

AGENDA

Trust Board – Public Session

Venue Churchvale/Hollyoak Rooms, Sandwell Hospital **Date** 30 June 2011; 1530h - 1730h

Members

Mrs S Davis (SD) [Chair]
 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 D O'Donoghue (DO'D)
 Mr R White (RW)
 Miss R Overfield (RO)
 Mr M Dodd (MD)

In Attendance

Mr G Seager (GS)
 Miss K Dhami (KD)
 Mrs J Kinghorn (JK)
 Mrs C Rickards (CR)

Guests

Ms A Pereira (AP)

Secretariat

Mr S Grainger-Payne (SGP) [Secretariat]

Item	Title		Lead
1	Apologies	Verbal	SGP
2	Declaration of interests <i>To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting</i>	Verbal	All
3	Chair's opening comments	Verbal	Chair
4	Minutes of the previous meeting <i>To approve the minutes of the meeting held on 26 May 2011 and 9 June 2011 as true and accurate records of discussions</i>	SWBTB (5/11) 125 SWBTB (6/11) 124	Chair
5	Update on actions arising from previous meetings	SWBTB (5/11) 125 (a)	Chair
6	Questions from members of the public	Verbal	Public
7	Outcome of Sandwell LINKs discharge review	SWBTB (6/11) 133 SWBTB (6/11) 133 (a)	AP
MATTERS FOR APPROVAL			
8	Use of the Trust Seal to the Deed of Variation	SWBTB (6/11) 137	RW

MATTERS FOR INFORMATION/NOTING

9	Safety, Quality and Governance		
9.1	Communications and engagement strategy update	SWBTB (6/11) 141 SWBTB (6/11) 141 (a)	JK
9.2	Same Sex Accommodation declaration	SWBTB (6/11) 143 SWBTB (6/11) 143 (a)	MD
9.3	Transforming Community Services – Post Transaction Integration and Benefits Realisation	SWBTB (6/11) 135 SWBTB (6/11) 135 (a)	MD
9.4	Update on complaints handling	To follow	JA
9.5	Briefing on ‘Listening into Action’	SWBTB (6/11) 130 SWBTB (6/11) 130 (a)	JA
9.6	Report from Sandwell Mental Health Trust Governor	SWBTB (6/11) 138 SWBTB (6/11) 138 (a)	RO
9.7	Freedom of Information requests update	SWBTB (6/11) 131 SWBTB (6/11) 131 (a)	SGP
10	Strategy and Development		
10.1	‘Right Care, Right Here’ programme: progress report	SWBTB (6/11) 144 SWBTB (6/11) 144 (a)	MS
10.2	Foundation Trust application: progress update	SWBTB (6/11) 140 SWBTB (6/11) 140 (a)	MS
10.3	Midland Metropolitan Hospital project: progress report	SWBTB (6/11) 139 SWBTB (6/11) 139 (a)	GS
11	Performance Management		
11.1	Monthly finance report	SWBTB (6/11) 128 SWBTB (6/11) 128 (a)	RW
11.2	Monthly performance monitoring report	SWBTB (6/11) 129 SWBTB (6/11) 129 (a)	RW
11.3	NHS Performance Framework monitoring report	SWBTB (6/11) 127 SWBTB (6/11) 127 (a)	RW
12	Update from the Board Committees		
12.1	Finance and Performance Management Committee		
▶	Draft minutes from meeting held 23 June 2011	To follow	RT
12.2	Foundation Trust Programme Board		
▶	Draft minutes from meeting held 26 May 2011	SWBTB (5/11) 027	SD
13	Any other business	Verbal	All
14	Details of next meeting <i>The next public Trust Board will be held on 28 July 2011 at 1500h in the Anne Gibson Boardroom, City Hospital</i>	Verbal	Chair

MINUTES

Trust Board (Public Session) – Version 0.2

Venue Anne Gibson Boardroom, City Hospital

Date 26 May 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:

Miss Kam Dhami	Mr Graham Seager	Mrs Jessamy Kinghorn
Miss Rachel Barlow (Observer)		

Secretariat:

Mr Simon Grainger-Payne

Minutes	Paper Reference
1 Apologies for absence	Verbal
Apologies were received from Mrs Gianjeet Hunjan.	
2 Declaration of Interests	Verbal
There were no declarations of interest raised.	
3 Chair's Opening Comments	Verbal
<p>The Chair reported that she had received a note from the Chair of the League of Friends at Sandwell Hospital to advise that the group had raised £40k for the Trust in the past year. The Board was advised that a formal note from the Board would be issued to thank the group for their dedication.</p> <p>The Chair congratulated Miss Overfield on the Ward Team Challenge event that had been held recently and asked for the Board's thanks to be conveyed to the team that had organised the occasion. Mr Trotman added his congratulations and made specific reference to Miss Overfield's Executive Assistant, Sue Gaskin, who</p>	

<p>had been central to the plans, despite recovering from a serious car accident.</p> <p>Mr Matthew Dodd was welcomed to the Board meeting in his capacity of Acting Chief Operating Officer. Miss Rachel Barlow was also welcomed to the meeting as the Chief Operating Officer designate.</p>	
<p>ACTION: The Chair to issue a note to the League of Friends to thank them for their fundraising efforts</p>	
4 Minutes of the previous meeting	SWBTB (4/11) 096
<p>The minutes of the previous meeting were presented for approval and were accepted as a true and accurate reflection of discussions held on 28 April 2011.</p>	
<p>AGREEMENT: The Trust Board approved the minutes of the last meeting</p>	
5 Update on actions arising from previous meetings	SWBTB (3/11) 072 (a)
<p>The updated actions list was reviewed and it was noted that there were no outstanding actions requiring discussion or escalation.</p>	
6 Questions from members of the public	Verbal
<p>No questions were raised by members of the public present.</p>	
7 Single Tender Action – Recharge of Salaries from Birmingham University	SWBTB (5/11) 126
<p>Mr White presented a Single Tender Action for approval by the Trust Board. He advised that a number of clinical academics from the University of Birmingham were based at Trust and that salaries were to be recharged to the value of £1,604,976.</p> <p>As the gross expenditure was above £500,000 the Trust Board was asked to agree to the waiver and to renew the agreement with the University of Birmingham for the 2011/12 financial year.</p> <p>The Trust Board approved the Single Tender Action.</p>	
<p>AGREEMENT: The Trust Board approved the Single Tender Action in respect of salary recharge from the University of Birmingham</p>	
8 Board Committees' Terms of Reference	
8.1 Quality and Safety Committee	SWBTB (5/11) 105 SWBTB (5/11) 105 (a)
<p>Mr Grainger-Payne presented the Terms of Reference for the Quality and Safety Committee for formal acceptance by the Board. It was noted that they had been considered previously as part of the Quality and Safety Strategy that had been approved at the April meeting of the Trust Board. Clarification that deputies in</p>	

<p>attendance do not count towards the quorum for the meeting was highlighted to have been included in the Terms of Reference, in accordance with a suggestion made as part of the discussion of the Quality and Safety Strategy.</p> <p>The Chair noted that the Terms of Reference stipulated that the membership of the Committee included three Non Executive Directors, when it had been agreed that four Non Executive Directors would attend. Mr Grainger-Payne offered to make this amendment.</p>	
<p>AGREEMENT: Subject to minor amendment, the Trust Board approved the Terms of Reference for the Quality and Safety Committee</p>	
<p>8.2 Charitable Funds Committee</p>	<p>SWBTB (5/11) 104 SWBTB (5/11) 104 (a)</p>
<p>Mr Grainger-Payne presented an amended version of the Charitable Funds Committee Terms of Reference for approval, which the Board was advised had been changed to remove the need for the Finance and Performance Management Director to be present in order for a meeting to be quorate. It was highlighted that this clause had been broadened to require an Executive Director to be present to meet the quorum.</p> <p>The Board was advised that the opportunity had been taken to clarify the instances when the Charitable Funds Trustees should consider a business case that is of sufficient value as needing Trust Board approval.</p>	
<p>AGREEMENT: The Trust Board approved the revised Terms of Reference for the Charitable Funds Committee</p>	
<p>8.3 Foundation Trust Programme Board</p>	<p>SWBTB (5/11) 109 SWBTB (5/11) 109 (a)</p>
<p>Mr Grainger-Payne presented the Terms of Reference for the FT Programme Board for approval, noting that at the last meeting the Board had approved in principle that delegated authority should be given to the Programme Board to progress the Trust's Foundation Trust application. Mrs Dutton suggested that the Terms of Reference should clarify that the Programme Board would normally meet monthly. Mr Grainger-Payne offered to make this amendment.</p> <p>On a separate matter, the Chair advised that the Non Executive membership of the Trust Board's Committees had been rationalised and would take immediate effect.</p>	
<p>AGREEMENT: Subject to minor amendment, the Trust Board approved the Terms of Reference for the Foundation Trust Programme Board</p>	
<p>9 Safety, Quality and Governance</p>	

9.1 Infection Control	
Quarterly report	SWBTB (5/11) 099 SWBTB (5/11) 099 (a)
Annual report	SWBTB (5/11) 100 SWBTB (5/11) 100 (a)
<p>Miss Overfield presented the key highlights from the quarterly and annual infection control reports.</p> <p>The Chair asked how the Trust's performance on infection control compared with that of other trusts. Miss Overfield advised that performance was ahead of a number of trusts in the local region.</p> <p>Mr Adler advised that the MRSA and <i>C difficile</i> trajectories for 2011/12 had been set according to the local performance for 2010/11. As such, the Trust was noted to be required to maintain current performance rather than be needed to improve upon it. This reflected the Trust's good position in relation to average national performance.</p> <p>Miss Overfield was asked whether surgical site infections were recorded. She advised that this was done where possible, although it was noted that the data was not especially meaningful. Dr Sahota suggested that comfort could be taken from nursing staff recording this information. Miss Overfield advised however, that in many cases the occurrence of a surgical site infection would not be known until after the patient had left the Trust. To improve the recording of this information, it was agreed that further work would be needed in collaboration with the PCTs. Prof Alderson confirmed that the majority of surgical site infections occur in the community setting and a spot check approach to tracking these infections may be possible. Mr O'Donoghue advised that it would be likely to be expensive to implement a robust recording mechanism for these infections which in his view was disproportionate to the value of the information.</p> <p>The Chair asked what Infection Control issues related to community services. Miss Overfield advised that one Infection Control nurse had transferred from Sandwell PCT as part of the Transforming Community Services plans, although this individual's role was predominantly to deliver training. The Chair asked that the next version of the Infection Control report includes commentary on the aspects related to community services.</p> <p>Miss Overfield was asked how achievable the Infection Control targets for 2011/12 were seen to be. She advised that the <i>C difficile</i> target in particular, although stretching, was realistic.</p> <p>Prof Alderson suggested that a watching brief should be kept on the incidence of Tuberculosis in the community, given that there appeared to be an increasing</p>	

number of cases reported. The Board was advised that the incidence of Tuberculosis could have a significant impact on Secondary Care.	
ACTION: Miss Overfield to ensure that commentary on the community services Infection Control position is included in the next quarterly update on Infection Control	
9.2 Cleanliness report	SWBTB (5/11) 100 SWBTB (5/11) 100 (a)
<p>Miss Overfield presented the cleanliness report for receipt and noting. It was highlighted that the external PEAT audit results had improved.</p> <p>The Board was advised that the laundry project, which planned to provide facilities to allow the Trust to use bespoke patient nightwear, was progressing well.</p> <p>Dr Sahota reported that he had undertaken a Board Walkabout at Sandwell Hospital recently and had spoken to a number of patients about the environment in which they were being treated. The Board was advised that the majority of patients are content with the food and service that they are receiving.</p>	
9.3 Update on complaints handling	Hard copy paper
<p>Miss Dhami presented a tabled report outlining progress with addressing issues with handling complaints. It was noted that there has been a detailed discussion on the matter at the Quality and Safety Committee earlier in the month.</p> <p>The Chair asked if there had been any formal communication from the Care Quality Commission (CQC) following the recent responsive review of compliance against the Outcome 17, complaints. Miss Dhami advised that there had been no further contact by the CQC although it was likely that the situation would be clarified at the routine meeting with the regional CQC representatives in mid June.</p> <p>Mr Trotman noted that at the Quality and Safety Committee meeting, it had been emphasised that a target of issuing 95 complaints responses per month to address the current backlog by December 2011 was challenging and that as 105 had been issued in the period, this was encouraging.</p> <p>Mr Adler remarked that it was pleasing to see that the number of complaints responses being issued had increased and that it appeared from his review of responses that the quality of responses was not being compromised.</p> <p>The Chair asked whether the responses being issued were proportionate to the complaint made. Miss Dhami confirmed that this was the case in that a full investigation report is now not always prepared for simple complaints.</p> <p>Mr Adler advised that where complaints refer to active care, consideration is</p>	

<p>being given to altering to process to ensure that these are passed to Divisions to handle for immediate attention. This would improve responsiveness and lessen the workload of the complaints department.</p>	
<p>9.4 Assurance Framework 2010/11 – Quarter 4</p>	<p>SWBTB (5/11) 098 SWBTB (5/11) 098 (a)</p>
<p>Mr Grainger-Payne presented the Assurance Framework for Quarter 4 of 2010/11 for receipt and noting.</p> <p>The Board was advised that the changes from the previous version had been highlighted in line with a recommendation from a recent Internal Audit review of the Assurance Framework.</p> <p>Mr Grainger-Payne advised that the Assurance Framework format would be altered slightly in line with further recommendations arising from the Internal Audit review and to incorporate the input from some best practice examples.</p>	
<p>9.5 National Inpatient Survey results</p>	<p>SWBTB (5/11) 106 SWBTB (5/11) 106 (a) SWBTB (5/11) 106 (b)</p>
<p>Mrs Kinghorn presented the results from the National Inpatient Survey, which she advised had been published in April 2011.</p> <p>The Board was asked to note that there had been an improvement in the Trust's position against a number of indicators, with the overall scores being in line with other trusts.</p> <p>Mr Dodd advised that one of the Quality and Efficiency Programme (QuEP) workstreams concerned improvements to patient flow, which should generate further efficiencies in this area.</p> <p>Miss Overfield suggested that the results of the survey should be considered in the context of the internal staff satisfaction survey results.</p> <p>The Chair asked whether there were plans in place to address those areas where there is noted to be room for improvement identified by the survey results. She was advised that these measures would be communicated within the 'Hot Topics' briefing to managers and in the staff newsletter, 'Heartbeat'.</p>	
<p>9.6 Change to the Birmingham Treatment Centre (BTC) Facilities Management provider</p>	<p>SWBTB (5/11) 116</p>
<p>The Trust Board was asked to receive and note the planned change to the Birmingham Treatment Centre (BTC) Facilities Management provider, the authority for which had needed to be given outside of the Trust's scheduled meeting cycle.</p>	

10 Strategy and Development	
10.1 'Right Care, Right Here' programme: progress report	SWBTB (5/11) 117 SWBTB (5/11) 117 (a)
<p>Mr Sharon presented the latest 'Right Care, Right Here' programme progress report, which the Board received and noted.</p> <p>The Board was advised that there had been no significant development since the last report and that progress with the decommissioning work would be reported at a subsequent meeting.</p> <p>The Board was advised that an event with the 'Right Care, Right Here' Partnership Board had been held to which GP consortia leads had been invited. At this event commitment had been given the 'Right Care, Right Here' plans in a collaborative and collective manner. The event was also reported to have highlighted the need for good relationships to be developed with consortia.</p> <p>The Board was informed that new streamlined governance arrangements for the 'Right Care, Right Here' programme were being developed.</p>	
10.2 Foundation Trust application: progress update	Verbal
<p>Mr Sharon advised that the Foundation Trust Programme Board and Foundation Trust Programme Team had been established.</p> <p>The Board was informed that a trajectory to be authorised as a Foundation Trust had been agreed with the Strategic Health Authority, with the required submissions to the Department of Health being planned for June 2012.</p> <p>Mr Sharon advised that a meeting was planned with the Chairs of the Overview and Scrutiny Committees to discuss whether there is a need for the Trust to undertake public consultation as part of its FT application. If this is not required, the Board was advised that a public engagement period would be needed. Mrs Kinghorn reported that there were plans to step up communication across the Trust, including with community services staff. Mr O'Donoghue asked what validation of membership was undertaken. Mrs Kinghorn advised this is performed as part of the active engagement process.</p> <p>The tabled minutes of the FT Programme Board held on 28 April 2011 were received and noted.</p>	
10.3 Midland Metropolitan Hospital project: progress report	SWBTB (5/11) 111 SWBTB (5/11) 111 (a)
Mr Seager reported that approval of the Outline Business Case (OBC) for the Midland Metropolitan Hospital remained awaited.	

<p>The Board was advised that the appointment of a demolitions contractor was planned. Local regeneration as part of the process and assessment are being considered.</p> <p>The Board was also informed that there is good engagement with the preparation of the commercial documentation.</p>	
<p>11 Performance Management</p>	
<p>11.1 Monthly finance report</p>	<p>SWBTB (5/11) 108 SWBTB (5/11) 108 (a)</p>
<p>Mr White presented the financial performance report for the period April 2011, which was noted to have been discussed in detail by the Finance and Performance Management Committee.</p> <p>The Board was advised that an unplanned deficit of £235k had been posted in month, meaning that the Trust had deviated from its financial trajectory to the value of £370k.</p> <p>Pressure on pay expenditure was noted specifically and the use of agency staff was highlighted to be high, despite the context of low sickness absence. The Board was advised that this situation was expected to be linked to some degree to the number of Bank Holidays during April.</p> <p>Mr White reported that the cash position remained strong due partly to the way in which the capital programme is phased.</p> <p>The Board noted that the financial performance of the Medicine & Emergency Care and the Surgery, Anaesthetics and Critical Care divisions particularly had contributed to the adverse variance against plan that had been generated. As such the Board was informed that financial recovery plans had been required from both divisions and these would be reviewed at forthcoming meetings.</p> <p>Overall it was noted that the circumstances did not represent a sound financial start to the year.</p> <p>Mr Trotman reported that the situation had been discussed significantly as part of the recent meeting of the Finance and Performance Management Committee. He advised that the Trust had experienced the odd minor reversal in the past but nothing of the magnitude reported for April. The Board was advised that there had been a small shortfall of £73,000 in income during the month, although the main adverse variance was in payroll costs. Mr Trotman advised that it was not completely clear why the expenditure on bank and agency had been so high, however as Mr White had explained, a contributing factor could have been staff attaching annual leave onto the various Bank Holidays in the month. The fact that sickness absence across the Trust was only of the order of 3.8% may lend some</p>	

support to this view.

Mr Trotman advised that the Executive Directors present at the meeting were questioned about the capacity of management in the Medicine & Emergency Care and the Surgery, Anaesthetics and Critical Care divisions and other key areas. It was agreed that the Chair of the Trust and the Chair of the Finance and Performance Management Committee would be briefed at the very earliest opportunity when the results for May were available.

Mr Trotman advised that there had been no guidance given at the Finance and Performance Management Committee meeting as to the actions that the Executive Team would need to take, however assurance is required that measures are being taken to cease the trends and recover the position during the remainder of the year.

Miss Overfield advised that at present an extra 66 beds than was planned were open, and although measures were being taken to ensure that adequate staffing is in place to handle this situation, further work was needed.

Mr O'Donoghue remarked that the financial circumstances would clearly create pressure on the relevant divisions, however a strong focus on the delivery of safe high quality care should be maintained. Mr Adler agreed that there was a need for the situation to be handled in a safe and structured way, including the reduction in capacity that was required.

Prof Alderson noted that the Medicine and Emergency Care division had been performing poorly in financial terms for several months. Mr Adler reported that historically there had been an issue with budgetary allocation for the division as evidenced by the Service Line Reporting position, however this had been corrected by adjusting the division's budget, yet disappointingly the division continued to report an adverse financial position. The Chair asked whether the issue lay more fundamentally with the productivity of the division. Mr O'Donoghue advised that this was likely to be a contributory factor and work to understand the extent to which this was impacting was being expedited.

Mr Sharon remarked that activity appeared to be reduced compared to the same period in 2010/11 and asked why the extra capacity remained open in the Trust. Mr Dodd advised that closure had not been possible due to the need to provide capacity in a month with a number of Bank Holidays, together with a number of outbreaks of Norovirus.

Mr White advised that a judgement call would be needed as to how the financial position of the divisions concerned could be reflected corporately, although he advised that there was no expectation that subsidy by other divisions would be arranged.

The Chair asked whether the recovery plans would be factored into the forward

forecast for the year. Mr White confirmed that this would be the case.	
11.2 Monthly performance monitoring report	SWBTB (5/11) 119 SWBTB (5/11) 119 (a)
<p>Mr White presented the performance monitoring report and advised the Trust Board that it had been reviewed in detail by the Finance and Performance Management Committee.</p> <p>Mr Dodd advised that the current capital works underway would further reduce the number of Same Sex Accommodation breaches incurred. It was noted that some breaches had needed to be incurred during the month due to the effect of Norovirus outbreaks on the operational situation.</p> <p>Miss Overfield highlighted the good reduction in sickness absence.</p> <p>Mr Adler noted that the report had been amended to take into account the new national targets set and the suite of CQUIN targets agreed for 2011/12. The Board was advised that further performance information would be included shortly to reflect those relevant to community services.</p>	
11.3 NHS Performance Framework update	SWBTB (5/11) 118 SWBTB (5/11) 118 (a)
<p>Mr White presented the NHS Performance Framework update for information.</p> <p>The Trust Board received and noted the report and was pleased to note that the Trust remains classified as a 'performing' organisation.</p> <p>It was noted that amber alerts included in the report were reflective of the current poor performance against the Delayed Transfers of Care target and of the current financial performance of the Trust.</p>	
12 Update from the Board Committees	
12.1 Finance and Performance Management Committee	Hard copy paper
<p>The Trust Board received and noted the draft minutes of the Finance and Performance Management Committee from the meeting held on 19 May 2011.</p> <p>Mr Trotman advised that the Committee had received an update on the financial position and key activities of the Women and Child Health division, which had presented a positive position. The Board was informed that the Finance Manager for Sandwell Adult Community Health Services had observed part of the meeting in preparation for the presentation that would be given by the division at the June meeting.</p>	
12.2 Governance and Risk Management Committee	SWBGR (3/11) 023 SWBGR (5/11) 101

	SWBGR (5/11) 101 (a)
The Trust Board received and noted the draft minutes of the Governance and Risk Management Committee from the meeting held on 24 March 2011. The Board also noted the Governance and Risk Management Committee Chair's annual report which had been accepted at the meeting held on 19 May 2011.	
12.3 Audit Committee	SWBAC (5/11) 103 SWBAC (5/11) 103 (a)
The Trust Board noted the Audit Committee Chair's annual report which had been accepted at the meeting held on 12 May 2011.	
13 Any other business	
Mr Trotman advised that Mr Peter Finch, the Trust's Local Security Management Specialist had been appointed as the Chair of the National Association for Healthcare Security. It was agreed that congratulation should be issued to Mr Finch on behalf of the Trust Board.	
ACTION: Mr Grainger-Payne to send the Board's congratulations to Peter Finch on his recent appointed as Chair of the National Association for Healthcare Security	
14 Details of the next meeting	Verbal
The next public session of the Trust Board meeting was noted to be scheduled to start at 1530h on 30 June 2011 and would be held in the Churchvale/Hollyoak Rooms at Sandwell Hospital.	

Signed:

Name:

Date:

Next Meeting: 30 June 2011, Churchvllae/Hollyoak Rooms @ Sandwell Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

26 May 2011, Anne Gibson Boardroom @ City Hospital








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

In Attendance: Mr G Seager (GS), Miss K Dhami (KD), Mrs J Kinghorn (JK)






Apologies: Mrs G Hunjan (GH)

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 24 June 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	31/07/11	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	
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	
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		
SWBTBACT.194	Nursing quality report	SWBTB (4/11) 088 SWBTB (4/11) 088 (a) - SWBTB (4/11) 088 (d)	28-Apr-11	Organise for the suggested nurse quality indicators to be added to future versions of the corporate performance report	RW	31/07/11	Now included in report but need further refinement	
SWBTBACT.199	Chair's opening comments	Verbal	26-May-11	Issue a note to the League of Friends to thank them for their fundraising efforts	SD	30/06/11	Note sent as suggested	
SWBTBACT.192	Quality and Safety strategy 2011-16	SWBTB (2/11) 053 SWBTB (2/11) 053 (a)	28-Apr-11	Clarify the escalation process to be used within the Quality and Safety strategy	KD	30/06/11	Included in the version launched at the Leadership Conference in June 2011	
SWBTBACT.201	Any other business	Verbal	26-May-11	Send the Board's congratulations to Peter Finch on his recent appointment as Chair of the National Association for Healthcare Security	SG-P	30/06/11	Note sent as suggested	

KEY:

	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
	Outstanding 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
	Outstanding action raised more than 3 months ago which has been deferred more than once
	Action that is scheduled for completion in the future and there is evidence that work is progressing as planned towards the date set
	Action that has been completed since the last meeting

Next Meeting: 30 June 2011, Churchvlae/Hollyoak Rooms @ Sandwell Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

26 May 2011, Anne Gibson Boardroom @ City Hospital

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

In Attendance: Mr G Seager (GS), Miss K Dhami (KD), Mrs J Kinghorn (JK)

Apologies: Mrs G Hunjan (GH)

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 24 June 2011

Reference No	Item	Paper Ref	Date	Agreement
SWBTBAGR.229	Minutes of the previous meeting	SWBTB (4/11) 096	26/05/2011	The Trust Board approved the minutes of the previous meeting as a true and accurate records of discussions held
SWBTBAGR.230	Single Tender Action - Recharge of Salaries from Birmingham University	SWBTB (5/11) 126	26/05/2011	The Trust Board approved the Single Tender Action in respect of salary recharge from the University of Birmingham
SWBTBAGR.231	Quality and Safety Committee terms of reference	SWBTB (5/11) 105 SWBTB (5/11) 105 (a)	26/05/2011	Subject to minor amendment, the Trust Board approved the Terms of Reference for the Quality and Safety Committee
SWBTBAGR.232	Charitable Funds Committee terms of reference	SWBTB (5/11) 104 SWBTB (5/11) 104 (a)	26/05/2011	The Trust Board approved the Terms of Reference for the Charitable Funds Committee
SWBTBAGR.233	FT Programme Board terms of reference	SWBTB (5/11) 109 SWBTB (5/11) 109 (a)	26/05/2011	Subject to minor amendment, the Trust Board approved the Terms of Reference for the FT Programme Board

Sandwell and West Birmingham Hospitals



NHS Trust

TRUST BOARD

DOCUMENT TITLE:	LiNk Discharge Report
SPONSORING DIRECTOR:	Jessamy Kinghorn, Head of Communications and Engagement
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DATE OF MEETING:	30 June 2011

SUMMARY OF KEY POINTS:

During 2010/11, the Sandwell Local Involvement Network undertook a review of Patient Discharge which was welcomed by the Trust. The purpose of the review was to explore the process of discharge, examining the joined up working within the local hospital trust and between partner organisations involved in the patient journey. The findings would then be reported to the Health and Wellbeing Board in Sandwell for the consideration and action of the Chief Executives and Chairs who sat at that meeting.

Their review included visits to a number of wards to talk to nursing staff, discussion with managers within the SWBH and within social care, surveys of patients in hospital at the time and those who had been recently discharged.

The report makes some recommendations, including:

- Improving joint work between health and social care.
- Reviewing how writing TTOs and getting prescriptions creates delays and introducing improvements.
- Improving joint working across healthcare, e.g. between the hospitals and mental health or district nurses.
- That existing good practice should be replicated, e.g. through a Listening into Action event.

The LiNk presented their report to the Health and Wellbeing Board on the 21st February and were then invited to present their findings to the Trust Board.

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

Approval	Receipt and Noting	Discussion
	X	X

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Board is asked to NOTE the report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Accessible and Responsive Care, Safe, High Quality Care
Annual priorities	Improve patient flow from admission through discharge to home care / after care; Improve reported levels of patient satisfaction; QuEP
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Health and Wellbeing Board, 21st February 2011

Discharge Review

Enter & View 02

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Executive Summary

This report covers the findings of Sandwell LINK in their study of the discharge process in Sandwell. The study entailed six 'Enter & View' visits to Sandwell General Hospital and City Hospital in August and September 2010. The data from the visits was then matched with information drawn from patients who attended the hospitals between June 2009 and October 2010 and to discussions with representatives from the Hospital Trust and Social Care.

The outcome of the findings of that research, which highlighted delays caused in a variety of areas, was a series of recommendations including the following:

- Improving join work between health and social care.
- Reviewing how writing TTOs and getting prescriptions creates delays and introducing improvements.
- Improving joint working across healthcare, e.g. between the hospitals and mental health or district nurses.
- That existing good practice should be replicated, e.g. through a Listening into Action event.

Foreword

At the beginning of 2010 Sandwell LINK invited people living in Sandwell to tell us of their concerns in the health and social care services they were receiving. One of the major concerns raised was the way patients were discharged from hospital.

The hospital discharge process was included in our work programme for the year and we decided to approach it in a variety of ways. Firstly we discussed the process being followed with one of the Hospitals Managers. As this raised even more concerns we then proceeded to a more in depth investigation.

Members of Sandwell LINK visited a number of wards to discover from the nursing staff what they thought of the current procedure. Questionnaires were left for the patients on the wards and people in Sandwell were also asked to complete these questionnaires if they had been discharged from hospital recently. We also interviewed managers within the acute hospitals and social care to gain an understanding of the bigger picture. This report shows the results we have found.

It has been a useful exercise as we will now be able to share these findings within the Health and Wellbeing Board where all agencies are represented. Sandwell LINK will then ask for our recommendations to be discussed and implemented.

This will result in an improved service for the people of Sandwell.

Signed:



Date: 12/01/11

Pam Jones

(Sandwell LINK Chairman)

Introduction

Context:

The purpose of the review was to explore the process of discharge, examining the joined up working within the local hospital trust and between partner organisations involved in the patient journey. The findings would then be reported to the Health and Wellbeing Board in Sandwell for the consideration and action of the Chief Executives and Chairs who sat at that meeting.

