Time to Initial Assessment (=<15 mins)	0.50														
A/E Time to treatment in department (median)	0.50														
Cancelled Operations - 28 day breaches	1.00	5.0%	15.0%	0%	3	3.00	0%	3	3.00	0%	3	3.00	0%	3	3.00
MRSA Bacteraemia	1.00	0	>1.0SD	0	3	3.00	0	3	3.00	0	3	3.00	0	3	3.00
Clostridium Difficile	1.00	0	>1.0SD	3	3	3.00	9	3	3.00	13	0	0.00	25	28	3.00
18-weeks RTT Admitted 95 Percentile(weeks)	0.50	<=23.0	>27.7	19	3	1.50	19	3	1.50	<=23.0*	3	1.50	<=23.0*	3	1.50
18-weeks RTT Non Admitted 95 Percentile(weeks)	0.50	<=18.3	>18.3	14	3	1.50	13	3	1.50	<=18.3*	3	1.50	<=18.3*	3	1.50
18-weeks RTT Incomplete Pathway 95 percentile (weeks)	0.50	<=28.0	>36.0	15	3	1.50	15	3	1.50	<=28.0*	3	1.50	<=28.0*	3	1.50
18-weeks RTT 90% Admitted	0.75	=>90.0%	85.0%	94.60%	3	2.25	94.6%	3	2.25	=>90.0%*	3	2.25	=>90.0%*	3	2.25
18-weeks RTT 95% Non -Admitted	0.75	=>95.0%	90.0%	97.60%	3	2.25	98.1%	3	2.25	=>95.0%*	3	2.25	=>95.0%*	3	2.25
Cancer - 2 week GP Referral to 1st OP Appointment	0.50	93.0%	88.0%	95.7%	3	1.50	94.6%	3	1.50	>93.0%*	3	1.50	>93.0%*	3	1.50
Cancer - 2 week GP Referral to 1st OP Appointment - breast symptoms	0.50	93.0%	88.0%	94.2%	3	1.50	92.9%	2	1.00	>93.0%*	3	1.50	>93.0%*	3	1.50
Cancer - 31 day diagnosis to treatment for all cancers	0.25	96.0%	91.0%	100.0%	3	0.75	98.8%	3	0.75	>96.0%*	3	0.75	>96.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (surgery)	0.25	94.0%	89.0%	100.0%	3	0.75	100.0%	3	0.75	>94.0%*	3	0.75	>94.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (drug)	0.25	98.0%	93.0%	100.0%	3	0.75	98.2%	3	0.75	>98.0%*	3	0.75	>98.0%*	3	0.75
Cancer - 31 Day second/subsequent treat (radiotherapy)	0.25	94.0%	89.0%	no pts		n/a	no pts		n/a	>94.0%*	3	0.75	>94.0%*	3	0.75
Cancer - 62 day urgent referral to treatment for all cancers	0.33	85.0%	80.0%	85.8%	3	1.00	88.7%	3	1.00	>85.0%*	3	1.00	>85.0%*	3	1.00
Cancer - 62 day referral to treatment from screening	0.33	90.0%	85.0%	98.0%	3	1.00	100.0%	3	1.00	>90.0%*	3	1.00	>90.0%*	3	1.00
Cancer - 62 day referral to treatment from hospital specialist	0.33	85.0%	80.0%	100.0%	3	1.00	100.0%	3	1.00	>85.0%*	3	1.00	>85.0%*	3	1.00
Stroke (Stay on Stroke Unit)	1.00	80.0%	60.0%	82.90%	3	3.00	82.20%	3	3.00	63.20%	2	2.00	76.70%	2	2.00
Delayed Transfers of Care	1.00	3.5%	5.0%	4.70%	2	2.00	4.30%	2	2.00	6.30%	0	0.00	5.10%	0	0.00
Sum	**14.00**					**34.25**			**33.75**			**28.00**			**32.00**
Average Score						**2.91**			**2.87**	* projected		**2.33**	* projected		**2.67**

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 TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2011/12

Financial Indicators

Criteria	Metric	Weight (%)		SCORING 3	SCORING 2	SCORING 1	2011 / 2012 April	Score	Weight x Score	2011 / 2012 May	Score	Weight x Score	2011 / 2012 June	Score	Weight x Score
Initial Planning	Planned Outturn as a proportion of turnover	5	5	Planned operating breakeven or surplus that is either equal to or at variance to SHA expectations by no more than 3% of income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to SHA expectations by more than 3% of planned income.	Operating deficit more than or equal to 2% of planned income	0.00%	3	0.15	0.00%	3	0.15	0.00%	3	0.15
Year to Date	YTD Operating Performance	25	20	YTD operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of forecast income.	Operating deficit more than or equal to 2% of forecast income	0.00%	2	0.4	-0.03%	2	0.4	0.00%	3	0.6
	YTD EBITDA		5	Year to date EBITDA equal to or greater than 5% of actual year to date income	Year to date EBITDA equal to or greater than 1% but less than 5% of year to date income	Year to date EBITDA less than 1% of actual year to date income.	4.60%	2	0.1	5.09%	3	0.15	5.23%	3	0.15
Forecast Outturn	Forecast Operating Performance	40	20	Forecast operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of income.	Operating deficit more than or equal to 2% of income	0.00	3	0.6	0.00	3	0.6	0.00	3	0.6
	Forecast EBITDA		5	Forecast EBITDA equal to or greater than 5% of forecast income.	Forecast EBITDA equal to or greater than 1% but less than 5% of forecast income.	Forecast EBITDA less than 1% of forecast income.	5.71%	3	0.15	5.70%	3	0.15	5.70%	3	0.15
	Rate of Change in Forecast Surplus o Deficit		15	Still forecasting an operating surplus with a movement equal to or less than 3% of forecast income	Forecasting an operating deficit with a movement less than 2% of forecast income OR an operating surplus movement more than 3% of income.	Forecasting an operating deficit with a movement of greater than 2% of forecast income.	0.00%	3	0.45	0.00%	3	0.45	0.00%	3	0.45
Underlying Financial Position	Underlying Position (%)	10	5	Underlying breakeven or Surplus	An underlying deficit that is less than 2% of underlying income.	An underlying deficit that is greater than 2% of underlying income	0.25%	3	0.15	0.44%	3	0.15	0.44%	3	0.15
	EBITDA Margin (%)		5	Underlying EBITDA equal to or greater than 5% of underlying income	Underlying EBITDA equal to or greater than 5% but less than 1% of underlying income	Underlying EBITDA less than 1% of underlying income	5.71%	3	0.15	5.70%	3	0.15	5.70%	3	0.15
Finance Processes & Balance Sheet Efficiency	Better Payment Practice Code Value (%)	20	2.5	95% or more of the value of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the value of NHS and Non NHS bills are paid within 30days	Less than 60% of the value of NHS and Non NHS bills are paid within 30 days	82.00%	2	0.05	64.00%	2	0.05	70.00%	2	0.05
	Better Payment Practice Code Volume (%)		2.5	95% or more of the volume of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the volume of NHS and Non NHS bills are paid within 30days	Less than 60% of the volume of NHS and Non NHS bills are paid within 30 days	76.00%	2	0.05	77.00%	2	0.05	86.00%	2	0.05
	Current Ratio		5	Current Ratio is equal to or greater than 1.	Current ratio is anything less than 1 and greater than or equal to 0.5	A current ratio of less than 0.5	0.95	2	0.1	0.96	2	0.1	0.97	2	0.1
	Debtor Days		5	Debtor days less than or equal to 30 days	Debtor days greater than 30 and less than or equal to 60 days	Debtor days greater than 60	12.08	3	0.15	11.92	3	0.15	15.32	3	0.15
	Creditor Days		5	Creditor days less than or equal to 30	Creditor days greater than 30 and less than or equal to 60 days	Creditor days greater than 60	40.40	2	0.1	41.13	2	0.1	39.59	2	0.1
						Weighted Overall Score			2.60			2.65			2.85

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

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Corporate Objectives 2011/12 – Progress Report (Quarter 1)
SPONSORING DIRECTOR:	Mike Sharon, Director of Strategy & Organisational Development
AUTHOR:	Ann Charlesworth, Head of Corporate Planning
DATE OF MEETING:	28 July 2011

SUMMARY OF KEY POINTS:

The report contains a summary of progress at the end of Quarter 1, towards the achievement of the Trust's Corporate Objectives set out in the Annual Plan 2011/12.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Trust Management Board on 19 July 2011

Sandwell and West Birmingham Hospitals NHS
NHS Trust

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

INTRODUCTION

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

QUARTER ONE PROGRESS

A summary of the position on each objective at the end of Quarter 1 is set out in the table that accompanies this report. An overview of the Q1 RAG assessment for each objective is set out in the table below.

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

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

At the end of quarter one, less than half (48.5%) of objectives have been assessed as green. There are two objectives which have been identified as red (3.2 Deliver Changes as part of RCRH Programme and 5.1 Begin to Procure a New Hospital). The remainder (45.5%) have been identified as amber.

CONCLUSION AND RECOMMENDATIONS

This report and the accompanying table present an overview of the position on our corporate objectives for 2011/12 at the end of Quarter 1. The Trust Board is recommended to:

- NOTE the progress made on the corporate objectives at Q1.

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

PROGRESS REPORTING

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

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

CATEGORISATION

Progress with the actions in the plan has been assessed on the scale set out in the table below.

Status	
3	Progressing as planned or completed
2	Some delay but expect to be completed as planned
1	Significant delay – unlikely to be completed as planned

