AGENDA

Trust Board – Public Session

Venue	Anne Gibs	on Boardro	om, City Hospital	Date	31 March 20)11; 143	0h - 1630h
Member	S			In Atten	dance		
Mrs S Da	vis	(SD)	[Chair]	Mr G Se	ager	(GS)	
Mr R Trot	man	(RT)		Miss K D	hami	(KD)	
Dr S Saho	ota	(SS)		Mrs J Kir	nghorn	(JK)	
Mrs G Hu	Injan	(GH)		Mrs C Ri	ckards	(CR)	
Prof D Al	derson	(DA)		Mr J Ca	sh	(JC) [S	Sandwell LINks]
Mr G Cla	arke	(GC)					
Mrs O Du	utton	(OD)		Guests			
Mr J Adle	er	(JA)		Mrs D Ta	albot	(DT)	[Item 7]
Mr D O'[Donoghue	(DO'D)		Mrs D Rł	noden	(DR)	[Item 7]
Mr R Kirb	у	(RK)		Prof C C	Clarke	(CC)	[Item 11.1]
Mr R Whi	te	(RW)					
Miss R Ov	verfield	(RO)		Secretar	iat		
				Mr S Gra	ainger-Payne	(SGP)	[Secretariat]

Item	Title		Lead
1	Apologies	Verbal	SGP
2	Declaration of interests To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting	Verbal	All
3	Chair's opening comments	Verbal	Chair
4	Minutes of the previous meeting To approve the minutes of the meeting held on 24 February 2011 as true and accurate records of discussions	SWBTB (2/11) 046	Chair
5	Update on actions arising from previous meetings	SWBTB (2/11) 046 (a)	Chair
6	Questions from members of the public	Verbal	Public
	PRESENTATION		
7	Patient experience update - Learning disability	SWBTB (3/11) 053 SWBTB (3/11) 053 (a)	DT/ DR
	MATTERS FOR APPROVAL		
8	Board reporting cycle 2011/12	SWBTB (3/11) 065 SWBTB (3/11) 065 (a)	SGP
9	Annual corporate plan 2011/12	SWBTB (3/11) 060 SWBTB (3/11) 060 (a)	MS
10	Annual financial plan and budget 2011/12	SWBTB (3/11) 064 SWBTB (3/11) 064 (a) - SWBTB (3/11) 064 (c)	RW

	MATTERS FOR INFORMATION/NOTING		
11	Safety, Quality and Governance		
11.1	Research and Development update	SWBTB (3/11) 067 SWBTB (3/11) 067 (a) - SWBTB (3/11) 067 (c)	CC
11.2	Quarterly risk report	SWBTB (3/11) 055 SWBTB (3/11) 055 (a)	KD
11.3	Adult inpatient satisfaction survey results	SWBTB (3/11) 054 SWBTB (3/11) 054 (a) SWBTB (3/11) 054 (b)	RO
11.4	National cancer patient experience survey results	SWBTB (3/11) 061 SWBTB (3/11) 061 (a) SWBTB (3/11) 061 (b)	JК
11.5	Maternity patient experience survey results – national and Serenity MLU	SWBTB (3/11) 062 SWBTB (3/11) 062 (a) - SWBTB (3/11) 062 (d)	JК
11.6	Revised Establishment Order for TCS	SWBTB (3/11) 056 SWBTB (3/11) 056 (a)	KD
12	Strategy and Development		
12.1	Tripartite Formal Agreement for Foundation Trust application	SWBTB (3/11) 069 SWBTB (3/11) 069 (a)	MS
12.2	'Right Care, Right Here' programme: progress report	SWBTB (3/11) 063 SWBTB (3/11) 063 (a)	MS
12.3	Midland Metropolitan Hospital project: progress report	SWBTB (3/11) 050 SWBTB (3/11) 050 (a)	GS
13	Performance Management		
13.1	Monthly finance report	SWBTB (3/11) 052 SWBTB (3/11) 052 (a)	RW
13.2	Monthly performance monitoring report	SWBTB (3/11) 049 SWBTB (3/11) 049 (a)	RW
13.3	NHS Performance Framework monitoring report	SWBTB (3/11) 048 SWBTB (3/11) 048 (a)	RW
14	Operational Management		
14.1	Same sex accommodation progress update	SWBTB (3/11) 051 SWBTB (3/11) 051 (a)	RK
15	Update from the Board Committees		
15.1	Finance and Performance Management Committee		
	Draft minutes from meeting held 24 March 2011	To follow	RT
15.2	Audit Committee		
	Draft minutes from meeting held 3 February 2011	SWBAC (2/11) 013	GH

16	Any other business	Verbal	All
17	Details of next meeting	Verbal	Chair
	The next public Trust Board will be held on 28 April 2011 at 1430h in the Churchvale/Hollyoak Rooms, Sandwell Hospital		
18	Exclusion of the press and public	Verbal	Chair
	To resolve that representatives of the Press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to		

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MINUTES

Trust Board (Public Session) – Version 0.2

<u>Venue</u> C	hurchvale/Hollyoak	Rooms, Sandwell I	Hospital <u>Date</u>	24 February 2011
<u>Present</u> : Mrs Sue Davis Mr Roger Troti	(Chair) man	Mrs Gianjeet Hun Mr John Adler	jan	Mr Richard Kirby Miss Rachel Overfield
Dr Sarindar Sa		Mr Robert White		Mr Mike Sharon
In Attendance	<u>.</u>			
Miss Kam Dha	mi	Mr Graham Seag	ler	Mrs Jessamy Kinghorn
Mr John Cash	(Sandwell LINks)	Mr David Naylor	(Burdett Trust)	Dr Beryl Oppenheim (Item 10.1)

Secretariat:

Mr Simon Grainger-Payne

Minutes	Paper Reference
1 Apologies for absence	Verbal
Apologies were received from Mr Gary Clarke, Mrs Olwen Dutton, Professor Derek Alderson, Mr Donal O'Donoghue and Mrs Chris Rickards.	
2 Declaration of Interests	Verbal
Mr Kirby advised that he had recently been offered and had accepted the position of Chief Executive at Walsall Hospitals NHS Trust.	
3 Chair's Opening Comments	Verbal
The Chair expressed her gratitude to the key members of staff involved in the recent assessment by the NHS Litigation Authority against the general standards at Level 2. The Trust Board was advised that the Trust had been successful in gaining accreditation at this level for the next two years.	
Mr Adler advised that in terms of the contract negotiations with commissioners, the main discussions had concluded. He remarked that settlement would mean that the financial position of the Trust would be tighter in the forthcoming year than in previous years, however the income forecast is consistent with the Trust's financial plans. The settlement does however mean that the £20m Cost Improvement Programme will be	

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critical to deliver the financial plan. The Board was advised that the risk sharing arrangements agreed would be shared in further detail at a future meeting. Mr Adler reported that the contract Heads of Terms would be signed imminently.	
4 Minutes of the previous meeting	SWBTB (1/11) 024
The minutes of the previous meeting were presented for approval and were accepted as a true and accurate reflection of discussions held on 27 January 2011.	
AGREEMENT: The Trust Board approved the minutes of the last meeting	
5 Update on actions arising from previous meetings	SWBTB (1/11) 024 (a)
The updated actions list was reviewed and it was noted that there were no outstanding actions requiring discussion or escalation.	
6 Questions from members of the public	Verbal
Mr Cash advised that a public engagement event concerning discharge had been cancelled at short notice recently, to the inconvenience of a number of attendees. He remarked that the event did not appear to have been rearranged. Mrs Kinghorn confirmed that the event had been cancelled due to the adverse weather, however she advised that a number of members of the public who had arrived for the meeting had been reimbursed their travel costs. The Board was advised that the event would be rearranged into the forward schedule of engagement meetings.	
7 Patient Experience update – learning disability	Presentation SWBTB (2/11) 034 SWBTB (2/11) 034 (a)
Miss Overfield advised that due to illness of the patient due to be interviewed for this item, the report would be deferred for consideration until the March meeting of the Trust Board.	
In connection with the earlier discussion regarding the discharge engagement event, Miss Overfield advised that Sandwell LINks had undertaken a review of discharge and suggested that it would be useful for the resulting report to be shared with the Trust Board. It was suggested that it may be appropriate to use the monthly themed patient experience agenda item for this purpose.	
8 Register of Interests	SWBTB (2/11) 044 SWBTB (2/11) 044 (a)
Mr Grainger-Payne presented the revised Register of Interests, which he advised had been amended following some recent changes to the Directors' declarations.	
Mr Trotman advised that a declaration of interest needed to be added to his list concerning the Regional Health Partnership. Subject to this	