The background to the issue originated with a series of problem discharges being reported to Sandwell LINK in early 2010. These culminated in an invitation to Matthew Dodd, Deputy Chief Operating Officer from Sandwell and West Birmingham Hospitals NHS Trust, to attend a Sandwell LINK meeting and discuss the process of discharge. At this time, LINK members utilised the Department of Health guidance document 'Ready to Go'¹ in order to benchmark what Matthew described. In the course of their meeting on 19th March 2010, LINK members drew Matthew's attention to the document (only one week old) and discussed the series of problems the hospital trust faced.² It was agreed to explore ways to work together with Sandwell and West Birmingham 'Listening into Action' events and Matthew agreed that receiving feedback on the process of discharge would be useful to his work in improving it.

Subsequently, based on the concerns raised at the meeting, it was agreed that Sandwell LINK would undertake a research project around discharge in addition to pursuing the joint work with Matthew. The methodology the LINK employed will be summarised below, but note that no further meetings with the Deputy Chief Operating Officer could ultimately be arranged.

Methodology:

The research Sandwell LINK elected to undertake was conducted using three parallel approaches to obtain the most detailed data possible. This included a patient survey for anyone who had been discharged in the past 18 months, a series of 'Enter & View' visits to hospital wards, and discussions with representatives from the hospital trust and social care.

The patient survey was a short survey aimed at gaining quantitative data through multiple choice questions. It was incentivised through the use of a prize draw and yielded a total of 83 responses, with

¹ SPLG, 'Ready to Go' (12 March 2010) Department of Health.

² Minutes of Sandwell LINK Health Subgroup, 19th March 2010, available at: http://www.sandwellink.org/What_LINK_do/minutes.php and accessed 5th December 2010.

only 7 invalidated by a failure to date them appropriately. The questions covered which hospital and ward was being discussed, what delays may have been experienced on the ward, what connecting services were used and whether these would produce delays. The survey was produced based on the Department of Health Guidance 'Ready to Go' and with the input of volunteers in both of Sandwell LINK's subgroups, including patients and organisation representatives, with the aim of asking the most relevant questions to enable the identification of areas for improvement.

The 'Enter and View' visits were carried out with a view to capturing detailed qualitative information from the hospital staff responsible for discharge. The decision was made to do unannounced visits in order to obtain the most accurate results on how discharge was understood at ward level and what staff knew about the patients due for discharge that day. There were six visits in total, three to each hospital, and the surveys used by the authorised representatives were designed based on the Department of Health guidance 'Ready to Go' and agreed by Sandwell LINK's subgroups in the same way as the patient surveys. The visits covered a range of ward specialities chosen for the contrast they would represent:

Ward	Speciality
MAU, City Hospital	Medical Assessment Unit
Priory 4, Sandwell General	Acute Elderly Care
ASU, City Hospital	Adult Surgical Unit, 23hr/Day Surgery
D47, City Hospital	Orthopaedic Rehabilitation and Transfers to Residential Care
Newton 3, Sandwell General	Female Orthopaedic Trauma Unit
Newton 2, Sandwell General	Short Stay Surgical Unit

Each visit was partnered with a request for the staff on the ward to pass on patient surveys to the patients they cared for; this was duly done and ward managers and their staffs can be credited with 23 additional patient survey replies coming in. Furthermore, the staffs visited during these visits were supplied opportunity to read and challenge the findings of the visits prior to publication.

Finally, Sandwell LINK also met with Linda Pascall, Deputy Chief Nurse at Sandwell and West Birmingham Hospitals NHS Trust, to discuss planned revisions to services, and a representative from social care to discuss their experience of discharge. These findings are also incorporated.

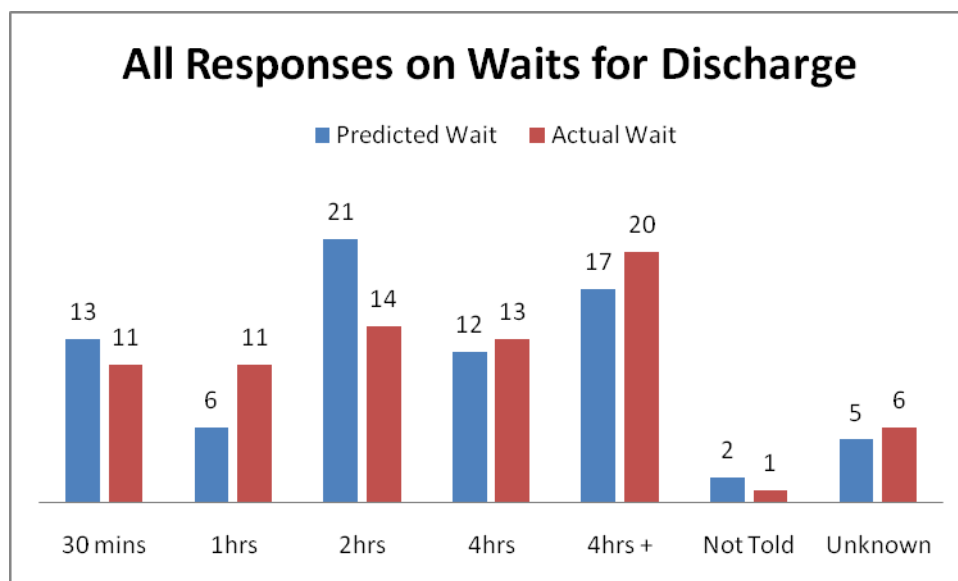
It was thought that through this blend of data, the most accurate picture of discharge would emerge.

Findings

Patient Surveys

The patient surveys were designed to cover recent discharges from the local hospitals in order to ensure the data was contemporary. This resulted in 76 valid results covering June 2009 to October 2010, with 7 replies invalidated as they did not specify a date. The majority of the surveys covered discharges from City Hospital (34) and Sandwell General Hospital (30), with a significant minority concerning Russells Hall Hospital (9) and single surveys for Rowley Regis Hospital, Walsall Manor Hospital and New Cross Hospital in Wolverhampton. As a result of this breakdown, efforts will be made to differentiate between the hospitals in results summaries.

The opening questions in the survey focused on discharge date, hospital and ward (see page 16 for ward case studies). The next questions focused on the difference between the amount of time patients were told they would have to wait and how long they actually waited for discharge. The graph below shows the overall findings, with hospital breakdown in appendix 1.

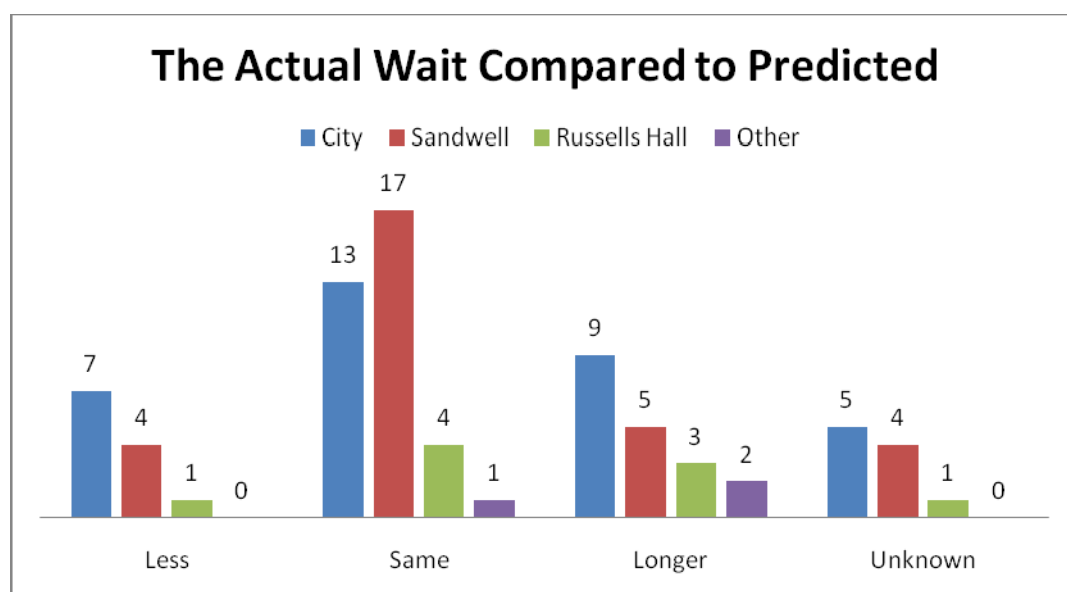


These findings generated two concerns. First and foremost was the number of patients who both expected and actually had to wait for 4hrs or more to be discharged after their discharge had been agreed. Of the 33 that actually took 4hrs or more, there were only 6 that were cases of day surgery and may have included their return to being medically fit in the hours of waiting. This still left 36% of patients who had to wait 4hrs or more to be discharged after being told they were ready to go. Furthermore, two cases specifically stated that '4hrs or more' meant almost a week: these were a

discharge from D47 at City that took one week and a discharge from Priory 5 at Sandwell delayed by 5 days. In both cases, the respondents felt it was important to identify these timescales.

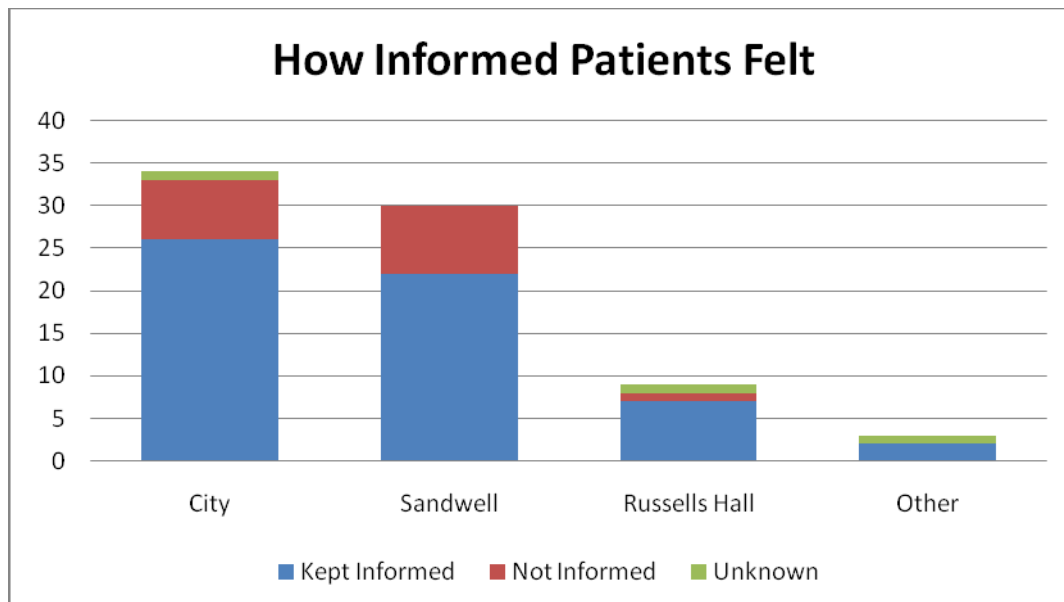
The case on D47 involved a patient who had already been in hospital 'too-long' and experienced further delays due to a ward closure connected to infection control. During this initial delay (not part of the week noted), social services had not known of the suspended discharge and had visited the patient's home anyway; once the ward was again able to discharge the patient, it took a further week to rearrange the connecting services. This underlines the financial outcome from poor communication between services; the cost of the social care visit and the use of the bed for a further week.

In the case from Priory 5, the patient was initially told discharge would be in 2hrs. The doctor then delayed it 5 days. This presumably does not have a wasteful financial implication as the doctor must have felt this was necessary, but it clearly had a big impact on the patient's experience of their hospital stay.



The second concern that arose from contrasting expected and actual discharge waiting times was the mismatch between the two. The graph above shows the extent of the fluctuations within each hospital. It should be noted that there was no direct relation between these variations and the ward on which the patients in question stayed. With 16% of patients discharged earlier than expected and 25% later, a hypothesis was formed that it left patients respectively unprepared or frustrated. This appears to be backed up by the fact that 15 of these 31 patients made additional comments and only 3 were positive. It should also be noted that

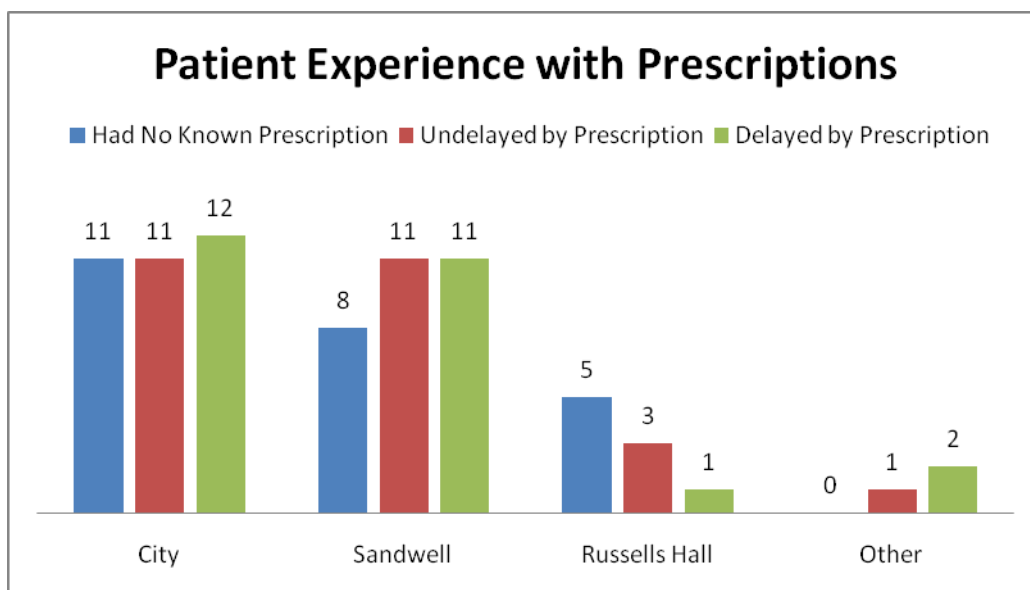
only 21 patients out of the 31 said that they felt they were kept informed of what was happening. The graph below shows how all patients responded when asked whether they had been kept informed throughout the entire discharge process.



These findings raised a new concern: 1 in 5 people at City Hospital and 1 in 4 people at Sandwell General reported themselves as themselves 'not understanding what was happening'. This was 21% of all respondents. What was unclear at this stage, and would hopefully be clarified by the 'Enter & View' visits, was whether this could or should be attributed to uninformed staff, for example as a result of training needs or relationships with partner organisations.

The next section of the write up will explore the obvious possibilities for delays: prescriptions/medication; discharge letters; transport; and assessments for partner services. Each time questions asked whether the patient had required that aspect of service and whether they felt it had caused a delay.

52 out of 76 patients stated that they had needed prescriptions to take out of hospital. 50% of these patients felt that the prescription delayed their discharge. The graph on the next page shows how each hospital appeared to perform. Interestingly, some patients who perceived a delay came from wards where staff did not, e.g. Newton 2 in Sandwell General (where medication was kept on ward) and D47 at City Hospital (where social service delays were felt to mask all others); there will be more on this in the case studies. Regardless of this, it is clear that many patients find the current system of dispensing prescriptions to delay their discharges.



With discharge letters, the findings indicated a slightly lower incidence of delay. 56 of the 76 patients recalled receiving discharge letters, and only 36% of these felt the letter specifically delayed their discharge. A further 10% did not answer and 54% felt that it had not delayed their discharge. Amongst the delays, 7 attended City, 9 Sandwell, 3 Russells Hall and 1 New Cross. It again seems clear that revisions to the current system of producing discharge letters would improve patient experience and prevent delays.

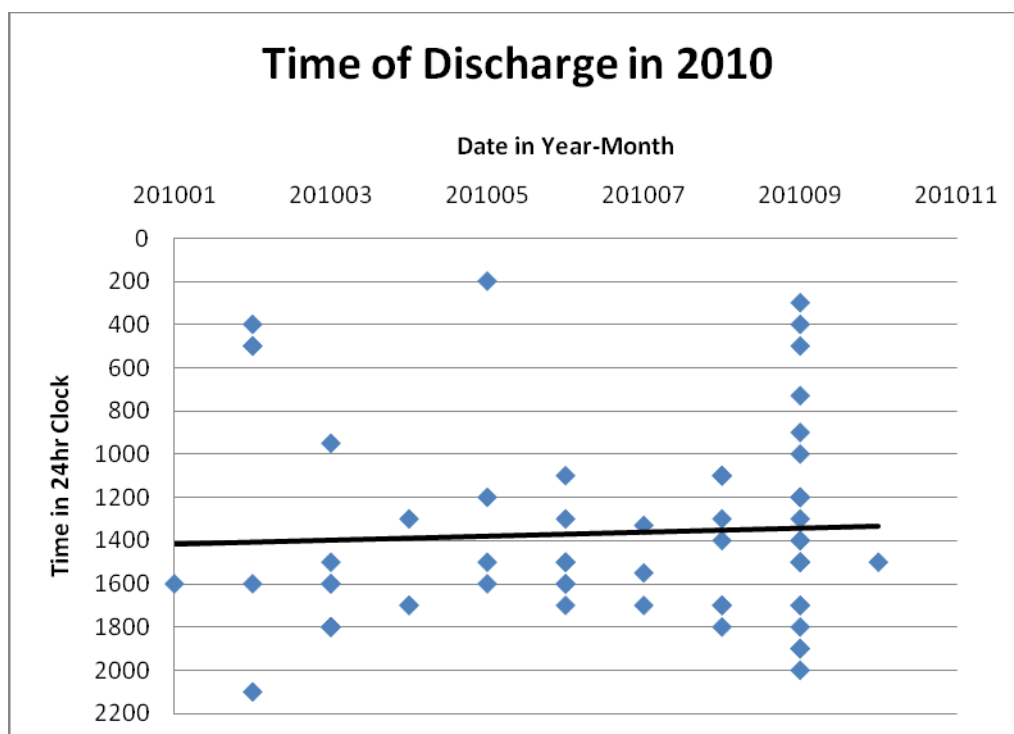
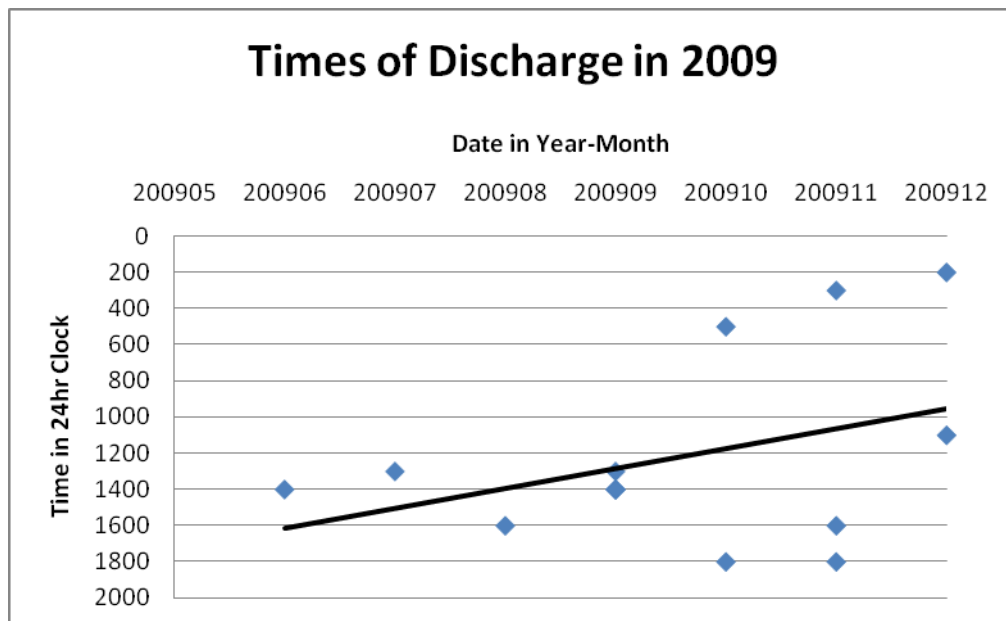
In keeping with the theme of understanding the process, the patients were all asked about their understanding of the information they took away with them. Only 6 (8%) said they had not understood it, but one cited a visual impairment as a contributing factor. In contrast, 70% said that they had understood it, with the remainder stating that it did not apply or failing to answer.

Unfortunately, only 4 individuals used specialised transport to get home. These individuals described it as 'okay' (2) or 'good' (1) and did not indicate it had caused any delay. More patients reported needing help upon reaching home (20) but, of the 10 who responded, no patient felt it had delayed their discharge.

The final questions that related to discharge as it occurs in the hospital setting focused on the time of discharge. Patients were asked initially if they felt they had been discharged at the right time for them. 60% replied to say that it had been the right time, and a further 20% declined to answer. Of the remaining patients, 11% felt they were discharged too late and 9% too soon. Notably, with the exception of 2 patients visiting Russells Hall A&E and one at City ASU, 5 of the patients discharged 'too late' did utilise further

support at home after discharge; none of these patients saw a cause and effect link in this, but the correlation appears high.

The question of being discharged at an appropriate time (relative to being fit) was purposefully separated from this last question relating to the hour of discharge. The results of this question have been separated into two scattergraphs that pinpoint the date (YYYYMM) against the time (24hr clock) to enable any trend to be identified.



The majority of discharge times in the 2009 graph indicate daytime discharges. The three exceptions were at Russells Hall A&E, City

D47 and Sandwell General (ward unspecified). There was a similar scattering of discharges in the early morning in 2010, 3 of the 7 attributable to trips to A&E at Russells Hall (2) and Sandwell General (1). The remaining 4 were attributed to Sandwell General's Cardiac Unit (1) and Day Surgery (1), and City Hospital's D47 and ASU. Other than these concerning exceptions, the general trend appears to be toward discharges in afternoons and early evenings. It should furthermore be noted that there is the possibility for the early morning discharges to have been circled accidentally by the patients instead of the afternoon options.

The final part of this section on the patient survey is focused on the 26% of respondents who needed help when they reached home. The majority of patients stated what form of help was provided, enabling the LINK to form a picture of the services engaged. This is shown in the table below; note some patients accessed more than one form of help and all but 2 speak of experiences in 2010. 12 of these patients were discharged from City Hospital and 8 from Sandwell General.

Form of Help	Number of Patients
Equipment, e.g. Crutches	7
Physiotherapy	3
District Nurse	6
Home Care/Social Support	5
Social Capital	1
Nothing	1
Unknown	2

The experience for those who needed equipment was variable; 2/7 described it as 'ok', 1/7 stated a friend fetched the item and 1/7 said some equipment took two months. Of the three patients needing physiotherapy, one reported receiving nothing, one stated the physiotherapy department were not told and the other did not comment, though they did say they felt they had been discharged too soon as their injury was unresolved.

The experience of district nurses was also variable. 2/6 could not comment, 2/6 reported experiences that were 'alright' and 'good' and the final 2/6 reported poorer experiences. In the case of one, they stated that their nurse was changed and the service was very good thereafter. For the other, the nurse failed to remove their stitches so they had to return to hospital.

Home care/social support had encountered generally positive responses. 2/5 described it as 'ok' and 2/5 described it as 'good' and even 'excellent'. Only one had a bad experience, stating

homecare was needed immediately and took 31 days to receive. It is important to note that one of the five describing it as 'okay' also cited the breakdown of communication between hospital and social services as delaying discharge for a week.

The final two included one patient who utilised a friend's support and another who described the help they received as 'nothing', citing a communication breakdown over needs.

Ultimately, 25% of these patients (5/20) encountered difficulty in the services they accessed outside of hospital. At the very least, this indicates flawed partnership working. It was this, particularly, that the other methodologies would examine closely in order to ascertain what could be done to bring about improvement.

Enter & View Visits

The 'Enter & View' visits were conducted by six authorised representatives undertaking visits as pairs escorted by the Host. Six visits were made during the last week of August and the first week of September. On each occasion, these visits were unannounced and staff members were found to be immensely accommodating. The data collected will be analysed overall initially, and ward specific case studies will follow.

On each visit, the authorised representatives went through a set questionnaire with two distinct sections. The first section focused on general data about that ward, usually gained from the ward manager or their equivalent on that shift. The second section requested anonymous information about patients due for discharge that day (or in the near future); in this way, staff members were able to communicate general difficulties and supply 15 case study example patients.

Section 1 of the survey asked for the ward manager (or equivalent) to relay the process of discharge for that ward. In all cases the ward managers clearly understood the process they were required to undertake and made it clear that all necessary parties were involved in the process of planning a discharge as early as possible. It immediately became clear that, as Sandwell LINK had hoped, the ward managers were the experts in identifying areas of the process that resulted in delays. There was also crossover between wards which enabled us to see the patient journeys. For example, MAU was the first ward visited and one of the difficulties cited was the availability of beds on wards to which they needed to transfer patients; this included D47, to which a later visit was made.

A common theme emerged amongst the longer stay wards. On D47, the challenge was in care packages; the same was found on Priory 4 and Newton 3. D47 varied marginally as patients would be transferred there after starting in a different ward (like MAU). This meant their section 2 (the initial notification of a need for social services) would be filled out on that other ward. In all three cases, social services would not actually act until section 5 (the final notification) had been sent off, and all felt that substantial delays (bed blocks) were created in waiting for a package of care this way. The paperwork was described by one ward manager as taking up to an hour and a half to fill out, and all three wards reported the need to spend a great deal of time on the phone to social workers in order to ensure it was being filled out correctly. The availability of support from discharge liaison nurses was additionally cited, but it was stressed that even with the focused pursuit of discharges from those nurses, delays continued: in both the case of Newton 3 and D47, 10 patients were medically fit but could not be discharged at the time of the visit; Newton 3 cited further problems connected to getting mental health assessments.

This message of difficulty with social services was duplicated on Newton 2 with their short stay surgical patients. It was noted that social services were reluctant to respond to the receipt of section 2s despite the fact that it was felt this could be very beneficial in cases of elective surgery. An example proposed was hip replacements, where requirements after surgery could be gauged in advance with a fair degree of accuracy.

The smoothest processes of discharge were described on ASU. This appeared to be as a result of two combined factors: it operated nurse-led discharge (as with Newton 2) and it would not take cases with complicated needs that required social care (unlike Newton 2). The staff's main concern was that they may come to experience greater difficulty with bed blocks in future, since any patients with complicated conditions could currently be transferred into the main City Hospital and this would no longer be the case when the new hospital was up and running across town.

Following the description of the discharge process, each manager was asked about formal and informal complaints they had received relating specifically to discharge in the four weeks prior to the visit. Only MAU had any formal complaints (2), but informal verbal complaints were more prevalent: on MAU, an estimated 5-6 had been made around waits for TTOs (discharge medication); on D47, an estimated 3-4 had been made relating to waits on social services; on Newton 3, a GP had made a verbal complaint about the clarity of a discharge letter.

The next general question queried whether routine duties created delays. Here, a clear contrast could be found between the shorter stay wards and the longer stay wards. Amongst the three shorter stay wards, the following was true: MAU cited delays due to blood tests and transport; ASU cited delays accumulating in the afternoon as the ward experienced theatre blocks and staffing reduced from 6-7 to only 4 (this was confirmed by one patient survey who noted a decrease in care standard with the reduced staff levels); and Newton 2 stated TTOs could be a problem when the doctor had not written them up. By contrast, routine duties appeared to impact longer stay wards less often because the length of wait for social services meant there was ample time for all other duties to be discharged. Only two other items were cited. One was on Newton 3, who indicated that their MDT (multi-disciplinary team) meetings could create delays as there was only an hour a week available for them; this was not reported on Priory 4 or D47 as an issue, but the description of their discharge process did highlight a need to wait for the MDT meeting to agree discharge and this may contribute to overall delays. The other item was raised on D47 and entailed individuals becoming ill again whilst on the ward; this was a serious concern and could contribute to long delays.

The next question asked when social workers were first contacted about patients that were deemed 'vulnerable'. This did not apply to ASU, but all other wards indicated that it was very early. Newton 2 highlighted their attempt to do it at pre-assessment and the difficulties encountered; MAU would do so within first 2–12hrs, and frequently the needs were picked up in A&E anyway; Newton 3 and D47 indicated that section 2 was dispatched upon arrival to their wards, and Priory 4 indicated it would be within the first week.

Experience with specialist transport (such as ambulances) was varied, but all indicated waiting times of a number of hours. MAU stated that patients waited in the discharge lounge for transport, this meant they were not certain how long the wait was for the patient, but the bed was freed for the ward; Priory 4 estimated it was around 2hrs for an ambulance and there were sometimes problems – a discharge had had to be cancelled due to lack of ambulance before; ASU experienced little delay during the daytime, but could experience problems after 5pm; D47 indicated that booking on the day could entail a wait of up to 4hrs, whilst even booking in advance could mean 1hr or more of waiting – it was noted that this was particularly problematic as patients usually needed to reach home in time for the first visit from their care package; Newton 3 indicated little problem in the week, but more problems on the weekends; and finally, Newton 2 said waits were

around 3hrs, with a discharge lounge available for the patient so that the bed could be freed up.

The final general question concerned how many staff had been trained in discharge procedure on each ward. These replies were variable. MAU were just beginning to train staff the day after the visit but the procedure was understood; Priory 4 described 15 qualified staff who had trained on the job; ASU had nurse-led discharge and trained nurses under the induction procedure – they noted there was a view to rolling the method of discharge out more widely; D47 said 2 had been trained, but all knew about discharge and study days were coming up; Newton 3 said there was no formal training, but their discharge liaison nurse had taken the initiative to do process mapping; and Newton 2 returned to the fact there was no specific training, only generic hospital discharge procedure. Training would later be discussed with Linda Pascall, Deputy Chief Nurse.

Section 2 of the survey focused around anonymous case study examples of patients due for discharge, thereby allowing the authorised representatives to follow the patients through the discharge process. 15 examples were gained, and in each case the patient's condition and complicating factors were discussed; only 5 out of 10 were deemed to have no complicating factors (ranging from diabetes to dementia). The questions mirrored those in the patient surveys, but went into greater depth. As a result of this, the findings for each ward will be examined separately in case studies and contrasted to the patient results.