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter One (June 2011)**	**Red /Amber /Green Assessment**
1.	***Accessible and Responsive Care***				
1.1	**Identify and implement specific ways of improving the health of the population we serve.** **DO'D**	• Catalogue of relevant indicators drawn from primary care but mapped to each directorate • Discussions with Directors of Public Health to establish priorities • Identify data sources and create data flow for each indicator • Incorporate indicators into SWBH QMF dashboards for each directorate or specialty • Incorporate indicators into a Clinical Quality dashboard for RCRH		• Some indicators identified. Mapping process due for August	**2**
1.2	**Ensure close and effective relationships with local GP consortia, PCT Clusters and Local Authorities.** **MS (with DO'D)**	• Deliver on medical engagement LIA action plan. • Identify leaders and opinion formers in each consortium and continue active engagement. • Promote and improve direct contacts between directorates and primary care clinicians. • Trust represented by Executive or senior Medical leads at all Cluster meetings for Birmingham and Solihull and the Black Country.	Consortia emerging, regular contact established but lack of systematic approach involving clinical divisions	• Uncertainty about future form and federating relationships with Commissioing groups has led to delay in setting up formal engagement structures • First joint meeting between BD and Divisions arranged to discuss Gp relationships • Senior input to cluster meetings achieved	**2**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter One (June 2011)**	**Red /Amber /Green Assessment**
		• Integrate work of Business Development Team with representatives from each Division. • Improve flow of information and communication between hospital doctors and GPs.			
1.3	**Deliver Access performance measures including those set out in the Operating Framework for 2011/12.** **MD (RB)**	• New A&E standards. • 18 weeks referral to treatment standard maintained (95th percentile).	Not available Not available Not available Not available Not available 96.99% 20 weeks (March 2011) 16 weeks (March 2011)	A/E Clinical Quality Indicators: - Total time (hrs:mins) in Dep't (95th centile) Actual 4:38 (June 2011) (Target <4:00) - Time (mins) to Initial Assessment (95th centile). Actual 30 mins (June 2011)(Target =<15) - Time (mins) to Treatment in Dep't (median) Actual 67 mins (June 2011)(Target =<60) - Unplanned reattendance rate (%) Actual 1.10% (Q1)(Target =<5.0) - Left Dep't without being seen rate (%) Actual 4.58% (Q1)(Target =<5.0) A/E 4-hour waits - 96.00% (Q1)(Target =>95.00) 18 weeks RTT Standards: - Admitted Care (weeks) (95th centile) Actual 19 weeks (May 2011)(Target =<23) - Non-Admitted (weeks)(95th centile) Actual 13 weeks (May 2011)(Target =<18.3)	**2**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter One (June 2011)**	**Red /Amber /Green Assessment**
		• Cancer waiting times (2 wks, 31 days & 62 days) standards maintained. • GUM 48 hr access standard maintained. • Rapid access chest pain standard (2 wk) maintained.	94.5% 94.7% 99.7% 88.0% 100% 100%	Cancer Waiting Times: - 2 weeks all cancers (%) Actual 95.1% (Apr/May 2011)(Target =>93) - 2 weeks Breast Symptomatic (%) Actual 93.7% (Apr/May 2011)(Target =>93) - 31 days diagnosis to treatment (%) Actual 99.4% (Apr/May 2011)(Target =>96) - 62 days urgent GP referral to treatment (%) Actual 87.4% (Apr/May 2011)(Target =>85) GUM 48 hour access: - Patients Offered App't within 48 hours (%) Actual 100% (Q1)(Target =>98%) Rapid Access Chest Pain: - Patients seen <14 days following urgent GP referral Actual 98% (Q1)(Target =>98%)	
1.4	**Continue to improve outpatient booking systems.** **MD (RB)**	• Hospital short notice cancellations reduced so that less than 20% of total are short notice. • DNA rate reduced to less than 10%. • Hospital initiated cancellations reduced to less than 15% of appts made in month.	(35% in Feb) (12% in Feb) (16% in Feb)	- Short notice cancellations actual 32.5% (June 2011) - DNA Rate New OP appointments actual 12.7% (June 2011) - DNA Rate Review OP appointments actual 11.8% (June 2011) - Hospital initiated cancellations actual 13.1% (June 2011)	**2**
1.5	**Improve patient flow from admission through discharge to home care / after care.** **MD (RB)**	• Acute delayed discharges reduced to less than 4% of acute beds. • Average hospital length of stay maintained at less than 4.5 days. • Numbers of very long stay	(5% in Feb) (4.4 in Feb) (187 in Feb)	- Acute delayed discharges actual 5.1% (Q1) - Average length of stay actual 4.5 days (Apr/ May 2011) - Long Stay Patients >28 days actual 184	**2**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter One (June 2011)**	**Red /Amber /Green Assessment**
		patients (>28 days) reduced to 150 or less. • Reduced readmissions within 30 days.	(8.0% following initial Elective or Non Elective Admission)	(June 2011) - Readmission Rate actual 6.8% (Apr/May 2011)	
2.	***High Quality Care***				
2.1	**Improve reported levels of patient satisfaction.** **RO (with all Execs)**	• Establish systems to seek patient/carer/user views that ensure all groups are represented. • Establish reporting and feedback systems of patient views at the Trust, Division, Directorate and Department level. • To ensure action plans exist and are delivered against areas of dissatisfaction/requiring improvement. • To have a list of priority patient experience improvement themes/topics and corporately plan and deliver the action. • Ensure external views are fed into internal feedback systems. • To deliver CQUIN target for patient experience improvement. • To measure behaviours against Trust Promises. • To develop an approach to 'customer care' training.		• Numbers of patient survey responses have now increased significantly. • Quarterly reports to divisions, directorates and wards. • Priority actions identified and being progressed.	**3**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter One (June 2011)**	**Red /Amber /Green Assessment**
2.2	**Continue to embed Customer Care promises.** **JK**	• Refresh the customer care promise action plan in line with the feedback from Hot Topics. • Regular analysis of patient survey results and complaints by customer care promises. • Revised recruitment, induction and appraisal processes focusing on customer care.		Customer care promise action plan has been refreshed with feedback from hot topics and following the establishment of a new sponsor group. Plan is currently in draft form awaiting sign off at next sponsor group.	**2**
2.3	**Improve the care we provide to vulnerable adults.** **RO**	• Ensure systems and processes for vulnerable adults are embedded in all clinical areas – including Deprivation of Liberty, Safeguarding, and Mental Health. • Deliver level 1 and 2 training targets. • Relevant policies are in place. • Delivery of targets set within dementia action plan. • Establishment of domestic violence training. • Achievement of standards/rules of the Mental Health Act. • CQC and NHSLA standards met. • Nutrition CQUIN achieved. • Falls and pressure damage targets achieved.		Systems in place and working well. WMQRS visit planned for 13th July to assess the Trust against standards. Nutrition, Privacy and Dignity Group established in response to CQC reports	**3**
2.4	**Make improvements in A&E services.** **JA**	• Build on the work from 2010/11 in respect of integration. • Ensure that newly developed systems become embedded and continue to support safer and more responsive care.	Baseline to be established at EDAT from evaluation new national quality	EDAT meeting monthly. Workforce investment plan in implementation – issues around consultant recruitment but otherwise on track. Resource commissioned to support production of Integrated Development Plan.	**2**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter One (June 2011)**	**Red /Amber /Green Assessment**
		• Ensure that the agreed financial investments lead to the successful recruitment of high quality Clinical staff (Medical and Nursing). • Implement systems to monitor and manage performance in respect of the new ED quality standards.	standards (not previously monitored)	Key incident trends improved but erratic compliance with pro-formas – under review	
2.5	**Make improvements in Trauma and Orthopaedic services.** **MD (RB)**	• 18 week waiting time standard achieved for orthopaedics (c. 70% in 18 weeks in Feb). • Workforce plan agreed and delivered for T&O wards. • Improved service line position for T&O. • Improved outpatient performance (reduced cancellations, short notice cancellations and review rates).	74.4% (March 2011)	- 18 week Admitted RTT 77.8% (May 2011) Discussions with Medical Director regarding plans for T&O have been held - speciality currently developing measures to improve efficiency and throughput as well as implementing decommissioning measures	**2**
2.6	**Make improvements in Stroke services.** **DO'D**	• Stroke dashboard fully populated and incorporated into the Quality Management Framework. • Ensure that performance remains in the top Quartile nationally. • Continued improvements in KPIs for Stroke and TIA pathways. • Ensure robust management structure for stroke services including clarity on reporting lines and accountability. • Develop an option appraisal in partnership with commissioners to ensure optimal configuration of		• Work on option appraisal now commenced • Stroke dashboard continues to evolve, though performance has been mixed • Stroke accountability now clarified and attributed to Elderly Care Directorate	**2**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter One (June 2011)**	**Red /Amber /Green Assessment**
		Acute and rehabilitation components of stroke/TIA services and pathways.			
2.7	**Embed the Quality and Safety Strategy incorporating the FT Quality Governance Framework.** **KD**	• Achieve the plan developed to ensure effective implementation of the Quality and Safety Strategy. • Positive outcomes to support the Trust's top 3 quality related priorities.		▪ Quality and Safety Strategy launched at the Leadership Conference and in Heartbeat in June ▪ Views on the new Strategy sought from staff via Hot Topics in June. ▪ Implementation Plan to be presented for discussion and approval to the Quality and Safety Committee.	**3**
2.8	**Improve and heighten awareness of the need to report and learn from incidents.** **KD (with all Execs)**	• Annual rate of incident reporting increased at least 10% on previous year. • Improved position with the NRLS report as benchmarked against similar size Trusts. • Reduced number of incidents that cause harm, of a similar nature and / or within the same environment / location.	Q1 – 2242 Q2 – 2630 Q3 – 2512 Q4 – 2430 Total - 9814	Q1 data shows that reported incidents totalled 1890 (including those waiting to be merged into the live database). Electronic rollout continues throughout the organisation, which may show a continued dip during Q2. Training on reporting incidents commences in July 2011, it is hoped this will improve reporting rates. Data for Oct 10-Mar 11 from NRLS expected during Q2 and hoped for improved position.	**3**
2.9	**Deliver the CQUIN targets** **RO/DO'D/MD (RB)**	• VTE prevention • Improve patient experience • Alcohol prevention • Smoking cessation • Nutrition assessment on admission	92.3% (Q4) 2041 referrals to smoking cessation	• VTE prevention remained on track through Q1 (>90% for each month in Q1 (Target =>90%) • Alcohol interventions still being developed • Smoking cessation interventions still being developed (401 referrals to smoking cessation service in Q1 (Target 500))	**2**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter One (June 2011)**	**Red /Amber /Green Assessment**
		• End of life care – choice of place to die • Enhanced recovery Stroke discharge • Medicines management – missed doses • Health Visiting response times • Falls assessment	End of Life Care (Acute) 56% (Q4) Falls assessment (Community) 25% (Q4)	• 71% (May 2011) • 9.9% (May 2011) • All on target for Chief Nurse responsibilities.	
3.	***Care Closer to Home***				
3.1	**Ensure a successful integration of adult and children's community services that has benefits for patients.** **MD (RB) (with RO)**	• Transfer successfully completed in April. • Agreed benefits realisation plan in place by end Q1. • Integration / benefits realisation delivered as planned.		Recent reviews suggest greater scope for benefits realisation than initially envisaged – revised plan to be developed.	**2**
3.2	**Deliver the agreed changes in activity required as part of the Right Care Right Here programme.** **MD (RB)**	• Decommissioning plan agreed with commissioners (value = £16m). • Plan successfully delivered by end of the year.		Decommissioning plan developed by SWBHT currently identifies 58% of the total value to be decommissioned Actions have been agreed with PCTs regarding implementation of some of the schemes, while plans and timetables for delivery are being worked up with the Divisions.	**1**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter One (June 2011)**	**Red /Amber /Green Assessment**
				Proposals are awaited from the PCT outlining their decommissioning initiatives along with anticipated values.	
3.3	**Play a key role in the local community, actively promoting healthy lifestyles and health education.** **JK**	• Development and approval of health promotion strategy. • Delivery of health promotion / education LiA and resulting action plan, involving all key stakeholders. • Launch of involvement website to promote healthy lifestyles. • Lead the development of a RCRH health promotion and education strategy. • Participate in joint venture tender for lifestyle services.	No baseline for 2010/11	• Staff feedback has been gained through Hot Topics, including a compilation of existing health promotion activity undertaken by staff and teams. Public health documents and priorities have been obtained from local PCTs to inform the strategy. • 'Engage' website will go live over the summer with healthy living section • Joint venture tender for lifestyle services complete but unsuccessful	**3**
3.4	**Develop a local response to national plans for Health Visiting.** **RO**	• Implementation plan supported by PCT/SHA. • Clear recruitment plans. • Increase University commissions. • Review of team skill mix. • Retention plan in place. • New models of care developed, including family partnerships.		Implementation plan produced. Briefing paper produced for Trust Committees. SIRG paper and workforce plan produced. Increase commissions done.	**3**
3.5	**Make fuller use of the facilities at Rowley Regis Community Hospital to provide care closer to home.** **MD (RB)**	• Launch of new intermediate care unit in June. • Agree and deliver plan for services at Rowley in 2011/12. • Increased numbers of outpatient clinics scheduled at Rowley.		Recruitment for the new reablement ward is taking place with a view to opening a 20 bed facility in September	**3**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter One (June 2011)**	**Red /Amber /Green Assessment**
4	***Good Use of Resources***				
4.1	**Deliver a £21.1m CIP and produce detailed plans to deliver a £20m annual CIP for a further three years.** **RW (with all Execs)**	• Presentation of the line by line CIP plan for the next financial year as assessed for quality and risk, deliverability and presented to the Finance and Performance Committee as part of the Trust Board's approval of the overall plan. Continuation of the robust monitoring and management of the plan via the Performance Management Board including tracking of replacement schemes, Full year/part year effects and any shifts from recurrent categories to non-recurrent. • Develop and agree the basis of allocating operational targets as part of 3 year CIP, ensuring capacity and expertise is developed so that plans are expressed in QUiPP and QuEP categories making use of all internal and external benchmarking data, e.g. SLR. Completion target to be consistent with commencement of strategic CIP work, end of Q1. • Integration of the plan within overall financial modelling including explicit cross-model audit trails of the impact of CIPs within the external and internal		Quarter 1 is showing some slippage against the year to date plan of £922k. There is a correlation between this and the financial positions of the Surgery A and Medicine divisions leading to immediate remedial action. The exceptions reporting and replacement scheme protocol is in place as part of recovering the position during 11/12 including the approval of replacement schemes were appropriate. Separate bi-weekly meetings and monitoring of weekly expenditure in some areas is in place as are regular reports to PMB, FPC and Trust Board. Additional resources are being placed into the Divisions to bolster capacity in order to assist with getting back on track.	**2**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter One (June 2011)**	**Red /Amber /Green Assessment**
		financial models (e.g. LTFM, LTSM, FIMS)			
4.2	**Achieve a £2m surplus.** **RW**	• Prepare a detailed financial plan with sufficient income based resources to meet anticipated expenditure in accordance with operating framework imperatives, capacity plans and risk reserves. • Ensure that Board reporting is clear between the DH target surplus and IFRS based bottom line results that take account of on-balance sheet treatment of long term contracts • Ensure that variations in the plan are reported at the earliest opportunity together with corrective mitigating plans as developed and implemented through the Performance Management Board.		Year to date surplus of £6k. This is slightly 'off plan' but is not altering the forecast to yearend owing to the measures being adopted to improve the position. Similar to the reporting of CIP performance, enhanced reporting is provided to the Finance committee along with action plans aimed at improving CIP performance and in turn contributing to the forecast outturn as agreed at the start of the year.	**3**
4.3	**Reduce premium rate working.** **MD (RB)**	• Premium rate working reduced by £1.8m compared with 2010/11 outturn. • Theatre utilisation improved: <20% late starts, <25% early finishes, average of >3.5 cases per list).	80% prompt starts (March 2011) 46% on time finishes (March 2011) 2.9 cases per	• 82% prompt starts (<15 mins late) (June 2011) • 47% on time finishes (<15 mins early) (June 2011) • 3.0 average cases per list (March 2011)	**2**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter One (June 2011)**	**Red /Amber /Green Assessment**
			list (March 2011)		
4.4	**Develop plans to improve the service line position of the Trust.** **MS**	• Identify three services. • Evaluate baseline position. • Develop improvement plan for each service.	Three services identified – Orthopaedics, Obstetrics and Dermatology	• Baseline position being verified through audit of input costs • Impact of CIP delivery being assessed • Benchmark services identified and other Trusts contacted to provide benchmark data	**2**
5	***21st Century Facilities***				
5.1	**Begin to Procure a new hospital.** **GS**	• OJEU notice placed. • GVD executed. • Clarity on Deed on Safeguard achieved.	Awaiting OBC approval.	Progress halted, awaiting approval from DH and HMT. DH resolving issues of Deed of Safeguard and FTPBC/PFI issues.	**1**
5.2	**Continue to improve current facilities.** **GS**	• Updated Estates Strategy. • Capital programme on plan. • Satisfactory environmental assessments (CQC, Hygiene Code, PEAT etc).	2010/11 Capital Programme delivered to plan.	Capital programme for 2011/12 agreed, being implemented.	**3**
5.3	**Develop detailed plans for the development of the community estate.** **GS**	• RCRH Community Facilities Programme Team embedded. • Programme for development agreed. • Initial projects commenced.	Engagement with PCTs commenced.	RCRH Community Facilities Programme team established, feasibility work being undertaken.	**3**
6	***An Effective NHS Organisation***				
6.1	**Make significant progress towards becoming a Foundation Trust.** **MS**	• Develop a detailed project plan. • Ensure delivery of all milestones in the project plan. • Secure any additional support required for the application	Project structure set up	• External support procured • Programme plan developed • Milestones delivered	**3**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter One (June 2011)**	**Red /Amber /Green Assessment**
		including stakeholder support.			
6.2	**Deliver a set of Organisational Development activities including a stronger voice for front line staff.** **MS**	• Develop an OD framework and action plan to support FT application. • Deliver a model of staff engagement and incentive system.	Lack of coherent set of OD activities	• Framework developed • OD programme Board agreed • OtF staff ambassadors being piloted in community services and pathology • Ambassador elections and welcome event held	2
6.3	**Develop our clinical systems and processes to reduce variability and ensure safe, error free care.** **DO'D**	• Continue diagnostic project in respect of Clinical Back Office Systems. • Establish Project Board to deliver on Paperlite and Clinical Back Office Projects. • Relevant processes (including SBAR for reliable clinical handover, "kitemarking" clinical offices and departments for information standards & root cause analysis) developed and embedded in all clinical departments.		• Paperlite and Clinical Back Office projects on track and expected to deliver 1st phase implementation by September • Standards out to consultation	**3**
6.4	**Improve staff satisfaction, health and wellbeing.** **MS**	• System of gathering staff views throughout the year. • Identify actions arising from staff views. • Publish staff survey results. • Regular communications to staff. • Health and Wellbeing action plan – delivery against timescales. • Reduction in sickness absence. • Measurable improvements in survey results.		• Reduced sickness rates being achieved. Trust and regional targets being met • Significant improvement in staff satisfaction score in 2010 but still below national average • Health and wellbeing action plan being delivered to timescales, new focus on nutrition advice	**3**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter One (June 2011)**	**Red /Amber /Green Assessment**
		• Links to OD/OTF plans around staff engagement and ownership.			
6.5	**Agree an IT strategy including an affordable route to procurement of an Electronic Patient Record.** **DO'D**	• Programme board set up and running. • Option appraisal complete. • Decision-making process agreed and underway.		• 1st workshop held to develop a plan for the plan • Remains on track	**3**
6.6	**Continue to develop and implement the Trust's approach to sustainability and transport and access.** **GS**	• Carbon Management Plan agreed. • Sustainability action plan on target. • Review and update travel plan.	Sustainability Action Plan being implemented.	Sustainability action plan and carbon management plan on track.	**3**
6.7	**Develop a training plan that reflects service needs, is resourced and supports the workforce plan.** **RO**	• Trust Training Plan developed by May. • Funding to support plan agreed June/July. • LBR and JIF funding identified. • Commissions with higher education institutions agreed. • L&D Committee monitoring of plan. • Plan clearly linked to workforce plan due September. • Learning Hub/Health tech proposal written and presented to relevant parties.		Training plan developed and submitted to SHA. LBR funding agreed. Non-medical commissions agreed.	**3**

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:	28 July 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 June 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: Ensure full Trust participation in the delivery of Right Care, Right Here programme exemplars project
Annual priorities	
NHS LA standards	
CQC Essential Standards of Quality and Safety	
Auditors' Local Evaluation	

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

Financial	**X**	The Right Care Right Here Programme sets out the future activity model for the local health economy including the transfer of activity into the community and to new PBC provider services.
Business and market share		
Clinical	**X**	The Right Care Right Here Programme sets the context for future clinical service models.
Workforce	**X**	The service redesign within the Right Care Right Here Programme will require development of the workforce to deliver redesigned services in a new way and in alternative locations. This will be overseen by the Workforce workstream within the Right Care Right Here programme.
Environmental		
Legal & Policy		
Equality and Diversity	**X**	The service redesign elements of the Right Care Right Here Programme will require equality impact assessments.
Patient Experience		
Communications & Media	**X**	Within the Right Care Right Here Programme there is a Communications and Engagement workstream.
Risks		

PREVIOUS CONSIDERATION:

Routine monthly progress report to Trust Board

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

RIGHT CARE RIGHT HERE PROGRAMME: PROGRESS REPORT JULY 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 July 2011. The Right Care Right Here Programme Director's report as presented to the Right Care Right Here Partnership Board at the end of June 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

The end of year monitoring reports for 2010/11 compared to 2009/10 showed the following activity trends:

- Outpatient Work - Overall levels of community outpatient activity continue to be in excess of levels reported in 2009/10 by 37%. This exceeds the position planned in the RCRH Activity and Capacity Model but is well below the planned level for 2016/17. At speciality level there are the ongoing exceptions of; ENT (-28%), Gynaecology (-51%), Dermatology (-11%) and Ophthalmology (-15%), with Gynaecology showing a slight improvement of 3%.

  The level of outpatient activity delivered by SWBH in acute hospital settings was marginally above the 2009/10 levels and well above the planned position for 2016/17.

- Emergency and Urgent Care - ED attendances continued on an overall downward trend, although activity in the last quarter showed a slight upward swing. ED performance overall was roughly in line with the position planned in the RCRH Activity and Capacity Model.

  The level of activity delivered through urgent care centres exceeded last year's outturn, ending at 109% above the RCRH Activity and Capacity Model 10/11 trajectory.