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amendment, the Trust Board approved the revised register.	
AGREEMENT: Subject to minor amendment, the Trust Board approved the revised Register of Interests	
9 Emergency Department workforce business case	SWBTB (2/11) 043 SWBTB (2/11) 043 (a)
Mr Adler presented a business case, proposing investment in the Trust's Emergency Department workforce. The Board was advised that the proposal had been considered and supported by the Finance and Performance Management Committee at its recent meeting. Meetings of the Strategic Investment Review Group (SIRG) were also reported to have been convened for the specific purpose of reviewing the plans, along with the Emergency Department Action Team.	
The Board was advised that the plans had been developed, following some work by the Emergency Department Action Team which indicated that compared to benchmarked information, the Trust has currently a lower level than recommended staffing levels in the Emergency Departments.	
Mr Adler advised that it was difficult to articulate the specific return on investment predicted from the business case. There would however be significant gains in quality terms.	
The Board was asked to note that a priority order for the investment had been developed as it was likely that it would be unfeasible to commit the full quantum of investment to the plans immediately. Furthermore, the Board was advised that there is unlikely to be immediate availability of some of the staff groups proposed to be recruited.	
Mr Adler highlighted that the plans incorporate the development of a Rapid Access Model (RAM) of care, meaning that an assessment may be made earlier in the patient journey.	
Mr Trotman remarked that it in view of the issues around current activity levels and the shortage of staff in the Emergency Department the Board must take action.	
Miss Overfield commented that the issues in respect of the Sandwell Emergency Department are clearly understood in particular and that the investment in nurse staffing proposed should give consistency to the decisions made and practice in the area. Equally, the need to support children being seen in the Emergency Department was highlighted to be critical and therefore an investment in a nurse leader, trained in Paediatrics is planned.	
Mr Kirby outlined the impact of the short staffing in the Emergency Departments, particularly given the recent staff departures and expressed his support for the approval of the business case. He advised that there is further administration and clerical resource needed to support the other	



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staff to be recruited. Mr Adler endorsed this view.	
Mr Sharon asked whether the planned removal of FY1 doctors was likely to be supported by the Deanery. Miss Dhami advised that no difficulties are anticipated in this respect, however the Deanery would need to be engaged with the plans.	
Miss Overfield highlighted that as the Trust moves to a single site in the future, then it is planned to reduce staffing the Emergency Departments again to a level suitable for the new configuration.	
The Chair expressed concern that training programmes for Physician Assistants were being closed, although part of the business case included a requirement for these posts within the Emergency Department. As such, she encouraged a discussion with local education providers about the Trust's requirements. Miss Overfield reported that the Strategic Health Authority had sanctioned the closure of some of the courses due to a lack of appetite for these posts. The Trust was highlighted to be in contact with one local provider which was continuing to deliver this training programme, however.	
Mr Adler advised that there are a number of indicators which will be monitored to assess the impact of the plans on patient experience. He reported that these metrics, together with a set of deliverables expected from the business case would be shared more fully with the Board at a future meeting.	
The Trust Board:	
 Approved the investment strategy outlined Endorsed the order of priority as described (noting the precommitments already made) Asked the Director of Finance and Performance Management to incorporate the investments required into financial planning for 2011/12, noting the order of priority Noted that the extent of the available investment will depend on the outcome of contractual negotiations for 2011/12 and other aspects of financial planning (including development of the Cost Improvement Programme) Agreed to take the final decisions on investment as part of the sign-off of the 2011/12 Financial Plan in March 2011 	
AGREEMENT: The Trust Board unanimously approved the business case for the investment in the Emergency Department workforce	
10 Quality and Governance	
10.1 Infection Control quarterly update	SWBTB (2/11) 031 SWBTB (2/11) 031 (a)
Dr Beryl Oppenheim joined the meeting to present an update on key infection control activities and performance over the previous quarter.	

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Dr Sahota commented that the report was very comprehensive and encouraging. He asked whether Surgical Site Infections (SSIs) and sepsis instances are monitored. Dr Oppenheim advised that the Trust is not required to take part in any mandatory SSI screening, particularly as it is difficult to monitor patients once they leave the Trust. The Board was advised that a pilot had been undertaken which found that gaining an overview of these infections is difficult, hence the monitoring has not been made mandatory.	
Mr Adler asked what proportion of Trusts use the new, more sensitive technique for detecting <i>C</i> difficile infections. He was advised that c. $70 - 80$ trusts out of c. 150 use this technique. It was highlighted that the Trust remained compliant with the target for these infection rates, despite the use of the more sensitive technique.	
The Chair noted that the Trust was likely to assume responsibilities for community services in Sandwell and asked whether the next quarterly update would incorporate this aspect. Dr Oppenheim reported that the Trust was not likely to take on responsibility for community-related <i>C difficile</i> infections as the majority are attributable to the GP practices from where medical care for the patient is given.	
The Chair reported that Dr Oppenheim was to leave the Trust shortly and she was congratulated and thanked for the impressive reductions in infection rates that had been achieved during her time in post, in addition to the informative and well-balanced reports presented to the Trust Board. Dr Oppenheim thanked the Board for its support and involvement in Infection Control matters. Mr Adler advised that the responsibilities for Infection Control would be assumed by Miss Overfield on an interim basis, who would be supported by key members of the microbiology team.	
10.2 Cleanliness quarterly update	SWBTB (1/11) 017 SWBTB (1/11) 017 (a)
Miss Overfield presented the quarterly update on cleanliness and PEAT activity.	
The Chair observed that although the Trust was performing well in the national standards of cleanliness audits, there remained a shortfall against the targets. Miss Overfield advised that the audits take into account the fabric of the building and highlighted that the ageing estate was impacting on the scores. The Board was advised that it is anticipated that there will be an improvement against the audits in the new hospital. Mrs Hunjan remarked that it would be expected that cleanliness scores would be higher in areas recently refurbished due to the same sex accommodation changes. Miss Overfield agreed, although advised that this standards could not be maintained indefinitely due to the age of the buildings being refurbished.	

programme. Miss Overfield advised that this programme included various areas, such as corridors, minor works, making good old walls and toilet redecoration.	
10.3 Equality and Diversity update	SWBTB (2/11) 035 SWBTB (2/11) 035 (a) SWBTB (2/11) 035 (b)
Miss Overfield presented the latest update on activities to ensure compliance with Equality and Diversity requirements within the Trust.	
Mr Trotman asked whether the suggestion that Asian staff are less likely to be promoted when applying for roles was linked to PDR outcomes. Miss Overfield advised that there was no obvious correlation in this respect.	
Dr Sahota asked how prevention of age discrimination for staff as part of the new Equality Bill is being handled within the Trust. Miss Overfield advised that these requirements had been built into relevant HR processes and implications of the new Bill had been cascaded to staff.	
Mr Cash asked whether formal cases involved grievance and disciplinary hearings. He was advised that this was the case. Mr Cash asked how the roadshows for Equality and Diversity were being publicised. Miss Overfield advised that groups already in existence and engaged by the Communications Department are used for this purpose.	
The Chair asked what guidance is given to staff concerning the use of their second language if applicable, within the hospitals. Miss Overfield informed the Board that staff are able to discuss day to day activities with patients if necessary, however on matters involving consent, the use of a recognised interpreter is mandated. If an interpreter is not available, then the patient's consultant may make a decision based on an assessment of the risk by using staff or family for the purpose. The Chair suggested that staff should be able to use a second language to aid good patient experience. Miss Overfield advised that in this case, care must be taken from the alternative perspective to ensure that English speaking patients are not made to feel isolated.	
10.4 Assurance Framework quarterly update	SWBTB (2/11) 026 SWBTB (2/11) 026 (a)
Mr Grainger-Payne presented the latest update of the Assurance Framework, which the Trust Board received and noted.	
11 Strategy and Development	
11.1 'Right Care, Right Here' programme: progress report	SWBTB (2/11) 042 SWBTB (2/11) 042 (a)
Mr Sharon presented the latest 'Right Care, Right Here' programme progress report, which the Board received and noted.	
The Board was advised that there had been an increase in attendances to	