Medical Assessment Unit, City Hospital – 24th August 2010

Three patients were discussed on MAU. All of them were described as having had their discharge folders opened upon admission, though one nurse noted that the predicted date of discharge tended not to be used. It was established that patients were told they would be discharged during the doctor's ward rounds and were discharged immediately afterwards; each patient discussed had been informed of their departure during the 9:30am ward round and were waiting to be able to leave (note that the visit was 10:00am to 11:00am). This fits with the patient survey results; 3 were returned from MAU, one not indicating wait time, one suggesting 4hrs and one 1hr.

Each of the patients discussed on the ward was thought to understand the discharge procedure and would be receiving copies of a discharge letter to take away. Again this matches the patient surveys, where all three felt they were kept informed and two noted they had been given discharge letters. In discussing adaptations for

patients to this information, it was noted one patient on the ward was being given extra information to encourage them to attend a service they needed (AA).

All three patients on the ward needed to wait for medication, and this was anticipated to be 1.5-2hrs. In one case, the doctor had not yet written the TTOs. The patient survey replies did not include patients needing medication.

For the three patients on the ward, only one was being discharged into the care of a family member but all three would have their next of kin notified that they were being discharged. All patients were additionally being discharged into care by other services; this included outpatients (2), via a letter, and an appointment with older people's service (1). The two outpatient referrals required assessments, but neither caused any form of delay.

None of the patients on the ward required any other sort of aid in the form of equipment or adaptations at home. Transport varied only slightly; one patient was to have a taxi ordered and another could get money for a bus.

The final point was to note that the discussion concerning the patient's discharge occurred at the bedside during the doctor's round.

Overall, the main sticking points on MAU were identified by the nurse during the course of discussion: a) waiting for the doctor's rounds, b) waiting for medication, c) waiting for blood results and d) waiting for transport. Bed blocking when patients needed to be discharged to another ward was also stressed as a difficulty.

Priory 4, Sandwell General Hospital – 26th August 2010

Two patients were discussed during the visit to Priory 4, an acute elderly care unit. These could then be matched against a further 2 patient surveys.

Both of the patients discussed on the ward had complicating factors. One had dementia and physical disabilities, whilst the other was bed bound and had tried intermediate care but their partner (their main carer) had not been happy. Both patients had had their discharge folders opened the day after admission to the ward, but the times of notification they could be discharged varied. For one patient, they had been told two days in advance. For the other, the patient had been medically fit and ready to leave (the patient's family being aware of this) for two weeks at the time of the visit; the delay was the result of waiting on their care package. Originally the discharge

date had been set for 30th August, but the discharge liaison nurse had brought this forward to 26th August. The two patient surveys indicated 1hr and 4hr+ waits, with both feeling they were kept informed of what was going on.

Only one of the patients was thought to understand the discharge procedure, due to complicating factors, but both would have discharge letters, etc. and these would be in the care of the main carer where relevant. This matched with the patient surveys, where both received discharge letters (1 feeling this caused a delay) and both understood the paperwork they took away. On the ward, both patients needed medication. This was already done for one patient, and would shortly be ready for the other patient; a last minute request from the carer meant it was being converted into a medi-dose pack. For the two patient surveys, both had needed medication and only 1 felt it caused a delay.

In both of the cases on the ward, the patients were due for discharge to their family's care, but would also be receiving social services support. Social services had initially been notified at the start of each patient's stay (second day of admission) but the patients had now been on the ward for 4-5 and 6 weeks respectively. Note that for the former (4-5), the patient had been medically fit and ready to leave for almost half that time. Both had had their assessments for care done whilst on the ward; this caused a one week delay in one case. In terms of any other help at home, one patient would require a Zimmer frame, but no adaptations to the home were anticipated. The patient surveys had not involved any help after discharge.

In terms of transport, only one patient on the ward required an ambulance and none of the patient surveys. This one patient was not expected to encounter any difficulty, but it had been a problem in the past.

Finally, decisions to discharge were made at the MDT meetings with the patient or their carer. It is worth noting that amongst the patient surveys was a comment about being looked after 'pretty well' by the doctors.

Overall, the main problems on Priory 4 are around an inability to get patients assessed and appropriate care arranged so that they can be discharged. Secondary to this, ambulances can be a problem due to being unavailable or too late. Discharges have been cancelled in the past due to lack of availability or the ambulance being too late in the evening to be acceptable when discharging an elderly patient.

Adult Surgical Unit, City Hospital – 1st September 2010

Three patients were discussed during the visit to ASU, an adult surgical unit specialising in day or 23hr surgeries. These can be matched to 6 patient survey replies from the same time period.

Of the three patients discussed, none had complicating factors. All had been through pre-admission checklists, where arrangements for discharge (address and who would collect the patient) were confirmed prior to the patient being admitted, and this was confirmed by the nurses prior to surgery as well. At this point, all patients would also have been informed of the guidelines for discharge: that it would take around 1hr after surgery for local anaesthetic and 3hrs for general, and the patient needed to fulfil a number of criteria, e.g. passing urine, before discharge could happen. This checklist was what enabled the ward to carry out nurse-led discharge and turn patients around more quickly. All patients were felt to understand this. This is supported by the patient surveys where varied waiting times were expressed and only 1 varied in the actual time compared to predicted. Only 1 of the patients said that they had not felt informed and were ultimately discharged too late. This same patient noted a point later raised by the staff themselves; that lower staffing levels in the afternoon contributed to delays.

As above, all three patients on the ward would have been clear from the outset about the predicted discharge time after surgery. The patients would all additionally receive discharge letters and leaflets tailored to their needs, e.g. concerning when stitches might need to come out. This is matched by all 6 patient surveys noting they had received discharge letters (1 feeling it caused a delay) and all 6 feeling they had understood those letters.

All three patients on the ward were expected to need medication and this was also anticipated to cause little delay as it was kept on the ward. Again, this was confirmed in the patient replies where 5 had received medication and none had felt this caused a delay.

In all three cases, the patients would be discharged into the care of a family member and the nursing staff would be notifying the carer of the anticipated time that the patient would be ready for discharge, confirming this was feasible. None would receive care at home or specialist transport, and this was mirrored in the patient surveys due to the nature of the ward.

Decisions concerning each patient's discharge were made by the nursing staff using the checklists; any variation from the checklist

or other cause for concern would require a doctor to be involved, and the nurse would discuss this with the doctor in private.

Ultimately, discharges from ASU are the smoothest encountered out of the six wards visited due to the nature of their work. Two of the patient survey replies credited them as 'very caring and very efficient' and stated they were 'very happy with standard of care'. However, ASU did encounter some difficulties due to the current staffing structure. Although 6-7 staff would be present for admissions at 7am, this reduced to 4 in the afternoon and these had to work to both discharge and admit further patients. Sometimes theatre times would additionally overrun, creating more problems. The particular concern of the staff was the fact that they can currently transfer patients who experience complications to the main hospital, ensuring their care and freeing the bed, but this will not be the case with the new hospital. Problems were also experienced with the availability of ambulances in the evenings when needed.

D47, City Hospital – 2nd September 2010

Only one patient was discussed during the visit to D47, a ward specialising in orthopaedic rehabilitation and transfers to residential care. This was because of demands on staff time, however the staff did distribute the surveys as requested and consequently the 1 patient on ward can be matched against 8 patient surveys.

The patient on the ward was identified as having two complicating factors: dementia and safeguarding concerns. Their discharge folder had been opened upon admittance to the ward and the patient had been medically fit and ready for discharge since 19th August. The patient and their family, however, were only notified of the discharge 24 hours in advance, though the ward was still waiting on social services at the time of the visit. This uncertainty matches to varied replies by the 8 patient surveys, 3 of whom ended up waiting longer than expected (a week in one case) and 2 who waited less.

It was made clear that the patient did not understand the discharge process because of their condition, but the family were aware and would receive copies of the discharge letter along with copies for the GP/District nurse, etc. This appears to be mirrored with the patient surveys; 6 patients felt they were kept informed of what was going on, with only 1 stating they had not. 7 patients had received discharge letters, 4 confirming they understood the information they took away and only 1 noting they had not due to a visual impairment. Furthermore, 6 of the patients identified themselves as being discharged at the right time, with only 1 stating they had been discharged too late.

The patient on the ward did need medication, which would take around 2hrs. This was a delay, but because social services had not confirmed with the ward, this was not the main contributing factor to the delay. Amongst the patients, 7 reported waiting for medication and 4 noted a delay whilst 3 did not.

The patient on the ward was due for discharge into the care of a new nursing home. Social services had been contacted as soon as the patient had been admitted and the doctor has assessed them, however a safeguarding concern meant that even on the date of the visit, discussions were still happening and the social worker had yet to confirm the discharge could proceed. Amongst the 8 patients, similar difficulty had been faced: 4 had needed extra help at home, 2 receiving it and having 'ok' or 'good' experiences whilst 1 received care and no physiotherapy and 1 received nothing.

The final questions around specialist transport identified that the patient on the ward would need this and it had been booked with a predicted 1-2hr wait. Of the patient surveys, 3 needed it and all had 'ok' (2) or 'good' experiences.

The agreement to discharge the patient was reached with the MDT in an office with the patient's family. It was also discussed on ward with the patient, though complicating factors meant they did not entirely understand.

Ultimately, the delays caused by waits for social services overshadowed other problems, but the D47 staff did experience waits for medication and transport as well. Particular concerns included the amount of staff time dedicated to filling out the paperwork required for discharge into care.

Newton 3, Sandwell General Hospital – 3rd September 2010

On Newton 3, two patients were discussed but there were unfortunately no patient surveys to match against. Newton 3 is female orthopaedic trauma unit.

Of the two patients discussed, neither had any complicating factors and both had had their discharge folders opened on the first day of admission. In the case of one patient, they had been told the preceding day that they were due for discharge; it was unclear if this was the case with the other patient. Both were due to be discharged into rehabilitation services in a care home and City Hospital respectively. Both patients were also thought to understand the procedure.

The patients were each to be given copies of their discharge information, a copy being sent to the care home as well for the relevant patient. Only one of the patients was due to need a prescription, but there was the potential for it to cause a problem. The nurse noted that if it were late, it would impact the ambulance booked for the afternoon and the patient may have to remain until Monday.

Social services had been contacted the day before discharge for one patient but difficulties had arisen because the care home would only admit 2 daily; the matter had been escalated as a problem within the trust. Similarly, the patient destined for City had been waiting for a week already. In both cases, no further delays were anticipated with the transfers. In addition to this, both patients required wheelchairs and this was expected to go smoothly. Both patients were also expected to use ambulances and would experience no delays.

Finally, the decision to discharge the patient was described as made using patient notes at their MDT meeting.

Despite the fact the two patients were expected to have smooth discharges from this point on, the ward staff did stress they encountered a great deal of difficulty. This included managing the problem of nurses having to spend 30-40% of their time (measured by the staff) on the phone or filling out forms. Duties that took up nurse time and contributed to delays included escorting assessors from partner organisations on the ward, chasing social services and chasing district nurses. Support from the discharge liaison team was acknowledged, but this was 1-1.5 days per week alone and needed expanding. Staff felt delays came from lack of capacity in receiving rehabilitation services and this meant they were currently hosting 10 patients who were medically fit for discharge. It was further noted that the situation became even more difficult if the patient required mental health support; two patients with learning disabilities had been waiting on the ward for assessments for two weeks at the time of the visit.

Newton 2, Sandwell General Hospital – 7th September 2010

Four patients were discussed during the visit to Newton 2, a short stay surgical ward. These can be matched against 11 patient survey replies. It was established from the outset that of the four, two had discussed the discharge process prior to their surgery and had a file opened afterwards; both expected to be discharged over the course of the day. The other two were being cared for by a bank nurse, one having begun the discharge process that morning and expecting to leave at 11:00am and the other having begun the process the

previous week; it was not clear when this patient was told he could go. All four patients were thought to understand the discharge procedure. This fit with the patient surveys, where it was clear the 11 patients had understood the length of time they would have to wait for discharge and all felt kept informed throughout the process.

All four patients were to be supplied with discharge letters; in one case it was translated verbally for the patient due to the complexity in the letter. In the patient survey, 8 of the 11 received discharge letters (3 feeling it had delayed them) and only one had trouble understanding it.

Interestingly, all four patients on the ward needed medication and staff felt there would be no delay due to the medication being on the ward. Amongst the patient surveys however, 10 needed medication and 5 of these felt it delayed their discharge.

All four patients on the ward were anticipated to be discharged into the care of their families, the families having been duly contacted. Only one would also utilise care services and this was STAR. The first visit had been arranged for that afternoon. It was noted STAR had been contacted several days before and would carry out the assessment in the home; there was no indication that this delayed discharge. Fitting with this, the same patient was the only one to need equipment and the nurse was unaware if home adaptations would be needed as this would be established by STAR. In the patient surveys, none identified themselves as needing help at home but 2 did feel they had been discharged too soon.

Only one patient was using specialist transport and this had been booked and was on time.

Ultimately, there were a number of factors potentially delaying discharges on Newton 2. These included delays in going into theatre: of the four patients, three had returned from theatre too late to be discharged that day and were being kept in overnight as a result (this was a likelihood explained to patients in pre-assessment). Additional delays highlighted by staff concerned medication not kept on the ward and social care provision. It was additionally explained to the LINK members that 70-80% of the patients were not short stay, with the patient who would now experience STAR services having been in hospital from 16th August to 7th September.

Discussions

The Internal Trust Discharge Review: Linda Pascall

On 3rd November 2010, two Sandwell LINK members met with Linda Pascall, Deputy Chief Nurse at Sandwell and West Birmingham Hospitals NHS Trust, in order to hear about what was happening within the hospitals around discharge. The meeting was to be attended by Matthew Dodd, Deputy Chief Operating Officer, but he was unable to make it. Linda explained that she and Matthew were working together on their review and she would therefore answer as many questions as she was able. Matthew covered process of discharge due to his role whilst Linda covered some process and education of staff.

The background to Linda and Matthew's work was the consequence of a need to meet required standards for safe and effective discharge during their audit. As a result, they had begun to collect detail on the process of discharge at present and were reviewing their policies around discharge internally (to other wards) and externally (into the community or other services).

Linda was open in acknowledging the findings of the Risk Manager involved in the review. There was a lack of confidence that the discharge checklist was being utilised and that the paperwork was being filled out. This was a problem both internally and with external discharges. In line with this, Matthew was reviewing the policy and tackling the checklist within that. Linda was working on developing a training programme to match this as no formal training in discharge existed. The training programme would need to effectively cascade learning, so part of the task was identifying who to start with. Linda would be responsible for writing and quality assessing this.

In the process of this work, a cross-party group had been established as a consequence of issues raised. This involved individuals within the hospital and from Sandwell Community Health Service, including matrons, risk managers, team leaders, etc. At the time of the discussion, only one meeting had occurred to discuss communication issues, e.g. matrons understanding who their counterpart was in other services. At their next meeting they planned to produce commonsense guidance on discharge. It was also hoped that if the integration with Sandwell Community Health Services proceeds from 1st April 2011 as planned, there would be opportunity for joint appointments across the hospitals and community services. It is intended that at that time, the

membership of the group would grow and the role and remit would be strengthened.

Nurse-led discharge (or the use of suitably qualified clinicians) was also addressed. The hospital trust was hoping to expand on this and formally roll out training from 1st December. It was noted that nurse-led discharge had its limitations however: it would only be okay where a clear parameter can be safely identified, irrespective of the specialty. This is more likely to be noncomplex cases.

Bank nurses and their capacity to discharge were also addressed. It was clarified that only bank nurses dedicated to the trust would be able to do this and policies made it clear what bank nurses would and would not be covered for in their work.

Linda also acknowledged the problems around the transfer between agencies, particularly social care. She said that discharge liaison teams do exist but they operate differently in each hospital. Matthew is dealing with this in principal, but current measures for accommodating an inability to discharge include having a 'hit squad' booked so that capacity of a ward can be flexed up between Friday and Monday when discharge cannot happen. She agreed that having social workers able to help in assessments on Mondays, Wednesdays and Fridays could make a lot of difference.

Lastly, it was noted that a different form of discharge review was happening in A&E due to the clinical issues. Work was being undertaken in Sandwell General and there was a great deal of competency. It was noted that the Rapid Assessment Teams and psychiatric assessments were working well.

The Social Care (STAR) Perspective: Tony Barnes

On 9th November 2010, Tony Barnes, Assistant Manager with STAR services joined Sandwell LINK Management Group to discuss the social care perspective. He explained the background to his team: STAR is a Short Term Assessment & Reablement Service set up on 28th July 2008. It used to be Sandwell Homecare and the team numbers 15-20 members per town with a capacity of supporting 160 service users to have 3 visits per day.

STAR is only one aspect of social service provision and it focuses on individuals who will benefit from reablement, i.e. who want to return to living as independently as they can. It is generally deemed inappropriate for those who are terminally ill. The service can be in place within 48 hours and it lasts for up to six weeks. It involves an in depth assessment in order to set up an on going care provision for that individual if required.

STAR is complemented by the Fast Response service, which has been running 7-8 years. This functions differently, providing full care support inside 1hr for people to avoid admission into hospital. It lasts for 6 days and has only 20 team members, trained to a high level. Fast Response additionally caters for terminal or palliative care. Furthermore, it can take referrals from A&E or EAU at the hospitals where patients will not have been admitted.

STAR has promoted its service to all wards, setting up contacts, and wards should therefore be able to refer patients to STAR. Currently the service picks up patients from Dudley, Sandwell and Birmingham. They also stay with those patients until a care package has been established; this has resulted in overrun so capacity is being addressed.

Within its team, STAR has a physiotherapist, occupational therapists, a rehab support worker, community care officers and care staff, which are supported by a management team. They additionally work alongside CCARS (Complex Crisis and Reablement Service) which picks up any diagnosis of mental health but predominantly people with dementia.

The LINK raised the issue of requiring medical personnel to identify the needs of patients before discharge (whilst filling out section 5) and whether this resulted in inappropriate referrals. Tony stated that this was not usually the case, with only 1 or 2 inappropriate referrals per month to his knowledge. An example of this was being told that the patient was mobile on the ward but finding they are not at home. Tony stated that for each referral, they check the council's system for data on the user. Unfortunately healthcare use a different system or this might have aided communication.

Finally, some discussion was had around the receipt of notifications from the hospital. Tony stated these went to the contact centre and he did not believe any delays occurred there because referrals he has received were usually only hours old. He agreed that there may be potential in the idea that social care services responds earlier to receipt of section 2s in the case of fairly 'predictable' discharges like hip replacements. It was envisaged that social care services may be able to approach the hospital to establish the care package sooner in a variety of circumstances where care needs could be predicted.

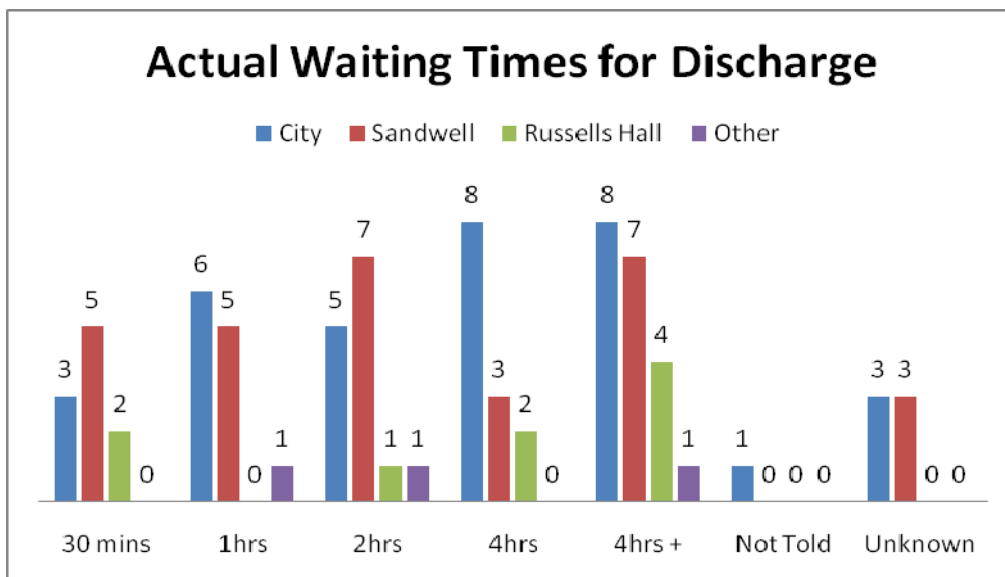
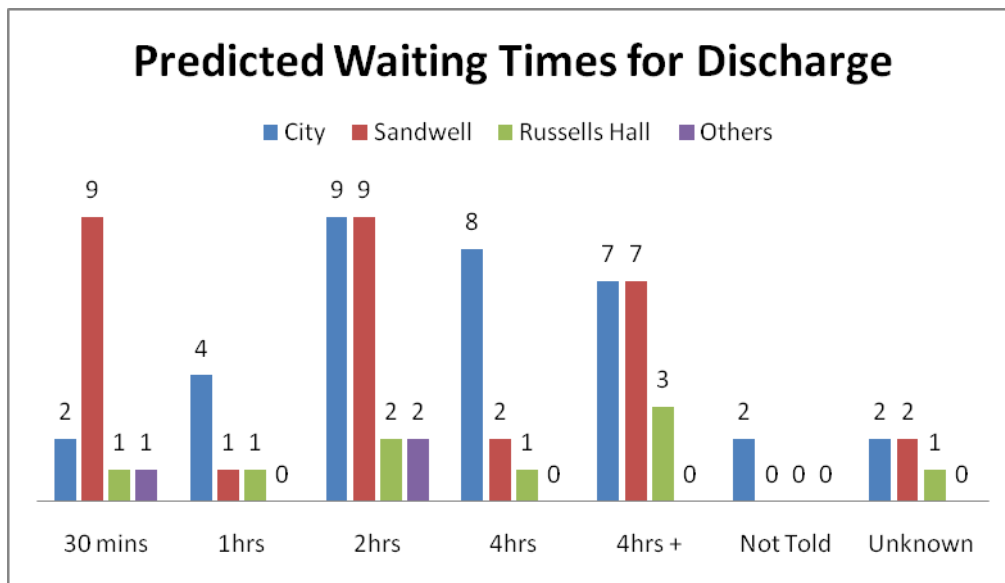
Recommendations

On the basis of the findings, Sandwell LINK Recommendations are as follows:

- Improve joint-working between health and social care, exploring options such as:
 - Using reablement funding to support social workers on the ward on Monday, Wednesday and Friday to help in establishing care packages.
 - Having the contact centre in social care respond to Section 2s and begin to establish packages of care, particularly for elective surgery, earlier.
- Reviewing how and when doctors write up TTOs.
- Reviewing delays in providing prescriptions.
 - To address both of these, the following possibilities might be considered: TTOs might be written up by someone else with appropriate training, whilst the doctor retained the ability to actually prescribe? Alternatively, or as well, the TTO could be done the day before the patient is due to depart, giving the pharmacy more time to prepare medication in advance.
- Consistency should be established across hospital sites.
- Improvement should be made in the provision of equipment and communication about referrals.
- Improvement should be made in links to district nurses, for example, implementing joint appointments as described by Linda Pascall as soon as possible.
- Improvement should be made in working alongside mental health services.
- Listening into Action events should be used to showcase improvements, e.g. those made by the staff that had done process mapping and time studies on Newton 3.
- Nursing levels on the wards need to be addressed in order to ensure continuity of care, e.g. the instances in ASU where reduced staff levels in afternoon as demands rose meant staff found it challenging to deliver the care they wanted to.

- Uniform training needs to be established for staff in the discharge procedure.
- There should also be clarity about having the appropriate staff in charge of discharge, e.g. only bank nurses dedicated to the Trust with the appropriate training.
- There needs to be efforts in embedding the understanding not to attempt to discharge elderly patients at night-time more thoroughly across all organisations.
- There should also be a process that includes advocates for those unable to communicate their thoughts appropriately.

Appendix 1: Detailed Graphs Relating to the Patient Survey



Sandwell and West Birmingham Hospitals



NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Deed of Variation
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Robert White, Director of Finance and Performance Mgt
DATE OF MEETING:	30 June 2011

SUMMARY OF KEY POINTS:

As part of finalising the contract documentation for the 2011/12 LDP (local delivery plan) 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.

Specifically, the Co-ordinating Commissioner and the Trust enters into a standard contract but this can be varied pursuant to clause 38 which permits the Parties to vary the contract to reflect variations. Following the publication of the NHS Operating Framework for 2011/12 in December 2010, it has been necessary to amend the national contract and as part of the LDP process and this is complete.

The Deed itself requires use of the Trust Seal and the Board is asked to assign the seal under signature by the Chief Executive and Director of Finance & Performance Management.

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to approve the application of the Trust Seal to the Deed of Variation.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	None specifically
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

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

Financial		
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy	X	Approval to apply the Trust Seal is a matter reserved to the Trust Board according to the SOs/SFIs & Schedule of Delegation
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

None

Sandwell and West Birmingham Hospitals



NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Same-Sex Accommodation Progress Report
SPONSORING DIRECTOR:	Matthew Dodd, Acting Chief Operating Officer
AUTHOR:	Matthew Dodd, Acting Chief Operating Officer
DATE OF MEETING:	30 June 2011

SUMMARY OF KEY POINTS:

At its meeting in March 2011, the Trust Board made a declaration of non-compliance with the national same-sex accommodation standards. This was due to the delays in undertaking work on D26 at City Hospital.

Following the completion of work on D26 at City Hospital, this paper recommends a declaration of compliance with the national standards as at 30th June 2011

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 report on ensuring compliance with same-sex standards and the reduction in the numbers or reported breaches of the standards in May 2011;
2. APPROVE the declaration of compliance with the national standards following the completion of the changes to ward D26 at City Hospital.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

Financial	X	£1.4m revenue allocated in the financial plan for 2011/12.
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience	X	Same-sex accommodation is a key part of good patient experience
Communications & Media		
Risks		Risks to the reputation of the trust and of fines from commissioners if standards are not complied with.

PREVIOUS CONSIDERATION:

Trust Management Board on 22 March 2011.
Trust Board on 31 March 2011

SAME-SEX ACCOMMODATION PROGRESS REPORT FOR TRUST BOARD – JUNE 2011

INTRODUCTION

At its meeting in March 2011, the Trust Board received an update on progress towards same-sex accommodation and made a declaration of non-compliance with the national same-sex accommodation standards. This was due to the delays in undertaking work on D26 at City Hospital.

It was agreed that a further update would be given to the Trust Board in June 2011 regarding progress with the remaining work.

PROGRESS

D26 was the elective orthopaedic ward for the Trust, with some orthopaedic rehabilitation provided on D47 in the Sheldon Block. The plan was to change to two wards (D26, Female and D28, Male), each combining elective orthopaedics and orthopaedic rehabilitation.

This has been undertaken and was completed on 6th June 2011.

We will continue our focus on standards of privacy and dignity on all of our wards through our system of regular ward reviews and audits. In particular there will be further reviews undertaken at Sandwell General Hospital where, although we are compliant on same-sex accommodation, we feel there may be scope for further improvement regarding privacy and dignity.

BREACH REPORTING

The national system for reporting breaches of same-sex accommodation standards to the Dept of Health requires us to report the number of patients having to share sleeping areas each month.

Our performance in this financial year has improved since last year and while there were 75 breaches in April, this had reduced to 4 in May (all in assessment units at City).

DECLARATION OF COMPLIANCE

All NHS Trusts and NHS Foundation Trusts are required to publish a formal annual declaration of compliance with the national same-sex accommodation requirements.

Following the changes to D26, the Trust is now able to make a formal declaration of compliance. The proposed draft declaration of compliance, which also includes the community beds now run by the Trust following the integration of Sandwell community services in April 2011, is attached as an appendix to this paper.

CONCLUSION AND RECOMMENDATIONS

This paper has provided the Trust Board with an update on progress in our work to ensure full compliance with the national same-sex accommodation standards.

The Trust Board is recommended to:

1. NOTE the progress report on ensuring compliance with same-sex standards and the reduction in the numbers of reported breaches of the standards in May 2011;
2. APPROVE the declaration of compliance with the national standards following the completion of the changes to ward D26 at City Hospital.

Matthew Dodd
22nd June 2011

DRAFT

SAME-SEX ACCOMMODATION STANDARDS ANNUAL PUBLIC DECLARATION

Our Approach

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. Sandwell and West Birmingham Hospitals NHS Trust (SWBH) is committed to providing every patient with same-sex accommodation because it helps to safeguard their privacy and dignity.

Level of Compliance

SWBH is able to confirm full compliance with the Government's requirement to eliminate mixed-sex accommodation except when it is in the patient's overall best interest or reflects their personal choice.

All our wards at City Hospital, Sandwell General Hospital, Rowley Regis Hospital and Leasowes Intermediate Care Centre are compliant with the national standards.

What does Same-Sex Accommodation Mean?

Same-sex accommodation means:

- the room where your bed is will only have patient of the same-sex as you;
- the toilet and bathroom will be just for your gender and will be close to your bed area.

It is possible that there will be both men and women patients on the ward but they will not share your sleeping area. You may have to cross a ward corridor to reach your bathroom but you will not have to walk through the opposite-sex areas.

You may share some communal space such as day rooms or dining rooms and it is very likely that you will see both men and women patients as you move around the hospital (e.g. on your way to x-ray or to the operating theatre).

It is probable that visitors of the opposite gender will come into the room where your bed is and this may include patients visiting each other. It is almost certain that both male and female nurses, doctors and other staff will come into your bed area.

If you need help to use the toilet or take a bath then you may be taken to a “unisex” bathroom used by both men and women but a member of staff will be with you and other patients will not be in the bathroom at the same time.

The NHS will not turn away patients just because a “right-sex” bed is not available immediately.

What This Means in Our Hospitals

In our Trust this means that:

- Patients admitted to Sandwell Hospital, Rowley Regis Hospital or the wards in the Sheldon Block at City Hospital are admitted to same-sex bays clearly separate from the main ward corridor. Patients have access to separate male and female toilet and washing facilities on each ward.
- Patients admitted to the main wards at City Hospital are admitted to same-sex wards.
- Patients admitted to Leasowes Intermediate Care Centre are admitted to single rooms with ensuite separate washing and toilet facilities. A shared large shower room is used however for patients unable to use their en-suite facilities as a result of their clinical condition.
- We are committed to ensuring high standards of privacy and dignity for all our patients all of the time. These standards are regularly audited on all of our wards to ensure they are maintained,

There are a small number of specialist areas where we may not always be able to separate men and women including:

- the Critical Care Units at both hospitals;
- the Coronary Care Units at both hospitals;
- the Acute Stroke and Brain Injury unit at City Hospital
- Recovery areas in our Theatres.