  If ED and UCC attendances are combined they were in excess of 09/10 performance, although the overall difference continued to reduce.

- Intermediate Care – The level of occupied bed days in the acute hospital are lower than in 2009/10 and below the position planned in the RCRH Activity and Capacity Model but remained well above the level planned for 2016/17. The analysis of actual average length of stay (AvLOS) performance shows that AvLOS for General Surgery and Trauma & Orthopaedics remains below that modelled for both 2010/11 and 2016/17, indicating the need for this level of performance to be maintained. Whereas General/Geriatric Medicine, Rehabilitation and Vascular Surgery were above the 2010/11 modelled levels, with much greater reductions required to deliver the planned position for 2016/17. The level of activity in community beds has remained the same whilst activity in the 'community bed alternative' services e.g. STAR and ICATT was higher than in 2009/10.

CARE PATHWAY AND SPECIALITY REVIEWS

Care Pathway reviews continue. The Hip Fracture pathway was presented and approved at June's RCRH Clinical Group. An additional 5 Care Pathway Review meetings were held in June and are expected to be presented at July's Clinical Group for approval pending financial impact estimations.

It was agreed at the June Clinical Group meeting to focus on a couple of localised pathways in order to determine how to move forward to publication. It was agreed to look at the Spinal Pain and Heart

Failure pathways as they both have a saving and a reduction of spend identified however, no costing of alternative services had been made by commissioners. It was agreed that these pathways would be worked through in detail.

The Speciality Review work for Rheumatology continues with the aim of completing the review by mid summer. Work is also taking place on a number of areas associated with a review of the 18-week pathway in Orthopaedics. Care pathway review work has been undertaken on Hip, knee and shoulder pathways. Further work is also planned to look at training and education and advice and patient management.

DECOMMISSIOINING AND RISK SHARING AGREEMENT

It was agreed between the Trust and PCTs, through the LDP process, that there would be a transfer of services 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 are developing plans to secure how this proceeds in detail. Within the Trust, the clinical divisions have developed proposals for a number of schemes and these are being discussed with commissioners. Work is ongoing to identify additional schemes.

PROGRAMME GOVERNANCE

The Programme Director has produced a paper proposing revised governance arrangements intended to streamline the decision making processes and tie decision making within the Programme more closely to annual contracting decisions and performance management. This paper has been circulated to partners including GP consortia leads for comments and will be discussed by the Partnership Board at a future meeting.

DISCUSSION WITH PCT CLUSTERS AND GP CONSORTIA LEADS

The RCRH Programme Director has had a series of discussions with both of the recently formed PCT Clusters and GP Consortia Leads. These discussions have confirmed ongoing support for the RCRH Programme and have highlighted some additional areas and priorities for future development. These include:

- Facilitating further discussions between GPs and secondary care consultants
- Identifying suggested specialities for the next Speciality Reviews
- Greater involvement of GP consortia leads in the Programme.

RECOMMENDATIONS

The Trust Board is recommended to:

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

Jayne Dunn
Redesign Director – Right Care Right Here
19th July 2011

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, 27th June 2011**

1. Summary and Recommendation

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

The Partnership Board is recommended to:

- Debate the content of the Combined Governance Paper at Appendix 1 and agree to receive a firm proposal at the July meeting (Section 2)
- Debate and agree the proposed approach of evaluating the ability of the SWBH programme board for IM&T to deliver the Programme's agreed Vision for the Use of Information Management and Technology (Section 3)
- Note the content of the remainder of the report in Section 4.

2. Combined Governance Arrangements

Board members will recall that I have been attempting for some time to achieve agreement on the rationalisation of decision–making and governance processes to speed up the delivery of changes to services following redesign activity through Care Pathway Reviews and now Specialty Reviews. The LDP negotiations provided an agreed set of principles within which to develop further proposals to achieve this aim. A detailed proposal has been developed, produced by Sohaib Khalid, Martin Stevens and I to generate debate and agreement on how this can be achieved.

The basic premise is to replace the many layers of approval with two groups, the Combined Governance Group and the Contract Management Group. These groups would need to be populated with relevant colleagues who are empowered to make service redesign decisions and commitments on behalf of their organisations. The Combined Governance Group would be the forum for this, with responsibility for implementation and evaluation of changes then being delegated to the Contract Management Group.

The changes proposed are far-reaching and would have implications for the internal governance processes relating to the Programme for the partner organisations. The Combined Governance Paper, given at Appendix1, is therefore consultative in nature and has been sent to partner organisations, including GP Consortia, and Programme Groups, for responses to be returned by 30th June 2011. After that date it is proposed to provide a firm proposal to Partnership Board for implementation.

In discussions to date, at the SWBH RCRH Implementation Board and in Sandwell PCT, at the Programme Board, the proposals have been broadly supported, although both groups have suggested that the Clinical Quality Group should remain as a separate group, rather than being incorporated into the Contract Management Group as proposed.

The Partnership Board is recommended to:

- Debate the content of the Combined Governance Paper at Appendix 1
- Agree to receive a firm proposal at the July meeting

3. Proposed IM&T Approach

3.1. Background

Board members will recall that the Partnership approved a Vision for the Use of Information Management and Technology in the Right Care Right Here Programme in September 2010. This is given at Appendix 2. It was agreed at that stage to take this vision forward for debate on implementation through joint working and development of IM&T systems with partner organisations through the Local Health Economy IM&T Board. This board did not meet from last summer to March 2011, because of uncertainty about the future of Connecting for Health. Given that this programme is now closed, the board has not met again and has been disbanded and therefore there is no obvious route through which to take forward the implementation of the IM&T vision of the Programme.

3.2 Current Context

Given current changes and future potential changes to responsibilities within partner organisations, and the need to work more closely with GP consortia as they develop commissioning responsibilities, it is not currently clear how this work can be carried forward. It is thought that there would be little value in establishing a Programme-led group at the moment, as the outcome and future shape of the government's reforms need to be clarified, including identification of where responsibility for primary care IM&T will be held. In addition, there has been considerable change locally, with community services being transferred to provider organisations, and changes in how IT services are managed in the PCTs. The establishment of PCT Clusters and the National Commissioning Board brings the potential for yet further changes.

3.3 SWBH Approach

The responsibility for IM&T in this trust has moved from the Chief Operating Officer on 1st April 2011 to the Medical Director. I have met with Donal O'Donoghue and the current position is that SWBH will be reviewing its vision and strategy over the next few months. This will result in a revised strategy and transition plan to achieve it by the end of 2011.

The discussion confirmed that SWBH would be developing its approach based on inter-operability of systems and open architecture, so this is in accordance with the Programme's agreed vision.

The Trust intends to establish a Programme Board to develop its strategy and manage its implementation and this will take into account the systems and IT needs of the community services for which it is now responsible. It has been confirmed that SWBH will welcome GP and Programme Team membership of this programme board.

3.4 Recommended Approach

Given the current uncertainty and the need for changes in organisations to be worked through, it is recommended that the Programme should take no further action at this stage. I propose that I should maintain a continuing dialogue with colleagues in all partner organisations and judge whether or not the SWBH programme board could fulfil the need of developing a programme-wide response for implementing the vision. If not, I would then re-consider the establishment of a Programme-led forum and bring this to the Strategy Group and Partnership Board for discussion and decision.

The Partnership Board is recommended to:

- Debate and agree the proposed approach of evaluating the ability of the SWBH programme board for IM&T to deliver the Programme's agreed Vision for the Use of Information Management and Technology

4. Items for Information

4.1. Discussion with Clusters

As reported at the last meeting, the meeting between the two PCT, SWBH and Partnership Chairs and Cluster Chief Executives was held on 23rd May 2011. The Cluster Chairs were unable to attend. An agreed note of the meeting is given at Appendix 3. In summary, the main points agreed in this positive discussion were:

- There was unanimous support for the continuation of the Programme, and this was reflected in the fact that the role and objectives of the Programme were explicit in each Cluster's System and QIPP Plans. There was an acknowledgement of the need for the Clusters to work together on issues relating to service transformation and reviewing acute capacity.
- There was a history of support for the Programme in the Birmingham and Solihull Cluster Executive Team, with a strong organisational memory and formal support. The Programme was described in discussions with GP consortia as being part of the solution, not part of the problem.
- The challenge for 2011/12 was delivery of change, maintaining and improving quality within financial reduction with every effort being made to deliver this. Alignment of the work programmes on this in the Black Country and Birmingham and Solihull would be essential, and having an agreed plan to deliver by April 2013 would be a huge achievement.
- It was agreed that some GP consortia continued to need nurturing and to be informed about the role of the Programme and in particular the cumulative impact of redesigning services.
- It was suggested that the Programme should look at how it can support GP consortia to achieve authorisation
- It was agreed that presentations to the Cluster Boards, or non executive development sessions, might be scheduled towards the end of the summer.
- The costs of the Transitional Financial Support were noted, as was the fact that the actual amounts were subject to annual renegotiation through the LDP process. The costs of the Programme Team were also noted.
- It was agreed to discuss the Senior Responsible Officer for the Programme outside the meeting.

4.2. Discussion with GP Consortia Leads

As reported at the last meeting, this was arranged for 25th May 2011. All but one of the GP Consortia Leads or their representatives attended, along with senior colleagues from SWBH and the two PCTs. Again this was a positive meeting. An agreed note of the discussion and outcomes is given at Appendix 4. The main points were:

- The Programme could usefully facilitate more discussions between Consultants and GPs, being more proactive in taking discussions into primary care settings
- The Activity and Capacity Model should be further broken down to identify planned activity and resource by GP consortium
- Communication about activities in the Programme needs to be improved, so that GPs are aware of change and know how to get involved
- Greater contact with clinical teams in SWBH would be welcomed, to get to the heart of collaborative working to improve the quality of the patient pathway
- The Programme should pursue facilitating discussions about improving T&O services including replacing the triage service in HoB which has just been decommissioned.
- In addition to the planned expansion of Specialty Reviews, after Rheumatology, the Programme should look at ENT and Paediatrics
- The evaluation of RAID needed to be undertaken effectively in a way which changes the trend to refer from A&E to secondary mental health
- It is important to sort out the chronic disease management process, and the work on developing a response to Medically Unexplained Symptoms was supported. The development of a strategic approach to how patients can be encouraged to develop greater self care skills was supported.
- The Programme's role in facilitating the debate and greater definition of the Decommissioning and Demand programme was supported
- The idea of establishing a GP consortia federation of those consortia with major interests in SWBH was discussed and warmly received by all
- GP consortia leads were interested in becoming members of the Partnership Board and it was agreed that appropriate meeting times would be canvassed for them. GP consortia leads expected to play an increasingly influential role in setting the agenda for service redesign and change
- It was suggested that a regular forum for looking at performance management and development issues might be established, involving the GP consortia leads, SWBH and the Programme. This need might be met by the Combined Governance paper

- There was discussion and general agreement about moving towards the notion of a clinician-led integrated care provider organisation across acute, community and primary care, with GPs being seen in the main as providers. It was noted that the Specialty Reviews could offer a powerful forum for beginning to explore these issues and reaching agreement on radical changes to how services are provided within a defined budget
- The development of such an integrated organisational model would need an appropriate investment in IT and systems across primary and secondary care

4.3 Health Impact Assessment Refresh

Following the inclusion of this in the Programme Objectives for 2011/12, I met with John Middleton and Paul Southon from Sandwell PCT Public Health Department separately and have agreed an approach which will centre on updating and refreshing the Health Impact Assessment for the Programme undertaken in October 2006. It is proposed to undertake this through an interactive workshop event before Christmas, with a final report in early 2012. The Programme Objectives will be updated accordingly.

5. Recommendation

The Partnership Board is recommended to:

- Note the content of the remainder of the report in Section 4.

Les Williams
Programme Director

2011-06-17 – 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:	Mike Sharon, Director of Strategy & Organisational Development
DATE OF MEETING:	28 July 2011

SUMMARY OF KEY POINTS:

The Project Director's report gives an update on:

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

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust 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 June 2011 – Overall status - Amber

Activities this period

•2nd draft LTFM completed
•Second draft market assessment completed
•Validation event held following which approach to CIPs provided by ATOS
•Strategic risks reviewed
•SWOT and PEST reviewed
•First draft IBP produced
•OSCs agreed approach to engagement
•Board effectiveness and staff surveys completed
•Staff focus groups held
•External stakeholder survey begun
•"Soft" mock Board to Board for September provisionally arranged for 15 September

Activities next period

•Make final amendments to IBP
•Submit IBP to SHA by 12 August
•Complete external stakeholder survey
•Provide more detail on milestones for the remainder of the programme
•SHA to provide initial 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 Boardroom, MEC, Sandwell Hospital **Date** 30 June 2011

Present:	Mrs Sue Davis	[Chair]	Mr Robert White
	Mr Roger Trotman		Miss Rachel Overfield
	Dr Sarindar Sahota		Mr Donal O'Donoghue
	Mrs Gianjeet Hunjan		Mr Graham Seager
	Mr Gary Clarke		Mr Matthew Dodd
	Mr John Adler		Mrs Jessamy Kinghorn
	Mr Mike Sharon		Miss Neetu Sharma

Observers: Mr Andrew Crawshaw [NHS West Midlands] Mrs Claire Heaney [Deloitte LLP]

Secretariat: Mr Simon Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Mrs Olwen Dutton and Miss Kam Dhami. The Chair welcomed Mr Crawshaw and Mrs Heaney to the meeting who were present to observe the meeting.	
2 Minutes of the previous meeting	**SWBFT (5/11) 027**
The minutes of the previous meeting were accepted as a true and accurate record of the discussions held on 26 May 2011.	
AGREEMENT: The minutes of the previous meeting were approved.	
3 Update on actions arising from previous meetings	**SWBFT (5/11) 027 (a)**
The Board received and noted the updated actions list. It was noted that there were no overdue actions or actions that required escalating for attention.	
4 FT Programme Critical Path	**SWBFT (6/11) 029** **SWBFT (6/11) 029 (a)**
Mr Sharon advised that Critical Path had not changed since the Board had reviewed it at the meeting in May. It was pointed out that the task concerning the	

production of the first draft of the IBP should be rated at green status and that the timing of the Board to Board meeting should be amended to reflect that this was scheduled for the end of September 2011. Mr Sharon advised that, although the meeting was identified in the Tripartite Formal Agreement (TFA) as a Board to Board, the SHA had agreed that it would be a meeting of executive directors and the CEO of the Trust and directors of the SHA to review the position of the Outline Business Case and the impact on the TFA timeline. It was agreed, however, that the date of the meeting should be held in the calendars of all Board members. Mr Sharon was asked whether the current financial position of the Trust would be likely to impact on the timetable for the Foundation Trust (FT) application and whether this would be discussed at the meeting scheduled for September. Mr Sharon advised that should the financial situation impact on the timetable for the application, a discussion would need to be held with the Strategic Health Authority (SHA) to renegotiate the timescales within the TFA. Mr Crawshaw advised that it was unlikely that the Trust's performance issues would be discussed as part of the meeting in September. It was noted that the recent outcomes of the CQC investigations and inspections would have been likely to impact on the FT application should these have occurred closer to the deliberations of the Department of Health and Monitor.	
5 FT workstream high level milestone plan	**SWBFT (6/11) 030** **SWBFT (6/11) 030 (a)**
Mr Sharon presented the high level milestone plans for the FT Programme, which he highlighted had been amended to show where any slippage had occurred. It was noted that the status needed to be updated against some actions. Mr Clarke suggested that actual slippage against planned slippage needed to be made clear within the plan.	
6 Update on external support for the FT application	**Verbal**
It was noted that this item would be covered within the Programme Director's report.	
7 Programme Director's report	**SWBFT (6/11) 031** **SWBFT (6/11) 031 (a)**
The Board considered a report by the Programme Director which outlined the progress of all key activities, including development of the Long Term Financial Model (LTFM) and Board Development. A key focus was reported to concern the preparation of the Integrated Business Plan (IBP) in readiness for submission to the SHA at the end of July 2011. The Board was advised that a 'soft' mock Board to Board would be arranged for September 2011 which would be facilitated by Deloitte. Mrs Heaney advised that	