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the Urgent Care Centres. Mr White remarked that this trend would be beneficial if it resulted in a reduction in acute attendances. Mr Kirby advised that it remained difficult to persuade patients arriving at Accident and Emergency in the Trust to be seen by the Urgent Care Centre instead.	
Mr Sharon reported that the level of outpatient work in the community had increased.	
Work was reported to have been undertaken to reduce the number of follow-up appointments in the acute setting.	
11.2 New acute hospital project: progress report	SWBTB (2/11) 029 SWBTB (2/11) 029 (a)
Mr Seager reported that the power to use the Compulsory Purchase Order had been granted to the Trust by the Secretary of State and was expected to be executed using a general vesting declaration.	
The Board was advised that an application for financial provision to cope with the impact of the land purchase on the cashflow of the Trust had been made to the Strategic Health Authority.	
Mr Seager reported that the approval of the Outline Business Case remains awaited.	
Mr Cash asked whether there was likely to be any further downsizing of the proposed number of hospital beds in the Midland Metropolitan Hospital. Mr Seager advised that as part of the recasting of the projected activity, the number of beds in the new hospital had been reviewed and factored into the Outline Business Case refresh to ensure that there is continued flexibility in this respect. The Board was advised that at present, there is no reason to prompt a change in the number of beds.	
Dr Sahota reported that Mr Seager had given a presentation recently to the Smethwick Delivery Board at which issues had been raised concerning the transport and accessibility of the Midland Metropolitan Hospital. Mr Seager advised that many of the concerns were incorporated into the 'Right Care, Right Here' transport strategy. Mr Sharon offered to circulate the presentation concerning transport and accessibility that had been discussed at a recent 'Right Care, Right Here' Partnership Board. Mr Cash remarked that there appeared to be significant work being undertaken on the transport strategy in respect of engaging stakeholders and transport providers. Mr Seager commented that the issue of public transport is challenging, given the need to balance the need for the service with the provision of accessibility.	
ACTION: Mr Seager to circulate the 'Right Care, Right Here' Programme Board presentation concerning transport and accessibility	
12 Performance Management	

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12.1 Monthly finance report	SWBTB (2/11) 030 SWBTB (2/11) 030 (a)			
Mr White presented the finance report for the period April 2010 – January 2011, which was noted to have been discussed in detail by the Finance and Performance Management Committee.	,			
The Board was advised that year to date, a surplus of £1,538k had been achieved and there was an expectation that the Trust was on course to meet its target of £2m by the year end. It was noted that five divisions had posted in-month deficits and the Medicine and Emergency Care and Surgery, Anaesthetics and Critical Care Divisions had agreed overspend to take into account the additional expenditure due to delivery of the 18 weeks waiting time target and to alleviate the effect of the marginal rate reimbursement for emergency admissions.				
The Board was pleased to learn that the Cost Improvement Programme target is anticipated to be met by the year end.				
Capital expenditure was reported to have accelerated due to the timing of some schemes and cash balance remains strong, despite a delay with receiving payments from some of the Trust's commissioners.				
Mr White summarised that overall, the Trust's financial position had been stable during the month.				
The Chair remarked that after 1 April 2011, the Trust would take on responsibility for Sandwell community services and asked whether the finance reports would identify the budget for those services. Mr White reported that this would be the case. Mr Kirby added that the performance of the adult community services division would be reported in an identical way to that of other divisions, however the children's services performance would need to be specifically delineated, as the services are to be reported as part of the overall performance of the Women and Child Health Division. The Chair suggested that a proposal for how the performance of the community services may be reported should be considered at the next meeting of the Finance and Performance Management Committee. Mrs Hunjan suggested that the detail of the resources transferred as part of the TCS plans, together with the costs needed to be articulated clearly as part of the reporting. It was agreed that the matter needed to be considered further by Mr Trotman, Mrs Hunjan and Mr White.				
ACTION: Mr White to discuss the level of detail required for the reporting of community services performance with Mr Trotman and Mrs Hunjan				
ACTION: Mr White to present a proposal as to how the performance of the community services might be reported at the next meeting of the Finance and Performance Management Committee				

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12.2 Monthly performance monitoring report	SWBTB (2/11) 041 SWBTB (2/11) 041 (a)
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.	
It was highlighted that the ongoing operational pressures were making it difficult to achieve the Strategic Health Authority mandated targets relating to delayed transfers of care and ambulance turnaround times. Performance against the Accident and Emergency waiting time target was reported to be satisfactory however.	
The Board was advised that the level of cancelled operations had increased during the month, due to an instance of equipment failure in Urology.	
Delayed transfers of care were reported to have increased at City Hospital but had reduced at Sandwell Hospital. Performance against the TIA target was reported to be 42.8%, which was highlighted as an improvement on performance of the previous month. Mr Adler added that following a recent validation exercise, the TIA position was now 58% against a target of 60%.	
An improvement on the level of sickness absence was reported, with the current rate being 4.18%. Likewise, an improvement in compliance against the mandatory training target was noted.	
In terms of performance against the CQUiN targets, the Board was advised that the achievement of the VTE assessment target is within reach, therefore further effort is to be given in March to meeting or exceeding the 90% compliance level required. Regarding the breastfeeding target, the Board was advised that discussions are ongoing with Sandwell PCT to define which patients may be counted towards the target.	
On a separate matter, Mr Kirby reported that in December 2010 and January 2011, there had been a decline in referrals to the Trust. The adverse weather during December was suggested to be a main reason for this dip, however it was noted that there continued to be a low level of referrals in January. The Chair asked whether this situation applied across all specialities and was advised that this was the case, although the position was more marked in the Heart of Birmingham area than Sandwell. It was highlighted that despite the situation, it appeared that market share remained stable. The Chair asked for further detail to be provided to the Trust Board, should the trend persist.	
Mr Cash returned to the issue of the delayed transfers of care reported and asked for the information to be provided by Local Authority. Mr Kirby agreed to provide Mr Cash with this information.	

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ACTION: Mr Kirby to provide Mr Cash with the delayed transfers of care information by Local Authority	
12.3 NHS Performance Framework update	SWBTB (2/11) 037 SWBTB (2/11) 037 (a)
Mr White presented the NHS Performance Framework update for information.	
The Trust Board received and noted the report and was pleased to note that the Trust remains classified as a 'performing' organisation.	
13 Update from the Board Committees	
13.1 Finance and Performance Management Committee	Hard copy paper
The Trust Board received and noted the draft minutes of the Finance and Performance Management Committee from the meeting held on 117 February 2011.	
14 Any other business	
There was none.	
15 Details of the next meeting	Verbal
The next public meeting of the Trust Board will be held on 31 March 2011 at 1430h in the Anne Gibson Boardroom at City Hospital.	
16 Exclusion of the press and public	Verbal
The Board resolved that representatives of the Press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1 (2) Public Bodies (Admission to Meeting Act 1960).	