Our Emergency Assessment Unit at Sandwell Hospital and the Medical Assessment Unit and Surgical Assessment Unit at City Hospital operate with a series of same-sex bays. Sometimes when we are exceptionally busy it has been necessary to admit patients to mixed-sex bays in these units and we are continuing to work with these units to avoid this in future.

What are our plans for the future?

We are continuing to work to improve standards of privacy and dignity including:

- continuing our focus on standards of privacy and dignity on all of our wards through our system of regular ward reviews and audits;
- ensuring that high standards of privacy and dignity are built into the plans for our new acute hospital scheduled for 2015/16 and including 50% single rooms.

How do we measure success?

We measure our success in meeting these standards in a range of ways including:

- patient surveys – both the annual national patient survey and our rolling programme of local surveys;
- monitoring the number of occasions on which we breach these standards – these are reported monthly to our board in public;
- regular reviews of standards of care on all of our wards;
- regular (six-monthly) reports to the Trust Board on progress with delivering same-sex accommodation.

Who do I contact for more information?

For more information or if you have any comments or concerns please contact:

Matthew Dodd
Acting Chief Operating Officer

0121 507 3020
matthew.dodd@nhs.net

This declaration was approved by the Trust Board on 30th June 2011. It will be formally reviewed annually.

Sandwell and West Birmingham Hospitals



NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Transforming Community Services: Post Transaction Integration and Benefits Realisation
SPONSORING DIRECTOR:	Matthew Dodd, Acting Chief Operating Officer
AUTHOR:	Matthew Dodd, Acting Chief Operating Officer
DATE OF MEETING:	30 June 2011

SUMMARY OF KEY POINTS:

The attached paper outlines: [a] the work that has been undertaken in the first 100 days post integration of the community services with SWBHT, to maintain services and ensure business continuity; and [b] the work being undertaken to deliver the benefits of integration

It notes the actions that have been taken by the community management teams but identifies some delays, in particular the migration of the Electronic Staff Record to SWBHT.

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 report on Stage 2 & Stage 3 and the actions taken over the first 3 months of the new Division/Directorate
2. NOTE the delays in the migration of the Electronic Staff Record
3. APPROVE the next steps outlined for Stage 3

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

Financial	X	Opportunities to reconfigure services and activity flows for the whole Trust
Business and market share	X	Opportunities to develop better links with primary care
Clinical	X	Ability to implement seamless patient pathways Better communication between clinicians between community and acute services
Workforce	X	Opportunities to share skills and develop greater flexibility and overlap between acute and community sectors
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience	X	The ability to increase choice and allow patients to receive care closer to home is a key part of good patient experience
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

None

TRANSFORMING COMMUNITY SERVICES: POST TRANSACTION INTEGRATION & BENEFITS REALISATION

PROGRESS REPORT FOR TRUST BOARD – JUNE 2011

INTRODUCTION

A post transaction integration and benefits realisation plan for Sandwell Community Healthcare Adult and Children's Services was submitted to the Trust Board in March 2011. This outlined three stages of work that the Trust needed to undertake:

- **Stage 1:** Organisational Transfer (critical activities to be undertaken prior to 1st April 2011)
- **Stage 2:** Organisational Integration Planning (critical activities to maintain service and business continuity from April 2011 – early July 2011)
- **Stage 3:** Organisational Integration Delivery (implementing service transformation to deliver the benefits of integration, from June 2011 onwards)

Stage 1 has already occurred and the community services were integrated with Sandwell & West Birmingham Hospitals NHS Trust as planned on 1st April 2011. This paper provides a progress report on delivery of Stages 2 & 3.

PROGRESS

STAGE 2: ORGANISATIONAL INTEGRATION PLANNING

The key outcome of this stage has been to commence operations as a single organisation. It has considered all critical activities required between Day 1 and Day 100 to ensure a seamless handover and maintain service and business continuity for both staff and patients during this period.

Initially the focus was on ensuring that community staff were welcomed into the organisation and had the necessary documentation, permissions and access to infrastructure support to continue to provide services. Actions at this stage included:

- Local induction for transferring staff
- Set up access to SWBH financial & ordering systems
- Establish new payroll arrangements
- Undertake Right to Work checks

- Ensure robust out of hours arrangements for the April and May bank holidays were in place
- Regular monitoring by the community management teams for any risks and service issues as they arose

It has been noted that signposting for staff regarding their new organisation is still required, and that there is a need for vigilance, in that lack of familiarity with processes may lead to unintended delays (for example, vacancy approval requests).

The actions associated with the first 100 days post integration are identified below:

- Programme Management:** The management teams have been established for both the Sandwell Community Adult Health Division and the Sandwell Community Child Health Directorate (which is part of the Division of Women and Child Health). These teams have regular meetings and receive finance and HR support. There was a commitment to establishing Management Boards for both services that would have membership from front line staff and from GPs. It was intended that these boards would have met in May, however in order to ensure that ambassadors and GP representatives are fully in place, the first board meetings have been rescheduled for July 2011.
- Service Planning:** The Division/Directorate have finalised their CQUIN targets for 2011/12 and have worked with the Trust's Head of Planning & Performance to develop key performance indicators that may be integrated with the corporate Trust monitoring reports. In both areas, there have been sessions with staff to identify and agree where there is scope for greater integration and service development.
- HR and Workforce:** The policy for the management of sickness & absence has been harmonised, while integrated job evaluation and workforce planning processes have been established. For the rest of this year, there will be a focus on harmonising key HR-related policies. The transfer of data from the PCT to SWBHT on the Electronic Staff Record has been delayed while negotiations take place with the Strategic Health Authority and the companies involved. Contingency arrangements are being developed for a manual transfer of data to take place should this not be resolved by September 2011.
- Finance:** The community finance systems have been fully integrated into SWBHT systems. Work is ongoing to rationalise the funding that has been transferred, with regards to splits between children's and adult services, as well as those staff and responsibilities that have been transferred over to corporate services. In some cases, such as Learning & Development, there are funds which may be due from external sources as well.

- e. **Communications and Engagement:** The Division and Directorate have been pilots for the implementation of 'Owning the Future', in particular the selection of ambassadors. A welcome event for ambassadors is planned for the 1st July and this will offer an opportunity to select those who will sit on the management boards.
- f. **IM&T:** Prior to integration, it was agreed that initially, IT support to the community systems would be purchased from the existing team then in the PCT. The SWBHT team is now recruiting staff to be able to provide this service in house, and it is envisaged that this will take place by September 2011. The ongoing cost of IT equipment for the community staff is being considered as part of the finance review outlined above.

STAGE 3: ORGANISATIONAL INTEGRATION DELIVERY

The organisational integration delivery phase will focus on the delivery of service transformation and integration to evidence and deliver the benefits to be derived following this acquisition. There are many examples already where service changes have been made which capitalise on the opportunities afforded by integration. These include:

- The management of Rowley Regis Hospital is now undertaken by the Sandwell Community Adults Division. This is intended to provide a greater community focus and better integration with primary care for the activities undertaken there
- The new 20 bedded reablement ward at Rowley Regis Hospital is to be run by the Division, with GP medical support, and will seek to develop new models of care
- The roles and job descriptions for Paediatric Liaison posts for Sandwell patients at both City and Sandwell emergency departments have been standardised, in order to ensure consistency of approach across the Trust
- The Specialist School Health Nurses have moved from Paediatrics to the Community Child Health Directorate, with the aim of reducing duplication of effort and enabling more effective targeting of specialist resources
- The separate Children's Safeguarding Committees previously run by both acute and community services have been merged, with the intention of improved and more effective communication

A brief description of the key areas that are being considered is given below:

- a. **Service Planning:** The community management teams are currently developing a development plan which will contribute to the Foundation Trust application process. Key themes are around developing and improving services for primary care, identifying new service opportunities and supporting the Right Care Right Here trajectories for the acute sector. Work is being undertaken with the surgical and medical divisions to identify means of helping them to decommission

their activity as well as how to reduce acute length of stay through work on admission avoidance and discharge processes.

- b. **Finance:** A review is to be undertaken of the finance support function in order to develop a structure best placed to meet both the organisation's and users' needs
- c. **Communications and Engagement:** The Listening into Action approach which was adopted as part of the staff engagement process during integration is being used as part of work to be undertaken in reviews around Health Visiting and School Nursing.
- d. **IM&T:** Work is being undertaken to allow community staff access to the Clinical Data Archive and acute staff access to System 1, where required. This is to improve communication and timeliness around notes, tests and patient pathways.
- e. **Commissioners:** Sandwell commissioners have identified five areas that they will seek to monitor as part of benefits realisation. These are:
 - Greater patient choice within End of Life care
 - Expansion of the Community Orthopaedic Service
 - Enhanced clinical leadership to support transformation and learning
 - Implementation of RCRH cardiology strategic model of care
 - Holistic community diabetes serviceThese areas are being addressed as part of the work programme of the Division/Directorate.

CONCLUSION AND RECOMMENDATIONS

This paper has provided the Trust Board with a progress on the integration and benefits realisation work that has been undertaken since 1st April 2011. The Trust Board is recommended to:

1. NOTE the progress report on Stage 2 & Stage 3 and the actions taken over the first 3 months of the new Division/Directorate
2. NOTE the delays in the migration of the Electronic Staff Record
3. APPROVE the next steps outlined for Stage 3

Matthew Dodd
20th June 2011

Sandwell and West Birmingham Hospitals



NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Listening into Action update
SPONSORING DIRECTOR:	John Adler, Chief Executive
AUTHOR:	Sally Fox. Listening into Action Facilitator
DATE OF MEETING:	30 June 2011

SUMMARY OF KEY POINTS:

This paper provides an update on the use of 'Listening into Action' within the Trust, together with the future plans for the approach.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Board is asked to RECEIVE and NOTE the update.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Continue to spread staff engagement through Listening into Action, including the delivery of the LiA 'Enabling our People' projects
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Previously discussed at the September 2010 meeting of the Trust Board.

Briefing on Staff Engagement for the Trust Board

Introduction

The Trust has been using the 'Listening into Action' approach since April 2008 as the principal means of engaging with staff about improving services for patients and also their own daily experience of working within the Trust.

The approach continues to spread across the Trust, with the number of LiA work streams now exceeding 100. LiA continues to be used to work on service improvement, change management and also to address organisation wide issues.

Current position

The Executive Sponsor Group has been overseeing the LiA action plan, which is designed to ensure that the LiA approach is fully embedded.

The key elements of that plan are now in place:

- 9 LiA champions have been trained and are in place to help teams who want to use the approach, supported by the LiA Facilitator.
- A new 'Easy Guide to Involving and Engaging Staff' is about to be printed to help give managers further guidance on how they can manage in an 'engaging way' and follow some of the principles identified in the 'Leadership Framework'.
- A new induction DVD has been produced to explain the LiA approach, and help create an expectation amongst new employees that staff engagement is considered to be crucial at this Trust.
- The communication strategy for LiA has been reviewed and has continued to be a high priority. The most recent staff survey indicated that 91% staff had heard of LiA, and e mail, Message Boards, Hot Topics and Heartbeat continue to be used to promote the LiA message.

External interest in the work that Trust has done in this area continues, with other NHS Trusts interested in sharing the learning.

Where next?

The Executive Sponsor Group continues to meet on a monthly basis to review the LiA work streams, and there are no plans to discontinue this reporting system at present.

A new action plan for 2011/12 will be presented to the Executive Sponsor Group shortly to ensure that LiA continues to spread and flourish.

Sally Fox

June 2011

SWBTB (6/11) 130 (a)

Sandwell and West Birmingham Hospitals



NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Communications and Engagement Strategy update
SPONSORING DIRECTOR:	Jessamy Kinghorn, Head of Communications and Engagement
AUTHOR:	Jessamy Kinghorn, Head of Communications and Engagement
DATE OF MEETING:	30 June 2011

SUMMARY OF KEY POINTS:

This is the bi-annual communications and engagement update, outlining activity over the last six months.

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 note the report and approve the proposed process for reviewing the strategy.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	All
Annual priorities	Supports delivery of Trust objectives
NHS LA standards	Patient information
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

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

Financial		
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy	X	The Trust has statutory duties around the information published on its website, and must meet certain requirements around accessibility of the website and involvement of patients and the public
Equality and Diversity	X	
Patient Experience	X	
Communications & Media	X	
Risks		

PREVIOUS CONSIDERATION:

Bi yearly update to the Trust Board.

Communications and Engagement Strategy Update

Paper to the Trust Board
June 2011

Report by Jessamy Kinghorn
Head of Communications and Engagement

In March 2009 the Trust Board approved a new three year Communications and Engagement Strategy and action plan. The strategy has fourteen objectives and progress is reported to the Trust Board six monthly.

Accessible and Responsive Care:

- Our patients, their carers and the clinicians responsible for their care (including GPs), will have the information they need to understand their treatment and to improve the experience they have in hospital, and their aftercare
- We will ensure patients and GPs have the information they need, when they need it, in the format they need, when choosing this hospital
- We will listen to our patients by establishing systems to monitor levels of patient satisfaction

High Quality Care:

- We will uphold public confidence in the Trust and its services through managing the Trust's reputation and promoting its services and successes
- We will facilitate implementation of the Trust's marketing strategy through appropriate marketing to and engagement with GPs, commissioners, community and patient groups
- We will develop our approach to engagement with patients, carers, stakeholders and local people to improve our services and undertake meaningful consultation and involvement in relation to changes and access to services

Care Closer to Home:

- We will promote the concept of care closer to home, the provision of services outside the main hospitals and the Towards 2010 Programme

Good Use of Resources:

- We will engage with the public over our use of resources

21st Century Facilities:

- We will engage with staff, partners, patients, their carers and local people to develop and promote plans for the new hospital

An Effective Organisation:

- We will ensure staff have the information they need and want to carry out their work effectively and play a full part in the organisation
- We will promote comprehensive staff engagement
- The communications crisis management and major incident response will be to a high standard
- We will enable our Foundation Trust members and key stakeholders play an important role in the activities and direction of the Trust, and will listen to their views and ideas
- We will implement a consistent brand across the organisation that reflects our values and increases awareness of the Trust

Each of the fourteen objectives has a significant number of actions associated with it, most of which have been completed. However, a small number are still in hand are listed below and will be completed during 2011/12. Those rated yellow are almost complete, those rated amber have seen a significant amount of work but still have some distance to go, and those rated as red have seen little progress during 2010/11.

Action	RAG	Further information
Develop a Board approved formal protocol for translating information		The background research for this has not yet been completed but it remains on the agenda for 2011/12
PALS and complaints poster campaign		This was delayed to allow for the merger of the complaints and PALS teams and is now being planned
Produce child friendly information about hospital care		Paediatrics has been one of the specialties to produce the most patient information over the last year and we are working with a specialist company to run sessions with some of our young patients to create animated videos of information.
Finalise policy for patient surveys and produce guidelines for staff wishing to carry out patient surveys		Work has been going on to pilot different approaches to patient surveys and a number of surveys have been completed. Advice is routinely given to departments but published guidelines are still being developed.
Audit the Trust's reputation with the media		This survey is currently in hand and a number of surveys have been returned.
Publish best practice communication guidance for staff		This is now being developed alongside the Owning the Future training and support programme.
Promote the Trust's values		A Trust values campaign is being planned for 2011/12.

In addition to continuing to work to the objectives set out in the strategy, the communications and engagement department is undertaking a review of the strategy and associated actions in the light of the ever changing communications landscape and 2011/12 Trust corporate objectives. Patient, public and staff use of social networking, Owning the Future and developing an approach to health promotion in order to achieve the Trust's objective and support the Right Care Right Here programme, are all new priorities which will need to be managed along with the existing department workload. In addition, the renewal of the foundation trust application and next stages of developing plans for the Midland Metropolitan Hospital are also anticipated to generate substantial pressure on workload.

The communications and engagement strategy is due to be renewed during this financial year. A revised membership strategy, new hospital communications and engagement strategy and new health promotion strategy are also required this year, and the team is working on a social networking strategy and patient and public engagement strategy. In addition, strategic direction needs to be given to other areas of the workload, such as owning the future and media relations. The charitable funds are looking to develop a fundraising strategy and the Right Care Right Here communications and engagement strategy is also likely to be refreshed during this financial year.

It is proposed that the Trust's communications and engagement strategy pulls these together as an umbrella strategy to ensure that there is consistency across the remit of the communications and engagement function. The objectives going forward may not change, but it is important that time is taken to reflect on whether they are the right communications and engagement objectives for the Trust for the next three years.

A proposal is set out below as to the process for renewing the strategy:

- Available data is used to assess effectiveness of current strategy, if necessary further surveys etc., carried out during July to September 2011
- Review of communications and engagement team workload and priorities
- Communications and engagement team LiA event
- Staff, public, patient, member, and GP engagement
- Discussion on communications and engagement and membership strategies by FT Programme Board or Trust Board
- Final sign off by Trust Board in December 2012

Appendix A highlights some of the day to day activity of the Communications and engagement function.

APPENDIX A:

Communications and Engagement Highlights: December 2010 – May 2011

1 Internal Communications

Heartbeat, Hot Topics and daily emails continue to be the main regular methods of communication within the Trust, although there is a significant amount of additional staff communication and engagement taking place, particularly through Listening into Action and the Owning the Future pilots.

Staff Awards 2011

The Staff Awards 2011 were launched at the beginning of June. This year there are eight categories for staff to vote for:

1. Employee of the Year
2. Team of the Year
3. Outstanding Leadership
4. Improving Patient Safety
5. Innovation Award (New for 2011)
6. Lifetime Achievement
7. Listening into Action Award for Staff Engagement
8. New leader

We are also asking patients, visitors, carers and members of the public to send in their nominations for a ninth award:

9. Excellence in Customer Care Award. This is presented to staff or teams who consistently uphold and demonstrate the Trust's nine Customer Care Promises.

Nomination forms are available from the Communications Department by calling 0121 507 5660 or can be downloaded off our website at www.swbh.nhs.uk

SWBH Staff Lottery

In May, seven grants of £500 were made to departments from the proceeds of the staff lottery. Between February 2010 and February 2011, 124 new players joined the staff lottery. In April 2011, there were 264 players purchasing 637 tickets. In order to be viable, the number of staff playing the trust lottery needs to increase.

2. Owing the Future

Owning the Future (OtF) is a new approach to further develop a culture of ownership and engagement within our organisation. It is based on the researched principle that good engagement combined with a broad range of incentives might have significant potential to improve engagement and performance.

OtF will build on the success of 'Listening into Action' giving all staff a real voice in the organisation on a permanent basis. The overriding objective of OtF is to involve staff more effectively at all levels in positive two way dialogue and action to deliver the highest quality patient care and staff satisfaction. Listening into Action is continuing to expand across the Trust and its use as an engagement technique is becoming well embedded.

OtF is based on the comprehensive approach to staff engagement adopted by the John Lewis Partnership. This approach is based on the sharing of knowledge and information about the business with staff, giving everyone the opportunity to contribute to decision-making as well as to challenge and question.

John Lewis has identified the following benefits of their approach

- Improved staff motivation
- Improved staff survey response of 94% (in which staff indicated they felt happy in their jobs, supported by their managers)
- Reduced turnover
- Staff have a better understanding of the business issues of the company;
- Staff suggest changes which improve the day to day running of the department
- Staff are more positive about change and understand the reasons behind the change and have been involved in deciding and shaping the change

In November 2010, staff were asked their views on the principles of OtF through Hot Topics. This allowed staff to influence decisions at the earliest point of the project. 54 teams responded to the Hot Topics questions, of which 50 (92%) supported the overall concept.

Three areas of the Trust are piloting Owning the Future, so that we can learn from experience before rolling it out across the Trust: the Sandwell Adult Community Health Division, the Sandwell Community Child Health Directorate and the Pathology Division.

The centrepiece of OtF is the election of Staff Ambassadors. Ambassadors will work closely with the team leader to ensure issues that are important to front line staff are on the agenda for team meetings. Staff will not put themselves forward to be Ambassadors, but all staff within the team are eligible and staff vote anonymously for the team member of their choice.

At the time of writing, voting in the pilot areas had closed (the Community services election ran a week ahead of the Pathology election to facilitate the administration of the process). The voting turnout rate in the Community Adult Health division was 54% and in Child Health, 55% and most ambassadors have been informed. Ambassadors, managers and union representatives have been invited to an event on 1st July to find out more about how Owning the Future will work.

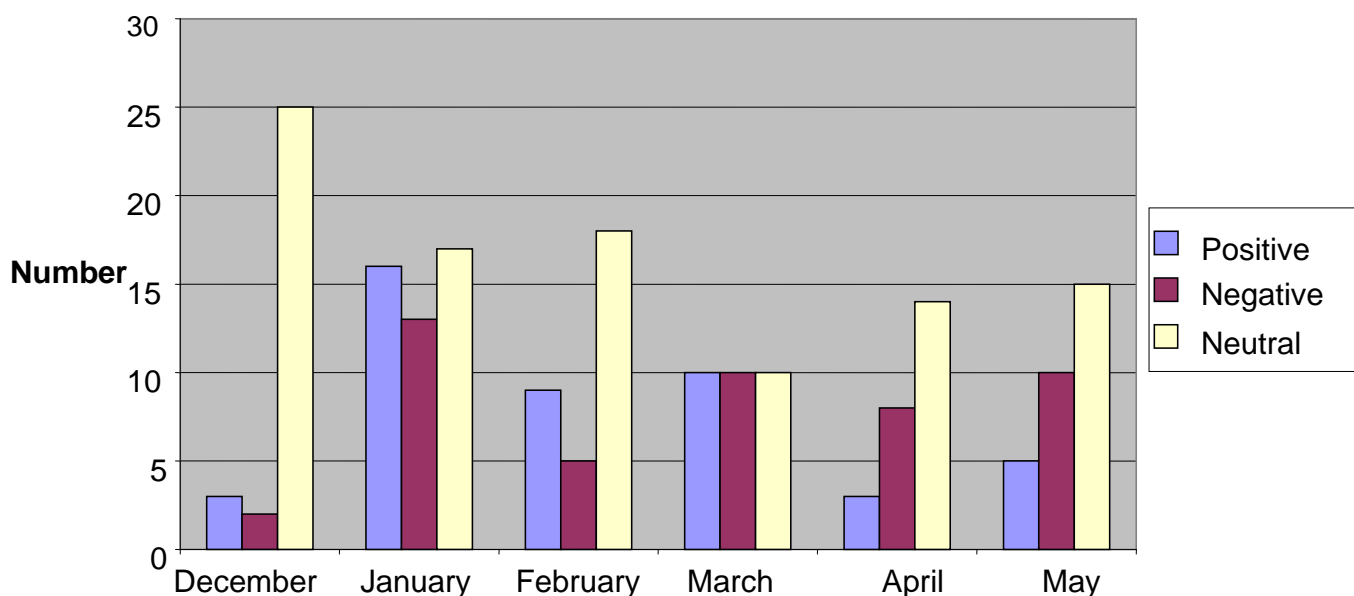
3 Media and external communications

We monitor the rate and tone of press enquiries with a view to recognising patterns and develop a more proactive strategy to dealing with enquiries.

PRESS ENQUIRY STATISTICS

Month	Working days	Number of enquiries	Positive	Negative	Neutral
December	21	30	3	2	25
January	20	46	16	13	17
February	20	32	9	5	18
March	23	30	10	10	10
April	18	25	3	8	14
May	19	30	5	10	15

Press enquiries by tone

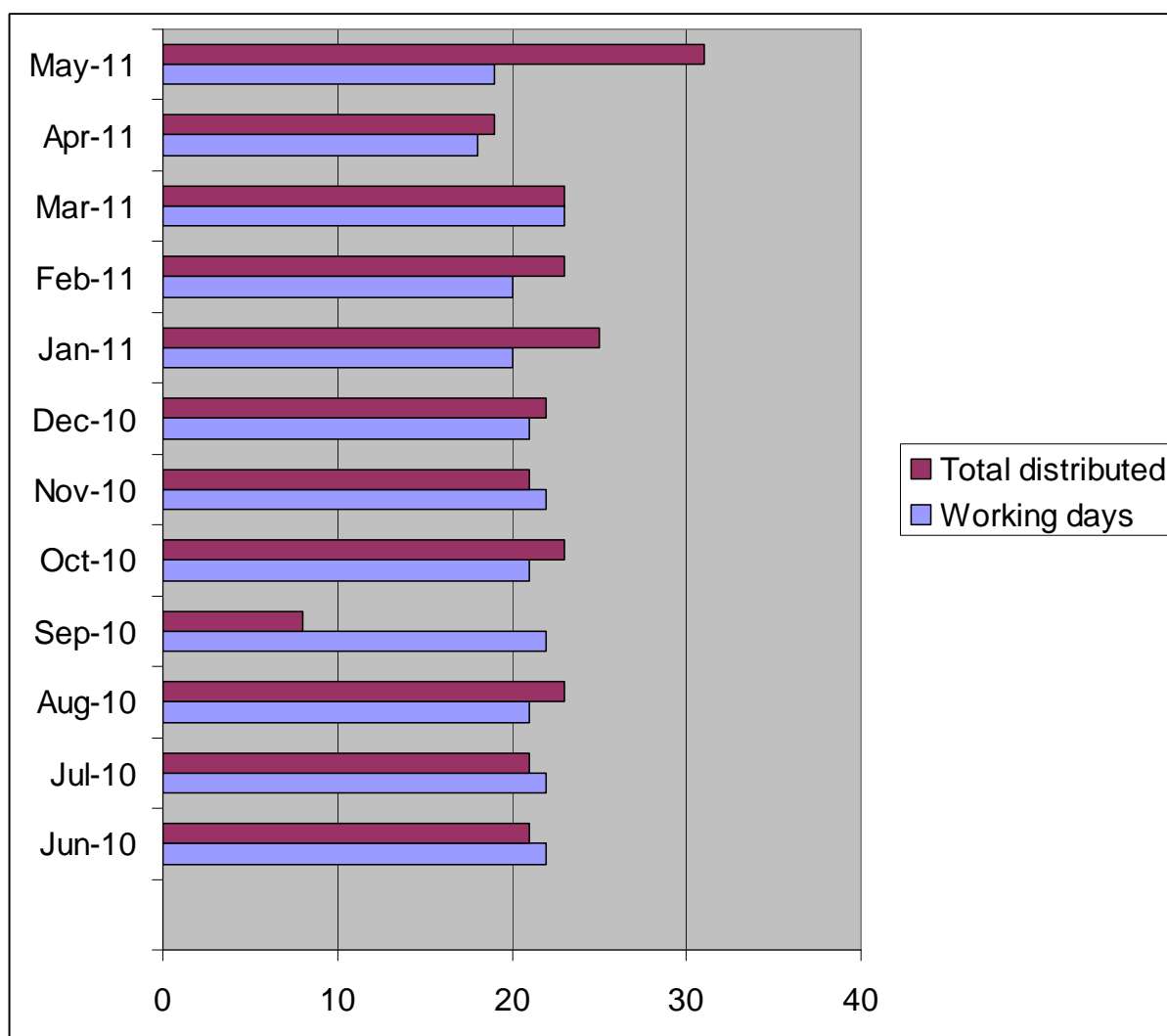


The number of enquiries, statements and press releases is recorded below. It should be noted that during Purdah (28th March – 6th May 2011), we were subject to some restrictions on our proactive media activity where this could be used to influence the political agenda.

Our record keeping has greatly improved since last December when we introduced a new data capture spreadsheet for enquiries. In May we introduced a new system for recording press releases and proactive media contacts and will be issuing monthly reports in future. However, these are taking a little time to be fully embedded.