a full Board to Board was a formal event, however a 'soft' Board to Board meeting was designed to be supportive and informative. The Board was advised outputs of the LTFM were to be considered within the next stage of work. It was suggested that Mr White needed to clarify the outcome of the recent McKinsey review of the impact of PFI schemes on FT applications when available, given that this would be critical to the progression of the programme. Mr Trotman reminded the Board that as part of the FT application a credible plan for the delivery of a four year Cost Improvement Programme (CIP) was needed. He highlighted that he had concerns over the work being undertaken by the Atos Origin consultants in this respect, particularly as the work did not appear to be progressing as swiftly as needed or that the key messages from the work were reaching deeply enough into the organisation. Mr Trotman emphasised the need to expedite the implementation of the set of LEAN experts into the Trust, on the basis that the Atos consultancy work was due to conclude in October 2011. It was also pointed out that there may be insufficient commitment to the work offered by the Trust's clinicians at present. Mr Adler advised that after a slow start, the consultancy work was delivering well. At a recent meeting, the Board was advised that the consultants had agreed that the elements of the Quality and Efficiency Plan (QuEP) were appropriate, although resourcing some of the workstreams needed to be improved. It was noted that the organisation of the outputs from Stage 1 of the consultancy work needed to be considered further and that in respect of introducing the LEAN resources, given the limited financial flexibility this would be a challenge. Mr O'Donoghue suggested that there should at least discrete pockets of LEAN expertise should be introduced into the Trust given the benefits that this approach would deliver.	
8 Initial Programme risk register	**SWBFT (6/11) 035** **SWBFT (6/11) 035 (a)**
Mr Sharon presented the FT Programme risk register. It was agreed that the risk register should be updated within the risks associated with the recent CQC inspections on Privacy, Dignity and Nutrition.	
9 Historical Due Diligence update	**SWBFT (6/11) 032** **SWBFT (6/11) 032 (a)**
Mr Sharon advised that all actions arising from the Historical Due Diligence exercise in 2009 had been completed.	
10 Deloitte readiness assessment	**SWBFT (6/11) 037** **SWBFT (6/11) 037 (a)**
Mr Sharon advised that Deloitte had undertaken an initial assessment of the Trust's FT Programme arrangement and provided a view of the version of the integrated Business Plan (IBP) that had been prepared in March 2009, to give	

ideas and suggestions to consider as part of the current iteration of the IBP. It was noted that the assessment of the FT Programme arrangements was considered satisfactory and that the current version of the IBP had incorporated many of the comments and suggestions proposed by Deloitte. Mrs Davis remarked that this input was useful for those responsible for preparing the chapters of the document. Mr Clarke asked how complete the current version of the IBP was seen to be. Mr Sharon advised that the document was c. 60% complete, with workforce information and the LTFM detail still to be added. It was highlighted that further work needed to be undertaken to ensure that the IBP read coherently across all chapters and to remove any duplication. Mr Adler asked what the assessment of the wider state of readiness for FT status had indicated. He was advised that there remained a significant amount of work to complete.	
11 Integrated Business Plan – Version 0.1	**SWBFT (6/11) 038** **SWBFT (6/11) 038 (a)**
The Board reviewed the draft Integrated Business Plan, considering each chapter in turn. The key themes and comments included: the need to clarify the greater complexity and challenging external environment within which the Trust was operating at present; the need to be more explicit about the ethnic mix of the population served by the Trust; inclusion of the Trust's overriding commitment to quality and safety needed to be reinforced throughout the document; that the document needed to be focussed with Monitor as its principal audience; the need to include greater detail on commissioning arrangement and their associated impact on the Trust; clarity that the Trust's strategy addressed the issues raised by the market assessment needed to be provided; the need to articulate the key risk to the organisation, based on the SWOT analysis should be included. Mr Sharon advised that the suggested amendments would be incorporated within the version of the IBP due for presentation to the Trust Board at its meeting in July 2011.	
12 NHS Modernisation	**SWBFT (6/11) 036** **SWBFT (6/11) 036 (a)**
The Board was asked to receive and note the analysis of the latest information received from the NHS Chief Executive concerning the plans to modernise the Health Service. The Board was advised that the information indicated that there would be a tighter grip on trusts from the centre, that there would be no relief on the FT process and timescales and that there was strong encouragement of commissioning support structures at regional or cluster level.	
13 Matters for information	**SWBFT (6/11) 033**

MINUTES

	SWBFT (6/11) 034
The Board received and noted the minutes from the meeting of the Monitor Board held in April 2011 and Monitor's FT bulletin published in May 2011.	
14 Any other business	**Verbal**
Mr O'Donoghue presented an analysis of the impact of the cessation of the National Programme for IT, which it was agreed would be considered in greater detail at the next meeting.	
15 Details of next meeting	**Verbal**
The next FT Programme Board meeting will be held on 28 July 2011 at 1300h in the Anne Gibson Boardroom at City Hospital.	

Signed ……

Print……

Date …….

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Midland Metropolitan Hospital Project: Project Director's Report
SPONSORING DIRECTOR:	Graham Seager, Director of Estates and New Hospital Project
AUTHOR:	Graham Seager, Director of Estates and New Hospital Project
DATE OF MEETING:	28 July 2011

SUMMARY OF KEY POINTS:

The Project Director's report gives an update on:

- Outline Business Case (OBC) approval
- RCRH Community Facilities Programme
- Learning from other schemes

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	21st Century Facilities
Annual priorities	
NHS LA standards	
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.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report to:	**Trust Board**
Report of:	**Graham Seager / Andrea Bigmore**
Subject:	**Project Director's Report**
Date:	**July 2011**

1. Outline Business Case (OBC) Approval

Engagement with the Department of Health (DH) is ongoing and feedback continues to be positive overall. The issues relating to Deed of Safeguard and the review of those trusts with PFI who are aiming to be Foundation Trusts still remain but a conclusion is anticipated shortly.

In the meantime the team is continuing the development and review of the procurement documents so that we are ready to start the procurement as soon as approval is given. The members of Trust Board are standing by ready to review the documents prior to initiation of the Procurement with an OJEU notice.

2. RCRH Community Facilities Programme

The RCRH Community Facilities Programme now reports to the Project Board and the first programme progress report was presented to the June meeting.

This is the programme of work required to develop community facilities across Sandwell, Rowley Regis, Sheldon Block and the Birmingham and Midland Eye Hospital (BMEC). The facilities will support the Right Care, Right Here (RCRH) Programme model of care and delivery needs to be carefully planned alongside the development of the Midland Metropolitan Hospital. A summary of the services planned to be located at each site is presented in the appendix.

The operational policies and specifications for the development of the facilities are currently being prepared by members of the team.

3. Learning from Other Schemes

The team is continuing to visit other schemes to ensure that we learn from others. We visited Enniskillen and Tunbridge Wells this month, which both have 100% single rooms.

Two senior nurses came on the visit to Tunbridge Wells giving us an opportunity to consider the approach to nursing patients in single rooms. We are still assuming 50% single rooms in our scheme.

The Enniskillen visit gave the team the opportunity to discuss how the procurement process worked for them – this is the first Trust with a completed project procured using the competitive dialogue process. It is important that we use the competitive approach to ensure

that we achieve the best possible design outcome and good value for money from the PFI contract.

Following the Enniskillen visit the team plans to seek lessons learned from other projects that are ahead of us in the competitive dialogue process.

Existing sites

SWBTB (7/11) 156 (b)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

> The existing sites will host Community hospitals that will deliver a range of outpatient, day surgery, intermediate care, community services, urgent care and diagnostic facilities. Other hospital outpatient clinics and health services will take place in health centres around the area, closer to where people live.

BIRMINGHAM TREATMENT CENTRE

OUTPATIENT SERVICES
General OP Specialities

Bespoke OP Specialities
- ENT
- Breast services
- Colposcopy
- Paediatrics
- Dental
- Orthotics
- Therapies (MSK, rehab, SLT, OT, Foothealth,)
- Cardiac Rehab

DIAGNOSTIC
Endsoscopy Unit
Imaging (PF, US, MRI, CT)
Medical Illustration
Phlebotomy
Cardiac Physiology
Respiratory Physiology (main dept)

DAY TREATMENT
Haemo oncology Services
Day Surgery Unit

OTHER
Pharmacy
Clinical and Corporate Admin
Facilities Support

SHELDON

Intermediate care beds x 34

OUTPATIENT SERVICES
Bespoke OP Specialities
- Dermatology (OPD, DTU, day surgery, PUVA, Lasers)

- Oral and maxillofacial Services (OPD, Minor surgery)

- Cardiac Rehabilitation
- Therapy Services (Rehab, OT, Neurology)

DIAGNOSTIC
Hearing Services Centre
Neurophysiology Service (main dept)

OTHER
Clinical and Corporate Admin
Mortuary
Facilities support

BMEC

OPHTHALMOLOGY
Outpatients & Paed OP
Day Surgery unit (3 theatres)
Visual Function dept
Ophthalmology A & E
Orthoptics
Optometry
Ophthlamology diagnostics
Dispensary
Clnical Admin / records
Wet Lab / training facility
(No inpatients, Paed surgery)

MIDLAND METROPOLITAN HOSPITAL

ACUTE INPATIENT BEDS 665
30 CCU
36 Neonatal
56 paediatric beds
17 Generic wards (32 beds)
14 Coronary care
64 EAU
16 High dependency beds

EMERGENCY / ELECTIVE SURGERY / Day Case
Emergency Department
2 Trauma theatres
2 Emergency theatres
8 Elective theatres
2 Maternity theatres
Delivery Suites x 12
Birthing centre x 6
Medical Daycase Unit / SCAT

DIAGNOSTIC
Endoscopy Unit
Cardiac Imaging and Therapy
Imaging (PF, US, Ante Natal US, MRI, CT,
Physics & Nuclear Medicine., IR)
Medical Illustration
Phlebotomy
Cardiac Physiology (main dept)
Respiratory Physiology
Neurophysiology

OUTPATIENT SERVICES
Bespoke OP Specialities
Fracture Clinic (Orthotics)
Ante Natal care
ENT
Paediatric
Urodynamics
Ophthalmology with Lasers
Complex Clinics

OTHER
Pharmacy
Clinical and Corporate Admin, Academic Unit
Multi faith
Mortuary
Facilities Support

SANDWELL COMMUNITY HOSPITAL

Intermediate care beds x 48

OUTPATIENT SERVICES
General OP Specialities

Bespoke OP Specialities
- Ophthalmology
- ENT
- Breast services
- Colposcopy
- Paediatrics
- Dental
- Genito Urinary Medicine
- Orthotics
- Antenatal
- Therapies (MSK, rehab, SLT, OT, Foothealth,)
- Cardiac Rehab

DIAGNOSTIC
Endsoscopy Unit
Imaging (PF, US, AN US, MRI, CT)
Medical Illustration
Phlebotomy
Cardiac Physiology
Respiratory
Pathology

DAY TREATMENT
Haemo oncology Services
Day Surgery Unit

PRIMARY CARE
Urgent Care / walk in
GP practice (8000 popn)

OTHER
Pharmacy
Mortuary inc PM , Forensic
Clinical and Corporate Admin
Facilities Support

ROWLEY COMMUNITY HOSPITAL

Intermediate care beds x 47 Palliative beds

OUTPATIENT SERVICES
General OP Specialities

Bespoke OP Specialities
- Ophthalmology
- Dental
- Orthotics
- Urology
- Therapies (MSK, rehab, SLT, OT, Foothealth,)

Provision for Speciality OP Community New providers
- Gynaecology

DIAGNOSTIC
Imaging (PF, US)
Phlebotomy
ECG

PRIMARY CARE
Urgent care / walk in
GP practice (8000 popn)

OTHER
Retail Pharmacy
Clinical and Corporate Admin
Mortuary
Main Catering Unit
Facilities support

Service Model by Site

Service Redesign Team
23.05.11

right care
right here

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Clinical Services Reconfiguration Programme - Progress Report
SPONSORING DIRECTOR:	Mike Sharon, Director of Organisational Development and Strategy
AUTHOR:	Jayne Dunn, Redesign Director – RCRH
DATE OF MEETING:	28 July 2011

SUMMARY OF KEY POINTS:

The paper provides a progress report on the work of the Clinical Services Reconfiguration Programme as at the end of June 2011.

It covers:

- The establishment of a Clinical Services Reconfiguration Programme Board
- An update of progress with each area of clinical service reconfiguration that the Trust is involved in, including a range of wider SHA/health economy plans for clinical service consolidation.
- Feedback from the recent Gateway Review of the Maternity Reconfiguration Project.
- Feedback from a meeting with the Joint Health Scrutiny Committee about the requirements for formal public consultation.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

1. NOTE the establishment of the Clinical Service Reconfiguration Programme Board and the intention to present the Trust Board with quarterly progress reports.

2. NOTE the draft report from the externally commissioned evaluation of the Emergency General Surgery and Trauma and Orthopaedic inpatient interim reconfiguration has been received by the Programme Board and will be published on the Trust internet site once an action plan has been agreed.

3. NOTE the recent Gateway Review of the Maternity Reconfiguration Project resulted in a green delivery confidence assessment and that the opening of the Halcyon stand alone Midwifery Led Unit will take place in October 2011 in line with the project plan.

4. NOTE that the Colorectal reconfiguration and Emergency Gynaecology changes will be implemented over the summer of 2011 and that the Joint Health Scrutiny Committee has agreed there is no requirement for formal public consultation in relation to these changes.

5. NOTE the current position and proposed timescales with regard to potential clinical service reconfigurations in Stroke, Vascular Surgery and Trauma services.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

Financial	**X**	Each area of clinical service reconfiguration will require a Business Case as part of the approval process.
Business and market share	**x**	The Business Case for each area of clinical service reconfiguration will require an assessment of the impact on market share.
Clinical	**X**	The prime driver for clinical service reconfiguration should be clinical and so each business case will include a clinical case for change and the benefits realisation will include benefits to clinical care.
Workforce	**X**	The Business Case for each area of clinical service reconfiguration will require an assessment of the impact on workforce and a related workforce plan.
Environmental		
Legal & Policy		
Equality and Diversity	**X**	The Business Case for each area of clinical service reconfiguration will require an equality impact assessment.
Patient Experience		
Communications & Media	**X**	Within the Right Care Right Here Programme there is a Communications and Engagement workstream.
Risks		

PREVIOUS CONSIDERATION:

Previous progress reports relating to Interim Reconfiguration and the Business Case and Implementation Plan for Maternity Reconfiguration.

Sandwell & West Birmingham Hospitals NHS Trust

CLINICAL SERVICES RECONFIGURATION PROGRAMME
July 2011

1. Introduction

In order to ensure future clinical sustainability, we have undertaken a number of clinical service reconfigurations over the last 3 years and identified a number of other clinical services with the potential need for reconfiguration ahead of the opening of the Midland Metropolitan Hospital (the single site new Acute Hospital) in 2016/17. In addition NHS West Midlands is looking at whether there are any clinical services which due to their specialist nature may require an element of consolidation within the SHA to ensure the critical mass necessary to develop and retain specialist skills and deliver the best clinical outcomes.

This purpose of this paper is to provide the Trust Board with an update of progress with each area of clinical service reconfiguration and to set out the proposed structure to ensure that the Trust has a coordinated approach to the planning and implementation of clinical service reconfiguration (including the evaluation of any reconfiguration changes) and is fully engaged in wider SHA/health economy plans for clinical service consolidation.

2. Background

Delivering the level of change associated with clinical service reconfiguration will be a challenge and will require robust project management to ensure the desired outcomes and benefits are achieved. In order to ensure a coordinated approach to clinical service reconfiguration within the Trust and to ensure full engagement in wider health economy work on clinical service reconfiguration a structured approach to clinical service reconfiguration will be undertaken and a corporate level Clinical Service Reconfiguration Programme Board has being established to oversee this work. The Programme Board will meet on a quarterly basis and report progress to Trust Board after each meeting. The Programme Board held its initial meeting on 30th June 2011.