Signed:	

Name:

Date:

Next Meeting: 31 March 2011, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

24 February 2011 - Sandwell Hospital

Members present: Mrs S Davis (SD), Mr R Trotman (RT), Mrs G Hunjan (GH), Dr S Sahota (SS), Mr J Adler (JA), Mr R White (RW), Mr R Kirby (RK), Miss R Overfield (RO), Mr M Sharon (MS)

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

Apologies: Mr G Clarke (GC), Mrs O Dutton (OD), Mr Donal O'Donoghue, Mrs C Rickards (CR)

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 25 March 2011

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Respo
SWBTBACT.139	Same sex accommodation update	SWBTB (1/11) 003 SWBTB (1/11) 003 (a)	27-Jan-11	Send a letter of thanks to the ward managers and matrons involved with the same sex accommodation work	AL	31/03/11 30/04/11	
SWBTBACT.135	Equal pay audit	SWBTB (11/10) 231 SWBTB (11/10) 231 (a)	25-Nov-10	Arrange for the apparent pay inequality issues in medical staff to be discussed by the Finance and Performance Management Committee	RO	16/12/10	Discussed briefly Performance Ma March and circu further review
SWBTBACT.137	Integrated risk, complaints and claims update - Quarter 2	SWBTB (1/11) 016 SWBTB (1/11) 016 (a)	27-Jan-11	Prepare a report for the March meeting of the Governance and Risk Management Committee, presenting cases that have been referred to the Health Service Ombudsman	KD		Prepared and p
SWBTBACT.184	New acute hospital project: progress report	SWBTB (2/11) 029 SWBTB (2/11) 029 (a)	24-Feb-11	Circulate the 'Right Care, Right Here' Programme Board presentation concerning transport and accessibility	GS	24/03/11	Circulated as re
SWBTBACT.185	Monthly finance report	SWBTB (2/11) 030 SWBTB (2/11) 030 (a)	24-Feb-11	Discuss the level of detail required for the reporting of community services performance with Mr Trotman and Mrs Hunjan			Discussed via e-
SWBTBACT.186	Monthly finance report	SWBTB (2/11) 030 SWBTB (2/11) 030 (a)	24-Feb-11	Present a proposal as to how the performance of the community services might be reported at the next meeting of the Finance and Performance Management Committee	RW	24/03/11	Discussed briefly Performance Ma March and circu further review
SWBTBACT.187	Monthly performance monitoring report	SWBTB (2/11) 041 SWBTB (2/11) 041 (a)	24-Feb-11	Provide Mr Cash with the delayed transfers of care information by local authority	RK	24/03/11	Sent with Board

SWBTB (2/11) 046 (a)

oonse Submitted	Status
	G
ly at the Finance and lanagement Committee in culated to Committee for	В
oresented as requested	В
equested	В
e-mail as requested	В
ly at the Finance and lanagement Committee in culated to GH and RT for	В
papers	В

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

ACTIONS

Next Meeting: 31 March 2011, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

24 February 2011 - Sandwell Hospital

Members present: Mrs S Davis (SD), Mr R Trotman (RT), Mrs G Hunjan (GH), Dr S Sahota (SS), Mr J Adler (JA), Mr R White (RW), Mr R Kirby (RK), Miss R Overfield (RO), Mr M Sharon (MS)

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

Apologies: Mr G Clarke (GC), Mrs O Dutton (OD), Mrs C Rickards (CR)

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 25 March 2011

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Reference No	Item	Paper Ref	Date	Agreement
	Minutes of the previous			
SWBTBAGR.217	meeting	SWBTB (1/11) 024	24-Feb-11	The Trust Board approved the minutes of the previous meeting as a true and
SWBTBAGR.218	Register of Interests	SWBTB (2/11) 044 SWBTB (2/11) 044 (a)	24-Feb-11	Subject to minor amendment, the Trust Board approved the revised Register
SWBTBAGR.219	Emergency Department workforce business case	SWBTB (2/11) 043 SWBTB (2/11) 043 (a)	24-Feb-11	The Trust Board unanimously approved the business case for the investment

SWBTB (2/11) 046 (a)

nd accurate record of discussions held

er of Interests

nt in the Emergency Department workforce

SWBTB (3/11) 053

Sandwell and West Birmingham Hospitals

NHS Trust

TRUST BOARD				
DOCUMENT TITLE:	Patient Experience - Learning Disability			
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse			
AUTHOR:	Diane Rhoden, Adult Safeguarding Nurse and Debbie Talbot, Assistant Director of Nursing			
DATE OF MEETING:	31 March 2011			

SUMMARY OF KEY POINTS:

The purpose of the report is to present to the Trust Board a real patient experience concerning Learning Disability and to update the Board on the current position regarding patients being admitted with a diagnosed learning disability, together with the action plan to handle this category of patients.

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

Approval	Receipt and Noting	Discussion
	Х	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to receive and note the contents of the attached report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	1.2 Continue to improve patient experience. 2.3 Vulnerable children and adults – improve protection and care.		
Annual priorities	1.2 Continue to improve patient experience.2.3 Vulnerable children and adults – improve protection and care.		
NHS LA standards	2.3.3 Safe	eguarding Adults	
CQC Essential Standards Quality and Safety	Regulation 9, Outcome 4 – Care and welfare of people who use services. Regulation 10, Outcome 16 – Assessing and monitoring the quality of service provision. Regulation 11, Outcome 7 – Safeguarding people who use services from abuse. Regulation 17, Outcome 1 – Respecting and involving people who use services.		
Auditors' Local Evaluation			
IMPACT ASSESSMENT (Indicate w	ith 'x' all those	that apply in the second column):	
Financial			
Business and market share			
Clinical	x		
Workforce			
Environmental			
Legal & Policy			
Equality and Diversity			
Patient Experience	х		
Communications & Media			
Risks			

PREVIOUS CONSIDERATION:

Not previously considered by the Trust Board.

Report Title	Patient Experience – Learning Disability
Meeting	Trust Board
Author	Diane Rhoden Adult Safeguarding Nurse and Debbie Talbot, Assistant Director of Nursing
Date	31 March 2011

1.0 Introduction

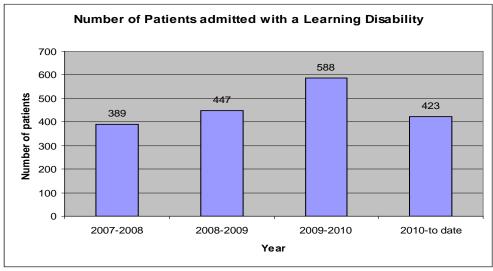
- The World Health Organisation defines learning disabilities as 'a state of arrested or incomplete development of mind'. Somebody with a learning disability is said also to have 'significant impairment of intellectual functioning' and 'significant impairment of adaptive/social functioning' However it should be noted that People with LDs are people first and foremost, they are brothers, sisters, uncles, aunts, neighbours, friends.
- There is no official statistic that tells us how many people there are with learning disabilities in the UK.
- Department of Health suggest the numbers are around 160,000 adults with severe and profound learning disabilities in England
- It is thought that 2.5% of the population have a learning disability.

There have been a number of national documents published since the Mencap report Death by Indifference (March 2007) whereby Mencap clearly stated they believed that there is institutional discrimination within the NHS. The Disability Rights Commission (DRC) published the results of a formal investigation into physical health inequalities experienced by people with learning disabilities and mental health problems. The investigation showed that people with a learning disability (LD) receive fewer screening tests and fewer health investigations.

2. Current Position SWBH

<u>2.1</u>

The graph below identifies the number of patients who were admitted to SWBH with a diagnosed LD, the data for 2010-2011 is till the end of the third quarter. The graph shows that there has been an increase year on year of patients admitted with an LD, we expect this to continue for the years to come due to increasing Healthcare Checks by GP's and subsequent referrals into the Acute Trust.



<u>2.2</u>

The highest proportion of patients admitted into the Trust are admitted to Paediatrics. The next highest is within general medicine. There are a surprisingly low number of patients admitted to cardiology with only 4 in the current year as coronary conditions are known to be a common co-morbidity of people with certain LDs such as Down's Syndrome.

Due to a safeguarding incident that has recently occurred within maternity services a specialised clinic with longer clinic time slots has commenced and so it is expected that the Trust will see and increase number of patients in maternity services.

<u>2.3</u>

It is recognised that as a Trust the number of patients admitted to the Trust with an LD is currently under recognised. This is because patients are not admitted into the Trust because of their Learning Disability but because of an acute medical condition so the data relies on the clinical coding of patients as a secondary category.

<u>2.4</u>

Changing our Lives, an organisation who advocates for service users and carers and who is involved nationally with setting standards for people with a learning disability, was invited by the Trust in 2009 to audit our services and follow a patients pathway through the organisation.

- The audit report formed an action plan which included the need for Learning Disability Facilitators to be accessed from the community.
- Currently we have facilitators from Birmingham walking wards at City Hospital to identify
 patients and then assisting with any issues. It is hoped that Sandwell Hospital will have its
 own Learning Disability Facilitator funded by the Local Authority in post by the end of
 March.
- A good practice checklist was devised with the aid of Birmingham Health Facilitators and is easily accessible on the Trust intranet.
- Every ward and department received a Communication Folder with pictures of every day items and needs to help with communicating with patients.
- Work is continuing around the area of training for staff and it is envisaged that the Sandwell based health facilitator role will take on much of this responsibility.