MEDIA ACTIVITY

Month	Working days	Number of enquiries	Press statements	Press releases	Total distributed
June	22	5	5	16	21
July	22	8	8	13	21
August	21	5	5	18	23
September	22	4	0	8	8
October	21	8	8	15	23
November	22	14	6	15	21
December	21	30	8	14	22
January	20	46	13	12	25
February	20	32	6	17	23
March	23	30	13	10	23
April	18	25	9	10	19
May	19	30	14	17	31

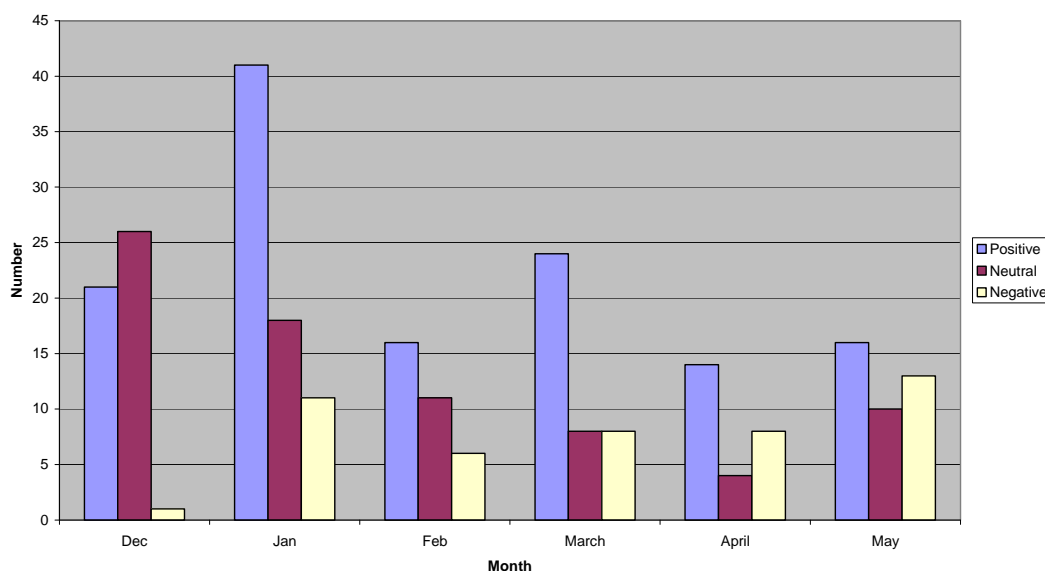


PRESS COVERAGE

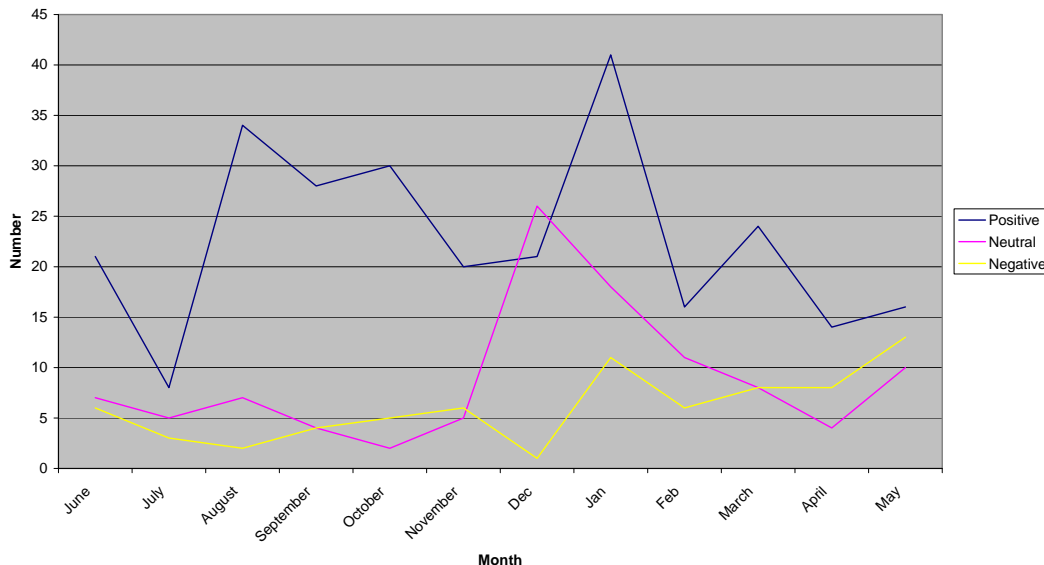
	Media articles		
Month	Positive	Neutral	Negative
June	21	7	6
July	8	5	3
August	34	7	2
September	28	4	4
October	30	2	5
November	20	5	6
Dec	21	26	1
Jan	41	18	11
Feb	16	11	6
March	24	8	8
April	14	4	8
May	16	10	13

Dec 10 to May 11 is new data. June 10 to Nov 10 has previously been reported but is included for information.

Press Coverage Dec 10 - May 11



Press coverage June 10 to May 11



EMERGENCY PLANNING

As well as participating in a wider Birmingham emergency response group, members of the Communications team participated in the following major incident exercises as training opportunities:

16th February 2011. Major Incident/Business Continuity Plan test exercise at Ardenleigh (Birmingham & Solihull Mental Health NHS Foundation Trust) designed to test evacuation procedures, during a major fire at a mental health secure facility.

2nd March 2011. Major Incident exercise tabletop at the Gerry Simons Clinic in West Bromwich. (Sandwell Mental Health and Social Care Trust)

28th March 2011. Exercise Eris (Greek Goddess of strife and discord) at Wolverhampton University. Organised and run jointly by the Trust, Wolverhampton City PCT and West Midlands Fire Service, the exercise was designed to test responses across regional health and emergency services in the event of a catastrophic incident involving mass casualties.

11th May 2011. Exercise Illuminate held at West Bromwich Albion FC, jointly organised by Sandwell MBC and WBA Safety Advisory Group.

The Communications team is currently helping organise a multi-agency major incident real exercise at City Hospital, to be held on Sunday 4th September.

DOCUMENTARIES

The Blast! Nursing documentary is in the final filming stages as they are currently in the editing process on three out of five programmes and nipping back to the hospital for ad hoc shots. All filming will be finished by July. Broadcast is expected later this year.

Additionally, we are facilitating filming in the Birmingham and Midland Eye Centre to be included in a single programme as part of a two part documentary on frontline medicine produced by the BBC. Equipment has been passed and filming is due to take place in the next couple of weeks, with Eye Consultant Wing Commander Rob Scott.

4 Patient Information

Earlier this year following a comprehensive assessment, the Trust was successful in being awarded the Information Standard, which automatically qualified for achieving the patient information standard for NHS LA level 2. The Information Standard recognises that we have processes and systems for producing patient information that is:

- Accurate
- impartial
- balanced
- evidence-based
- accessible
- and well-written

It means the Trust is able to display The Information Standard logo on leaflets which have been through its production process.

The amount of patient information available on the Trust's intranet site has almost doubled since December and comprehensive information on how to develop information is also available. The Trust policy continues to be rolled out and applied to patient information and, following the transfer of Sandwell's community services, is now also being applied to community based patient information.

5 Patient and Public Involvement, and Membership

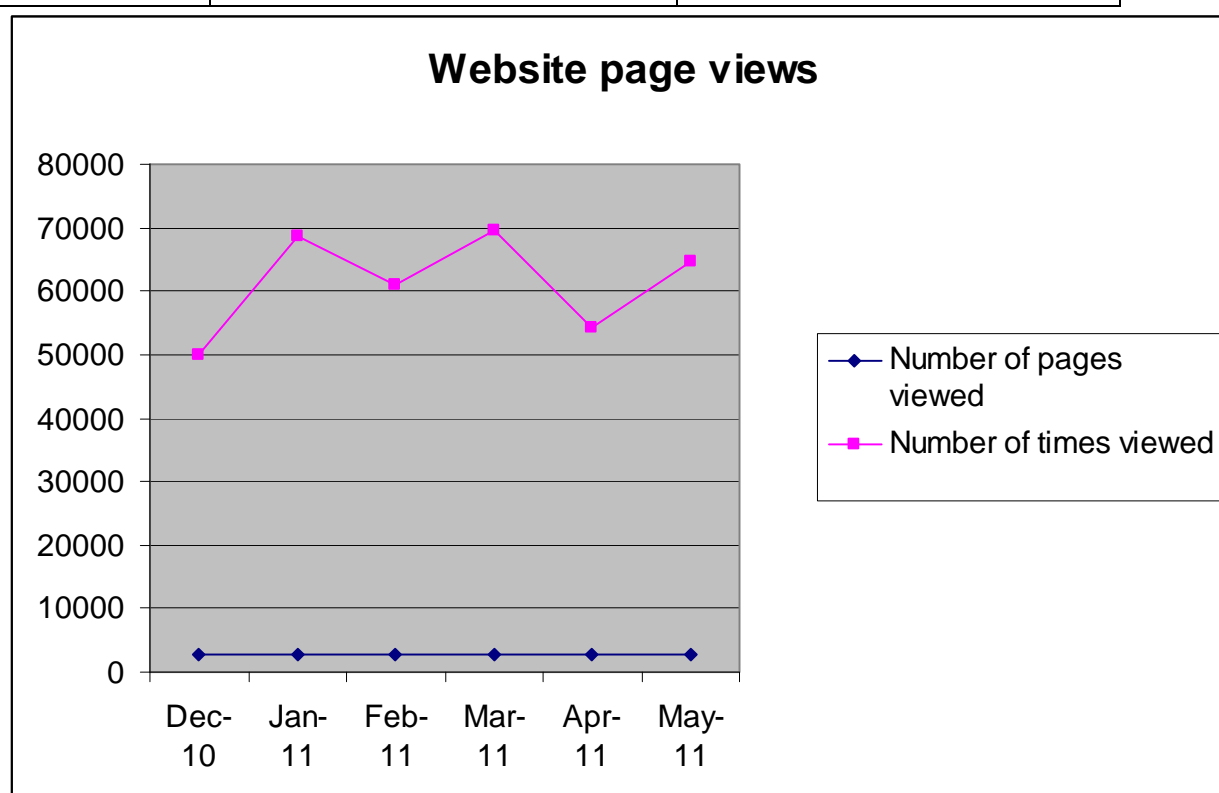
Patient and public involvement activities continue both at corporate and specialty level, often as part of the Trust's membership strategy. As a direct result of patient and public feedback, more joint staff and patient events are being planned, along with feedback events, an additional newsletter and work to increase patient surveys. A 'you said, we did' campaign is in progress and being closely monitored and focused work with community and minority groups has been taking place.

The membership strategy is currently being redeveloped, although a programme of activities for members is still active and membership numbers have marginally increased since December 2010. Membership information will be reported to the FT programme board as part of the preparations for the Trust's foundation trust application.

6. Website and e-communications

The table below and graph on the following page show the volume of traffic to the Trust website over the last six months:

Month	Number of pages viewed	Number of times viewed
May-11	2689	64534
Apr-11	2832	54234
Mar-11	2818	69703
Feb-11	2778	61107
Jan-11	2682	68661
Dec-10	2791	49999



Website Achievements

- A function that allows patients to cancel or request a new appointment has been developed
- The best month in terms of usage was March, with 17,952 users.
- The average number of unique visits per month is 21,002, with the site attracting an average of 677.48 visits per day (although this is still fairly low, it marks a 12.93% increase in the last six months).
- A button promoting the Staff Awards is now in place
- New sections continue to be developed. Gastroenterology is a good example of how clinicians have embraced the opportunity to raise their presence on the Trust website.

Issues

- Although the website is an improvement on the previous website, template is still not as flexible as we would like. This may be down to the Joomla! content management system (CMS) and we are currently out to tender for a new package of support for our website
- It remains difficult to engage with some clinicians to get up-to-date content.
- The functionality for users to rate how well staff have met the Customer Care Promises is not as engaging as we would like. It has been decided that in the short term the survey will go on the new Engage website, which is expected to go live this summer.
- People have commented on issues about the website not displaying properly when viewed within the Trust (for example, the campaign button on the homepage). This can usually be attributed viewing the website using the Internet Explorer 6 (IE6) browser. Many large websites no longer support this browser, which could be a problem if the Trust wishes to establish a social media presence (IE6 support for Twitter, Facebook and YouTube has now stopped). Internet Explorer 9 was released in February and the number of visitors accessing the Trust website with this browser has naturally been increasing. In May, only 12.31 per cent of users accessed the website using IE6

Usage:

- March was the most popular month, with 17,952 users. December was the least popular with 12,999 users. This figure jumped to 17,216 in January.
- There was an average of 15,496 users in the six-month period.
- An average of 2,765 pages were viewed an average of 61,373 times
- The most popular pages relate to finding / contacting the hospitals, visiting and recruitment. Making these pages more engaging may keep users on the website.

Future plans:

- Further redevelopment of the website to make it more flexible, including a review of the use of Joomla!
- The Engage website will be going live in the summer and the link to this should be prominent on the main SWBH website. The engage website has been developed as part of the membership strategy and will be used as a tool for engaging with our members. An impression of what the site will look like once it is finished is on the following page.

SWBH Engage - Microsoft Internet Explorer provided by SWBH IT Department

http://dev.socialmediapartnership.org.uk/swbhengage/home.htm

File Edit View Favorites Tools Help

★ Favorites Clinician's Home Page Suggested Sites Trust Intranet Web Slice Gallery

Hospital Leaflets(Communica... SWBH Engage

Page Safety Tools

engage connect, discuss, share

Sandwell and West Birmingham Hospitals **NHS**

Members Events Kids Zone Health Advice Discussions Blog Get Involved Governors SWBH site

Engage with SWBH and our members to develop health services in the West Midlands.

The members of our community share their experiences and interests and tell us what they need to succeed in life. SWBH Engage is committed in supporting our members with a voice to share opinion and connect with our growing community.

Email
Password
Login Forgotten Password?

Activity Messages
Discussions Friends
Events Mentions
Profile Settings

Sign up today

Health Advice

1. Maternity 2. Allergy 3. Infection control 4. Stroke 5. Diabetes

6. Heart disease 7. Healthy foods 8. Quit smoking 9. Mental health 10. Obesity

Kids Zone

1. Maternity 2. Allergy 3. Infection control 4. Stroke 5. Diabetes

6. Heart disease 7. Healthy foods 8. Quit smoking 9. Mental health 10. Obesity

Most talked about

1. Maternity 2. Allergy 3. Infection control 4. Stroke 5. Diabetes

6. Heart disease 7. Healthy foods 8. Quit smoking 9. Mental health 10. Obesity

Events Discussions Blogs

An event with a very long name will be displayed on two lines
Thursday 8th February 2011

Name of event
Thursday 8th February 2011

View all Events

Get Involved

What features from our new website do you enjoy the most

☒ Healthy Living
☐ Social Networking
☐ Kids Zone
☐ Discussions

Submit Answer

Featured Video

Sandwell and West Birmingham Hospitals **NHS**

00:00 / 47:42 50%

Name of the video
Thursday 8th February 2011

Twitter feed

@swbhengage Lorem ipsum dolor sit seclatur adipiscing elit.

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Internet 50%

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Sandwell and West Birmingham Hospitals



NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Sandwell Mental Health Trust – Governor's Report
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Debbie Talbot, Assistant Director of Nursing
DATE OF MEETING:	30 June 2011

SUMMARY OF KEY POINTS:

Debbie Talbot is the nominated representative as a stakeholder governor for Sandwell Mental Health and Social Care Foundation Trust.

Attached is a progress report for 2010/11.

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 as a stakeholder organisation.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	None specifically
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Considered annually – last presented at the Trust Board meeting in June 2010

Report to : Trust Board
Report from: Debbie Talbot, Assistant Director of Nursing –
Quality and Patient Experience
Dated: June 2011
Subject: Sandwell Mental Health and Social Care NHS FT
Governor

Introduction / Background

Organisations operating as Foundation Trusts (FT) are mandated to hold an Assembly of Governors consisting of:

- 21 Public Governors representing Sandwell (17), Dudley (1), Walsall (1) & Birmingham (1)
- 6 Staff Governors representing medicine, nursing, social care, professional, administrative/management and support staff
- 10 Stakeholder Governors representing Sandwell MBC, Sandwell PCT, SWBH, Changing Our Lives, Service User Reference Group, Sandwell Children's Trust, Sandwell Agewell, Sandwell CARES, Sandwell Multi-faith Network.

As NSF lead in Mental Health (Learning Disabilities) I was elected to represent SWBH as a stakeholder governor in December 2008.

Initial requirements included formal Declaration of Interests and provision of a personal profile.

July 2010 –June 2011 Up-date -

Meeting July 2010

- White paper briefly discussed – extra-ordinary meeting arranged to discuss implications for organisation
- Up-date on TCS
- Financial report – *stakeholders asked questions regarding reinvestment of any 'savings'. Financial director explained importance of allowing some resource slack in view of TCS ect. Stakeholders asked about areas of underperformance such as the Early Intervention project. The Finance Director felt , based on current caseload, this would improve later in the year.*
- Appointment of Non- Executive Director and skills required to undertake the role
- Seek appointment of stakeholder governor from Sandwell Service User Network

Meeting Sept 2010

- To receive Annual Report, Quality Report and Annual Accounts for year ending March 2010. *Stakeholders asked numerous questions regarding workforce issues , targeting of LD services, removing the stigma of MH in Asian communities, TCS, quality of services, closure of buildings.*
- Internal and external auditors quality assurance
- *Stakeholders asked for an up-date on the Early Intervention project. The Finance Director reinforced that PCT targets would be met.*
- Results of elections for Governors

TCS Stakeholder Event 26th October 2010

- Attendees from Assembly of Governors and all potential 'partners' following transfer of community service to the Trust.

Meeting Nov 2010

- Up-date membership Development Strategy (work of sub-group)- *the key message was the need to recruit members from the age 12-16 age group*
- Appointment of Non – Executive Director
- Spending review
- Operational Performance
- Review of composition of Assembly of Governors- in view of TCS
- Review of Glebefields Resource Centre – report- formal consultation in progress

Meeting Jan 2011

- Appointment of Deputy Chairman
- Sub – group to review future format of meetings

Meeting March 2011

- Presentations regarding new organisation and structure (TCS)
- Summary of Operational Performance
- Single Equality Scheme.
- *Stakeholders asked for information regarding proposed service 'partners'.*
- Draft Annual Plan 2010-13

Meeting May 2011- Unable to Attend

- Annual Plan 2010/11
- Annual appraisals for Chairman and Non –Executive Directors
- Membership of the Assembly of Governors – representation from Acute Trusts as stakeholder governors no longer indicated due to service expansion and diversity.

General:

- Most meetings took the form of powerpoint presentations and handouts by Executives .
- Workshops were available for stakeholdes who required further information or preparation
- Sub- groups were formed as required
- On occasions meeting were delayed due to lack of quorum –often public or staff governor representation.
- The original time commitment seemed to increase

Sandwell and West Birmingham Hospitals



NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Freedom of Information Update
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	30 June 2011

SUMMARY OF KEY POINTS:

An update on Freedom of Information requests received between 1 April 2010 – 31 March 2011 is presented.

229 requests were received during this period, 96% of which were processed during the statutory 20 working day timeframe as required by the Act.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to RECEIVE and NOTE the report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

Financial		
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy	X	Requests are processed in line with the requirements of the Freedom of Information Act 2000
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Governance Board on 3 June 2011.

FREEDOM OF INFORMATION REQUESTS UPDATE

INTRODUCTION

This is the annual update to the Governance Board on Freedom of Information requests received by the Trust.

The report covers the period from 1 April 2010 – 31 March 2011 and provides comparative information concerning the number of requests received, types of request and request originators.

THE FREEDOM OF INFORMATION ACT 2000

The Freedom of Information Act came into force in January 2005. The Act requires all public authorities to make any information they hold available on request, in the spirit of public accountability and transparency.

PUBLICATION SCHEME

The Freedom of Information Act requires each public authority to draw up a publication scheme. The scheme, approved at the April 2009 meeting of the Governance Board, sets out the documents which the organisation will routinely make available to the public, such as Board meeting minutes and annual reports. The scheme also outlines the organisation's key contacts and sets out the fee-charging scheme for copies of information requested from the publication scheme.

REQUEST HANDLING

All requests received are processed and responded to by the Trust Secretary, regardless of where they are received in the Trust. A set of contacts across the Trust has been established with whom the Trust Secretary liaises to gather the information needed to respond to the requests.

ACTIVITY APRIL 2010 – MARCH 2011

Between 1 April 2010 - 31 March 2011, 229 requests were received by the Trust – this compares to 241 received in the same period last year. Of these requests, 220 (96%) were processed within the statutory 20 working day timeframe.

Of the responses that were not issued within 20 working days, renegotiation of the deadline was agreed with the requester where possible. The main reason for the failure to meet the required timeframe relates to delays with receiving the information from the relevant contact in the Trust, either due to the complexity of the information requested or in one instance, the individual was the sole person able to provide the data and yet was away from the Trust for an extended period.

Responses to 15 requests were not issued, because either the requester withdrew the request or clarity was not provided from the requester on a matter in the request despite being asked.

A breakdown of the responses is provided in Figures 1 – 4 within Appendix 1.

July 2010 and February & March 2011 saw the highest number of requests during the period, with 25 and 24 being received in each month respectively.

KEY TRENDS

As in 2009/10, requests with an operations and workforce theme were the most commonly received during the period. Examples include requests for information concerning A & E attendance with different diagnoses, services provided by the Trust and the Trust's nurse bank processes. Other most commonly received requests covered clinical effectiveness matters, including the use of certain drugs in the Trust and workforce enquiries, such as sickness absence in specific functions and questions related to medical staffing specifically. There were also numerous requests for the organisational structures of some of the Trust's support functions.

The most prolific requesters of information under the Freedom of Information Act during the period have been private individuals. Compared to 2009/10, far fewer requests were received from representatives of political parties. Significantly more requests were received during the year from health organisations and institutions than in 2009/10.

Of the 229 requests received, 16 individuals or companies submitted more than one request. Other bodies submitting in excess of five requests during the period include a local newspaper organisation, a national newspaper organisation and a Pharmaceutical representative.

Very few exemptions that would justify withholding the information from the requester could be applied to the requests received. A number were received however, where the information was withheld in part on the basis that the information was not held by the Trust, was already in the public domain or to reply to the request would mean exceeding the time and cost limit (18 hours of £450) for the provision of information free of charge under the terms of the Act.

LEARNING POINTS

Following adverse media attention around a couple of responses issued, the need to contextualise fully the information supplied in a response has been a key point of learning.

During the period, more work has been undertaken with departments across the Trust, namely Communications and Complaints & Litigation, to ensure a co-ordinated and consistent approach is taken to responding to requests for information and queries received by these departments, with a view to directing them through the Freedom of Information route when the requests are of a nature where it is appropriate to do so.

RECOMMENDATION

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

Appendix 1

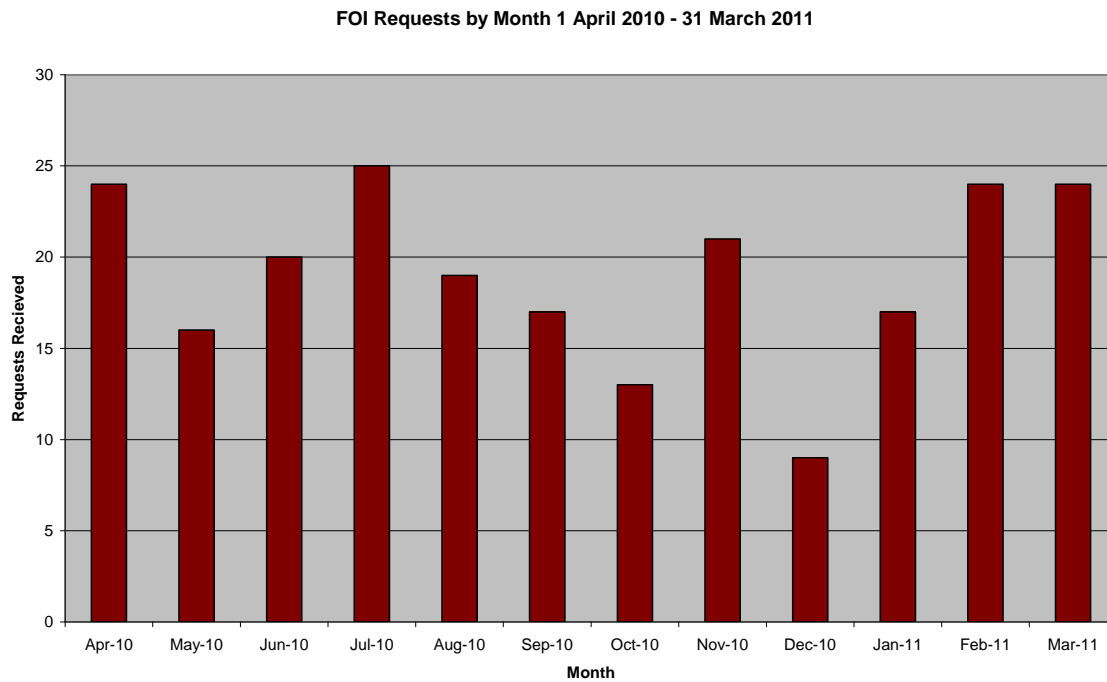


Figure 1: Freedom of Information requests by month

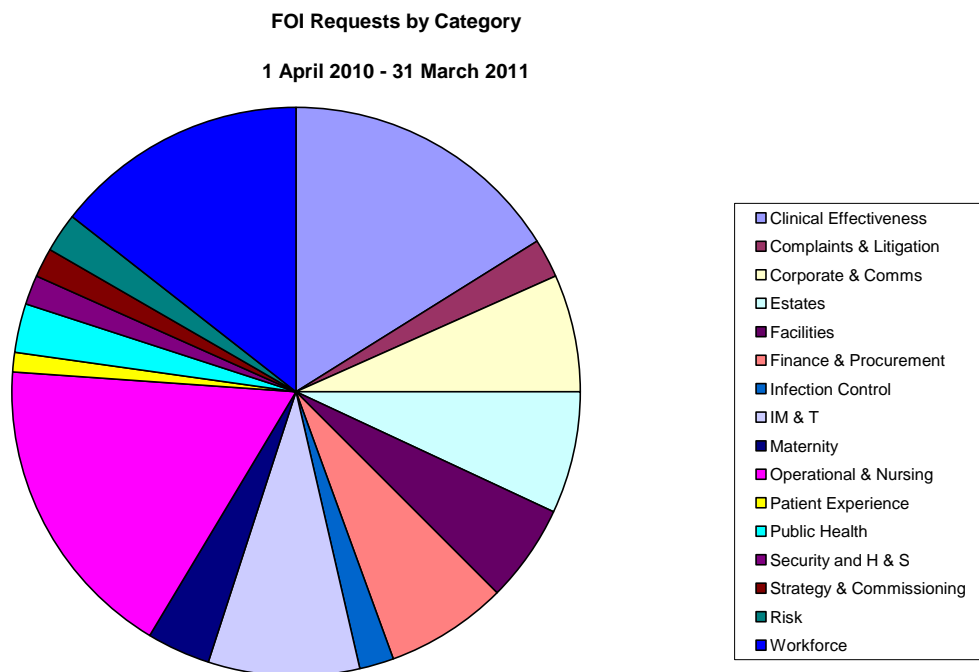


Figure 2: Freedom of Information requests by category

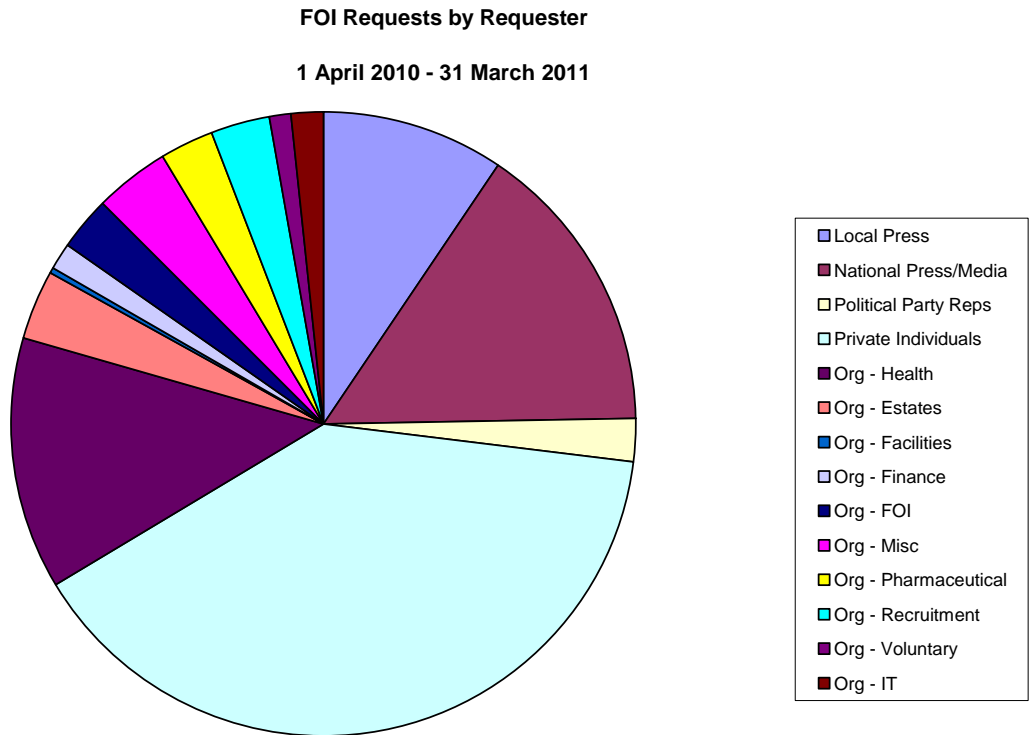


Figure 3: Freedom of Information requests by originator

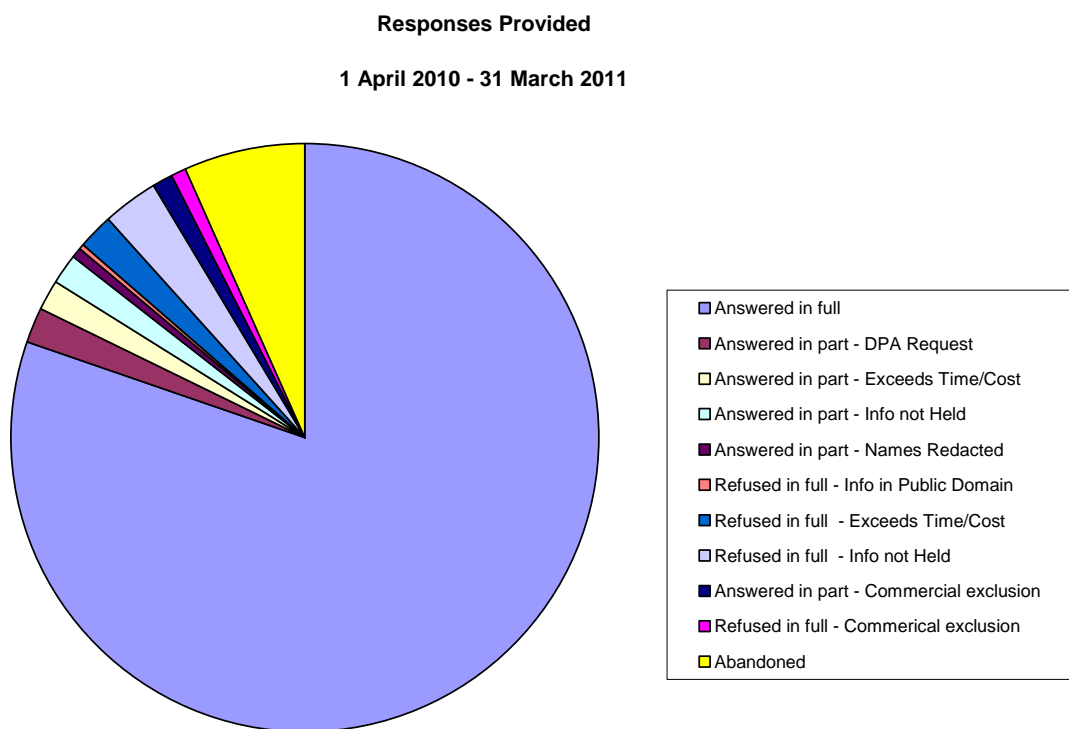


Figure 4: Responses provided to Freedom of Information enquiries

Sandwell and West Birmingham Hospitals



NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – May 2011
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Management
AUTHOR:	Robert White/Tony Wharram
DATE OF MEETING:	30 June 2011

SUMMARY OF KEY POINTS:

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

For May, the Trust generated a “bottom line” surplus of £25,000 which is £6,000 better than the planned position (as measured against the DoH performance target).