3. Clinical Service Reconfiguration

The following is a summary of the clinical services where there are potential or actual reconfigurations:

3.1 Ongoing Reconfigurations:

- ***Emergency General Surgery and Trauma and Orthopaedic Inpatient Interim Reconfiguration*** – implemented Feb-May 2009; external 12 month evaluation commissioned (including patient and stakeholder feedback) and the draft report was presented to the Clinical Service Reconfiguration Programme Board at its meeting on 30th June 2011. Overall the report found that the reconfiguration has been positively received, by staff and Stakeholders, who in general believe that services are improved. Complex changes have been planned and implemented successfully, and staff generally felt that the change process was well managed. A number of recommendations were made and we will develop an action plan for these and then publish the report and action plan on our internet site as public documents.

- ***Maternity Reconfiguration*** (inpatients and consultant led services) phase 1 (acute services) implemented in January 2011 and phase 2 (the Halcyon stand alone MLU) is due to be implemented in October 2011. There is a well established project team overseeing the implementation of these service changes. A third Gateway Review was held in July 2011. The Review considered the implementation and early impact of phase 1 and the project's readiness to implement phase 2 in October 2011. The Review assessed the project as having

a Green delivery confidence assessment status i.e. successful delivery of the project appears highly likely and there are no major outstanding issues that at this stage appear to threaten delivery significantly. The Review made the following two recommendations:

- Review the Benefits claimed by the project and include a full consideration of those arising from the integration of community midwife services.
- Publicise the new development and its effective implementation to ensure the public and the wider health community are aware of the benefits of the care model.

An evaluation of the changes, involving patient feedback will be undertaken 12 months after full implementation and the final Gateway Review is expected in January 2013.

- ***Colorectal Inpatient Surgery*** – there are proposals to further consolidate this service with all colorectal inpatients being at Sandwell Hospital. The implications for Gynae-Oncology and Gastroenterology in terms of Colorectal support to these specialities have been confirmed and the Trust's Strategic Investment Review Group (SIRG) has approved the resource implications. The proposed changes formed part of the formal consultation for the interim reconfigurations relating to General Surgery and Trauma and Orthopaedics and therefore the Joint Health Scrutiny Committee has confirmed that further formal public consultation is not required. The plan is to implement this change over July and August 2011 ahead of the change in junior doctors in order to ensure continuity.

3.2 Proposed Reconfigurations:

- ***Emergency Gynaecology Services –*** We are undertaking a review of the emergency Gynaecology services. This is based on an internal clinical review of existing services undertaken by the newly appointed Consultant Lead for Emergency Gynaecology.

  The purpose of the internal clinical review was to identify any potential areas for improvement and change in light of recent national guidance, Trust priorities, risk and governance issues and organisational change across the Trust. On the basis of the review we are planning to re-design our emergency gynaecology services to have fewer emergency admissions through the use of alternative outpatient based pathways and to focus the service on one site. The proposed site is City Hospital to ensure strengthened links with other Gynaecology services. The ability would remain to assess women presenting to Sandwell A&E with emergency Gynaecology conditions and to provide immediate treatment where this is required with subsequent transfer to the service at City Hospital if further assessment or treatment is needed. It is also proposed that an Early Pregnancy Assessment Unit (EPAU) remains at Sandwell Hospital.

  This consolidation of emergency gynaecology services will

  - Support delivery of a consultant led service
  - Improve quality
  - Improve patient outcomes
  - Improve patient satisfaction
  - Avoid inpatient admissions by offering outpatient based care
  - Improve training experience for junior medical staff.

  It follows the initial steps in the plan to improve our Emergency Gynaecology service including the appointment of a consultant, clinical review of the service and development of a service model.

  Consolidation of the service on one site is the next step of the plan and we are keen to make progress with this as soon as possible in order to deliver the identified improvements. Our Strategic Investment Review Group (SIRG) has approved the resource implications. We therefore intend to implement this change over the summer of 2011. In particular this would allow us to strengthen the consultant led nature of the service and respond to the changes in junior doctor cover.

This change to the Emergency Gynaecology Services will involve a relatively small number of women, many of whom can be redirected at the time of GP referral and initial assessment will be available for women self presenting in Sandwell A&E along with any life saving treatment that may be required. On this basis the Joint Health Scrutiny Committee has confirmed that formal public consultation is not required.

- ***Vascular Services*** - NHS West Midlands has developed proposals to consolidate screening and inpatient services in Vascular Surgery to cover populations of 800 000. We currently have a cross site Vascular Surgery service with inpatients consolidated at City Hospital and emergency consultant cover provided jointly with University Hospitals of Birmingham NHS Foundation Trust (UHB). The SHA proposals would result in our inpatient Vascular Surgery service being transferred to the new Queen Elizabeth Hospital either in total or just complex cases. If in total this would impact on about 600 patients based upon activity undertaken in 2010/11. Day case and outpatient Vascular Surgery would continue to be provided at City and Sandwell Hospitals along with arrangements to provide emergency cover. A Steering Group has been established to coordinate this work with the lead organisation being UHB. It is not clear at this stage whether formal consultation is likely to be required. The proposal is to implement this change by Summer 2012.

3.3 Reviews Likely to Result in Reconfiguration as One Option:

- ***Stroke Services*** – a recent peer review visit by the West Midlands Quality Review Service to look at our stroke services raised concerns about the long term sustainability of maintaining high quality acute stroke services on both City and Sandwell Hospital sites that are able to robustly meet the standards identified for stroke services. We had also undertaken some initial work that identified similar concerns. Our initial work has included staff engagement events to look at drivers for change and a long list of options. It is likely that one of the options for addressing the concerns will be consolidation of acute stroke and TIA services on one site. We have developed a clinical case for change which was presented to the Programme Board and are now working with our PCTs to establish a formal reconfiguration project. Such a project will need to include patient and carer engagement and if the project results in a short list of options that includes consolidation of services on one hospital site a formal consultation is likely to be required. We are planning to present a business case to the Programme Board and Trust Board in the autumn setting out the clinical case for change, the short list of options and any requirement for formal public consultation.

3.4 Other Services with Potential for Reconfiguration:

- ***Major Trauma Centres*** – NHS West Midlands has developed proposals to consolidate major trauma services in fewer Trauma Centres including one at UHB. The SHA has established a clinical steering group to develop more detailed proposals. The number of patients presenting with major trauma is fairly small (estimated at fewer than 250 for our Trust). It is expected that any formal consultation around these proposals would be coordinated at SHA level. There is still an ongoing discussion about the number and location of Trauma Units (next level of trauma care) and we would want to be a designated Trauma Unit. It is expected that the SHA will coordinate a formal public consultation on its proposals for Trauma Centres and related Trauma networks in the autumn or winter of 2011.

4. <u>Formal Consultation</u>

We intend to undertake any clinical service reviews likely to result in reconfiguration in accordance with national guidance as set out in *Changing for the Better* (DoH 2008). A key element of this guidance is that the focus should be on improving the quality of services and should be clinically led. In addition The Health Act 2006 (Section 242) requires NHS organisations as soon as they start to

develop change proposals to involve patients and the public in planning service changes and decisions affecting the operation of those services.

In line with this requirement and in partnership with our PCTs we will seek to work with service users regarding proposed changes and in the development of options. This principle will be important in all of the proposed service reviews described above. In addition we will follow the latest guidance on service reconfiguration as set out by the Secretary of State in 2010 and including the four tests of:

1. real engagement with patients and public
2. GPs particularly in their commissioning role have being actively involved in shaping the options
3. Full use of evidence base for service change by clinical leaders across the continuum of change
4. Commissioners properly consider how proposals affect choice of provider, setting and intervention; making a strong case for quality and improvements in patient experience.

We presented a briefing paper about our ongoing and proposed areas of clinical service reconfigurations to the Joint Health Scrutiny Committee in June 2011 in order to raise their awareness of these clinical service reviews and to have a discussion about where formal public consultation is likely to be required. At the Committee meeting it was agreed that formal public consultation is not required for the reconfiguration of Colorectal inpatients or Emergency Gynaecology services. It was felt that formal public consultation is likely to be required for any reconfiguration proposals relating to Stroke services and may be required for the proposed changes to Vascular Surgery services. It was agreed that we would meet with the Committee in September to discuss the short listed options for reconfiguration of Stroke services and in November to consider the options for Vascular Surgery services.

5. Conclusion

We are undertaking or involved in a number of clinical service reviews which may generate options involving consolidation of services onto one hospital site and away from others. We have set up a Clinical Service Reconfiguration Programme Board to oversee this work and had an early discussion with the Joint Health Scrutiny Committee to make the Committee aware of these clinical service reviews and to have a discussion as to where formal public consultation may be required.

The Trust Board is recommended to:

1. NOTE the establishment of the Clinical Service Reconfiguration Programme Board and the intention to present the Trust Board with quarterly progress reports.

2. NOTE the draft report from the externally commissioned evaluation of the Emergency General Surgery and Trauma and Orthopaedic inpatient interim reconfiguration has been received by the Programme Board and will be published on the Trust internet site once an action plan has been agreed.

3. NOTE the recent Gateway Review of the Maternity Reconfiguration Project resulted in a green delivery confidence assessment and that the opening of the Halcyon stand alone Midwifery Led Unit will take place in October 2011 in line with the project plan.

4. NOTE that the Colorectal reconfiguration and Emergency Gynaecology changes will be implemented over the summer of 2011 and that the Joint Health Scrutiny Committee has agreed there is no requirement for formal public consultation in relation to these changes.

5. NOTE the current position and proposed timescales with regard to potential clinical service reconfigurations in Stroke, Vascular Surgery and Trauma services.

Jayne Dunn
Redesign Director Right Care Right Here
18th July 2011

MINUTES

Clinical Service Reconfiguration Programme Board

Venue Board Room, MEC, Sandwell Hospital **Date** 30th June 2011

Present:

Mrs. Gianjeet Hunjan (Chair)
Mr. John Adler
Prof. Derek Alderson
Mr. Mike Beveridge
Mr. Andrew Brown
Mrs. Jayne Dunn
Mrs. Jessamy Kinghorn
Mrs. Sue Murray
Mrs. Elaine Newell
Mr. Donal O'Donoghue
Mr. Mike Sharon
Mr. Roger Trotman
Mr. Robert White

In Attendance:

Mr. Iain Snelling
Dr. Kamel Sharobeem

Secretariat:

Mrs. Lesley Broadway

MINUTES	PAPER REFERENCE
1 Apologies for absence	**Verbal**
Apologies were received from Mr. Paul Bosio, Mr. James Nevin, Mrs. Rachel Overfield and Dr. Deva Situnayake.	
2 Terms of Reference and Membership	**SWBRB (6/11) 001**
The Terms of Reference and Membership were received and presented by Mrs. Dunn. The purpose and frequency of the meetings was noted. The Chair advised that the Reconfiguration Board would report to the Trust Board and it was agreed that an update report would be presented to each Trust Board meeting along with a copy of the minutes of the meetings when held. It was further agreed that the quorum for the meetings would be 1 x Non-Executive Director and 2 x Executive Directors. The Chair queried whether it was the intention that the Reconfiguration Board would consider community service reconfiguration issues. Mr. Sharon advised that there was a process already in place for reporting community services issues to the Board on a quarterly basis. He advised that a paper had been submitted to the Trust Board for discussion	

MINUTES	PAPER REFERENCE
regarding integration plans. However it had not been decided how this would link with the Reconfiguration Board. It may be necessary to change the membership of the Board in the future. Mr. Adler advised that if community services were not to be included within the remit of the Reconfiguration Board it would be necessary to ensure appropriate oversight of any issues arising. The Chair suggested there may be a need for further discussion on this item at a future meeting. The Terms of Reference were accepted following inclusion of the agreed changes.	
ACTION: Mrs. Dunn to provide monthly update report for Trust Board meetings.	
3. Clinical Services Reconfiguration Update	**SWBRB(6/11)002**
3.1 Briefing	
A briefing paper regarding the clinical services reconfiguration programme was presented by Mrs. Dunn. The paper gave the background on existing reconfiguration changes and the potential areas for reconfiguration namely colorectal inpatient surgery, urology inpatient surgery, emergency gynaecology, stroke services, vascular services, trauma centre, pathology and neonatal designation. With regard to colorectal inpatient surgery, it was noted that a business case had been presented to SIRG and had been approved subject to written confirmation from gynae-oncology around proposed cover arrangements. It was noted however that Mr. Beveridge had recently resubmitted the business case to Mr. Adler due to an issue around resources. Mr. Adler updated on the current position and advised that the problem was that the original business case had implied there were additional costs for ward staffing (ie a recurrent cost pressure). It had been agreed to defer a decision until the outcome of current surgical financial situation was known. In the meantime the Division would continue with operational planning for this with an implementation date for August 2011 to coincide with the junior doctors' change over. The revised business case would need to go back to SIRG and was likely to require pump-priming finance. With regard to Emergency Gynaecology, Mrs. Murray reported that a paper regarding the proposed changes would be considered at SIRG on 12th July. In answer to a query from the Chair regarding the outcome of the clinical review which had indicated that the Trust was currently providing less than optimum care, Mrs. Murray advised that this had been due to out-dated working by Consultants and the need to improve the	

MINUTES	PAPER REFERENCE
clinical quality that was provided It was noted that the implementation date for vascular services reconfiguration was Summer 2012. Reconfiguration was being led by UHB. Mr. Beveridge advised that a steering group meeting had taken place. Mr. O'Donoghue was a member of the group along with the Trust vascular surgeons. The group was currently undertaking a scoping exercise because of the anticipated disinvestment. The expectation was that the Trust would consolidate outpatient and day case 23 hour stay work at SWBH by building on this part of the agreement with UHB. It was hoped that the scoping exercise would be finalised at the next meeting in July. He was arranging to meet with colleagues at UHB to work through the detail. From a clinical perspective, clinical colleagues have linked with other specialties that would be affected by centralisation of the service (ie interventional radiology). A LIA had taken place to bring people up to a common understanding and to work through some of the issues involved in the process. Mr. O'Donoghue advised that he had met with Dr. Benham and Mrs. Morton to discuss and understand their concerns with regard to implications for interventional radiology as a result of the vascular services reconfiguration. Their main concern was the resultant difficulties that may arise when recruiting staff. It had been agreed that they would liaise with colleagues at UHB to ascertain whether there were options for joint working. Mrs. Dunn suggested setting up a Trust steering group to develop the business case for implications from the transfer of the service on the Trust including impact on other specialities and reduction in capacity. Mr. Sharon considered that vascular services reconfiguration would have implications for trauma. Mr. O'Donoghue advised that vascular surgery was not recorded as a criterion for Level 2 trauma. However there would be a need to look at out-of-hours working. Mrs. Kinghorn queried whether the Trust had been made aware of the SHA's proposals for the Black Country Consortium. Mr. Sharon reported that providers had been advised to discuss issues and concerns between themselves to reach an agreement. Mr. O'Donoghue reported that issues were being address by the clinical senate. The proposals were not revenue neutral and financial issues would need to be discussed as there could be high financial consequences for the Trust. There would also need to be strategic thinking with the SHA kept advised of progress. Mr. Sharon explained that there had been a shift with an increased pressure from the SHA in progressing reconfiguration. PIDS for Trauma and Pathology had been received. Following a suggestion from the Chair it was agreed that a detailed paper regarding vascular services reconfiguration would be available for the next	