<u>2.5</u>

To improve patients and staff access to the specialised services, as identified above, it is anticipated that the Trust will work with the Health Facilitator service to access databases that some GP's already hold of patients that are registered with each GP practice and have a learning disability. It is anticipated that this data will be inputted onto trust IT systems then when a patient with LD is admitted to the hospital an e-mail can be sent to the Health Facilitators so that they can be included within the care of the patient.

<u>2.6</u>

Clinical incidents and Safeguarding alerts currently are not recorded and categorised as to whether the person has a learning disability. However from red table top investigations and safeguarding investigations the current themes are known, these include

- Patients deemed as non-compliant with medication and treatment however a formal assessment of capacity function is not recorded. A patient cannot be deemed noncompliant if they do not understand the consequences of their actions.
- Quality of life decisions being made without discussion with patients and or family and carers. This then affects the course of treatment that the patient receives.
- Assumptions that altered clinical observations are 'normal'
- In the case of patients who are deemed to lack capacity and who have no-one but paid carers to help them make life sustaining treatment decisions then Independent Mental Capacity Advocates should be instructed. There are incidences where this has not occurred.
- A Clinical incident investigation identified concerns that patients admitted into A&E are not necessarily following the same pathway as a person admitted without a Learning Disability.
- It has been identified that staff do not understand that carers whether informal or paid have a large amount of quality information about the patient that would help us with our decision making.
- Patients who present with a challenging behaviour are being referred to Mental Health services.

<u>2.7</u>

Safeguarding training is to include a scenario of a patient being admitted to the Trust with a LD. There is also to be a specific training package to focus on communication issues and most common co-morbidities of patients with a LD

3 Conclusions

There are national reports which have identified the inequalities within healthcare even stating that the NHS is institutionally discriminating against people with a Learning Disability.

There is progress being made within the Trust with regards to the needs of patients admitted with a learning disability and there is access to specialised support and advice for patients, carers and staff, however there is much still to do to ensure that patients are all treated equally and in a timely fashion.

SWBTB (3/11) 065

Sandwell and West Birmingham Hospitals

NHS Trust

TRUST BOARDDOCUMENT TITLE:Trust Board Reporting Cycle 2011/12SPONSORING DIRECTOR:Kam Dhami, Director of GovernanceAUTHOR:Simon Grainger-Payne, Trust SecretaryDATE OF MEETING:31 March 2011

SUMMARY OF KEY POINTS:

The Trust Board reporting cycle for 2011 is presented for approval.

The reporting cycle is similar to that for the previous year, being based on the model included in the Appointment Commission's 'The Intelligent Board' publication, together with some items of specific relevance to the Trust.

New items added into the reporting cycle include:

- Monthly patient experience themes reports
- Monthly FT application update
- Update on maternity reconfiguration in August
- Quarterly TCS integration/benefits realisation update

Matters requiring the Board's urgent attention will continue to be presented at the earliest opportunity outside of the standard cycle of business.

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 its proposed annual cycle of business.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	None specifically but supports good corporate governance arrangements in the Trust
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		
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy	х	
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Issued to the Executive Team to allow time for comment and amendment prior to presentation to the Trust Board.

TRUST BOARD REPORTING CYCLE 2011/12

		QUARTER 1	
	APRIL	MAY	JUNE
QUALITY, SAFETY AND GOVERNANCE	 Patient Experience – themed report (CN) Assurance Framework update (Q4) (DG) Register of seals (DG) Register of directors' interests (DG) Approve changes to SOs & SFIs (DFPM) 	 Patient Experience - themed report (CN) Infection control quarterly report (CN) Cleanliness report (CN) Quarterly risk report (Q4) (DG) Agree 2011/12 Assurance Framework (DG) Freedom of Information annual report (DG) Audit Committee annual report (CoAC) Quality and Safety Committee annual report (CoQSC) Quality Accounts (MD) 	 Patient Experience – themed report (CN) National patient surveys (HCE)
STRATEGY AND DEVELOPMENT	 'Right Care, Right Here' programme: progress report (DSOD) FT application update (DSOD) Midland Metropolitan Hospital programme: progress report (DENHP) Update on Workforce strategy (CN) 	 'Right Care, Right Here' programme: progress report (DSOD) FT application update (DSOD) Midland Metropolitan Hospital programme: progress report (DENHP) Communications and engagement strategy update (HCE) ◆ 	 'Right Care, Right Here' programme: progress report (DSOD) FT application update (DSOD) Midland Metropolitan Hospital programme: progress report (DENHP) TCS integration/benefits realisation update (COO)
PERFORMANCE MANAGEMENT	 Financial performance (DFPM) Performance monitoring report (DFPM) NHS performance framework update (DFPM) Progress against corporate objectives (Q4) (DSOD) 	 Financial performance (DFPM) Performance monitoring report (DFPM) NHS performance framework update (DFPM) 	 Financial performance (DFPM) Performance monitoring report (DFPM) NHS performance framework update (DFPM)
OPERATIONAL MANAGMENNT	 Sustainability (DENHP) 	 Staff survey report and action plan (CN) Nursing update(CN) Presentation by PCT Director of Public Heath (Sandwell PCT) <i>TBC</i> 	 Sandwell Mental Heath Governors report (CN)

[QUARTER 2			
	JULY	AUGUST	SEPTEMBER	
QUALITY, SAFETY AND GOVERNANCE	 Patient Experience – themed report (CN) Assurance Framework update (Q1) (DG) Annual Health and Safety report (DG) 	 Patient Experience – themed report (CN) Infection control quarterly report (CN) Cleanliness report (CN) Equality and Diversity update (CN) Quarterly risk report (Q1) (DG) 	 Patient Experience – themed report (CN) Safeguarding update (CN) National patient surveys (HCE) Annual risk report (DG) Annual complaints report (DG) 	
STRATEGY AND DEVELOPMENT	 'Right Care, Right Here' programme: progress report (DSOD) FT application update (DSOD) Midland Metropolitan Hospital programme: progress report (DENHP) 	 'Right Care, Right Here' programme: progress report (DSOD) FT application update (DSOD) Midland Metropolitan Hospital programme: progress report (DENHP) Annual plan process for 2012/13 (DSOD) Update on maternity reconfiguration (CN) 	 'Right Care, Right Here' programme: progress report (DSOD) FT application update (DSOD) Midland Metropolitan Hospital programme: progress report (DENHP) IM & T strategy (MD) ◆ TCS integration/benefits realisation update (COO) 	
PERFORMANCE MANAGEMENT	 Financial performance (DFPM) Performance monitoring report (DFPM) NHS performance framework update (DFPM) Progress against corporate objectives (Q1) (DSOD) 	 Financial performance (DFPM) Performance monitoring report (DFPM) NHS performance framework update (DFPM) 	 Financial performance (DFPM) Performance monitoring report (DFPM) NHS performance framework update (DFPM) 	
OPERATIONAL MANAGMENNT	 Sustainability (DENHP) 			

	QUARTER 3			
	OCTOBER	NOVEMBER	DECEMBER	
QUALITY , SAFETY AND GOVERNANCE	 Patient Experience – themed report (CN) Assurance Framework update (Q2) (DG) 	 Patient Experience – themed report (CN) Infection control quarterly report (CN) Cleanliness report (CN) Quarterly risk report (Q2) (DG) 	 Patient Experience – themed report (CN) Fire safety annual report (DENHP) Radiation protection annual report (COO) National patient surveys (HCE) 	
STRATEGY AND DEVELOPMENT	 'Right Care, Right Here' programme: progress report (DSOD) FT application update (DSOD) Midland Metropolitan Hospital programme: progress report (DENHP) Estates strategy annual review (DENHP) 	 'Right Care, Right Here' programme: progress report (DSOD) FT application update (DSOD) Midland Metropolitan Hospital programme: progress report (DENHP) 	 'Right Care, Right Here' programme: progress report (DSOD) FT application update (DSOD) Midland Metropolitan Hospital programme: progress report (DENHP) Communications and engagement strategy update (HCE) TCS integration/benefits realisation update (COO) 	
PERFORMANCE MANAGEMENT	 Mid year review of annual plan and budget (DFPM) Performance monitoring report (DFPM) NHS performance framework update (DFPM) Progress against corporate objectives (Q2) (DSOD) Sign off annual audit letter (DFPM) 	 Financial performance (DFPM) Performance monitoring report (DFPM) NHS performance framework update (DFPM) 	 Financial performance (DFPM) Performance monitoring report (DFPM) NHS performance framework update (DFPM) 	
OPERATIONAL MANAGMENNT	 Sustainability (DENHP) 	 Presentation by PCT Director of Public Heath (Heart of Birmingham tPCT) Nursing update(CN) 		