For the year to date, the Trust has a deficit of (£204,000) which is £296,000 worse than the planned position

Capital expenditure for the year to date is £1,017,000 and the cash balance at 31st May was £11.6m above the plan.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Performance Management Board and Trust Management Board on 21 June 2011.
Finance and Performance Management Committee on 23 June 2011.

Sandwell and West Birmingham Hospitals



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:	30 June 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 – May 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:

Performance Management Board and Trust Management Board on 21 June 2011.
Finance and Performance Management Committee on 23 June 2011.

Exec Lead	NATIONAL AND LOCAL PRIORITY INDICATORS				January	February	March	April			May			To Date (*=most recent month)	TARGET		Exec Summary Note	THRESHOLDS			11/12 Forward Projection	09/10 Outturn	10/11 Outturn									
					Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust	YTD	11/12																	
COO	ALL	Cancer	2 weeks	%	94.6	▼	94.8	▲	96.5	▲	→	95.7	▼	→	95.7	⇒93	⇒93		No variation		Any variation	●	93.9	94.5								
	ALL		2 weeks (Breast Symptomatic)	%	95.1	▼	96.6	▲	93.1	▼	→	94.2	▲	→	94.2	⇒93	⇒93		No variation		Any variation	●	93.6 (Q4 only)	94.7								
	ALL		31 Day (diagnosis to treatment)	%	100	▲	100	■	99.4	▼	→	100	▲	→	100	⇒96	⇒96		No variation		Any variation	●	99.7	99.7								
	ALL		31 Day (second/subsequent treatment - surgery)	%	100	▲	100	■	100	■	→	100	■	→	100.0	⇒94	⇒94		No variation		Any variation	●		99.5								
	ALL		31 Day (second/subsequent treatment - drug)	%	100	■	100	■	100	■	→	100	■	→	100.0	⇒98	⇒98		No variation		Any variation	●		100								
	ALL		31 Day (second/subsequent treat - radiotherapy)	%	n/a		n/a		100	■	→	no pts		→	no pts	⇒94	⇒94		No variation		Any variation			100								
	ALL		62 Day (urgent GP referral to treatment)	%	87.6	▼	88.7	▲	85.7	▼	→	85.8	▲	→	85.8	⇒85	⇒85		No variation		Any variation	●	89.1	88.0								
	ALL		62 Day (referral to treat from screening)	%	91.7	▼	100	▲	100	■	→	98.0	▼	→	98.0	⇒90	⇒90		No variation		Any variation	●		99.2								
	B		62 Day (referral to treat from hosp specialist)	%	94.1	▲	100	▲	100	■	→	100	■	→	100	⇒85	⇒85		No variation		Any variation	●		95.6								
	COO			Cancelled Operations	Elective Admissions Cancelled at last minute for no clinical reasons	%	1.1	■	0.6	■	0.8	■	0.6	▼	1.0	▼	0.8		0.1	▲	0.6	■	0.4	■	0.7	<0.8	<0.8	a	<0.8	0.8 - 1.0	>1.0	●
N		28 day breaches	No.		0	■	0	■	0	■	→	0	■	→	0	■	0	0	0	0	0	0	0	3 or less	4 - 6	>6	●		0	1		
B		Delayed Transfers of Care	Acute	%	4.7	■	5.0	▼	5.6	▼	4.7	■	4.7	■	4.7	3.3	■	5.4	■	4.3	▲	4.6	<3.5	<3.5	b	<3.5	3.5 - 5.0	>5.0	●●	3.0	4.6	
DOD	B	Stroke Care	>90% stay	%	70.8	■	80.0	■	79.5	▼	→	82.9	▲	→	89.7	▲	86.2	80	80	c	No Variation	0 - 2% Variation	>2% Variation	●	62.0	72.8						
	S		TIA Treatment <24 hours from initial presentation	%	33.3	▲	37.5	▲	46.2	■	→	33.3	▼	→	28.6	▼	30.0	60	60		No Variation	0 - 2% Variation	>2% Variation	●●		46.15						
			TIA Treatment <24 hours referral rec'd by Trust	%	58.3	▲	62.5	■	61.5	▼	→	33.3	■	→	42.9	▲	40.0	60	60		No Variation	0 - 2% Variation	>2% Variation	●●		61.54						
			Brain Imaging for Em. Stroke Admissions	%	94.3	■	88.9	■	89.8	■	→	92.7	▲	→	89.7	■	91.4	90.0	90.0		No Variation	0 - 2% Variation	>2% Variation	●	81.8	90.4						
COO	ALL	Accident & Emergency	4-hour waits	%	97.1	■	97.8	▲	95.1	■	97.3	▲	96.3	■	96.7	■	98.5	▲	95.8	▼	96.8	▲	96.79	⇒95	⇒95	d	⇒95		<95	●	98.55	96.99
	ALL		Total Time in Department (95th centile)	h/m	→	→	→	→	→	→	3.57	■	→	→		3.57	⇒<4hrs	⇒<4hrs	⇒<4hrs	⇒<4hrs	⇒<4hrs	⇒<4hrs	●									
	ALL		Time to Initial Assessment (=<15 mins)(95th centile)	mins	→	→	→	→	→	→	26	■	→	→		26	<15	<15	<15	<15	<15	<15	●●									
	ALL		Unplanned re-attendance rate	%	→	→	→	→	→	→	1.42	■	→	→		1.42	⇒<5.0	⇒<5.0	⇒<5.0	>5.0	●											
	ALL		Left Department without being seen rate	%	→	→	→	→	→	→	3.47	■	→	→		3.47	⇒<5.0	⇒<5.0	⇒<5.0	>5.0	●											
	ALL		Time to treatment in department (median)	mins	→	→	→	→	→	→	63	■	→	→		63	⇒<60	⇒<60	⇒<60	>60	●											
R0	ALL	Infection Control	C. Difficile	No.	3	▲	4	▼	4	■	2	▼	1	▲	3	▲	5	▼	4	▼	9	▼	12	19	109	e	No variation		Any variation	●	158	120
	ALL		MRSA Bacteraemia	No.	1	▼	0	▲	0	■	0	■	0	■	0	■	0	■	0	■	0	■	0	1	6		No variation		Any variation	●	14	5
			MSSA Bacteraemia	No.	→	→	→	→	→	→	0		0		0		1		0		1			No. Only	No. Only						22	
			E Coli Bacteraemia	No.	→	→	→	→	→	→	4		3		3		3		3		6		10	No. Only	No. Only						73	
COO	S	Cervical Cytology	Diagnostic Report Turnaround	Days	<9 days	■	<9 days	■	<9 days	■	→	<9 days	■	→	<9 days	■	<9 days	<9 days	<9 days		<9 days	<9 days	<9 days	<9 days	<9 days		<9 days	9-12 days	>12 days	●		<9 days
COO	S	RTT 18 week Milestones	Admitted Median Wait	Wks	5	■	7	▼	6	▲	→	6	■	→	6*	⇒<11.1	⇒<11.1	f	⇒<11.1		>11.1	●		6								
	ALL		Admitted 95th Percentile	Wks	20	■	22	▼	20	▲	→	19	▲	→	19*	⇒<23.0	⇒<23.0		⇒<23.0	23.1 - 27.6	>27.7	●		20								
	N		Admitted Care (RTT <18 weeks)	%	91.5	▼	91.0	▼	92.7	▲	→	94.6	▲	→	94.6*	⇒90.0	⇒90.0		⇒90.0	85-90	<85.0	●	93.4	92.7								
	S		Non Admitted Median Wait	Wks	4	■	6	▼	4	▲	→	5	▼	→	5*	⇒<6.6	⇒<6.6		⇒<6.6		>6.6	●		4								
	ALL		Non Admitted 95th Percentile	Wks	15	■	16	▼	16	■	→	14	▲	→	14*	⇒<18.3	⇒<18.3		⇒<18.3		>18.3	●		16								
	N		Non-Admitted Care (RTT <18 weeks)	%	97.5	▼	97.9	▲	96.7	▼	→	97.6	▲	→	97.6*	⇒95.0	⇒95.0		⇒95.0	90 - 95	<90.0	●	97.6	96.7								
	S		Incomplete Pathway Median Wait	Wks	5	■	4	▲	4	■	→	5	▼	→	5*	⇒<7.2	⇒<7.2		⇒<7.2		>7.2	●		4								
	B		Incomplete Pathway 95th percentile	Wks	17	■	18	▼	16	▲	→	15	▲	→	15*	⇒<28.0	⇒<28.0		⇒<28.0	28.1 - 36.1	>36.1	●		16								

Exec Lead	NATIONAL AND LOCAL PRIORITY INDICATORS (Cont'd)				January	February	March	April			May			To Date (*=most recent month)	TARGET		Exec Summary Note	THRESHOLDS			10 / 11 Forward Projection	09/10 Outturn	10/11 Outturn									
					Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		S'well	City		Trust	YTD	11/12												
COO	S	Same Sex Accommodation Breaches	Total Number of Breaches	No.	339	227	166	17		58		75		0		4		4		4	0	0	g	0		>0			1064			
	S		Breaches in Assessment Units (inc in above)	No.	72	67	65	17		0		17		0		4		4		4	0	0		0		>0			445			
DO'D	S	Mortality in Hospital	Hospital Standardised Mortality Rate	HSMR	100.8	99.5	99.8	→			105.1	→			95.5	98.1	< Lower Confidence Limit	< Lower Confidence Limit	>Upper Confidence Limit				93.0	93.5								
			Peer (SHA) HSMR	HSMR	94.7	93.2	100.8	→			100.1	→			94.6	97.3																
COO	S	Readmission Rates (to any specialty) within 30 days of discharge	Following initial Elective Admission	%	2.7	2.8	2.4	→			2.8	→				2.8	No. Only	No. Only														
	S		Following initial Non-Elective Admission	%	12.7	11.1	12.0	→			11.3	→				11.3	No. Only	No. Only										13.6				
	S		Following initial EL or NEL Admission	%	7.4	6.7	6.7	→			6.9	→				6.9	No. Only	No. Only										8.0				
RO	S	Sickness Absence	Long Term	%	3.57	▲	3.24	▲	3.01		→			2.63		→			2.63	<2.75	<2.40		<2.75	2.75-3.10	>3.10		3.10	3.12				
	S		Short Term	%	1.16		0.99	▲	1.02		→			0.76	▲	→			0.76	<1.15	<1.10		<1.15	1.15-1.30	>1.30		1.31	1.05				
	S		Total	%	4.73	▲	4.23		4.03	▲	→			3.39		→			3.39	<3.90	<3.50		<3.90	3.90-4.40	>4.40		4.41	4.17				
		Learning & Development	PDRs (includes Junior Med staff)	No.	337		267		242	▼	→			322	▲	→			278	▼	600	1120	6720	h	0-15% variation	15 - 25% variation	>25% variation	● ●	4748	4635		
			Mandatory Training Compliance	%	84.9	▲	87.7	▲	86.8	▼	→			87.4	▲	→			87.6	▲	87.6	100	100		=>80	50 - 79	<50		71.1	86.8		
	CQUIN SCHEMES			Value £000s																												
DO'D	S	Acute	VTE Risk Assessment (Adult IP)	482	%	88.5	▲	91.8		92.3	▲	→			93.4	▲	→			91.9	▼	91.9*	90	90	i	=>90		<90		●	n/a	92.3
RO	Pt. Experience (Acute) - Personal Needs		482	Score	→			→			→			Composite of 5 Qs - Survey October			Composite of 5 Qs - Survey October				69.3	69.3	No variation				Any variation		n/a	67.3		
RO	Smoking Cessation (Acute) - Training		450	%	→			→			→			Quarterly Data			Quarterly Data					90	No variation				Any variation		2041			
COO	Smoking Cessation (Acute) - Delivery		450	%	→			→			→			→			87		→			131	▲	218		333	2000	=>167		per month	<167	● ●
RO	End of Life Care		450	%	→			→			→			Q1 Establish Baseline			72.0	Q1 Establish Baseline				72.0	Base +10%	Base +10%		=>20%		<20%				
RO	Medicines Management - Missed Doses		450	%	→			→			→			Q1 Establish Baseline			Q1 Establish Baseline					Base -10%	Base -10%	=>-10%			<-10%					
RO	Nutritional Assessment		450	%	→			→			→			Quarterly Data			Quarterly Data					75	=>75			<75						
COO	Enhanced Recovery		450	%	→			→			→			Quarterly Data			Quarterly Data															
COO	Stroke Discharge		225	%	→			→			→			Quarterly Data			Quarterly Data					90										
DOD	Mortality Review		225	%	→			→			→			→			15.3		→				15.3	15		60	No variation		Any variation		●	
DOD	Alcohol Screening		450	%	→			→			→			Quarterly Data			Quarterly Data					80										
RO	Community		Pt. (Community) Exp'ce - Personal Needs	90	Score	→			→			→			Composite of 6 Qs - Survey October			Composite of 6 Qs - Survey October					69.0	No variation			Any variation					
RO			End of Life Care	90	%	→			→			→			Q1 Establish Baseline			20.9	Q1 Establish Baseline				20.9	Base +10%		Base +10%	=>10%		<10%			
RO			Health Visiting	90	%	→			→			→			→			58.8		→				58.8		56	70	No variation		Any variation		●
RO			Falls Prevention	90	%	→			→			→			→			25.0		→				25.0		20.0	55.0	=>-30%		<-30%		●
RO			Smoking Cessation (Comm) - Training	120	%	→			→			→			→			29.1		→				29.1		0	80	No variation		Any variation		●
COO			Smoking Cessation (Comm) - Delivery	120	%	→			→			→			→			45.1		→				45.1		30	90	No variation		Any variation		●
COO	Specialised Commissioners	Access to Chemotherapy Out of Hospital	95	%	→			→			→			→			67		→			69	▲	69.0	50.0	50.0	=>50		<50		●	
RO		Improving Access to Organs for T'plant	32	%	→			→			→			Met			→			Met	Met			Meet 5 measures						●		
COO		Screening for Retinopathy of Prematurity	63	%	→			→			→			→			94		→				94.0	80	95	No variation		Any variation		●		
COO		Auditing Neonatal Pathways	63		→			→			→			→			Compliant	→				Compliant			Comply with audit				No variation		Any variation	

CLINICAL QUALITY				January	February	March	April			May			To Date (*=most recent month)	TARGET		Exec Summary Note	THRESHOLDS			10 / 11 Forward Projection	09/10 Outturn	10/11 Outturn		
				Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust	YTD	11/12										
RO	Infection Control	Savings Lives Compliance	%	99	▼	100	▲	100	■	→		100	■	→		100	>95	>95			99.0	100		
		MRSA Screening (Elective)	No.	3116	▲	2857	▼	3278	▲	Numerator = 2574	Denominator = 2400	2574	▼	Numerator = 2970	Denominator = 2160	2970	▲	5544	4560	30000		24710	33404	
		MRSA Screening (Non-Elective)	No.	1635	▼	1569	▼	1777	■	Numerator = 1713	Denominator = 2490	1713	■	Numerator = 1724	Denominator = 2520	1724	▼	3437	5010	30000		18571	23514	
DO'D	Obstetrics	Post Partum Haemorrhage (>2000 ml)	No.	1	▼	0	▲	2	▼	→		3	▼	→		0	▲	3	8	48		10	9	
		Admissions to Neonatal ICU	%	→		8.9	▼	7.2	▲	→		10.9	■	→				10.9	≡<10	≡<10		5.5	7.2	
		Adjusted Perinatal Mortality Rate	/1000	→		8.9	▼	6.5	■	→				→					<8.0	<8.0		10.9	6.5	
		Caesarean Section Rate	%	21.1	■	22.6	▼	23.7	▲	→		24.7	▼	→		23.9	▲	24.3	<25.0	<25.0		23.3	23.6	
RO	Infant Health & Inequalities	Maternal Smoking Rates	%	→		→		10.1	■	→		→		→		→			<11.5	<11.5		11.6	11.9	
		Breast Feeding Initiation Rates	%	→		→		70.0	▲	→		→		→		→			>63.0	>63.0		63.1	65.6	
COO	Hip Fractures	Operation <24 hours of admission	%	60.0	■	50.0	▼	88.9	■			68.7	■			87.5	■	75.0	70.0	70.0		55.0	64.7 (Q4)	
COO	Data Quality	Valid Coding for Ethnic Category (FCEs)	%	95	▲	95	■	95	■	→		95	■	→		95	■	95.0	90	90		95.5	94.5	
		Maternity HES	%	5.3	▲	5.7	▼	6.1	▼	→		5.7	▲	→		5.9	▲	5.7	<15	<15		5.8	5.4	
RO	Budgeted Posts (wte)	Wards <1.5 Trained to Untrained Staff	No.	→		→		→		→		→		→		11		11	No. Only	No. Only	j			
		Wards <1.0 Nurse per Bed	No.	→		→		→		→		→		→		11		11	No. Only	No. Only				
	Actual Posts (wte)	Wards <1.5 Trained to Untrained Staff	No.	→		→		→		→		→		→		8		8	No. Only	No. Only				
		Wards <1.0 Nurse per Bed	No.	→		→		→		→		→		→		6		6	No. Only	No. Only				
PATIENT EXPERIENCE																								
KD	Complaints	Active complaints in system	No.	→		→		→		→		→		→		333		333	No. Only	No. Only	k			
		First Formal Complaints received	No.	→		→		→		→		→		→		77		77	No. Only	No. Only				
		Linked Complaints received	No.	→		→		→		→		→		→		4		4	No. Only	No. Only				
		Responses to First Formal Complaints	No.	→		→		→		→		→		→		87		87	No. Only	No. Only				
		Responses to Linked Complaints	No.	→		→		→		→		→		→		14		14	No. Only	No. Only				
		Responses to First Formal & Linked Complaints	No.	→		→		→		→		→		→		101	■	101	≡>95	≡>95		≡>95 / month	80 - 94 / month	<80 / month
		First Formal Responses outstanding >75 days	No.	→		→		→		→		→		→		110	■	110	0	0		0		>0
		Above where first negotiated date > 75 days	No.	→		→		→		→		→		→					0	0		0		>0
COO	Elective Access Contact Centre	Number of Calls Received	No.	11052		9806		10827		→		8193		→		9935		18128	No. Only	No. Only				
		Average Length of Queue	mins	0.37	■	0.45	▼	0.21	▲	→		0.20	▲	→		0.15	▲	0.15*	<1.0	<1.0		<1.0	1.0-2.0	>2.0
		Maximum Length of Queue	mins	15.1	▲	33.2	▼	6.3	■	→		7.2	▼	→		11.2	▼	11.2*	<6.0	<6.0		<6.0	6.0-12.0	>12.0
	Telephone Exchange	Number of Calls Received	No.	77520		69366		78392		→		67599		→		72166		139765	No. Only	No. Only				
		Calls Answered	%	89.6		92.0		90.8		→		90.1		→		90.1		90.1	No. Only	No. Only				
		Answered within 15 seconds	%	49.9		59.1		54.3		→		54.1		→		50.6		52.2	No. Only	No. Only				
		Answered within 30 seconds	%	65.6		75.3		70.7		→		69.2		→		66.4		67.8	No. Only	No. Only				
		Average Ring Time	Secs	25.6		18.5		21.2		→		23.1		→		25.2		25.2*	No. Only	No. Only				
		Longest Ring Time	Secs	591		699		731		→		575		→		537		537*	No. Only	No. Only				
incomplete data																						1100521	909301	
																						83.6	90.5	
																						43.8	52.4	
																						58.8	68.4	
																						36.0	21.2	
																						646	731	
Page 3 of 8																								

QUALITY AND EFFICIENCY PROGRAMME				January	February	March	April			May			To Date ("=most recent month)	TARGET		Exec Summary Note	THRESHOLDS			10 / 11 Forward Projection	09/10 Outturn	10/11 Outturn	
				Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	11/12								
COO	Outpatient Improvement	New : Review Rate	Ratio	2.63 ▲	2.80 ▼	2.67 ▲	2.85 ▼	2.60 ▲	2.68 ▼	2.82 ▲	2.64 ▼	2.70 ▼	2.69	2.30	2.30		No Variation	0 - 5% Variation	>5% Variation		2.59	2.70	
		OP Cancs / Rescheduled - Trust Initiated	No.	15247	10749	12165	→		9110	→		9633	18743	No. Only	No. Only						134113		
		OP Cancs / Rescheduled - Trust Initiated	%	22.6	16.3	16.6	→		15.6 ■	→		14.0 ▲	14.0*	15.0	10.0		No variation		Any variation		16.6		
		OP Cancs (<14 days) - Trust initiated	No.	4850	3703	3552	→		2974	→		2972	5946	No. Only	No. Only						45833		
		OP Cancs (<14 days) - Trust initiated	%	31.8	34.5	29.2	→		32.6 ■	→		30.9 ▲	30.9*	33.0	20.0		No variation		Any variation		29.2		
		OP Cancs (>2 since last app't) - Trust initiated	No.	1399	905	1065	→		674 ■	→		516 ▲	516*	1000	700		No variation		Any variation		10938		
		DNA Rate - New Referrals	%	13.7 ▲	11.8 ■	12.2 ■	10.0 ■	12.3 ▲	11.5 ■	12.4 ■	13.5 ▼	13.0 ■	12.4	12.2	10.0		No variation		Any variation		13.5	13.1	
		DNA Rate - Reviews	%	13.3 ▼	10.2 ■	11.6 ▼	9.7 ■	11.0 ■	10.6 ■	10.6 ▼	11.7 ▼	11.3 ▼	11.1	12.2	10.0		No variation		Any variation		12.3	11.9	
		New OP seen within 6 weeks	%	68.8	76.1	78.9	→		76.8 ■	→		70.9 ■	70.9*	75.5	80.0		No variation		Any variation			78.9	
COO	Patient Flow Improvement	Average Length of Stay	Days	4.4 ▲	4.3 ▲	4.3 ■	5.5 ▼	4.0 ▼	4.6 ■				4.6	4.3	4.3		No Variation	0 - 5% Variation	>5% Variation		4.4	4.3	
		All Patients with LOS > 28 days	No.	187	187	194	102	88	190 ■	95	79	174 ▲	174*	186	150		No variation		Any variation		195	194	
		Readmissions Following initial EL Admission	%	2.7	2.8	2.4	→		2.8	→			2.8	No. Only	No. Only						2.8		
		Readmissions Following initial NEL Admission	%	12.7	11.1	12.0	→		11.3	→			11.3	No. Only	No. Only						13.6		
		4-hour waits	%	97.1 ■	97.8 ▲	95.1 ■	97.3 ▲	96.3 ▲	96.7 ▲	98.5 ▲	95.8 ▼	96.8 ▲	96.79	=>97	=>97		=>97		<97		98.55	96.99	
		Delayed Transfers of Care (Acute)	%	4.7 ■	5.0 ▼	5.6 ▼	4.7 ▲	4.7 ▲	4.7 ▲	3.3 ■	5.4 ▼	4.3 ▲	4.6	<4.0	<4.0		<4.0		>4.0		3.0	4.6	
		Occupancy Rate	%	87.0 ■	86.7 ■	87.8 ■	86.0 ■	82.0 ■	84.0 ■	84.4 ■	83.1 ▲	83.7 ▼	84.2	86.5-89.5	86.5-89.5		86.5 - 89.5	85.5-86.4 or 89.6-90.5	<85.5 or >90.5		86.0	86.6	
		Beds Open at month end (exc Obstetrics)	No.	926 ▲	918 ▲	929 ■	454	454	908 ■	430	459	889 ▲	889*	938	1028		No Variation	0 - 5% Variation	>5% Variation		989	929	
		Min. Stay Rate (Electives (IP/DC) <2 days)	%	93.8 ▲	92.5 ▼	93.2 ▲	94.5 ▼	91.8 ■	92.9 ▼	95.1 ▲	91.0 ▼	92.9 ▼	92.9	92.0	92.0		No Variation	0 - 5% Variation	>5% Variation		92.3	93.1	
JD	RCRH Demand Management / Decommissioning	Assessment Unit Admissions under ED Cons	£000s	→	→	→	→		Included elsewhere	→			Included elsewhere	-33	-339	I	=>90% Plan	70 - 89% Plan	<70% Plan				
		GP Ref. Pt's Admitted to Ass. Unit from ED	£000s	→	→	→	→		27 ■	→			27	-13	-152		=>90% Plan	70 - 89% Plan	<70% Plan				
		Emergency Admission Avoidance	£000s	→	→	→	→		-26 ■	→			-26	-71	-851		=>90% Plan	70 - 89% Plan	<70% Plan				
		ED Attendances avoidance	£000s	→	→	→	→		-83 ■	→			-83	-45	-545		=>90% Plan	70 - 89% Plan	<70% Plan				
		Long Stay patients - reduction in XS bed days	£000s	→	→	→	→		-337 ■	→			-337	-83	-1000		=>90% Plan	70 - 89% Plan	<70% Plan				
		OP Demand Management - Reduced OPN	£000s	→	→	→	→		-147 ■	→			-147	-251	-4358		=>90% Plan	70 - 89% Plan	<70% Plan				
		OP F/U Reduction (impact 10/11 targets)	£000s	→	→	→	→		99 ■	→			99	-401	-3152		=>90% Plan	70 - 89% Plan	<70% Plan				
		OP F/U Reduction (reduce FUN Rate to 2.4)	£000s	→	→	→	→		Included elsewhere	→			Included elsewhere	-152	-1824		=>90% Plan	70 - 89% Plan	<70% Plan				
		Jt Inj / Minor Skin Cases (impact 10/11 targets)	£000s	→	→	→	→		171 ■	→			171	-118	-1416		=>90% Plan	70 - 89% Plan	<70% Plan				
		Con:Con Ref Reduction (impact 10/11 targets)	£000s	→	→	→	→		Included elsewhere	→			Included elsewhere	-83	-1001		=>90% Plan	70 - 89% Plan	<70% Plan				
		Proc's of limited clin value (impact 10/11 targets)	£000s	→	→	→	→		-200 ■	→			-200	-155	-1855		=>90% Plan	70 - 89% Plan	<70% Plan				
		Other OP Schemes etc. (impact 10/11 targets)	£000s	→	→	→	→		30 ■	→			30	-79	-953		=>90% Plan	70 - 89% Plan	<70% Plan				
		Total	£000s	→	→	→	→		-466 ■	→			-466	-1346	-16167		=>90% Plan	70 - 89% Plan	<70% Plan				
RO	Effective Workforce Utilisation	Total Sickness Absence	%	4.73 ▲	4.23 ■	4.03 ▲	→		3.39 ■	→			3.39	<3.90	<3.50		<3.90	3.90-4.40	>4.40		4.41	4.17	
		Nurse Bank Shifts covered	No.	4569 ▼	4408 ▲	5405 ■	→		4811 ▲	→		4551 ■	9362	8980	46980		0 - 2.5% Variation	5.0% Variation	>5.0% Variation		61621	54952	
		Nurse Bank Costs	£000s	331 ▲	489 ▼	617 ■	→		615 ▼	→		465 ▲	1080	819	4286		0 - 2.5% Variation	5.0% Variation	>5.0% Variation		6263	5013	
		Nurse Agency Shifts covered	No.	590 ▼	305 ■	350 ▲	→		632 ■	→		653 ▼	1285	750	3820		0 - 5% Variation	5 - 10% Variation	>10% Variation		5388	4550	
		Nurse Agency Costs	£000s	110 ▼	116 ▼	45 ■	→		119 ■	→		170 ▼	289	144	733		0 - 5% Variation	5 - 10% Variation	>10% Variation		1268	873	
		Other Agency Costs	£000s	204 ▲	188 ▲	345 ▼	→		207 ■	→		190 ▲	397	395	2045		0 - 5% Variation	5 - 10% Variation	>10% Variation		2600	2362	
RO	High Impact Nursing Actions	Inpatient Falls reduction	%	→	→	→	→			→				Base - 10%	Base - 10%		=>-10%		<-10%			1024	
		Tissue Viability - Hosp Acq'd Grade 2/3/4	%	→	→	→	→		23 ■	→			23	26	317		=<26/m		>26/m			404	
		Nutritional Assessment (MUST)	%	→	→	→	Quarterly Data			Quarterly Data					75		=>75		<75				
		Fluid Balance Chart Completion	%	→	→	→	→			→					30		=>+30%		<+30%				
		End of Life Care	%	→	→	→	Q1 Establish Baseline			72.0	Q1 Establish Baseline			72.0	Base +10%		Base +10%	=>+20%			<+20%		
		Falls Prevention (Community)	%	→	→	→	→			25.0 ■	→				25.0		20.0	55.0	=>-30%			<-30%	