MINUTES	PAPER REFERENCE
meeting. Mrs. Newell reported that discussions were on-going with regard to Neonatal designation. Commissioners had not yet agreed the pathway.	
ACTION: Mr. Beveridge to produce vascular services update paper for next meeting.	
3.2 Maternity	**SWBRB(6/11)003**
The latest updated report on Maternity Reconfiguration was presented by Mrs. Newell. It was noted that the report is presented to the Joint Health Scrutiny Committee on a monthly basis. The majority of actions were on track or had been completed and the Stand Alone Midwifery Unit (MLU) is still on track to open in October 2011. There had been some delay in the commencement of induction and training for midwives for the stand alone MLU but this will not impact on the opening of the Unit. In answer to a request from Mr. Adler, Mrs. Newell outlined the exclusion criteria for the Stand Alone MLU. She explained that the Unit in Smethwick would be open for low risk pregnancies (ie those suitable for home births and those with no previous problems/complications). They were currently operating an opt-out model for the Serenity Midwifery Led Birth Centre and this would continue. If patients were low risk they could opt to give birth at home, in the Stand Alone MLU or in the Serenity Midwifery Led Birth Centre (i.e. co-located MLU). The criteria would be closely monitored and kept tight. Mr. Adler commented that he thought there would not be an opt-out for the Stand Alone MLU. Mrs. Newell explained that the opt-out model would be for low risk women to have a midwifery led birth but these women would then be able to choose the location (i.e. home, Stand Alone MLU or Serenity). These women can choose to opt out of a midwifery led birth and choose a consultant led birth in the Delivery Suite at City Hospital. The Operational Policy for the Stand Alone MLU would be submitted to Governance Board for approval. Mr. O'Donoghue expressed concern that the section regarding workforce training and development did not include a statement regarding the need to maintain skills irrespective of where midwifery staff would be working. Mrs. Newell advised that it was not the intention to staff the Stand Alone MLU on a 24/7 basis but it would operate on a domino model. All staff would be based at the Serenity Birth Centre and would go to the Stand Alone MLU when a woman rang to say she would be arriving there. This model is used elsewhere and is clearly stated in the Operational Policy. Midwifery staff will rotate through all areas to ensure skills are maintained.	
3.3 Consultation and Joint Health Scrutiny Committee	**SWBRB(6/11)004**
A copy of the report that had been forwarded to the Joint Health Scrutiny Committee was received and presented by Mrs. Dunn. The report would	

MINUTES	PAPER REFERENCE
be considered by the Joint HSC at its meeting on 5th July. The report drew attention to the fact that some reconfiguration of services (ie Stroke and Vascular Surgery) may require consultation. Mr. Sharon advised that the Joint HSC may raise a query with regard to the Emergency Gynaecology Services as to why there was a need for this service to be reconfigured so quickly. Further information had now been provided for the meeting and Professor Luesley would be in attendance. Mr. O'Donoghue suggested that the concerns regarding Interventional Radiology should be drawn to the Joint HSC's attention. It was agreed that it was not appropriate to raise this at this stage but to present an update at a future point.	
3.4 Pathology	**SWBRB(6/11)005**
A copy of a briefing paper regarding the NHS West Midlands Pathology Reconfiguration Proposals was received and presented by Mr. Sharon. He advised that a Project Initiation Document (PID) had now been received from the SHA in response to the Carter Review. The aim was to streamline and make savings across pathology services in the West Midlands as there were significant savings that could be made. There was a preferred option to form three clusters in addition to the cluster for Mid and North Staffordshire and it was proposed that SWBH would be part of the Central and West Cluster. An estimated saving of £38 million based on 2010/11 data was anticipated. The Central and West Cluster would be largest pathology service. Dr. Berg had expressed reservations regarding this proposal and as he would be attending a meeting on 7th July, along with directors and DGMs, to consider the PID, he had requested a steer regarding the future location of the Trust's Pathology Department in retained estate (post opening of the Midland Metropolitan Hospital) from the Executive Team for reporting at that meeting. It was noted that within the Central and West Cluster two other Trusts, namely Royal Wolverhampton and Dudley Group were likely candidates for becoming a pathology hub. Mr. O'Donoghue reported that he had had discussions with Dudley who had expressed concern regarding the proposals. Dr. Berg had expressed the view that a working collaboration between the Trust and Dudley might be problematic. It was felt however that if the Trust and Dudley worked as a Network this may be an acceptable solution. It was noted that pathology services may be accommodated in retained estate following approval of the OBC. This would need to be considered as part of future planning for delivery of pathology services by cluster competitors or commissioners. Mr. Seager commented that monthly	

MINUTES	PAPER REFERENCE
meetings were taking place to discuss the future of pathology services with regard to the Midland Metropolitan Hospital and it was likely that pathology services would be provided within retained estate at Sandwell Hospital. Professor Alderson questioned the logic of including the Trust within the Central and West Cluster due to the Trust's current catchment area. Dr. Berg was also of the view that the other two clusters were more reflective of current practice.	
ACTION: Mr. Adler to arrange for Pathology Reconfiguration to be discussed at Executive Team in order to give Dr. Berg a steer for the meeting on 7th July.	
4 Evaluation of Emergency Surgery Interim Reconfiguration	**SWBRB(6/11)006**
A copy of the 2nd draft report on the Evaluation of Changes to Emergency General Surgery, Trauma and Orthopaedic Services undertaken by the Health Services Management Centre was received and a presentation on the report was given by Iain Snelling. It was noted that the document may need to be revised prior to being circulated within the public domain. 80 patients had been interviewed as part of the evaluation process and transcripts of the interviews were available if required. At the request of the Chair it was agreed that Mr. Adler would give a steer as to when the document should be published and timescales. It was agreed that this should not take place until the Trust had a response to the issues raised in the document and an action plan had been drawn up. It was acknowledged that there would be more follow up action required as a result of this evaluation than following previous evaluations that had previously been carried out. Mrs. Dunn and Mr. Beveridge would meet to go through the document in order for an action plan to be brought to the next meeting. In addition Mrs Kinghorn, Mrs Dunn and Mr Sharon would consider the wording required to make the report a public document. A key conclusion from the evaluation had been that reconfiguration was seen as a process rather than an event and that change was still on-going. Mr. Adler felt that a forum was required to debate these issues. Mrs. Kinghorn expressed the view that she hoped the final report would reflect the fact that people were generally happy following the reconfiguration of services.	
ACTION: Mrs. Dunn to arrange for an action plan to be produced for discussion at the next meeting.	
5 TRAUMA	**SWBRB(6/11)007**

MINUTES	PAPER REFERENCE
Mr. Sharon reported that a Project Initiation Document had been received for improving trauma care in the West Midlands. This work was being led by the SHA and an impact assessment would be undertaken in July. Dr. Ahee and Mr. Parekh were representing the Trust on the Trauma Group and arrangements were in hand to set up an internal steering group which would meet during July to work through the specification. It was agreed that a copy of the PID document should be circulated to Reconfiguration Board members. Mr. Brown felt it important that whilst there was a level of uncertainty it was important to work through the specification to ensure that the Trust was in the best position as possible when it was assessed by the SHA to become a Trauma Unit. Mr Brown is setting up a Trust Steering Group for this purpose. Mr. O'Donoghue felt that, should the Trust be designated Level 2, it should not have an impact at the coal face. Agreed that trauma services would be an agenda item for the next meeting.	
ACTION: Mr. Sharon would circulate the PID document to Board members. **ACTION: Mrs. Dunn would arrange for Trauma to be an agenda item for the next meeting.**	
6 Review of Stroke Services	**SWBRB(6/11)008**
A copy of a document entitled Stroke and TIA Service: Clinical Case for Change (March 2011) was received. The purpose of the document was to set out the clinical case for change in relation to SWBHT Stroke and TIA services which were currently provided across Rowley, City and Sandwell Hospitals. Dr. Sharobeem gave a presentation which gave an update on the stroke reconfiguration project. The need for a reconfiguration of stroke services had been highlighted following a WMQRS visit undertaken in October 2010. National drivers and national stroke strategy had also been taken into account. This had led to a big impact on how the Trust should deal with patients on the acute site. Following the WMQRS visit the Trust Management Board had asked that a review of services be undertaken to accommodate services on one site. A Stroke Steering Group had been established which met on a fortnightly basis. Two LIA events would take place on 1st and 7th July to consider the list of 6/7 models that had been drawn up. Mr. Adler felt that work was progressing well. A formal consultation process would be required and it was anticipated implementation would be in approximately 12-18 months' time. Stroke services were not currently part of the SHA's reconfiguration drive.	

MINUTES	PAPER REFERENCE
The issues had been discussed with the Stroke Network and Sandwell PCT who were both very supportive of reconfiguration. Sandwell PCT/Black Country Cluster would be the lead organisation and HOBtPCT was aware of the proposals. Mrs. Dunn would progress with the PCTs. The long list of models would be discussed following which a shortlist would be drawn up and the case for going to formal consultation (depending on the short listed options) would be presented to the Reconfiguration Board and then Trust Board. It was anticipated that this case would be avaialble in September. In answer to a query from Professor Alderson, Dr. Sharobeem advised that there were 2.5 WTE Consultants providing stroke services, which was not sustainable. The neurologists also provide cover at UHB. Mr. Adler reported that in light of the staffing issues, SIRG had agreed an interim package of investment including a further stroke consultant. Mr. O'Donoghue felt that the progress that had been made since the receipt of the WMQRS report was encouraging. This view was supported by the Chair. The Reconfiguration Board confirmed that it was happy with the proposals outlined in the paper and agreed that it should be discussed by the Trust Board. A Gateway Review would be required in due course. The Stroke Network was awaiting proposals from the Trust.	
7 Any Other Business	
7.1 Schedule of Meetings	
Following a query from Mr. Trotman, it was confirmed that the scheduling of future meetings did not clash with Audit Committee.	
8. Date and Time of Next Meeting	
Thursday 8th September 2011 from 1.30 pm to 3.30 pm in the Executive Meeting Room, City Hospital.	

Signed: .....

Name: .....

Date: .....

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Audit Committee – Version 0.2

Venue Executive Meeting Room, City Hospital **Date** 12 May 2011

Members	In Attendance		Secretariat
Mrs G Hunjan [Chair]	Mr R White		Mr S Grainger-Payne
Mr R Trotman	Mr T Wharram		
Dr S Sahota	Mr P Smith		
Mr G Clarke	Mr P Capener	(CW Audit)	
Mrs O Dutton	Mrs R Chaudary	(CW Audit)	
	Mr D Ferguson	(CW Audit)	
	Mrs S-A Moore	(KPMG LLP)	

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
Apologies were received from Professor Derek Alderson, Mr Paul Westwood and Mr Mike McDonagh.	
2 Minutes of the previous meeting	**SWBAC (2/11) 013**
The minutes of the meeting held on 3 February 2011 were approved as a true and accurate reflection of the meeting.	
AGREEMENT: The minutes of the meeting held on 3 February 2011 were approved	
3 Matters arising	**SWBAC (2/11) 013 (a)**
The Committee received and noted the updated actions log.	
3.1 Update on process for monitoring back to work interviews	**SWBAC (5/11) 027**
Mr White reported that information on back to work interviews had been gathered from ESR, which had suggested that low numbers of interviews were held. The Committee was advised that this position was reflective of	

considerable under reporting however. Mrs Dutton noted that the matter had been discussed previously by the Finance and Performance Management Committee as part of a wider discussion around sickness absence management. Mr White advised that the Chief Executive was to hold specific sickness absence management meetings with divisions, where a range of tools to assist with improving the position would be discussed, including the use of back to work interviews. Mrs Hunjan reported that the number of interviews was recorded within the HR dashboard that was considered by the Finance and Performance Management Committee on a quarterly basis. Mrs Dutton suggested that managers' appraisals should consider compliance with the sickness absence policy as a general point, however Mr White advised that there was no uniform expectation at present that this would form a separate objective for managers. He agreed to discuss this matter with Mrs Lesley Barnett, Deputy Director for Workforce.	
ACTION: **Mr White to discuss the possibility of including compliance with the sickness absence policy as a set objective within managers' annual appraisals**	
3.2 Update on statutory sick pay	**Verbal**
Mr White reported that the Trust was able to reclaim statutory sick pay, however this is not collected at present, due to the threshold set in respect of the level of sickness absence which must be reached before this is permitted. The threshold was reported to be circa 11% sickness absence, determined by the percentage of sick pay as a proportion of National Insurance payments, which was highlighted to be far higher than the current level of sickness absence in the Trust. Mr White was asked whether the sick pay as a percentage of National Insurance calculation was monitored routinely. Mr White offered to investigate whether this was the case.	
ACTION: **Mr White to determine whether sick pay as a percentage of National Insurance payments is monitored routinely**	
3.3 Sickness absence data benchmarking	**SWBAC (5/11) 026**
Mrs Moore presented information showing the Trust's position in respect of staff not taking any sickness absence against that of a number of trusts across the region during 2009/10. The Committee was advised that the organisation with which the Trust was being compared were those where the relevant information was publicly available as part of their Annual Accounts. Mrs Moore highlighted that the Trust's position compared favourably to that of the other trusts used for the exercise.	

4 External Audit Matters	
4.1 External Audit progress report	**SWBAC (5/11) 023**
Mrs Moore reported that since the last meeting, the audit nplan had been refreshed and the interim audit work for the 2010/11 annual accounts had been completed. A review of the Trust's Cost Improvement Programme (CIP) was reported to have been undertaken. The Committee was advised that the review of the 2009/10 Reference Costs submission had also been completed. Mrs Moore reported that the planning for the 2011/12 audit had commenced. Completion of the audit of the statutory accounts for 2010/11 was reported to be planned shortly in parallel to a review of the 2010/11 Quality Account. The Committee was asked to receive and note the technical updates provided. Mrs Hunjan asked for further clarity as to the progress that had been made with reviewing the Quality Account. She was advised that the fee for reviewing the Quality Account had been set by the Audit Commission and that the document would be presented to the Audit Committee for its consideration at the meeting planned for 9 June 2011. Mrs Hunjan asked whether the Quality Account needed to be sent to the Trust's commissioners for input and was advised that this was the case. Mr Trotman suggested that the impact of tax on public sector pensions needed to be communicated to those staff affected. Mr White advised that few non-medical staff were expected to be impacted, although staff should be encouraged to review their arrangements on a personal basis. It was agreed that if the change prompted staff to review their employment arrangements with the Trust resulting in an adverse impact on the Trust, then this should be reported back to the Audit Committee. Mr Trotman asked who was responsible for completing the Carbon Reduction Commitment (CRC) audits and what the associated approval process for these was. Mr White offered to investigate this matter and report back at the next meeting.	
ACTION: Mr White to determine the responsibility for and approval process of Carbon Reduction Commitment audits	
4.2 Audit Plan refresh and Value for Money audit approach 2010/11	**SWBAC (5/11) 021**
Mrs Moore outlined the key changes to the audit process planned and highlighted that there would be no change in the risk profile of the audit as a consequence. The Committee was advised that the Value for Money (VFM) assessment	

had replaced the Auditors' Local Evaluation (ALE) and the key steps as part of the assessment were outlined. The Committee was advised that Mr Andy Bostock had joined the audit team, as Director and Engagement Lead. Mrs Moore advised that Mr Bostock would attend future meetings of the Audit Committee and Mr Mike McDonagh, Relationship Manager would join the meeting once per year Mr Trotman asked what the auditors had experienced regarding the interactions with Foundation Trusts' (FTs) Boards of Governors in terms of the appointment process for External Audit. Mrs Moore advised that in FTs the choice of auditor is within the remit of the Trust rather than with the Audit Commission, with the Audit Committee making a recommendation to the Board of Governors for the appointment of the auditor. Governors were reported to be often included within the appointment panel for the auditors. The Committee was advised that the relationship between External Audit and the Board of Governors varied according to the way in which the Trust chooses to use its governors. Mrs Moore advised further that External Audit occasionally would be expected to attend meetings of the Board of Governors.	
4.3 Review 2009/10 Reference Costs submission to the Department of Health	**SWBAC (5/11) 022**
Mrs Moore reported the review of Reference Costs had replaced the Payment by Results (PBR) work and was mandated by the Department of Health. The Committee was advised that the output of the review was to make three improvement recommendations which Mrs Moore reported had been discussed with the Head of Financial Services. It was noted that these were developmental recommendations rather than substantive issues. Mrs Hunjan observed that some areas appeared to attract more complicated and complex cases, and therefore these would automatically increase the reference costs. It was highlighted that overall the Trust had an adequate process for preparing its Reference Costs submission and it used a consistent methodology. Mr Clarke asked where the reasons behind the positions for Cardiology and Chemotherapy were reported. Mr White advised that this would be evident within the Service Line Reporting information. It was noted that the information was useful for benchmarking against competitors. Mrs Hunjan suggested that the benchmarking information should be considered by the Audit Committee at its meeting planned for 8 September. Dr Sahota encouraged the Committee not to lose sight of this analysis in	

the context of the changing economic climate and suggested that it should be monitored to identify any areas of difficulty in future.	
ACTION: Mr White to arrange for benchmarking of Reference Cost information to be presented at the next meeting of the Audit Committee	
4.4 Annual Plan letter 2011/12 and agreement of fees	**SWBAC (5/11) 024**
Mrs Moore presented the Annual Plan letter for 2011/12 and advised that the audit would not differ considerably from that held in 2010/11. The audit fee for 2011/12 was proposed to be £171,361 which was noted to be a reduction on the fee in 2010/11 which had been £183,350. The proposed fee was agreed by the Audit Committee and the reduction in the cost was gratefully acknowledged.	
AGREEMENT: The audit fee for 2011/12 was agreed by the Audit Committee	
4.5 External Audit interim report	**SWBAC (5/11) 024**
The Committee was advised that a draft External Audit interim report had been issued, which had included a review of the Trust's Quality and Efficiency Programme (QuEP). The recommendations raised were highlighted to have no impact in the Use of Resources assessment. Mrs Hunjan observed that the clearance of suspense accounts was raised as a recommendation and noted that the matter had been raised previously. Mr White was asked to develop a plan to address the issue and to report on progress at the next meeting. Mr Trotman advised that Atos Origin consultancy had been engaged by the Trust to assist with the development of the three year Cost Improvement Plan, work which would also entail a review of the QuEP.	
ACTION: Mr White to develop a plan to address the recommendation concerning the clearance of suspense accounts and report on progress at the next meeting	
4.6 Review of draft statutory accounts 2010/11	**SWBAC (5/11) 015** **SWBAC (5/11) 015 (a)** **SWBAC (5/11) 015 (b)**
By way of introduction, Mr White advised that the discrepancy between the accounts and the Department of Health target related principally to the revaluation of assets that had been undertaken recently. It was noted that the accounts were planned to be submitted the day before they were required to be. Mr White thanked Mr Wharram and his team for their efforts in preparing the accounts.	