		QUARTER 1	
	JANUARY	FEBRUARY	MARCH
QUALITY, SAFETY AND GOVERNANCE	 Patient Experience – themed report (CN) Assurance Framework update (Q3) (DG) 	 Patient Experience - themed report (CN) Infection control quarterly report (CN) Cleanliness report (CN) Equality and Diversity update (CN) Quarterly risk report (Q3) (DG) 	 Patient Experience - themed report (CN) Safeguarding update (CN) Sign off annual external audit plan (DFPM) Annual cycle of business for Trust Board (DG) National patient surveys (HCE)
STRATEGY AND DEVELOPMENT	 'Right Care, Right Here' programme: progress report (DSOD) FT application update (DSOD) New acute hospital programme: progress report (DENHP) 	 'Right Care, Right Here' programme: progress report (DSOD) FT application update (DSOD) New acute hospital programme: progress report (DENHP) 	 'Right Care, Right Here' programme: progress report (DSOD) FT application update (DSOD) New acute hospital programme: progress report (DENHP) CQC annual declaration (DG) ◆ TCS integration/benefits realisation update (COO)
PERFORMANCE MANAGEMENT	 Financial performance (DFPM) Performance monitoring report (DFPM) NHS performance framework update (DFPM) Progress against corporate objectives (Q3) (DSOD) 	 Financial performance (DFPM) Performance monitoring report (DFPM) NHS performance framework update (DFPM) 	 Financial performance (DFPM) Performance monitoring report (DFPM) NHS performance framework update (DFPM) Annual corporate plan (DSOD) ◆ Annual financial plan and budget (DFPM) ◆
OPERATIONAL MANAGMENNT	 Sustainability (DENHP) Update on Research & Development (MD) 		

KEY

DFPM DSOD	Director of Finance and Performance Management Director of Strategy and Organisational Development
COO	Chief Operating Officer
CN	Chief Nurse
MD	Medical Director
DG	Director of Governance
DENHP	Director of Estates/New Hospital Project
HCE	Head of Communications and Engagement
CoAC	Chair of Audit Committee

CoQSC Chair of Quality and Safety Committee

NHS Trust

TRUST BOARD		
DOCUMENT TITLE:	Annual Plan 2011/12	
SPONSORING DIRECTOR:	Mike Sharon, Director of Strategy & Organisational Development	
AUTHOR:	Mike Sharon, Director of Strategy & Organisational Development	
DATE OF MEETING:	31 March 2011	

SUMMARY OF KEY POINTS:

The latest draft Annual Plan 2011/12 is attached for approval.

The document brings together a summary of performance/projected outturn in the current year and sets out high level plans for the year ahead. It includes the Trust's priorities for 2011/12.

The document is not quite in its final form but the few elements outstanding and any amendments identified will be brought together into a final draft during the next week.

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

Trust t Board is requested to consider and approve the Annual Plan 2011/12.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

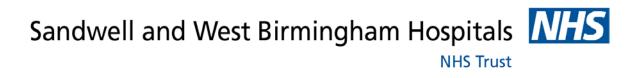
IMPACT ASSESSMENT (Indicate with 'x' all those that apply in the second column):

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

PREVIOUS CONSIDERATION:

Trust Management Board on 22 March 2011.

SWBTB (3/11) 060 (a)



ANNUAL PLAN 2011/12

Draft v6 (03-11)

ANNUAL PLAN 2011/12

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ANNUAL PLAN 2011/12

Introduction

This Annual Plan sets out our priorities for 2011/12. These are designed to:

- continue to improve the services we provide to the people of Sandwell, western and central Birmingham and surrounding areas;
- make progress with our long-term strategy for a new acute hospital as part of the Right Care Right Here Programme;
- realise the benefits offered by the transfer of Sandwell Adult and Children's Community services;
- respond to a challenging financial position by improving both quality and productivity;
- Prepare for becoming a Foundation Trust.

The context in which we expect to be operating is set out in more detail in what follows. We expect 2011/12 however to be a particularly challenging year as we adjust to the changes to the system envisaged in *"Equity and excellence: Liberating the NHS"*, to the financial challenges posed to the system and as we continue to make progress towards our six strategic objectives. These are:

- Accessible and Responsive Care.
- Safe High Quality Care.
- Care Closer to Home.
- Good Use of Resources.
- 21st Century Facilities.
- An Effective Organisation.

Successful delivery of the objectives set out in this plan will ensure that we continue to develop the Trust as a provider of high quality healthcare services to the population of Sandwell, western and central Birmingham and surrounding areas.

Sue	Davis	CBE
Cha	ir	

John Adler Chief Executive

1. Past year performance

1.1 Chief Executive's summary of 2010/11

2010/11 has been another important year in the ongoing development of the Trust and the services that we provide. Thanks to the hard work, energy and commitment of our staff, we have continued to make significant progress in improving our services. This section provides an overview of our progress in 2010/11 and therefore we should acknowledge some of our achievements as we begin our plan for 2011/12.

- We reached agreement with Sandwell PCT to become the provider of Adult and Children's Community services for Sandwell and to host temporarily the Bradbury Day Centre. This is a significant addition to the range of services we provide and helps to achieve our shared ambition to provide care closer to people's homes and to help people stay well and healthy.
- We have maintained our achievement of the National waiting time standards.
- We are forecast to meet our Department of Health financial target with a small surplus of £2m.
- We are set to achieve our CQUIN targets for the year. This includes the extremely challenging 90% VTE assessment target for Jan-March 2011 which we are very close to achieving at the time of writing.
- We have continued to perform well against all Infection control targets.
- We have reconfigured our Maternity services as planned concentrating consultant births at City Hospital alongside the midwifery-led birth centre and progressing plans for a new community based midwifery-led birth centre in Sandwell to open in 2011.
- Our plans for the Compulsory Purchase of land for the new hospital were approved and the revised Outline Business Case for the new hospital was submitted to the DH and Treasury for approval.
- We have continued to see an increasing number of teams using Listening into Action methodology to work together on service changes.
- We have carried out refurbishment work and reconfigured our wards in order to comply with same-sex ward accommodation requirements a significant task given the age of parts of our hospital estate.
- In February 2011 we achieved NHSLA level 2 accreditation, passing 43 out of the 50 standards relating to risk, quality and safety. This was a tremendous achievement given the size and complexity of the organisation.

The progress made during 2010/11 should provide a firm base for the organisation to build upon in facing the challenges that lie ahead in 2011/12.

1.2 Performance against our Corporate Objectives for 2010/11

The Trust set 37 annual objectives for 2010/11. The table below contains a summary of our corporate objectives for 2010/11 with a "traffic light" indication of their achievement (as at end of December 2010).