Exec Lead		FINANCE & FINANCIAL EFFICIENCY		January		February		March		April			May			To Date ("=most recent month)		TARGET		Exec Summary Note		THRESHOLDS						
				Trust		Trust		Trust		S'well	City	Trust	S'well	City	Trust			YTD	11/12									
RW	Net Income & Expenditure (Surplus / Deficit (-))		£000s	332	▼	222	▲	445	■	→		-235		▼	→		71	■	-113	183	1808		0%	0 - 1%	>1%			
	Gross Margin		£000s	2168	▼	1847	■	2114	■	→		1580		■	→		1872	■	3501	3809	23568		0%	0 - 1%	>1%			
	CIP		£000s	1771	▲	1766	■	1803	▲	→		1228		■	→						21447		0 - 2.5%	2.5 - 7.5%	>7.5%			
	In Year Monthly Run Rate		%	0.91	▼	8.29	▲	-26.2	■	→		-426		▼	→		9.23	■	-161	0	0		NO or a + variation	0 - 5% variation	>5% variation			
COO	Income / WTE		£s	5109	▲	5119	▲	5512	■	→		5018		■	→		5001	▼	5010	5127	5127	m	No variation	0 - 5% variation	>5% variation			
	Income / Open Bed		£s	34087	▲	34983	▲	37970	▲	→		34775		▼	→		35499	▲	35135	32697	32697		No variation	0 - 5% variation	>5% variation			
	Income per Spell	Total Income	£s	3043	▼	3301	▲	3193	▼	→		3380		▲	→		3246	▼	3339	2908	2908		No Variation	0 - 4% Variation	>4% Variation			
		Clinical Income	£s	2774	▼	2980	▲	2749	▼	→		3069		▲	→		2915	▼	2995	2580	2580		No Variation	0 - 4% Variation	>4% Variation			
		Non-Clinical Income	£s	269	■	321	■	444	■	→		311		■	→		331	■	344	328	328		No Variation	0 - 4% Variation	>4% Variation			
	Cost per Spell (* Excludes the cost of drugs which are recharged directly to PCTs)	Total Cost	£s	3008	▲	3275	▼	3779	▼	→		3452		▲	→		3275	▲	3355	2891	2891		No Variation	0 - 4% Variation	>4% Variation			
		Total Pay Cost	£s	2096	▲	2240	▼	2109	▲	→		2373		▼	→		2268	▲	2316	1909	1909		No Variation	0 - 4% Variation	>4% Variation			
		Medical Pay Cost	£s	587	▲	628	▼	560	■	→		663		■	→		625	▲	643	555	555		No Variation	0 - 4% Variation	>4% Variation			
		Nursing Pay Cost (including Bank)	£s	620	■	679	■	608	■	→		717		■	→		674	▲	694	660	660		No Variation	0 - 4% Variation	>4% Variation			
		Non-Pay Cost	£s	912	■	1035	■	1670	▼	→		1080		▲	→		1007	■	1039	982	982		No Variation	0 - 4% Variation	>4% Variation			
		Mean Drug Cost* / IP Spell	£s	142	▲	150	▼	139	▲	→		135		▲	→		159	■	156	124	124		No Variation	0 - 4% Variation	>4% Variation			
		Mean Drug Cost* / Occupied Bed Day	£s	52	■	58	■	53	▲	→		51		■	→		60	■	59	49	49		No Variation	0 - 4% Variation	>4% Variation			
STRATEGY																												
COO	Referrals	Total	No.	13852	▲	14147	▲	15782	▼	→		12906		■	→			12906	13045	182625		No Variation	0 - 2% Variation	>2% Variation				
		Total GP Referrals	No.	9465	▲	9932	■	10814	■	→		8688		■	→			8688	8861	124050		No Variation	0 - 2% Variation	>2% Variation				
		Total Other Referrals	No.	4387	▲	4215	▼	4968	▲	→		4218		■	→			4218	4184	58575		No Variation	0 - 2% Variation	>2% Variation				
		By PCT - Heart of B'ham	No.	3736	▲	3757	▲	4361	▲	→		3463		■	→			3463	3515	49208		No Variation	0 - 2% Variation	>2% Variation				
		By PCT - Sandwell	No.	7192	▲	7405	▲	8034	▼	→		6644		■	→			6644	6614	92600		No Variation	0 - 2% Variation	>2% Variation				
		By PCT - Other	No.	2924	▲	2985	▲	3387	▼	→		2799		▲	→			2799	2915	40817		No Variation	0 - 2% Variation	>2% Variation				
		Conversion (all referrals) to New OP Att'd	%	96.8		86.9		94.4		→		88.3			→			88.3	No. Only	No. Only								
ACTIVITY																												
COO	Spells	Elective IP	No.	913	▲	944	▼	1109	■	→		853		■	→		883	▲	1742	1868	11750	n	No Variation	0 - 2% Variation	>2% Variation			
		Elective DC	No.	4554	▲	4298	▼	4987	▲	→		3948		▼	→		4308	▲	8275	7375	46384		No Variation	0 - 2% Variation	>2% Variation			
		Total Elective	No.	5467	▲	5242	■	6096	▲	→		4801		▼	→		5191	▲	10017	9243	58134		No Variation	0 - 2% Variation	>2% Variation			
		Non-Elective - Short Stay	No.	1190	▲	1143	▼	1187	▲	→		1023		▼	→		1036	▲	2059	2247	13454		No Variation	0 - 2% Variation	>2% Variation			
		Non-Elective - Other	No.	3716	▼	3344	■	3763	■	→		3399		■	→		3495	▼	6894	7684	46013		No Variation	0 - 2% Variation	>2% Variation			
		Total Non-Elective	No.	4906	▲	4487	▼	4950	■	→		4422		■	→		4531	▲	8953	9931	59467		No Variation	0 - 2% Variation	>2% Variation			
	Outpatients	New	No.	13414	■	12290	■	14901	■	→		11402		■	→		13321	■	24953	23764	145833		No Variation	0 - 2% Variation	>2% Variation			
		Review	No.	35272	■	34437	▼	39733	▲	→		30876		▼	→		35975	▲	67245	60424	380023		No Variation	0 - 2% Variation	>2% Variation			
	A/E Attendances	Type I (Sandwell & City Main Units)	No.	14532	■	13293	■	15576	■	6060	■	7595	■	13655	■	6937	■	8693	▲	15630	■		30699	31211	175340	No Variation	0 - 2% Variation	>2% Variation
		Type II (BMEC)	No.	2889	■	2800	▲	3278	▲	→		2890		■	→		3508	■	3508	■	6677		6197	34815	No Variation	0 - 2% Variation	>2% Variation	
	Adult Community	Aggregation of 19 Individual Service Lines	No.	41723	■	41569	▼	44717	▲	→		37151		■	→			37151	39926	479112	No Variation		0 - 2% Variation	>2% Variation				
	Childrens Community	Aggregation of 4 Individual Service Lines	No.	11177	■	10985	▼	12953	▲	→		9551		▼	→			9551	9165	109980	No Variation		0 - 2% Variation	>2% Variation				

SWBTB (6/11) 129 (a)	
09/10 Outturn	10/11 Outturn
2279	2193
30436	23811
15075	21840
0.44	0.41
5058	5129
32697	34834
2908	3103
2580	2772
328	331
2891	3158
1909	2084
555	591
660	621
982	1074
124	138
49	54

13722	11748
52729	53959
66451	65707
18769	16460
47072	42540
65841	59000
164358	163493
425850	440812
190254	181494
34836	36756
	461797
	102773

Exec Lead		PATIENT ACCESS			January	February	March	April			May			To Date (*=most recent month)	TARGET		Exec Summary Note	THRESHOLDS										
					Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		S'well	City		Trust	YTD	11/12								
COO	Diagnostic Waits	Diagnostic Waits greater than 6 weeks	No.	32	▲	24	▲	15	▲	→	6	▲	→		6*	0	0		0		>0							
	Admissions	Day of Surgery (IP Elective Surgery)	%	90.6	▲	90.0	▼	91.0	▲	89.9	▼	89.2	▼	89.5	▼	93.9	▲		90.7	▲	92.0	▲	90.2	82.0	82.0	No Variation	0 - 5% Variation	>5% Variation
		Day of Surgery (IP Non-Elective Surgery)	%	72.4		75.8		74.2		68.6		72.1		71.2		68.2			75.7		73.5		73.1	No. Only	No. Only			
		With no Procedure (Elective Surgery)	%	7.9		8.4		7.6		8.9		5.9		6.9									6.9	No. Only	No. Only			
		Per Bed (Elective)	No.	5.43	■	5.60	■	7.16	■	4.25	■	5.72	■	4.99	■	4.92	▲	6.04	■	5.50	▲	5.24	5.90	5.90	No Variation	0 - 5% Variation	>5% Variation	
	Cardiology	Primary Angioplasty (<150 mins)	%	100	▲	100	■	82	▼	100	▲	100	■	100	▲							100	⇒80	⇒80	⇒80	75-79	<75	
		Rapid Access Chest Pain	%	100	■	100	■	100	■	100	■	100	■	100	■	100	■	100	■	100	■	101	⇒98	⇒98	⇒98	96 - 97.9	<96	
	Discharges	Pt's Social Care Delay	No.	28	■	22	▲	23	▼	9	■	7	■	16	■	9	■	19	■	28	■	28*	<18	<18	b	No Variation	0 - 10% Variation	>10% Variation
		Pt.'s NHS & NHS plus S.C. Delay	No.	15	■	19	▼	22	▼	8	▲	11	▲	19	▲	5	■	8	▲	13	▲	13*	<10	<10		No Variation	0 - 10% Variation	>10% Variation
	Day Case Rates	All Procedures	%	82.0	▲	81.2	▼	80.7	▼	85.1	▼	78.6	▲	81.3	▲	84.8	▼	79.3	▲	81.7	▲	81.6	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation
		BMEC Procedures	%	86.4	▲	80.9	▼	81.3	▲	→	85.4	▲	85.4	▲	→	89.7	▲	89.7	▲	89.7	▲	87.4	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation
	GUM 48 Hours	Patients seen within 48 hours	%	86.1	▲	77.7	■	79.3	▲	→	77.9	▼	→	80.4	■	79.3	⇒90	⇒90	⇒90	80-89	<80							
		Patients offered app't within 48 hrs	%	100	■	100	■	100	■	→	100	■	→	100	■	100	⇒98	⇒98	⇒98	95-98	<95							
	Ambulance Turnaround	In Excess of 30 minutes	%	27.2	▲	24.1	▲	27.0	▼	26.0	▲	28.2	▼	27.3	▼	27.1	▲	24.4	▼	25.9	▼	25.9*	<10.0	<10.0		<10	10 - 12.5	>12.5
		(West Midlands average)	%	32.1		30.2		27.7		→	29.8		→	29.8		29.8*	No. Only	No. Only										
		In Excess of 60 minutes	No.	78	▲	29	▲	54	▼	14	■	15	▲	29	▲	9	▼	28	▲	37	▲	37*	0	0		0	1 - 5	>5
THEATRE UTILISATION																												
COO	Sitrep Declared LateCancellations by Specialty	General Surgery	No.	5	■	1	▲	9	■	2		0	2	■	0	2		2	■	4		10	60	a	0-5% variation	5 - 15% variation	>15% variation	
		Urology	No.	22	▼	2	■	8	■	0		0	0	■	0	0		0	■	0		8	48		0-5% variation	5 - 15% variation	>15% variation	
		Vascular Surgery	No.	0	■	1	■	0	■	0		14	14	■	0	0		0	■	14		1	3		0-5% variation	5 - 15% variation	>15% variation	
		Trauma & Orthopaedics	No.	2	▲	0	▲	6	▼	0		1	1	▲	2	0		2	■	3		12	72		0-5% variation	5 - 15% variation	>15% variation	
		ENT	No.	1	■	2	■	1	■	0		0	0	▲	0	3		3	■	3		2	12		0-5% variation	5 - 15% variation	>15% variation	
		Ophthalmology	No.	14	■	12	■	7	■	0		6	6	▲	0	13		13	■	19		18	108		0-5% variation	5 - 15% variation	>15% variation	
		Oral Surgery	No.	1	■	1	■	4	■	0		0	0	■	0	0		0	■	0		2	8		0-5% variation	5 - 15% variation	>15% variation	
		Cardiology	No.	1	▼	0	▲	2	■	0		1	1	■	0	0		0	▲	1		4	21		0-5% variation	5 - 15% variation	>15% variation	
		Gynaecology / Gynae-Oncology	No.	4	■	6	■	11	▼	2		2	4	■	1	0		1	▲	5		9	54		0-5% variation	5 - 15% variation	>15% variation	
		Plastic Surgery	No.	0	▲	0	■	1	▼	0		1	1	■	0	0		0	▲	1		2	12		0-5% variation	5 - 15% variation	>15% variation	
		Dermatology	No.	0	■	0	■	0	■	0		0	0	■	0	0		0	■	0		4	24		0-5% variation	5 - 15% variation	>15% variation	
		TOTAL	No.	50	▼	25	■	49	■	4		25	29	■	3	18		21	▲	50		72	422		0-5% variation	5 - 15% variation	>15% variation	

SWBTB (6/11) 129 (a)	
09/10 Outturn	10/11 Outturn
3	15
85.5	88.7
69.7	73.4
9.7	8.2
5.49	8.20
86.2	90.7
99.7	100.0
	23
	22
79.4	81.5
79.7	82.2
86.8	84.5
99.8	100.0
23.9	27.0
25.5	27.7
46	54
81	67
48	93
8	8
66	55
23	18
139	138
24	14
7	16
63	69
11	9
27	13
497	500
Page 6 of 8	

Exec Lead		WORKFORCE				January	February	March	April			May			To Date ("=most recent month)	TARGET		Exec Summary Note	THRESHOLDS			09/10 Outturn	10/11 Outturn				
		Trust				Trust			S'well	City	Trust	S'well	City	Trust		YTD	11/12										
COO	WTE in Post	Total	No.	6178	▲	6274	▼	6400	▼	→	7002	■	→	7020	▲	7020	7175	7008		No Variation	0 - 1% Variation	>1% Variation	6539	6400			
		Medical and Dental	No.	746	▲	752	▼	746	▲	→	754	■	→	744	▲	744	810	788		No Variation	0 - 1% Variation	>1% Variation	825	746			
		M'ment, Admin. & HCAs	No.	2512	▲	2522	▼	2529	▼	→	2785	■	→	2757	▲	2757	2938	3041		No Variation	0 - 1% Variation	>1% Variation	2046	2529			
		Nursing & Midwifery (excluding Bank)	No.	1744	▲	1761	▼	1759	▲	→	2040	■	→	2035	▲	2035	2174	2014		No Variation	0 - 1% Variation	>1% Variation	2385	1759			
		Scientific and Technical	No.	984	▲	981	▲	975	▲	→	1164	■	→	1170	▼	1170	1254	1165		No Variation	0 - 1% Variation	>1% Variation	1002	975			
		Bank Staff	No.	192		258		391		→	259		→	314		314	No. Only	No. Only					281	391			
		Gross Salary Bill	£000s	21737	▼	21796	■	23299	■	→	23911	▲	→	24014	■	47924	47630	281533		No Variation	0 - 1% Variation	>1% Variation	252557	259889			
COO	Bank & Agency	Nurse Bank Fill Rate	%	82.0		86.9		86.2		→	85.8		→	86.1		86.0	No. Only	No. Only		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	85.1	86.2			
		Nurse Bank Shifts covered	No.	4569	▼	4408	▲	5405	■	→	4811	▲	→	4551	■	9362	8980	46980		0 - 5% Variation	5 - 10% Variation	>10% Variation	61621	54952			
		Nurse Agency Shifts covered	No.	590	▼	305	■	350	▲	→	632	■	→	653	▼	1285	750	3820		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	5388	4550			
		Nurse Bank AND Agency Shifts covered	No.	5159	▼	4713	▼	5755	■	→	5443	■	→	5204	▲	10647	9730	50800		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	67009	59502			
		Nurse Bank Costs	£000s	331	▲	489	▼	617	■	→	615	▼	→	465	▲	1080	819	4286		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	6263	5013			
		Nurse Agency Costs	£000s	110	▼	116	▼	45	■	→	119	■	→	170	▼	289	144	733		0 - 5% Variation	5 - 10% Variation	>10% Variation	1268	873			
		Medical Agency Costs	£000s	269	▼	294	▼	399	▼	→	372	▲	→	422	▼	794	199	1192		0 - 5% Variation	5 - 10% Variation	>10% Variation	2384	2709			
KD	Bank & Agency	Medical Locum Costs	£000s	231	▼	194	■	257	■	→	260	▼	→	251	▲	511	375	2250	0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	2896	2509				
		Med Ag./Loc Costs as % Total Med Costs	%	7.9		7.6		9.9		→	9.7		→	9.7		9.7	No. Only	No. Only				7.0	7.6				
		Med Staff Exp variance from Budget	%	4.4	▼	4.8	▼	6.4	▼	→	5.1	▲	→	1.1	▲	3.06	0	0	No Variation	0 - 1% Variation	>1% Variation	3.24	4.02				
		Other Agency Costs	£000s	204	▲	188	▲	345	▼	→	207	■	→	190	▲	397	395	2045	0 - 5% Variation	5 - 10% Variation	>10% Variation	2600	2362				
COO		Agency Spend cf. Total Pay Spend	%	2.49	▲	2.74	▼	3.59	▼	→	2.92	▼	→	3.26	▼	3.09	<2.00	<2.00	<2	2 - 2.5	>2.5	2.47	2.60				
RO	Recruitment & Retention	Permission to Recruit	wte	62		40		109		→	29		→	63		92	No. Only	No. Only		⇒>80	50 - 79	<50		97			
		New Starters	wte	47		81		59		→	84		→	37		121	No. Only	No. Only							1017	962	
		Leavers	wte	48		73		68		→	54		→	61		115	No. Only	No. Only							928	959	
		Corporate Inductions	%	96	▲	96	■	86	▼	→	90	▲	→			90	100	100									
KEY TO PERFORMANCE ASSESSMENT SYMBOLS																						KEY TO FORWARD PROJECTION ASSESSMENT					
▲	Fully Met - Performance continues to improve																					●	Maintain (at least), existing performance to meet target				
■	Fully Met - Performance Maintained																					●	Improvement in performance required to meet target				
▼	Met, but performance has deteriorated																					● ●	Moderate Improvement in performance required to meet target				
▲	Not quite met - performance has improved																					● ● ●	Significant Improvement in performance required to meet target				
■	Not quite met																										
▼	Not quite met - performance has deteriorated																										
▲	Not met - performance has improved																										
■	Not met - performance showing no sign of improvement																										
▼	Not met - performance shows further deterioration																										
KEY TO WHICH INDICATORS COMPRISE THE PERFORMANCE ASSESSMENT FRAMEWORKS																											
ALL	Features in NHS Performance Framework, Monitor Compliance Framework and SHA Performance Framework																										
B	Features in BOTH NHS Performance Framework and SHA Performance Framework																										
S	Features in SHA Performance Framework ONLY																										
N	Features in NHS Performance F'work ONLY																										

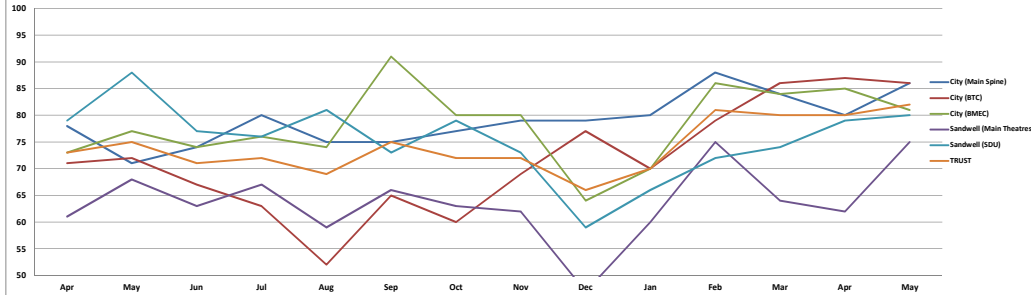
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SUPPLEMENTARY DATA THEATRE UTILISATION

PROMPT STARTS (%)	2010 / 2011												2011 / 2012				
Theatre Location	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
City (Main Spine)	78	71	74	80	75	75	77	79	79	80	88	84	80	86			
City (BTC)	71	72	67	63	52	65	60	69	77	70	79	86	87	86			
City (BMEC)	73	77	74	76	74	91	80	80	64	70	86	84	85	81			
Sandwell (Main Theatres)	61	68	63	67	59	66	63	62	47	60	75	64	62	75			
Sandwell (SDU)	79	88	77	76	81	73	79	73	59	66	72	74	79	80			
TRUST	73	75	71	72	69	75	72	72	66	70	81	80	80	82			

KEY: GREEN = <5.1% deviation from target, AMBER = 5.1 - 15.0% deviation, RED = >15.0% deviation (TARGET 85% by March 2012)

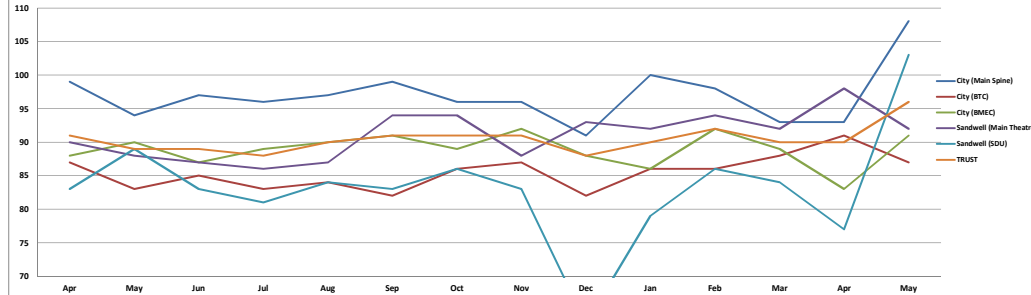
Lists Starting on Time (<15 mins late) (%)



SESSION UTILISATION (%)	2010 / 2011												2011 / 2012				
Theatre Location	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
City (Main Spine)	99	94	97	96	97	99	96	96	91	100	98	93	93	108			
City (BTC)	87	83	85	83	84	82	86	87	82	86	86	88	91	87			
City (BMEC)	88	90	87	89	90	91	89	92	88	86	92	89	83	91			
Sandwell (Main Theatres)	90	88	87	86	87	94	94	88	93	92	94	92	98	92			
Sandwell (SDU)	83	89	83	81	84	83	86	83	63	79	86	84	77	103			
TRUST	91	89	89	88	90	91	91	91	88	90	92	90	90	96			

KEY: GREEN = <5.1% deviation from target, AMBER = 5.1 - 15.0% deviation, RED = >15.0% deviation

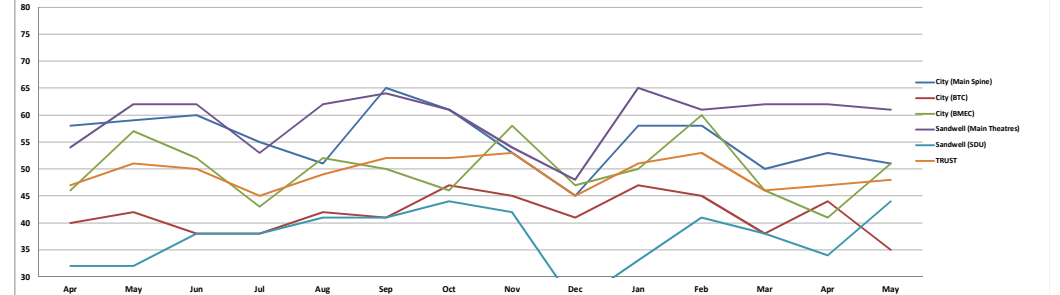
Session Utilisation (%)



ON TIME FINISHES (%)	2010 / 2011												2011 / 2012				
Theatre Location	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
City (Main Spine)	58	59	60	55	51	65	61	53	45	58	58	50	53	51			
City (BTC)	40	42	38	38	42	41	47	45	41	47	45	38	44	35			
City (BMEC)	46	57	52	43	52	50	46	58	47	50	60	46	41	51			
Sandwell (Main Theatres)	54	62	62	53	62	64	61	54	48	65	61	62	62	61			
Sandwell (SDU)	32	32	38	38	41	41	44	42	25	33	41	38	34	44			
TRUST	47	51	50	45	49	52	52	53	45	51	53	46	47	48			

KEY: GREEN = <5.1% deviation from target, AMBER = 5.1 - 15.0% deviation, RED = >15.0% deviation (TARGET 70% by March 2012)

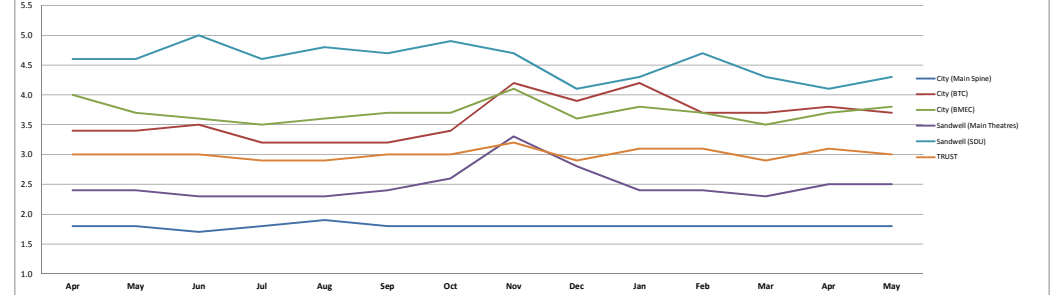
Lists Finishing on Time (<15 mins early) (%)



THROUGHPUT / SESSION	2010 / 2011												2011 / 2012				
Theatre Location	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
City (Main Spine)	1.8	1.8	1.7	1.8	1.9	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8			
City (BTC)	3.4	3.4	3.5	3.2	3.2	3.2	3.4	4.2	3.9	4.2	3.7	3.7	3.8	3.7			
City (BMEC)	4.0	3.7	3.6	3.5	3.6	3.7	3.7	4.1	3.6	3.8	3.7	3.5	3.7	3.8			
Sandwell (Main Theatres)	2.4	2.4	2.3	2.3	2.3	2.4	2.6	3.3	2.8	2.4	2.4	2.3	2.5	2.5			
Sandwell (SDU)	4.6	4.6	5.0	4.6	4.8	4.7	4.9	4.7	4.1	4.3	4.7	4.3	4.1	4.3			
TRUST	3.0	3.0	3.0	2.9	2.9	3.0	3.0	3.2	2.9	3.1	3.1	2.9	3.1	3.0			

KEY: GREEN = <5.1% deviation from target, AMBER = 5.1 - 15.0% deviation, RED = >15.0% deviation (TRUST TARGET 3.5 cases / session by March 2012)

Patient Throughput per Session



Sandwell and West Birmingham Hospitals



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:	30 June 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 (May):

There is 1 area of underperformance during the month of May; Delayed Transfers of Care.

The overall weighted score for the month of May is calculated as 2.92 with the Trust classified as Performing.

Financial Performance (May):

The weighted overall score is 2.65 and is classified as Performing. Underperformance is indicated April in 5 areas; Year to Date Operating Performance, Better Payment Practice Code (Value), Better Payment Practice Code (Volume), Current Ratio and Creditor Days.

Foundation Trust Compliance (May) Summary report:

There were no areas of underperformance reported during the month of May 2011. Performance in areas where no data are currently available for the month are expected to meet operational performance thresholds. The projected overall score for the month is 0.0, the overall Governance Rating is GREEN

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

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Accessible and Responsive Care, High Quality Care and Good Use of Resources
Annual priorities	National targets and Infection Control
NHS LA standards	
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 21 June 2011 Finance and Performance Management Committee on 23 June 2011.