Mr Wharram reported that the format of the accounts was similar to that used in previous years. In line with Mr White's introduction the Committee's attention was drawn to the impairment of assets figure of £9.5m, the majority of which was reported to relate to the land on the Grove Lane site, on which the new Midland Metropolitan Hospital would be built. The impairment figure was also noted to concern the revaluation of fixed assets that had been undertaken by the District Valuer. Mr Trotman asked how often a revaluation is undertaken. Mr Wharram advised that this was within the remit of the Trust to decide, however it was reported to be good practice to conduct a revaluation exercise as part of the preparation of the statement of the financial position for the annual accounts. Overall, the Committee was asked to note that a deficit of £6,885k had been generated due to the technical adjustment related to the impairment. Mr Wharram reported that the Trust's performance against the External Finance Limit (EFL) had been exceeded and that the cash balance was healthy as at the year end. An underspend of £703k against the Capital Resource Limit (CRL) was reported, which was noted to be an acceptable position. Dr Sahota recommended that the costs associated with consultancy services be clarified to reflect that the majority of the expense relates to the 'Right Care, Right Here' programme. Mr Clarke highlighted that the receipt of Government grant assets had moved considerably from the previous year. Mr Wharram explained that the majority of this figure related to carbon credits awarded by the Government which could be bought and sold for cash if desired. Mr Capener advised that this situation was also indicative of the good use carbon by the Trust. Mrs Hunjan noted that sickness absence figures were omitted from the accounts. Mr Wharram advised that the figures mandated by the Department of Health would be included in the final version of the accounts. Mrs Dutton asked whether there was an expectation that there would be a change to employer pension contributions in the new financial year. She was advised that no increases were forecast. Mrs Hunjan thanked Mr White and his team for the work put into preparing the annual accounts.	
ACTION: **Mr Wharram to clarify in the final accounts that the costs associated with consultancy services reflect that the majority of the expense relates to the 'Right Care, Right Here' programme**	

5 Prompt payment improvement plan	**SWBAC (5/11) 028** **SWBAC (5/11) 028 (a)**
Mrs Hunjan reminded the Committee that Mr White had been asked to provide an update on the plans to improve performance against the prompt payment target in response to an apparent deterioration against the payment time for NHS payments. Mr White reported that the issue did not concern liquidity of the Trust but related to the processes by which payments are processed. A significant contributory factor to the position was highlighted to concern the JACS Pharmacy system which duplicated entries. The Committee was advised that this would be rectified by the end of Quarter 1 which would improve the overall prompt payment position. Other issues related to the prompt payment problem were reported to concern delays to the confirmation of goods being received from staff around the Trust. It was suggested that penalties should be imposed on divisions not confirming when goods are received. It was further suggested that the requirement should be reinforced through Divisional Reviews. Mr Trotman suggested that invoices under dispute should be removed from the analysis given that this had the potential to needlessly adversely affect the position. Dr Sahota asked whether the Trust received any invoices prior to receiving the goods. Mr White advised that this was possibly the case although did not present a significant issue. Mrs Hunjan highlighted the plan to achieve improvement by November 2011.	
ACTION: Mr White to present an update on progress with improving the performance against the prompt payment target at the December meeting of the Audit Committee	
6 Internal Audit Matters	
6.1 Draft Annual Head of Internal Audit report and assessment of the Board Assurance Framework 2010/11	**SWBAC (5/11) 017** **SWBAC (5/11) 017 (a) - SWBAC (5/11) 017 (c)**
Mr Capener presented the draft Head of Internal Audit report and the assessment of the Assurance Framework for 2010/11, which the Committee was asked to receive and note. The Committee was advised that the documents had been submitted to the Strategic Health Authority. The opinion of the Assurance Framework was noted to be unqualified. An opinion of Significant Assurance overall was noted to be reported in the Head of Internal Audit report.	

6.2 Internal Audit annual report 2010/11	**SWBAC (5/11) 016** **SWBAC (5/11) 016 (a)**
Mrs Chaudary reported that during 2010/11, the majority of Internal Audit reviews had received an opinion of Significant Assurance. In terms of recommendations, the Committee was advised that 372 actions had been implemented during the year, although some were noted to have been given a revised completion date. The Committee was pleased to see that there had been a reduction in the number of actions that had been open in excess of six months.	
6.3 Internal Audit progress report and recommendation tracking	**SWBAC (5/11) 016 (b)**
The Committee considered a supplementary report detailing the outcome and key points to note from the internal audits conducted in 2010/11. Regarding the Cost improvement Programme (CIP) audit, Mr White advised that there was a formal process by which CIP changes were reviewed by the Performance Management Board and the Finance and Performance Management Committee, a responsibility that had been delegated to it by the Trust Board. The Committee was advised however, that the arrangements for communicating back to divisions whether the proposed changes had been accepted needed to be strengthened. In connection with the review of ESR and payroll, Mrs Dutton noted that there were occasions reported where temporary changes to pay had not been implemented and she suggested that managers should be held to account for their role in the weakness of this process. Mr Capener asked the Committee to note that there had been no significant control issues noted during the year. Mr White reported that on reviewing the draft Statement on Internal (SIC) Control, the Strategic Health Authority (SHA) had asked the Trust to consider whether there was a need to disclose the recent complications with Pharmacy stocks as a significant control issue. Mr Grainger-Payne advised that the SHA had been informed that there was sufficient internal oversight of the issues and actions had been implemented to correct the problems, therefore it had been proposed that the matter was not included in the 2010/11 SIC.	
Outpatient utilisation review	**Hard copy paper**
Mrs Chaudary reminded the Committee that the draft review had been presented at the December 2010 meeting and highlighted that the version now being considered included the management response. Robustness of job plans was noted to be a key concern arising from the review. The Committee was asked to note that Moderate Assurance had been gained by the review. It was agreed that a follow up to the audit would be	

presented at a future meeting of the Audit Committee. Mr White advised that the learning points and issues would be cascaded through the Chief Operating Officer Team meetings and recommended that the operational implications of the review should be considered by the Finance and Performance Management Committee where necessary. Mr Grainger-Payne was asked to ensure that Miss Rachel Barlow, the Chief Operating Officer Designate be sent a copy of the report.	
ACTION: Mr Grainger-Payne to send Rachel Barlow as copy of the Outpatient Utilisation Internal Audit review	
6.4 Counter Fraud progress update	**Verbal**
Mr Ferguson reported that a key activity since the last meeting concerned the Counter Fraud staff survey that had been conducted, the results of which were highlighted to be important for the Qualitative Assessment. The Committee was advised that the Qualitative Assessment submission had been completed as planned. Mr Ferguson was asked to present an update on the outcome of the Qualitative Assessment at the next meeting of the Audit Committee. An update on new and open cases was given.	
ACTION: Mr Ferguson to present an update on the outcome of the Qualitative Assessment at the next meeting	
6.5 Counter Fraud staff survey results	**SWBAC (5/11) 029** **SWBAC (5/11) 029 (a)**
Mr Ferguson presented the results of the recent Counter Fraud staff survey, highlighting that there had been positive feedback in some areas. The action plans to address the areas of improvement were reviewed and the Committee was advised that progress with the actions would be considered as part of future Counter Fraud updates. Dr Sahota observed that the response rate to the staff survey had been low, as only 165 responses had been received. Mr Ferguson explained that the launch of the survey had coincided with the release of another questionnaire which had impacted to some degree. It was noted that training in Counter Fraud appeared to be low. Mr Ferguson advised that a presentation was run routinely as part of the corporate induction course, however the completion of the evaluation forms following the training session was poor, thereby generating the impression that the number of staff being trained was low. Mrs Moore advised that this was a common issue given that staff tend to complete evaluation questionnaire only if they have an issue with the training. Mrs Hunjan asked Mr Ferguson to give further consideration to measures that would enhance the completion of the surveys in future, which it was	

noted was important given that the Trust is measured on this feedback. Mr Ferguson agreed, however advised that incentivisation may not be productive. Mr Clarke suggested that a target completion rate should be set. Mrs Dutton suggested that the scheduling of surveys should be better co-ordinated to avoid clashes such as the one affecting the Counter Fraud survey. She also suggested that line managers should be made more aware of their responsibilities in respect of Counter Fraud and the need to ensure that staff complete surveys when requested to do so.	
ACTION: **Mr Ferguson to consider further measures to ensure a higher response rate to the Counter Fraud survey**	
6.6 Qualitative Assessment 2010 action plan	**SWBAC (5/11) 030** **SWBAC (5/11) 030 (a)**
Mr Ferguson presented the actions and associated implementation dates that had been developed to address the recommendations and areas for improvement that had been identified as part of the Qualitative Assessment action plan 2010. It was agreed that progress with the action plan would be considered at the next meeting of the Audit Committee.	
ACTION: **Mr Ferguson to present progress with the Qualitative Assessment 2010 action plan at the September 2011 meeting of the Audit Committee**	
7 Governance matters	
7.1 Review of losses and special payments	**SWBAC (5/11) 019** **SWBAC (5/11) 019 (a)** **SWBAC (5/11) 019 (b)**
Mr Smith presented the schedule of losses and special payments covering the period April 2010 – March 2011. It was highlighted that 590 cases had been reported during the year, compared to 630 for the prior year. The Committee was advised that there had been a significant reduction in the value of bad debts written off for overseas visitors during the year. The reference to a 'loss of cash' due to 'other causes' was noted to relate to a discrepancy with issuing stamp stocks through the cash office. Mr Trotman advised that in connection with overseas debts, a pilot was being undertaken with an overseas debt collection agency to recovery the outstanding payments. It was suggested that future reports need to provide a more detailed analysis of the 'other debtors' category to ensure that it is clear to which type of cases this relates.	
ACTION: **Mr Smith to ensure that future versions of the losses and**	

special payments report provides a more detailed analysis of the 'other debtors' category	
7.2 Review of waived tenders and breaches to the Trust's Standing Orders and Standing Financial Instructions	**SWBAC (5/11) 019** **SWBAC (5/11) 019 (a)**
Mr White presented the annual report on waived tenders and breaches to the Trust's Standing Orders and Standing Financial Instructions. The Committee was advised that the information is shared with divisions in an effort to discourage further breaches where possible.	
7.3 Draft Statement on Internal Control 2010/11	**SWBAC (5/11) 018** **SWBAC (5/11) 018 (a)**
The Audit Committee received and noted the draft Statement on Internal Control (SIC) for 2010/11. Mrs Dutton suggested that the paragraph discussing the key partners with which the Chief Executive works closely to discharge his responsibilities should be broadened to reflect the key positions arising from the new commissioning arrangements. It was highlighted that the text may be mandated in accordance with the Department of Heath proforma for the SIC, however Mr Grainger-Payne agreed to check.	
ACTION: Mr Grainger-Payne to determine whether changes can be made to the section of the SIC dealing with the Chief Executive's key relationships	
8 Minutes from Trust Board Committees	
8.1 Finance and Performance Management Committee	**SWBFC (2/11) 014** **SWBFC (3/11) 029** **SWBFC (3/11) 041**
The Committee noted the minutes of the Finance and Performance Management Committee meetings held on the 17 February 2011, 24 March 2011 and 21 April 2011.	
8.2 Governance and Risk Management Committee	**SWBGR (1/10) 009**
The Committee noted the minutes of the Governance and Risk Management Committee meeting held on 20 January 2011.	
8.3 Charitable Funds Committee	**SWBGR (2/11) 004**
The Committee noted the minutes of the Charitable Funds Committee held on 3 February 2011.	
9 Any Other Business	**Verbal**
There was none.	

10 Date and time of next meeting	**Verbal**
The date and time of the next meeting will be 9 June 2011 at 1500h in the Anne Gibson Boardroom, City Hospital.	

Signed:……..

Name:……

Date:…….

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Audit Committee – Version 0.2

Venue Anne Gibson Boardroom, City Hospital **Date** 9 June 2011

Members	In Attendance	Secretariat
Mrs G Hunjan [Chair]	Mrs S Davis	
Mr R Trotman	Mr J Adler	Mr S Grainger-Payne
Dr S Sahota	Mr R White	
Prof D Alderson	Mr D O'Donoghue [Part]	
Mr G Clarke	Mr A Bostock (KPMG LLP)	
	Mrs S-A Moore (KMPG LLP)	

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
Apologies were received from Mrs Olwen Dutton and Mr Mike McDonagh. Mrs Hunjan welcomed Mr Andy Bostock, Engagement Lead and Director of KPMG LLP to the meeting.	
2 2010/11 annual accounts	**SWBAC (6/11) 031** **SWBAC (6/11) 031 (a)** **SWBAC (6/11) 031 (b)**
Mr Wharram presented the 2010/11 annual accounts which he advised had been audited. The Committee was reminded that it had reviewed the draft accounts at the meeting held in May and that following the audit very little amendments had been needed. It was highlighted however, that the improved performance against the Capital Resource Limit (CRL) had been reflected in the final draft of the accounts. The end of year financial position reported that a surplus of £2,193k had been generated, which was noted to be slightly in excess of the target surplus. Mr White clarified that the deficit against the statutory target was reflective of the revaluation of assets exercise which had been undertaken during the year.	