Strategic Objective	Annual Objective	R / A/ G Rating
1. Accessible and Responsive Care	1.1 Continue to achieve national waiting time targets	
	1.2 Continue to improve patient experience	
	1.3 Make communication with GPs quicker and more consistent	
	1.4 Improve our outpatient services including appointment system	
	1.5 Ensure customer care promises are part of day to day behaviour	
2. High Quality Care	2.1 Infection control, cleanliness – continue high standards	
	2.2 Formalise quality system – maintain/improve quality of care	
	2.3 Vulnerable children and adults – improve protection and care	
	2.4 NHS Litigation Authority – achieve accreditation Level 2	
	2.5 Implement outcome of Maternity Review	
	2.6 Continue to improve services for Stroke patients	
	2.7 Improve quality of service and safety in A&E Departments	
	2.8 Achieve new CQUIN targets	
	2.9 Improve key patient pathways	
	2.10 Deliver quality and efficiency projects	
	2.11 Implement national Nursing High Impact Changes	
3. Care Closer to Home	3.1 Make full use of outpatient & diagnostic centre at Rowley Regis	
	3.2 Right Care Right Here Programme – make full contribution to projects	
4. Good Use of	4.1 Deliver planned surplus of £2.0m	
Resources	4.2 Improve expenditure by delivery of CIP of £20m	
	4.3 Review corporate expenditure in key areas	
	4.4 Ensure right amount of wards, theatres and clinic capacity	
5. 21 st Century	5.1 Continue process to buy land for the new hospital	
Facilities	5.2 Start formal procurement for construction of new hospital	
	5.3 Full involvement with PCTs on design of community facilities	
	5.4 Continue to improve current facilities	

Strategic Objective	Annual Objective	R / A/ G Rating
6. An Effective NHS FT	6.1 Care Quality Commission registration	
	6.2 Embed Listening into Action	
	6.3 Implement next stages of new clinical research strategy	
	6.4 Implement sustainability strategy	
	6.5 Progress plans for new organisational status and structure	
	6.6 Embed clinical directorates and service line management	
	6.7 Implement our Leadership Development Framework	
	6.8 Refresh Workforce Strategy and progress implementation	
	6.9 Continue to develop IM&T Strategy and improve systems	
	6.10 Develop our strategy for medical education and training	
	6.11 Improve health and well-being of staff – reduce sickness absence	

Of the 37 objectives 20 are rated Green (completed or on track to be completed), 16 are Amber (likely to be completed but delayed) and one is Red (unlikely to be completed). The single red rating reflects the fact that activity levels limited the planned reduction in bed capacity in line with our long term plans.

1.3 Service Quality Performance Rating

In the summer of 2010, following the release of the revised NHS Operating Framework, the Department of Health stated that the periodic review of NHS Organisations would cease. The Care Quality Commission (CQC) subsequently stated that there would not be a formal scored assessment of performance, but it would publish performance data aligned to the various indicators for all organisations during late autumn.

Prior publication by the CQC of the majority of performance thresholds, against which organisations would be assessed, along with a number of national operational thresholds, enabled the Trust to evaluate its performance against the various indicators which hitherto had fed into the Quality of Services component of the CQC rating.

This evaluation suggested that if a formal assessment had taken place the Trust would have achieved the required performance in all but one of the indicators, 'Delayed Transfers of Care'. As such the Trust would have improved its rating for 2009/10 for Quality of Services to Excellent, the highest rating.

1.4 National Survey Results

The results of the 2010 National Staff Survey have recently been published. They show that in six out of ten categories of the survey, the Trust performs better than most acute hospitals. It performs less well in one category and about the same in three categories.

Compared with last year the Trust has improved scores in four categories and has a worse score in two categories

The number of staff agreeing that care of patients is the Trust's top priority has climbed every year since 2007 from 45 per cent to 64 per cent last year. This figure is 6 per cent higher than the national average for acute trusts.

Other areas in which the Trust is performing well compared to other acute trusts include:

- Staff agreeing that the Trust communicates clearly about what it is trying to achieve is 59 per cent 10 per cent better than average.
- Staff saying senior management set a clear vision of where the organisation is headed is 56 per cent 8 per cent better than average.
- Staff saying senior management is focused on meeting the needs of patients is 62 per cent 7 per cent better than average.

Two areas in which the Trust was not performing as well as other trusts were:

- staff saying hand washing facilities were always available
- agreeing that they could approach their immediate manager to talk about flexible working.

While the results overall are encouraging, the Trust will work to understand in more detail the messages and lessons to learn from the staff survey and use this to inform action that needs to be taken next year.

<u>Please note</u>

The results of the national inpatient survey undertaken in 2010 have not yet been released.

1.5 Patient Activity in 2010/11

The table below summarises the Trust's high level activity for 2008/09 – 2010/11.

Туре	2008/09	2009/10	2010/11	2010/11	2010/11 vs
	Outturn	Outturn	Plan	Projected	2009/10
				Outturn	%
Admitted Patient Care:					
(Spells)					
Day cases	50,936	51,995	45,742	49,330	-5.13
Electives	13,120	13,137	12,644	11,557	-12.03
Emergencies	69,494	62,961	62,214	66,249	5.22
Unbundled		58,495	17,619	19,838	-66.09
Total	133,550	186,588	138,219	146,974	-21.23
Outpatients (attendances):					
New	155,584	158,289	155,477	155,581	-1.71
Review	380,578	410,378	371,419	419,843	2.31
With Procedure		28,163	25,515	20,357	-27.72
Total	536,162	596,830	552,411	595,781	-0.18
A&E attendances	226,871	224,811	226,978	214,073	-4.78
Rehabilitation OBDs	23,096	23,501	21,472	23,644	0.61
Neonatal OCDs	9,549	9,969	10,754	9,967	-0.02
Births	6,068	6,175		6,225	0.81
Referrals	178,070	192,945		184,029	-4.62

Patient Activity 2008/9 – 2010/11 (projected)

NB. Births are also included in the emergency spell totals in the first section of the table

The activity planned for 2010/11 was reduced in line with decommissioning targets. At month 10, outturn is projected to be higher than planned, suggesting that delivery on decommissioning has not been achieved as expected. However, this assessment may change when the figures are finalised as much of the decommissioning was profiled towards the year end.

There are also counting changes between 2009/10 and 2010/11 including:

- Obstetrics antenatal admissions are now counted as Outpatient attendances (usually a review attendance) rather than admissions – c10, 000 per annum change.
- PbR changes to unbundled activity re-bundled imaging in 2010-11, hence the large drop in plan and actual from 09-10.
- PbR also redefined (reduced numbers of) Outpatient procedures in 2010-11, again leading to the drop in actual between 2009-10 and 2010-11.

1.6 Financial Performance in 2010/11

The table below summarises the Trust's financial performance in 2010/11.

Financial Performance 2008/9 – 2010/11 (projected)					
£ million	2008/09 Outturn £m	2009/10 Outturn £m	2010/11 Plan £m	2010/11 Forecast Outturn	
	Liii	Liii	LIII	£m	
Income					
NHS Clinical Income	321.0	341.2	340.3	344.2	
Non NHS Clinical Income	1.8	3.9	2.3	3.3	
Other Income	36.4	39.7	36.2	37.2	
Total Income	359.2	384.8	378.8	384.8	
Expenditure					
Pay costs	(238.7)	(252.6)	(257.8)	(259.2)	
Non-pay costs	(94.0)	(101.3)	(93.9)	(101.4)	
Total Costs	(332.7)	(353.9)	(351.7)	(360.6)	
Operating Surplus (EBITDA)	26.5	30.9	27.1	24.2	
Depreciation, Amortisation,	(16.5)	(52.6)	(21.1)	(21.7)	
Interest and Impairments					
PDC Dividend	(9.3)	(6.9)	(7.7)	(5.7)	
Net surplus/(deficit)	2.5	(28.6)	(1.7)	(3.2)	
DH technical adjustments	0	35.9	3.7	5.2	
Surplus/(deficit) against DH	2.5	7.3	2.0	2.0	
target					

Financial Performance 2008/9 – 2010/11 (projected)

The Trust is forecast to achieve its annual Department of Health performance target of a surplus of $\pm 2,038k$ for the year ending 31^{st} March 2011.

1.7 Right Care Right Here - Progress in 2010/11

We have continued to work with partners within the RCRH Programme to develop services that deliver care closer to home, building on the exemplar projects from previous years as well as new service models. These include:

- Setting up a new Community Gynaecology service which will allow us to deliver about 20% of Gynaecology outpatient appointments in eight community locations.
- We have continued to work with partners in developing local urgent care services in Parsonage Street (Sandwell) and Summerfield Health Centre (Birmingham) as alternatives to attending A&E. These new services have seen a growth in activity with 36% of all urgent and emergency care now being provided in the community. Attendances at A&E have started to fall and are now in line with the level forecast as part of the RCRH plans.
- Increasing the use of community alternative outpatients with higher levels of activity in community locations for Cardiology, Diabetes, Musculoskeletal and Respiratory conditions than in the previous year. About 20% of outpatient activity is now being delivered in community locations.