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

Operational Standards and Targets

Indicator	Weight	Thresholds	
		Performing	Underperforming
A/E Waits less than 4-hours	1.00	95.00%	94.00%
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%
MRSA Bacteraemia	1.00	0	>1.0SD
Clostridium Difficile	1.00	0	>1.0SD
18-weeks RTT Admitted 95 Percentile(weeks)	0.50	≤23.0	>27.7
18-weeks RTT Non Admitted 95 Percentile(weeks)	0.50	≤18.3	>18.3
18-weeks RTT Incomplete Pathway 95 percentile (weeks)	0.50	≤28.0	>36.0
18-weeks RTT 90% Admitted	0.75	⇒90.0%	85.0%
18-weeks RTT 95% Non -Admitted	0.75	⇒95.0%	90.0%
Cancer - 2 week GP Referral to 1st OP Appointment	0.50	93.0%	88.0%
Cancer - 2 week GP Referral to 1st OP Appointment - breast symptoms	0.50	93.0%	88.0%
Cancer - 31 day diagnosis to treatment for all cancers	0.25	96.0%	91.0%
Cancer - 31 day second or subsequent treatment (surgery)	0.25	94.0%	89.0%
Cancer - 31 day second or subsequent treatment (drug)	0.25	98.0%	93.0%
Cancer - 31 Day second/subsequent treat (radiotherapy)	0.25	94.0%	89.0%
Cancer - 62 day urgent referral to treatment for all cancers	0.33	85.0%	80.0%
Cancer - 62 day referral to treatment from screening	0.33	90.0%	85.0%
Cancer - 62 day referral to treatment from hospital specialist	0.33	85.0%	80.0%
Stroke (Stay on Stroke Unit)	1.00	80.0%	60.0%
Delayed Transfers of Care	1.00	3.5%	5.0%

Sum

14.00

Average Score

April 2011	Score	Weight x Score	May 2011	Score	Weight x Score
96.70%	3	3.00	96.80%	3	3.00
0%	3	3.00	0%	3	3.00
0	3	3.00	0	3	3.00
3	3	3.00	9	3	3.00
19	3	1.50	≤23.0*	3	1.50
14	3	1.50	≤18.3*	3	1.50
15	3	1.50	≤28.0*	3	1.50
94.60%	3	2.25	⇒90.0%*	3	2.25
97.60%	3	2.25	⇒95.0%*	3	2.25
95.7%	3	1.50	>93.0%*	3	1.50
94.2%	3	1.50	>93.0%*	3	1.50
100.0%	3	0.75	>96.0%*	3	0.75
100.0%	3	0.75	>94.0%*	3	0.75
100.0%	3	0.75	>98.0%*	3	0.75
no pts		n/a	>94.0%*	3	0.75
85.8%	3	1.00	>85.0%*	3	1.00
98.0%	3	1.00	>90.0%*	3	1.00
100.0%	3	1.00	>85.0%*	3	1.00
82.90%	3	3.00	89.70%	3	3.00
4.70%	2	2.00	4.30%	2	2.00
		34.25			35.00
		2.91	* projected		2.92

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				SCORING			2011 / 2012			2011 / 2012		
Criteria	Metric	Weight (%)		3	2	1	April	Score	Weight x Score	May	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
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
	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
Forecast Outturn	Forecast Operating Performance	40	20	Forecast operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of income.	Operating deficit more than or equal to 2% of income	0.00	3	0.6	0.00	3	0.6
	Forecast EBITDA		5	Forecast EBITDA equal to or greater than 5% of forecast income.	Forecast EBITDA equal to or greater than 1% but less than 5% of forecast income.	Forecast EBITDA less than 1% of forecast income.	5.71%	3	0.15	5.70%	3	0.15
	Rate of Change in Forecast Surplus or Deficit		15	Still forecasting an operating surplus with a movement equal to or less than 3% of forecast income	Forecasting an operating deficit with a movement less than 2% of forecast income OR an operating surplus movement more than 3% of income.	Forecasting an operating deficit with a movement of greater than 2% of forecast income.	0.00%	3	0.45	0.00%	3	0.45
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
	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
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
	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
	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
	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
	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

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

Weighted Overall Score

2.60

2.65

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

MINUTES

FT Programme Board – Version 0.2

Venue Executive Meeting Room, City Hospital

Date 26 May 2011

Present:

Mrs Sue Davis	[Chair]	Mr Robert White
Mr Roger Trotman		Miss Rachel Overfield
Dr Sarindar Sahota		Mr Donal O'Donoghue
Mrs Olwen Dutton		Miss Kam Dhami
Mr Gary Clarke		Mr Graham Seager
Mr John Adler		Mrs Jessamy Kinghorn
Mr Mike Sharon		

Secretariat: Mr Simon Grainger-Payne

Minutes	Paper Reference
1 Apologies for absence	Verbal
Apologies were received from Mrs Gianjeet Hunjan and Miss Neetu Sharma.	
2 Minutes of the previous meeting	SWBFT (4/11) 018
The minutes of the previous meeting were accepted as a true and accurate record of the discussions held on 28 April 2011.	
AGREEMENT: The minutes of the previous meeting were approved.	
3 Update on actions arising from previous meetings	SWBFT (4/11) 018 (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 (5/11) 020 SWBFT (5/11) 020 (a)
Mr Sharon advised that the FT programme Critical Path had been amended slightly in accordance with changes to the Tripartite Formal Agreement. The changes were highlighted to reflect that it was likely that a period of public engagement would be undertaken, as opposed to a formal consultation, although this would be confirmed following a meeting planned with the Overview and Scrutiny Committee managers. It was reported that the meeting with the Overview and Scrutiny Committee managers would also be used to outline	

MINUTES

<p>proposed future reconfiguration plans and the suggested amendments to the composition of the Council of Governors. The proposed name of the Trust, following Authorisation as a Foundation Trust would also be discussed.</p> <p>The Board was advised that a Board to Board meeting with the Strategic Health Authority is likely to be held at the end of September 2011, which would be a more formal event if public consultation is required.</p> <p>A further change to the FT Programme Critical Path was noted to concern the conclusion of the estates strategy work in November 2011. The second draft of the Integrated Business Plan (IBP) was highlighted to be required by February 2012. Mrs Davis asked how the estates strategy work related to the PCT estate associated with community services. Mr Seager advised that no work had been undertaken in respect of the PCT estate to date, however this would form part of the overall estates strategy. Dr Sahota asked what measures would be needed should the PCT estate require significant investment. Mr Sharon advised that this consideration had been taken into account as part of the TCS Due Diligence work and it has been agreed that the buildings would be rationalised or made fit for purpose where needed.</p> <p>The Board was advised that the FT application would be likely to be submitted to the Department of Health in June 2012, although this might change should a need for formal consultation be identified.</p> <p>Mr Adler advised that in terms of the Outline Business Case for the Midland Metropolitan Hospital, approval was still awaited, pending resolution of the position concerning the Deed of Safeguard. The Board was advised that consultation or engagement would not commence prior to approval of the Outline Business Case.</p>	
<p>5 FT workstream high level milestone plan</p>	<p>SWBFT (5/11) 021 SWBFT (5/11) 021 (a)</p>
<p>Mr Sharon presented the high level milestone plans for the FT Programme.</p> <p>It was highlighted that the first draft of the IBP needed to be completed in time for the FT Programme Board on 30 June 2011, meaning that all workstream leads needed to submit their relevant chapters of the IBP to Mr Sharon by 17 June 2011.</p> <p>It was agreed that further consideration needed to be given to the means by which slippage or rescheduling of an activity was represented on the plan.</p>	
<p>ACTION: Mr Sharon to consider further the means by which slippage or rescheduling of an activity is represented on the milestone plan</p>	
<p>6 Update on external support for the FT application</p>	<p>Verbal</p>

MINUTES

<p>Mr Sharon advised that Deloitte had prepared a proposal for the various elements of the Board Development work that was planned. The Board was informed that a questionnaire would be issued to 1000 staff as part of these plans and a number of focus groups would also be arranged. An external stakeholder survey was reported to be being planned. The Board was advised that a 360 degree feedback tool would be issued to Board members for completion.</p> <p>Mr Sharon asked the Board whether it was satisfied with the planned work, which it confirmed was the case.</p> <p>Mrs Dutton remarked that traditionally, response rates to questionnaires and surveys is poor and suggested that consideration be given to the use of incentives for completion. It was suggested that further consideration also needed to be given to the means by which staff who do not have access to e-mail are able to participate in the surveys. It was agreed that to make the results of the surveys meaningful, benchmarking information would be needed, which it was suggested may be available from the Foundation Trust Network.</p>	
<p>7 Tripartite Formal Agreement</p>	<p>Verbal</p>
<p>It was agreed that the changes to the Tripartite Formal Agreement had been discussed in sufficient detail as part of the item concerning the FT Programme Critical path.</p>	
<p>8 Initial Programme risk register</p>	<p>SWBFT (5/11) 022 SWBFT (5/11) 022 (a)</p>
<p>Mr Sharon presented the FT Programme risk register, which he reported had been updated with risks identified as part of the 'Time Out' session held on 1 April 2011 and by the workstream leads.</p> <p>It was agreed that a link with the Trust Risk Register should be made where possible.</p>	
<p>9 Update on actions and agreements from the Trust Board 'Time Out' – 1 April 2011</p>	<p>SWBFT (5/11) 025 SWBFT (5/11) 025 (a)</p>
<p>Mr Sharon presented the updated actions list from the Trust Board 'Time Out' on 1 April 2011. It was noted that the log had been expanded to reflect the agreement that had been reached on the Trust name and to capture the discussions concerning the composition of the Council of Governors. It was noted that at the time it had been assumed that the PCTs did not need to be represented by stakeholder governors, however subsequent advice indicated that these needed to be included within the Council of Governors, until such time as the legislation abolishing PCTs is formally included in statute. To accommodate this requirement without increasing the overall number of governors, it was agreed that the number of staff governors could be reduced to eleven if needed.</p>	

MINUTES

10 Matters for information	SWBFT (5/11) 023 SWBFT (5/11) 024
The Board received and noted the minutes from the meeting of the Monitor Board held in March 2011 and Monitor's FT bulletin published in April 2011.	
11 IBP SWOT analysis and response	Presentation
An interactive session was held, whereby members of the Board were invited to update the section of the IBP concerning the Trust's Strengths, Weaknesses, Opportunities and Threats. The output of the exercise is contained within the appendix to these minutes.	
11 Any other business	Verbal
Mrs Davis advised that at a recent Foundation Trust Network event, there had been some discussion as to whether aspirant FT members should have their membership withdrawn when the FTN launches as an independent organisation on 21 June 2011. It was agreed that should the Trust's membership be withdrawn, then consideration should be given as to which other networks could be joined or formed.	
12 Details of next meeting	Verbal
The next FT Programme Board meeting will be held on 30 June 2011 at 1300h in the Boardroom at Sandwell Hospital.	

Signed

Print.....

Date

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:	30 June 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 May 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
JUNE 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 May 2011.

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

Monitoring continues of the level of activity continuing to be provided in community settings for those services redesigned through former pilot projects. For the period April 2010 to the end of February 2011, overall the levels of community activity continue to be in excess of levels reported for the same period last year, with the exception of, ENT (-28%), Gynaecology (-54%), Dermatology (-11%) and Ophthalmology (-14%) where community activity is below last year's level at the same rate and for the same reasons as reported in previous months. For ENT, Ophthalmology and Gynaecology this position is expected to show an improvement as a result of a review of clinic codes, start of Ophthalmology clinics at Rowley Regis Hospital and the Gynaecology community clinics although these clinics will take several months to reach full capacity.

Monitoring of performance has also continues for the current service redesign workstreams within the RCRH Programme.

- Emergency and Urgent Care - Emergency Department (ED) and Urgent Care activity for the first 11 months of the year compared to the same period last year shows that the level of demand for urgent and emergency care combined continues to be greater compared to the same period last year. This includes SWBH ED attendances being lower than the same period last year and in line with the plan in the Activity and Capacity Model. The level of urgent care centre attendances are 75% higher than for the same period last year.
- Outpatient Work – Comparison between 09/10 outpatient activity and this year shows that for the first 11 months of this year the level of activity in the community has increased (36% above the level achieved for the same period last year) but the level of outpatients being delivered by SWBH in the hospital continues to be above the trajectory for 2010/11 as a result of increases in outpatient referrals and follow ups.
- Intermediate Care – Whilst comparison with the first 11 months of the year compared to the same period last year shows that the level of occupied bed days in the acute hospital are lower than the trajectory for 2010/11 they are still significantly higher than those in the trajectory for 2016/17. An analysis has been undertaken of actual average length of stay (AvLOS) performance to modelled length of stay for the current year and the 16/17 trajectory for key specialties identified as having the greatest proportion of beds being utilised by patients requiring intermediate care. This shows that AvLOS for General Surgery and Trauma & Orthopaedics is below that modelled for both the current year and 16/17, indicating the need for this level of performance to be maintained. Whereas General/Geriatric Medicine, Rehabilitation and Vascular Surgery need to achieve reductions in AvLOS to achieve 10/11 modelled levels, with much greater reductions required to deliver the modelled position for 16/17. The level of activity in 'community bed alternative' services is higher than last year.

CARE PATHWAY AND SPECIALITY REVIEWS

Care Pathway reviews continue along with work on the approach for approving, publishing and implementing reviewed care pathways. The Pain Management pathway was presented and approved at this month's RCRH Clinical Group.

The Speciality Review work for Rheumatology continues with the aim of completing the review by mid summer.

DECOMMISSIONING AND RISK SHARING AGREEMENT

The Divisions continue to develop detailed plans for schemes included in the LDP decommissioning agreement. The aim is to have these plans confirmed by the end of June for discussion and agreement with PCTs in July. Progress against the Decommissioning plan will be set out in future reports.

PROGRAMME GOVERNANCE

The Programme Director has produced a paper proposing revised governance arrangements intended to streamline decision making processes and tie decision making within the programme more closely to annual contracting decisions and performance management. This paper will be discussed by the Partnership Board in July

RCRH DEVELOPMENTAL WORK: SUPPORTED SELF CARE, WIDENING PARTICIPATION AND TELE-HEALTH CARE

The RCRH Programme is developing its approach to these important areas of work through hosting events in May and June to develop a local health and social care economy view on how to proceed in each area. Trust representatives including senior clinicians are involved in all of the events.

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
21st June 2011

TFA document 16.05.11



**Supporting all NHS Trusts to achieve NHS Foundation
Trust status by April 2014**

Tripartite Formal Agreement between:

- Sandwell and West Birmingham Hospitals NHS Trust
- NHS West Midlands
- Department of Health

Introduction

This tripartite formal agreement (TFA) confirms the commitments being made by the NHS Trust, their Strategic Health Authority (SHA) and the Department of Health (DH) that will enable achievement of NHS Foundation Trust (FT) status before April 2014.

Specifically the TFA confirms the date (Part 1 of the agreement) when the NHS Trust will submit their “FT ready” application to DH to begin their formal assessment towards achievement of FT status.

The organisations signing up to this agreement are confirming their commitment to the actions required by signing in part 2a. The signatories for each organisation are as follows:

NHS Trust – John Adler, Chief Executive Officer
SHA – Ian Cumming, Chief Executive Officer
DH – Ian Dalton, Managing Director of Provider Development

Prior to signing, NHS Trust CEOs should have discussed the proposed application date with their Board to confirm support.

In addition the lead commissioner for the Trust will sign to agree support of the process and timescales set out in the agreement.

The information provided in this agreement does not replace the SHA assurance processes that underpin the development of FT applicants. The

agreed actions of all SHAs will be taken over by the National Health Service Trust Development Authority (NTDA)¹ when that takes over the SHA provider development functions on 1 April 2012.

The objective of the TFA is to identify the key strategic and operational issues facing each NHS Trust (Part 4) and the actions required at local, regional and national level to address these (Parts 5, 6 and 7).

Part 8 of the agreement covers the key milestones that will need to be achieved to enable the FT application to be submitted to the date set out in part 1 of the agreement.

Standards required to achieve FT status

The establishment of a TFA for each NHS Trust does not change, or reduce in any way, the requirements needed to achieve FT status.

That is, the same exacting standards around quality of services, governance and finance will continue to need to be met, at all stages of the process, to achieve FT status. The purpose of the TFA for each NHS Trust is to provide clarity and focus on the issues to be addressed to meet the standards required to achieve FT status. The TFA should align with the local QIPP agenda.

Alongside development activities being undertaken to take forward each NHS Trust to FT status by April 2014, the quality of services will be further strengthened. Achieving FT status and delivering quality services are mutually supportive. The Department of Health is improving its assessment of quality. Monitor has also been reviewing its measurement of quality in their assessment and governance risk ratings. To remove any focus from quality healthcare provision in this interim period would completely undermine the wider objectives of all NHS Trusts achieving FT status, to establish autonomous and sustainable providers best equipped and enabled to provide the best quality services for patients.

¹ NTDA previously known as the Provider Development Authority – the name change is proposed to better reflect their role with NHS Trusts only.

Part 1 - Date when NHS foundation trust application will be submitted to Department of Health


1st June 2012

Part 2a - Signatories to agreements

By signing this agreement the following signatories are formally confirming:

- their agreement with the issues identified;
- their agreement with the actions and milestones detailed to support achievement of the date identified in part 1;
- their agreement with the obligations they, and the other signatories, are committing to;

as covered in this agreement.


John Adler Chief Executive Sandwell and West Birmingham Hospitals NHS Trust	 Date: 25 May 2011
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Ian Cumming OBE Chief Executive NHS West Midlands	Signature  Date: 31/03/2011
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Name, Job Title (Ian Dalton)	Signature Date:
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Part 2b – Commissioner agreement

In signing, the lead commissioner for the Trust is agreeing to support the process and timescales set out in the agreement.

Robert Bacon Chief Executive Black Country Cluster	Signature  Date:
-------------------------------------------------------	------------------------------------------------------------------------------------------------------------

Part 3 – NHS Trust summary**Short summary of services provided, geographical/demographical information, main commissioners and organisation history.****Current CQC registration (and any conditions):**Unconditional**Financial data (figures for 2010/11 should to be based on latest forecast)**

	2009/10 £000	2010/11 £000
Total income	384,774	383,816
EBITDA	30,876	23,480
Operating surplus\deficit	(28,646)	(3,237)
Performance Against DoH target	7,260	2,038
CIP target	15,075	20,840
CIP achieved recurrent	13,564	20,797 [#]
CIP achieved non-recurrent	1,511	43

[#] Recurrent full year effect reported in-year mitigating schemes account for 25%

Note: reported operating surplus/deficit includes the impact of impairments and IFRS accounting which are excluded from the measurement of performance against the DH target.

The NHS Trust's main commissioners

	2009/10 £000	2010/11 £000
Sandwell PCT	157,658	162,574
Of which 'Right Care Right Here' Programme Transitional Framework Funding (via Sandwell PCT)		9,000
Heart of Birmingham PCT	88,859	86,454
Birmingham East & North PCT	21,145	20,933
South Birmingham PCT	17,569	17,723

Summary of PFI schemes (if material)

The Trust has submitted an OBC with a capital value of £370m for the construction of a single hospital site to deliver the majority of the Trust's acute services. The OBC assumes a bed reduction from around 950 acute beds to 666. The Trust has recently completed a submission to inform HM Treasury's economic evaluation of the scheme and the OBC is now awaiting final DH/HMT approval.

Further Information

Sandwell and West Birmingham Hospitals NHS Trust (SWBH) is one of the largest teaching Trusts in the United Kingdom with a reputation for excellent, friendly staff who provide high quality care from City Hospital in Birmingham and Sandwell General in West Bromwich. Both are busy acute hospitals providing many specialist services and a broad range of emergency services, including Accident & Emergency at both sites. In addition, from April 2011, the Trust provides comprehensive community services to the Sandwell area, including from Rowley Regis Community Hospital, Leasowes Intermediate Care Centre and the Lyng Centre for Health and Social Care.

The Trust has an income of £415m (2011/12) and employs around 7000 WTE staff. It has circa 950 beds and serves a population of over 500,000

The Trust is a key partner along with local PCTs, GPs and local authorities in the “Right Care Right Here” programme which seeks to deliver an ambitious redevelopment of local health services. This has the backing of the West Midlands Strategic Health Authority and has been approved as a national priority scheme by the Department of Health. The programme includes major investment in new facilities including a new acute hospital.

The Trust’s current strategy focuses on the period leading up to the new hospital with an emphasis on driving clinical integration by reconfiguration of services between the existing sites, strengthening key specialties and on quality and productivity improvement. Successful reconfigurations have included paediatrics, maternity, neonatology, general surgery, trauma and orthopaedics and pathology.

The Trust is a pioneer in developing new and more effective approaches to staff engagement through its “Listening into Action” programme which harnesses the energy and ideas of front line staff to improve services. This is the largest programme of its kind in the NHS and has received widespread national recognition.

The Trust hosts the Birmingham and Midland Eye Centre which is a supra-regional specialist facility, as well as the Pan-Birmingham Gynaecological Oncology Centre, Birmingham Skin Centre, Sickle Cell and Thalassaemia Centre and regional base of the National Poisons Information Service.

Aside from being one of the largest providers of patient services in the Midlands, the Trust also has a substantial teaching and research agenda with several academic departments including rheumatology, ophthalmology, cardiology, gynaecological oncology and neurology.

Part 4 – Key issues to be addressed by NHS trust

Key issues affecting NHS Trust achieving FT	
Strategic and local health economy issues Service reconfigurations Site reconfigurations and closures Integration of community services Not clinically or financially viable in current form Local health economy sustainability issues Contracting arrangements	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>
Financial Current financial Position Level of efficiencies PFI plans and affordability Other Capital Plans and Estate issues Loan Debt Working Capital and Liquidity	<input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Quality and Performance QIPP Quality and clinical governance issues Service performance issues	<input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>
Governance and Leadership Board capacity and capability, and non-executive support	<input type="checkbox"/>
Please provide any further relevant local information in relation to the key issues to be addressed by the NHS Trust:	
<p>Contracting Arrangements</p> <p>The health economy has agreed a medium term Transitional Funding programme as part of the implementation of the Right Care Right Here Programme. This amounts to some £65m in total and is £10m in 2011/12. Our plans require transitional funding to continue until opening of new hospital in 2016/17.</p> <p>PFI plans</p> <p>OBC approval by DH and HM Treasury is currently awaited. Public engagement cannot commence until final approval of the OBC has been received as it is central to the Trust's strategy.</p> <p>Successful procurement of a PFI partner also requires a Deed of Safeguard (DoS) or equivalent guarantee.</p> <p>In order to achieve compliance with Monitor Financial Risk Ratings, the Trust will require the same dispensation relating to the Prudential Borrowing Code as was previously granted to existing FTs with large PFI schemes.</p> <p>A national financial review of Trusts with a PFI hospital is taking place to gain a common understanding of any issues that might be an obstacle to passing the financial elements of the FT assessment process. The dates contained within the TFA will be subject to the outcome of this review in enabling any issues outlined in this agreement to be resolved.</p>	

Capital Plans and Estate issues

These relate to the management of an affordable retained estate and enabling resources to make some of the preparatory estate changes.

Quality and clinical governance issues

The Trust will be unable to confirm full compliance with same sex accommodation standards in the annual public declaration for 1 April (1 ward will remain non-compliant). However, the Trust will be compliant by end of June 2011.

Part 5 – NHS Trust actions required

Key actions to be taken by NHS Trust to support delivery of date in part 1 of agreement	
Strategic and local health economy issues	
Integration of community services	<input type="checkbox"/>
Financial	
Current financial position	<input type="checkbox"/>
CIPs	<input type="checkbox"/>
Other capital and estate Plans	<input checked="" type="checkbox"/>
Quality and Performance	
Local / regional QIPP	<input type="checkbox"/>
Service Performance	<input type="checkbox"/>
Quality and clinical governance	<input checked="" type="checkbox"/>
Governance and Leadership	
Board Development	<input type="checkbox"/>
Other key actions to be taken (please provide detail below)	<input checked="" type="checkbox"/>
<p>Describe what actions the Board is taking to assure themselves that they are maintaining and improving quality of care for patients.</p> <ul style="list-style-type: none"> • The Board receives regular comprehensive reports on quality and safety issues as well as the experience of patients. • Board members undertake ward visits on a regular basis and feed back findings to the Chief Nurse and the Board itself. • The Quality and Safety Committee of the Board provides support for the Board to examine issues in greater depth. • The Board has approved a new Quality and Safety Strategy in April 2011. This includes a fully integrated approach addressing Monitor's Quality Governance Framework. <p>Please provide any further relevant local information in relation to the key actions to be taken by the NHS Trust with an identified lead and delivery dates:</p> <p>Capital and estate Plans</p> <ul style="list-style-type: none"> • Complete land acquisition via voluntary and compulsory purchase by August 2011(links to OBC approval) (Director of Estates) • Complete updated estates strategy to reflect RCRH community hospital programme by October 2011 (Director of Estates) • Continue to provide any further information required by Treasury/DH in relation to OBC and continue to maintain close contact with SHA/DH <p>Quality and Clinical Governance</p> <ul style="list-style-type: none"> • Conversion of a ward into two same sex wards by June 2011(Director of Estates) <p>Other Actions</p> <ul style="list-style-type: none"> • Incorporate transitional funding into LTFM in agreement with commissioners (Director of Finance) 	

Part 6 – SHA actions required

Key actions to be taken by SHA to support delivery of date in part 1 of agreement	
Strategic and local health economy issues	
Local health economy sustainability issues (including reconfigurations)	<input type="checkbox"/>
Contracting arrangements	<input type="checkbox"/>
Transforming Community Services	<input type="checkbox"/>
Financial	
CIPs\efficiency	<input type="checkbox"/>
Quality and Performance	
Regional and local QIPP	<input type="checkbox"/>
Quality and clinical governance	<input type="checkbox"/>
Service Performance	<input type="checkbox"/>
Governance and Leadership	
Board development activities	<input type="checkbox"/>
Other key actions to be taken (please provide detail below)	<input checked="" type="checkbox"/>
<p>Please provide any further relevant local information in relation to the key actions to be taken by the SHA with an identified lead and delivery dates.</p> <ul style="list-style-type: none"> • Provide capital resource limit for land purchase by April 2011 (Director of Finance) • Support discussions with DH and Treasury to achieve OBC approval 	

Part 7 – Supporting activities led by DH

Actions led by DH to support delivery of date in part 1 of agreement	
Strategic and local health economy issues Alternative organisational form options	<input type="checkbox"/>
Financial NHS Trusts with debt	<input type="checkbox"/>
Short/medium term liquidity issues	<input type="checkbox"/>
Current/future PFI schemes	<input checked="" type="checkbox"/>
National QIPP workstreams	<input type="checkbox"/>
Governance and Leadership Board development activities	<input type="checkbox"/>
Other key actions to be taken (please provide detail below)	<input type="checkbox"/>
<p>Please provide any further relevant local information in relation to the key actions to be taken by DH with an identified lead and delivery dates:</p> <ul style="list-style-type: none"> • Approval of OBC by DH and Treasury (asap) • Deed of Safeguard or equivalent solution confirmed (July 2011) • Resolution of issues relating to Prudential Borrowing Code compliance (July 2011) <p>A national financial review of Trusts with a PFI hospital is taking place to gain a common understanding of any issues that might be an obstacle to passing the financial elements of the FT assessment process. The dates contained within the TFA will be subject to the outcome of this review in enabling any issues outlined in this agreement to be resolved.</p>	

Part 8 – Key milestones to achieve actions identified in parts 5 and 6 to achieve date agreed in part 1

Programme Stage/Activity	Timeline (Including 12 week consultation)
1. Approval of OBC	ASAP
2. Agree resource limit increase for land purchase	April 2011
3. Ensure compliance with same sex accommodation standards	June 2011
4. Deed of Safeguard confirmed	July 2011
5. Resolution of PBC issues	July 2011
6. Draft IBP and LTFM submitted	August 2011
7. Assess and challenge IBP/LTFM	End of August/early September 2011
8. Complete land acquisition	August 2011
9. SHA Board to Board to review progress	Early Sept 2011
10. Public engagement commences	October 2011
11. Historical Due Diligence Stage 1 begins	September 2011
12. Complete updated estates strategy to reflect RCRH community hospital programme	November 2011
13. Historical Due Diligence Stage 1 ends	October 2011
14. Engagement ends	December 2011
15. Finalise IBP & LTFM	February 2012
16. SHA Approval Review	February/March 2012
17. FT Quality and Safety Assessment	February 2012
18. Historical Due Diligence Stage 2 begins	March 2012
19. Historical Due Diligence Stage 2 ends	April 2012
20. SHA/NTDA recommend to Exec Board (2 nd B2B)	May 2012
21. Submission of papers to DH	1 st June 2012

Provide detail of what the milestones will achieve\solve where this is not immediately obvious. For example, Resolves underlying financial problems – explain what the issue is, the proposed solution and persons\organisations responsible for delivery.

The resolution of the OBC, PBC ratios and DoS are required from DH and Treasury before the IBP can be submitted. These matters have a significant effect on the content of the IBP. Significant further expenditure on developing the IBP beyond first draft without knowing the outcome would not seem a prudent use of public funds

Describe what actions\sanctions the SHA will take where a milestone is likely to be, or has been missed: The SHA will follow its normal escalation process in the event of a key milestone being missed and no improvement achieved.

Key Milestones will be reviewed every quarter, so ideally milestones may be timed to quarter ends, but not if that is going to cause new problems. The milestones agreed in the above table will be monitored by senior DH and SHA leaders until the NTDA takes over formal responsibility for this delivery. Progress against the milestones agreed will be monitored and managed at least quarterly, and more frequent where necessary as determined by the SHA (or NTDA subsequently). Where milestones are not achieved, the existing SHA escalation processes will be used to performance manage the agreement. (This responsibility will transfer to the NTDA once it is formally has the authority by April 2012)

Part 9 – Key risks to delivery

Risk	Mitigation including named lead
OBC Approval	Maintain close contact with DH and respond rapidly to further requests for information (Director of Estates)
CRL Limit increase	Maintain close communication with SHA (Director of Finance)
Secure Deed of Safeguard	Maintain close liaison with DH (Director of Estates)
Failure to deliver Right Care Right Here Activity and Capacity reductions	RCRH activity and capacity model used to guide annual contracting negotiations, programme management tracks and manages delivery of trajectory- (COO)

Sandwell and West Birmingham Hospitals



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:	30 June 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

- Final TFA agreed
- First working draft IBP produced
- First cut market assessment completed
- First cut LTFM produced
- Board impact survey for staff issued
- Board effectiveness survey
- Draft readiness assessment received from Deloitte
- Review of 2009 IBP undertaken by Deloitte
- Additional modelling capacity procured (funded partly from FT Prog, NHP and HR) – value is £40k in total

Activities next period

- Complete 2nd draft LTFM
- Complete second draft market assessment
- Complete CIPs description
- Review strategic risks
- Review SWOT and PEST
- Produce first draft IBP
- Agree approach to engagement with OSCs
- Complete Board effectiveness and staff surveys
- Set up staff focus groups on Board impact
- Conduct external stakeholder survey
- Arrange “soft” mock Board to Board for September

Issues for resolution and risks in next period

- Developing outputs from LTFM early enough to be able to inform redrafting of IBP
- Reducing size of IBP by >50%
- Ensuring coherent story from market assessment and PEST to Strategy to SWOT to Service developments
- Outputs from McKinsey review of our PFI position expected

Sandwell and West Birmingham Hospitals



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:	30 June 2011

SUMMARY OF KEY POINTS:

The Project Director's report gives an update on:

- Outline Business Case (OBC) approval
- Review and approval of procurement documents
- Update to the risk register and process
- 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	21 st 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.

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

1. Outline Business Case (OBC) Approval

Engagement with the Department of Health (DH) has continued. Feedback continues to be positive and all queries on the OBC have been closed for some time now.

Two issues are now impacting on approval. The first of these is that the DH is considering whether to continue to provide a Deed of Safeguard for new PFI Projects. The Deed of Safeguard is part of the Standard Form contract documentation. The purpose of the document is to provide a guarantee in the case of an NHS Foundation Trust being unable to perform its obligations under the contract.

The Deed of Safeguard has been given in all PFI contracts previously. Informal discussions with DH indicate that they are minded to keep it and that the process of consideration is nearing conclusion.

The second of the issues is that DH is delaying sign off by the Health Minister pending the completion of a review of the impact of PFI schemes on the financial standards required of Foundation Trusts. A review is being undertaken by McKinsey on the 22 Trusts affected. Most of the organisations involved already have an operational scheme, so our project will require a bespoke assessment.

McKinsey has said that the review will be complete by mid-July and proposals on solutions should be available by September.

The good news is that it has now been confirmed that the OBC is currently with the Treasury and dialogue between DH and the Treasury has commenced.

2. Review and Approval of Documents

The procurement documents will need review and approval by Project Board and Trust Board prior to initiating the procurement process with an OJEU notice.

The documents are currently being reviewed by the project advisory team and the Private Finance Unit (PFU) prior to presentation for approval. The project's legal advisors will attend meetings to support the process and to ensure that Trust Board members are aware of Trust obligations.

3. Risk Register and Process

In response to the Gateway Review recommendations the risk register and risk process is being reviewed in readiness for the next stage of the project. The Project Board is reviewing progress with this work this month.

4. Learning from Other Schemes

The team is continuing to visit other schemes to ensure that we learn from others. This gives us the opportunity to see what works well or what could be improved in hospital design. A considerable amount of information has been gathered over the last few years to inform the brief for our scheme.

The team is visiting two particularly interesting schemes during June and July. Enniskillen and Pembury have both developed their schemes with 100% single rooms. These visits will give us an opportunity to consider the approach to nursing patients in single rooms ensuring good levels of observation and avoiding patients feeling isolated. We are still assuming 50% single rooms in our scheme.