Mrs Hunjan noted that the cost balances opening values had changed on the property, plant and equipment schedule. Mr Wharram reported that the net value of assets had not changed, although the presentation of the information had been amended and in particular that concerning depreciation. Mr Wharram was asked whether the sickness absence information represented an improvement on the position during the previous year. Mr Wharram reported that this was not a significant change. Mrs Hunjan noted that narrative around the changes to the delivery of community services was included within the 'events after the reporting period' schedule. Mr Wharram advised that this information had been slightly amended from that within the version presented to the Committee in May. Mrs Davis remarked that the total days lost in years due to sickness absence appeared to be inaccurate. She was advised however, that this related to the total that would have been lost in terms of WTE years. The Committee was asked and agreed to recommend the adoption of the annual accounts to the Trust Board at its meeting later that day.	
AGREEMENT: The Audit Committee agreed to recommend the adoption of the annual accounts to the Trust Board	
3 2010/11 audit memorandum	**SWBAC (6/11) 032**
Mr Bostock advised that an unqualified opinion was to be provided in respect of both the annual accounts and the Use of Resources assessment. The Committee was advised that a number of qualified opinions had been issued across the NHS for 2010/11 results, therefore he congratulated the Trust on its performance. Mr Bostock highlighted that the audit process had run smoothly and that there had been a good relationship and communications between the Trust and the auditors. Mrs Moore presented the ISA 260 report, which summarised the conclusion to the audit work. The Committee was advised that there had been no material unadjusted differences, however one difference that had not been adjusted was highlighted to relate to £4.288m of deferred income relating to monies provided by the PCTs to fund developments in respect of the 'Right Care, Right Here' programme. An audit difference related to classification of revenue goods received but not invoiced was also highlighted, where the classification of these goods from 'Trade Payables' to 'Accruals and Deferred Income' was noted to have been undertaken. In terms of other matters to note, it was proposed that a clean Value for Money conclusion would be issued. The Committee was advised that the minor recommendations raised as part of the review had been discussed	

with the finance team and would be addressed. In terms of the Quality Account, the Committee was informed that work was ongoing, with an expected completion date of the end of June 2011. Mrs Moore advised that a separate audit certificate would be issued for this in due course. Mr Adler noted that the final report should be presented to the Medical Director; not the Chief Operating Officer and Chief Nurse. Mrs Moore thanked Messrs White and Wharram for their assistance and co-operation with the audit. Mrs Davis asked whether the segmental reporting required for the community services element of the Trust would be an ongoing requirement. Mrs Moore advised that measure was required to meet the requirements of Accounting Standard IFS8. Mr Adler remarked that it was concerning that a number of trusts had received a qualified opinion on their accounts given that 2010/11 was a year of greater financial flexibility than those to come. Mr Bostock agreed and advised that the qualified opinions usually concerned the failure to deliver CIPs, the need to be supported non-recurrently or was given if the organisation was in deficit and therefore was in a position of low financial resilience. It was suggested that a number of trusts may be awarded a qualified opinion in future, particularly if the organisation has a Private Finance Initiative (PFI). Mrs Hunjan thanked the finance and audit teams for their assistance with conducting the audit and ensuring the accounts were to be filed ahead of plan.	
4 Revised 2010/11 Statement on Internal Control	**SWBAC (6/11) 034**
Mr White presented the final draft Statement on Internal Control. The Committee was asked to note that the significant control issues reported concerned the loss of an unencrypted media stick and the declared non-compliance with Same Sex Accommodation guidance as at 31 March 2011. It was agreed that the Audit Committee would recommend to the Trust Board that the Statement on Internal Control should be signed by the Chief Executive.	
AGREEMENT: The Audit Committee supported the proposal to recommend to the Trust Board that the Statement on Internal Control should be signed by the Chief Executive	
5 Letter of Representation	**SWBAC (6/11) 033**
Mr White presented the Letter of Representation, which he advised was a declaration that the auditors had been appraised of all information	

necessary for them to form an opinion on the annual accounts and Value for Money assessment. The Committee agreed to recommend to the Trust Board that the Letter of Representation should be signed by the Chief Executive and Director of Finance and Performance Management.	
AGREEMENT: The Committee agreed to recommend to the Trust Board that the Letter of Representation should be signed by the Chief Executive and Director of Finance and Performance Management	
6 Quality Account 2010/11	**SWBAC (6/11) 035** **SWBAC (6/11) 035 (a)**
Mr O'Donoghue joined the meeting to present the Quality Account 2010/11. In connection with the statement that 27% of deaths had been reviewed, Mrs Hunjan asked how these had been selected. She was advised that cases are intercepted in the death certification office and sent to the Clinical Director with responsibility for the area in which the patient died. Mr O'Donoghue advised that the robustness of the process needed to be improved and that there needed to be a cultural change to ensure that consultants routinely review deaths. Mrs Hunjan asked whether there was a breakdown of the deaths reviewed by speciality. She was advised that this was the case, however the number of deaths reviewed was dependent on the nature of the speciality. Mr Adler reported that a CQuIN target of 60% deaths to be reviewed had been set for 2011/12. Mr O'Donoghue advised that he hoped to exceed this target. The priorities for attention for 2011/12 were reviewed, which the Committee noted included Accident and Emergency services and the embedding of the Quality and Safety Strategy. Dr Sahota asked what benefit would be realised by assigning priority to a particular area. He was advised that in terms of VTE assessment, for instance, the routine administration of prophylaxis would be expected to have a significant benefit on patients. Mrs Davis added that there was an expectation that the planned reduction in falls would result in shorter lengths of stay. Mr Adler reported that further work had been undertaken on the QuEP programme for 2011/12 to ensure that there is a clear link between the QuEP workstreams and the financial benefit expected. Mrs Hunjan noted that in some cases, there had been a shortfall in the amount of submissions made to national clinical audits and asked what effect was likely to result. Mr O'Donoghue advised that there would be little impact on the national position and locally there would be no effect. Mr Adler reported that additional investment into clinical audit had been recently agreed which would strengthen the data collection in future.	

Dr Sahota noted that 10% of 'phone calls to the Trust's call centre are not answered. Mr Adler advised that this represented an improved position compared with that three years previously. Mr O'Donoghue was asked to provide clarity on the issue concerning under reporting of incidents. He advised that under reporting was reflective of the cultural issues in the Trust and the current lack of feedback provided to staff reporting incidents. The Committee was advised that there were plans to address these matters in future, including the issue of a safety newsletter and implementation of electronic incident reporting. Mrs Hunjan asked, in terms of clinical coding errors by primary diagnosis, whether the Trust's position was markedly different to that of other trusts. She was advised that this was not the case. The Committee was asked for and gave its approval to recommend to the Trust Board that the Quality Account 2010/11 should be accepted, subject to amendments required as a result of the conclusion to the External Audit review.	
AGREEMENT: The Audit Committee supported the proposal to recommend to the Trust Board that the Quality Account 2010/11 should be accepted, subject to amendments required as a result of the conclusion to the External Audit review	
7 Any Other Business	**Verbal**
There was none.	
8 Date and time of next meeting	**Verbal**
The date and time of the next meeting will be 8 September 2011 at 1100h in the Executive Meeting Room.	

Signed:……..

Name:……

Date:…….

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Charitable Funds Committee – Version 0.2

Venue Executive Meeting Room, City Hospital **Date** 12 May 2011 at 1430h

Present		**In attendance**	
Dr S Sahota	[Chair]	Mr P Smith	
Mr R Trotman		Mrs J Kinghorn	
Mrs S Davis		Mr M Burgess	[Barclays Wealth]
Mr G Clarke		Mr I Walker	[Barclays Wealth]
Mr J Adler			
Mr R White		**Secretariat**	
Mr M Sharon		Mr S Grainger-Payne	
Mr D O'Donoghue			

Minutes	**Paper Reference**
1 Apologies	**Verbal**
Apologies were received from Mrs Olwen Dutton, Prof Derek Alderson and Miss Rachel Overfield.	
2 Minutes of the previous meetings	**SWBCF (2/11) 004 Tabled paper**
The minutes of the meeting held on 3 February 2011 were approved subject to minor amendment. A tabled set of minutes from the meeting held on 2 December 2010 was presented for ratification given that the meeting on 3 February 2011 had not been quorate. The minutes were approved.	
AGREEMENT: The minutes of the previous meetings were approved subject to minor amendment	
3 Matters arising from the previous meeting	**SWBCF (2/11) 004 (a)**
The Trustees received and noted the updated actions log.	
4 Investment update – Barclays Wealth	
4.1 Investment review and valuation from Barclays Wealth for the three	**SWBCF (5/11) 007**

month period 1 January 2011 to 31 March 2011	
Mr Burgess reported that during the first quarter of 2011, the value of the Charitable Funds portfolio had not changed significantly, however the market was described as being volatile. The portfolio was highlighted to continue being managed at a medium level of risk. The value of the portfolio as at 31 March 2011 was reported to be £4,820,140. The Trustees were advised that the bond content of the portfolio had been changed in the light of possible interest rises and the current inflationary position. Mr Burgess advised that over the course of the year the discount in bonds and gilts had narrowed. The equity content of the portfolio was reported to remain largely unchanged. The equity rates were noted to be falling. The Trustees were informed that the price of oil had started to fall, although the reasons for this decline were unclear. The overall price of oil was reported to remain high overall however. Mr Burgess advised that opportunities would be taken to use the cash in the portfolio to best advantage where possible. The performance of the portfolio was reviewed and was noted to be out performing mainly due to the UK equity performance against the index rate. It was reported that the German economy was outpacing others within the Eurozone and in particular that of Portugal, Italy, Ireland, Greece and Spain. Mr Sharon asked what the impact of Greece being removed from the Euro was likely to be. Mr Burgess advised that this was difficult to judge, however there would likely be ramifications on the currency markets and equity markets to a lesser extent. The Trustees were informed that should the growth rate in China change, then this was likely to have a more significant impact. Mr Clarke observed that the property markets were not performing well and had not been for some time. Mr Burgess agreed and advised that the portfolio held a commercial property fund which although had performed poorly recently, should be retained on the basis that there was potential to perform better should interest rates remain low. It was noted that the fund also offered a good dividend yield. Dr Sahota asked whether there was an expectation that industrial markets would perform better in future. Mr Burgess confirmed that this was anticipated given that there was an expectation that the Sterling would appreciate in the next period. It was highlighted that the Japanese climate was weak at present. Mr Burgess assured the Trustees that this would have limited effect on the portfolio however.	

Mr Trotman asked for guidance as to whether the asset allocation of the portfolio should be changed at this point in time. Mr Burgess advised that there should be no change at present and that the portfolio should continue to be managed at a medium level of risk. Dr Sahota noted that the return on the cash holding was low at present due to the continued low interest rates. Mr Burgess advised that this was not a matter of significance given that cash represented a relatively small element of the portfolio. He further advised that a cash fund should continue to be held to enable sufficient flexibility to take advantage of investment opportunities as they arise. Mr Sharon asked whether there were any additional ethical considerations relevant to the portfolio aside from no investment in tobacco products. Mr White advised that this agreement had been reached in discussion with the advisers previously. Mr Clarke suggested that consideration to ethical matters should be considered more fully, including the possibility of establishing an ethical fund. Mr White advised that there was a need to ensure that there was sufficient flexibility for maximum gains. It was noted that the cash position was sufficiently healthy to ensure that the income from the portfolio is reinvested into the Charitable Funds account. Mr Burgess was thanked for his informative presentation and advice.	
5 Quarterly finance report	**SWBCF (5/11) 006** **SWBCF (5/11) 006 (a) - SWBCF (5/11) 006 (d)**
Mr Smith reported that the cash balance as at 3 May 2011 was £251k. Income received during the quarter was reported to be £532k, a significant proportion of which related to legacies. It was noted that the list of funds had been updated to remove some individuals who had left the Trust. Effort was reported to be being made to obtain the names of second fund managers. Mr Sharon observed that a number of funds related to community activity and asked whether these had been transferred across as part of the Transforming Community Services (TCS) plans. He was advised that these funds had been within the portfolio for some time. Mr Trotman noted that some funds related to wards that had closed, an issue which he suggested would be exacerbated when the Trust moved to the new hospital. He asked whether these could be combined or converted into a fund for a different purpose. Mr Smith advised that funds are moved with a ward if the Finance Team is notified of the change, although they are not changed if the move if temporary. The Trustees were advised that some work had been undertaken to	

review the funds of a similar name and nature, particularly those belonging to the same fund manager. It was highlighted however that care needed to be taken to ensure that funds could be appropriately merged given that it is not permitted to harmonise funds associated with different causes or intentions. Mr Smith advised that he would investigate the matter further including the possibility of establishing some discretionary funds. It was agreed that the possibility of harmonising funds, where there had been no activity for 18 months or more irrespective of value, should be considered. Mr White suggested that a policy should be developed to outline the steps to take, should there be no activity within a fund for a set period of time. It was agreed that this was a sensible proposal and the policy should be considered at the next meeting. Dr Sahota noted that in a number of cases, only one fund manager was identified. Mr Smith confirmed that every effort was being made to identify a second fund manager in such cases.	
ACTION: Mr Smith to present a proposal for the management of inactive funds at the next meeting	
6 Rationalisation of funds	**SWBCF (5/11) 008** **SWBCF (5/11) 008 (a)**
Mr Smith reported that those funds which had not seen any activity since December 2010 had been reviewed. The Trustees were advised that 47 funds under £500 had been identified, all of which could potentially be amalgamated. Mrs Davis suggested that these funds should be amalgamated as soon as possible. Mr Trotman agreed and highlighted that the funds were not being lost; they were being merged to create a bigger pot from which the original fund managers could draw. It was agreed that clarity needed to be provided to the funds managers as to how they might access the amalgamated fund. The Trustees unanimously agreed to the proposal that the funds should be amalgamated.	
AGREEMENT: The Trustees agreed that the inactive funds with a balance threshold of £500 should be amalgamated to be brought under Trustee control	
7 Fundraising investment plan	**SWBCF (5/11) 009** **SWBCF (5/11) 009 (a)**
Mrs Kinghorn presented a number of options for implementing a fundraising function within the Trust, which she advised had taken into account the advice provided at the previous meeting by the Director of the NHS Charities Association. The Trustees were advised that an in house fundraising function was proposed. It was noted that the return on the investment required to establish a fundraising function was likely to be significant based on the evidence collected.	

Mrs Davis highlighted that the population served by the Trust was culturally accustomed to donating. Mr Trotman agreed that the Trust was in a situation where it was possible to increase the level of donations from the current position by using a formal fundraising structure. He suggested that as an initial step work should be undertaken to improve the information available on making donations. Mr Adler asked what rationale was behind the proposal to undertake a scoping study for fundraising. Dr Sahota advised that this was an option available and was not mandatory. Mrs Kinghorn reported that the scoping study would outline where to direct the fundraising effort. It was agreed however that this should be a matter for the fundraising team when established. In terms of the results expected of the team, it was proposed that the salaries of the individuals involved should be met by donations and then targets should be set for a level of income over and above this. Given the need to ensure that the choice of individuals for the role of fundraising needed to be made carefully, it was suggested that the posts should be offered initially on a fixed term basis. The Trustees agreed that Option 3 should be pursued, the investment in a small team of staff to develop the strategy for fundraising and increase income. The costs were highlighted to be expected to be c. £160m per annum against a return of £1.5m. As a priority, it was agreed that the recruitment of a fundraising manager should be progressed. Mr Clarke suggested that the possibility of sponsoring wards could be considered. It was agreed that the most appropriate reporting line for the fundraising function needed to be clarified.	
AGREEMENT: The Trustees approved Option 3 of the fundraising plans, the investment in a small team of staff	
8 Application for the use of Charitable Funds	
8.1 Support for the 2011 Trust Ball	**SWBCF (5/11) 010**
The proposal to provide support for the 2011 Trust Ball was presented. The Trustees were asked to approve a contribution of £12,500 towards the event, which it was noted was the same level requested for the 2010 Trust Ball. The Trustees approved the request for support.	
AGREEMENT: The Trustees approved the request to contribute £12,500 of Charitable Funds towards the 2011 Trust Ball	
9 Any other business	**Verbal**

An amendment to the terms of reference for the Charitable Funds Committee was proposed to remove the need for the Director of Finance and Performance Management to be present for a meeting to be quorate. Instead, it was proposed that the quorum should be five members, including one Non Executive director and one Executive director. Mrs Davis reported that on review of the staff bids for lottery funds, many were noted to be separate bids for the same purpose which when amalgamated, could constitute a larger bid which could be presented to the Trustees. It was agreed that the co-ordination of these bids should fall within the remit of the Fundraising Manager. It was further agreed that a specific co-ordinated approach to the replacement of television sets in advance of the digital switchover should be investigated. Mr Trotman reported that he had received a letter from Jackie Cooper, Divisional General Manager for Surgery B, thanking the Trustees for their support with the purchase of chairs for the Birmingham and Midlands Eye Centre.	
10 Details of the next meeting	**Verbal**
The next meeting is to be held on 8 September 2011 at 0930h in the Executive Meeting Room at City Hospital.	

Signed ……..

Print ……..

Date ……..