2. Future Business Plans

2.1 Strategic overview

Our planning for 2011/12 has been based on our assessment of the national and local context within which we operate. It takes account of the need to continue to make progress with the implementation of our local health economy shared service strategy "Right Care Right Here". It also recognises the major changes and challenges facing the health service as the transition to the new system envisaged in the White Paper *Equity* and *Excellence: Liberating the NHS (July 2010)* and the *Health & Social Care Bill (January 2011)* takes place.

Specifically:

- the emergence of GP Consortia and Clusters of PCTs will mean that new commissioning bodies, possibly with new priorities will be taking shape during 2011/12
- new providers are likely to enter the local and national healthcare arena as the move towards a more competitive landscape takes shape
- the combined effect of reduced growth funding and changes to the contracting and tariff arrangements will mean productivity needs to improve significantly while improving and maintaining quality of services.

2.1.1 National Context

The Operating Framework for the NHS in England 2011/12 (December 2010) sets out the challenges in implementing the first year of this major transition whilst maintaining and improving service quality and financial performance.

Particular features include:

- NHS Commissioning Board in shadow form during 2011/12: fully operational from April 2012.
- PCT Clusters to ensure statutory functions delivered during transition and handover to GP Consortia.
- Pathfinder GP Consortia in 2011/12. All GP practices to be in consortia by April 2012.
- All NHS Trusts to become Foundation Trusts by 31st March 2014.
- Patient power, local accountability, better information, more choice to drive service improvement. Choice of any willing healthcare provider. Choice of individual consultant.
- Access standards generally to be maintained.
- Quality improvements expected in a number of areas such as cancer and stroke services. Dementia Strategy to be implemented.
- Increase Health Visitor numbers by 4200 by April 2015.
- Quality, Innovation, Productivity and Prevention (QIPP) efficiency challenge of £20 billion by end of 2014/15.

- Finance moving from position of growth to more stable settlements. Running costs will need to be reduced at every level. Two year pay freeze for staff earning over £21,000.
- Overall tariff reduction between 2010/11 and 2011/12 of 1.5% (includes efficiency).
- Best practice tariffs to be expanded and a change in the way long stays in hospital are funded.
- Services may be provided below tariff price.
- Hospitals will not be reimbursed for emergency readmissions within 30 days of discharge following an elective admission (further guidance has adjusted /redefined circumstances where this will apply).
- 30% marginal emergency admissions rate continues.
- Achieving quality targets (CQUIN) to continue to be worth 1.5% of contract income.

In addition *The NHS Outcomes Framework 2011/12*, also published by the Department of Health in December 2010, sets out the outcomes and corresponding indicators to be used to focus on delivering the outcomes that matter most to people.

The responsibilities of the NHS are set out as five domains:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

A range of indicators and improvement areas are identified across these domains and those relevant to our Trust will need to be considered during 2011/12.

2.1.2 Local Context

From 1st April 2011 Sandwell Community Health Services will become part of our Trust. About nine hundred staff will join the Trust bringing a budget of c£33m. Services transferring will include: District Nursing, Health Visiting, School Nursing, Intermediate Care, Respiratory, Musculoskeletal, Community Palliative Care, Continence, Diabetes, Foot Health, Nutrition and Dietetics, Family Planning, Tissue Viability, Children's Therapies, Heart Failure and supporting services.

The community provider function for Heart of Birmingham PCT, however, is transferring to the newly formed Birmingham Community Healthcare NHS Trust.

Locally, the shape of GP Consortia is taking form. There will be 5 Consortia which mainly commission services from the Trust, including one that crosses the boundary between the Trust's two main PCTs; Sandwell and Heart of Birmingham.

The PCTs have grouped into Commissioning Clusters. The Trust's main commissioners fall into two clusters. Sandwell PCT forms part of the Black Country Commissioning Cluster and Heart of Birmingham PCT part of the Birmingham and Solihull Commissioning Cluster.

The Birmingham and Solihull Cluster System Plan for 2011/12 includes a series of goals and initiatives upon which they will focus:

Service Development

- Planned Care
- Prescribing
- Productive Care
- Provider efficiency and configuration

Pathway Transformation

- End of life
- Maternity and children
- Mental health and dementia
- Urgent care

Healthier Living and Independence

- Ageing well
- Alcohol and tobacco
- Continuing healthcare
- Long term conditions

The Black Country Cluster System Plan highlights the following key service priorities for its population:

- Cardiovascular disease prevention and treatment
- Reducing deaths from Cancer
- Improving mental health and well-being
- Gaps in service provision for older people
- New community services in diabetes
- Improving the health of young people
- Reducing harm caused by rising alcohol consumption and abuse
- Improving maternity services reducing risks to health of babies in the first year of life and improving health of mothers.

2.1.3 Trust Strategy

The national and local contexts reinforce the need for the Trust to:

- Relentlessly focus on continuously improving all aspects of patient care
- Work closely with local commissioners as they create new organisations
- Become more efficient
- Make progress towards becoming a Foundation Trust

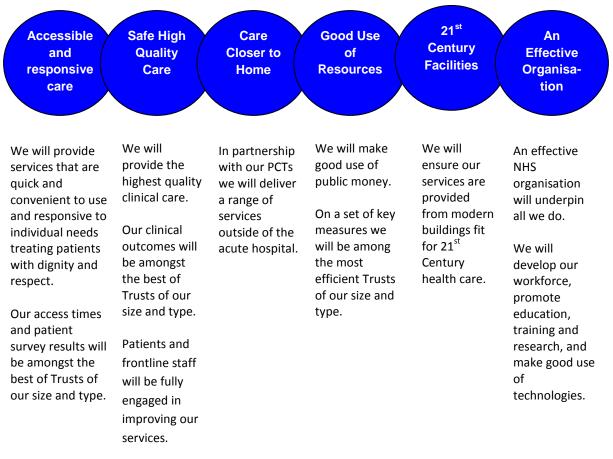
We will also need to secure approval for our Outline Business Case for a new hospital in Smethwick and achieve the benefits of integration of acute and community services in Sandwell

Having considered the changes to the external context we have not changed our vision for the future and made only a small change to our six strategic objectives that we originally set out in 2008/09.

Our vision describes an ambitious future for our organisation.

We will help improve the health and wellbeing of people in Sandwell, western Birmingham and surrounding areas, working with our partners to provide the highest quality healthcare in hospital and closer to home.

Our six strategic objectives are designed to ensure we make progress towards the successful delivery of our vision.



The change we have made to our Strategic Objectives is to change the objective to provide "High Quality Care" to an objective to provide "Safe High Quality Care" This is to reflect the ever increasing efforts we are making to improve all aspects of patient safety.

The following section sets out the actions we will take to achieve our strategic objectives.

2.1.4 Annual Objectives 2011/12

In order to ensure continued progress towards our six strategic objectives the Trust has set 33 objectives for 2011/12. These have been prepared following consultation with public and staff. The objectives, the measures we will use to judge our success and the lead director/s responsible are set out in the table below.

Sti	rategic Objective	Annual Objective 2011/12	Measure of Success	Lead Director(s)
1.	Accessible and Responsive Care	1.1 Identify and implement specific ways of improving the health of the population we serve.	 Catalogue of relevant indicators drawn from primary care but mapped to each directorate Discussions with Directors of Public Health to establish priorities Identify data sources and create data flow for each indicator Incorporate indicators into SWBH QMF dashboards for each directorate or specialty Incorporate indicators into a Clinical Quality dashboard for RCRH 	Medical Director
		1.2 Ensure close and effective relationships with local GP consortia and PCT Clusters.	 Deliver on medical engagement LIA action plan. Identify leaders and opinion formers in each consortium and continue active engagement. Promote and improve direct contacts between directorates and primary care clinicians. Trust represented by Executive or senior Medical leads at all Cluster meetings for Birmingham and Solihull and the Black Country. 	Director of Strategy & Organisational Development (with MD)

Strategic Objective	Annual Objective 2011/12	Measure of Success	Lead Director(s)
		 Integrate work of Business Development Team with representatives from each Division. Improve flow of information and communication between hospital doctors and GPs. 	
	1.3 Deliver Access performance measures including those set out in the Operating Framework for 2011/12.	 New A&E standards. 18 weeks referral to treatment standard maintained (95th percentile). Cancer waiting times (2 wks, 31 days & 62 days) standards maintained. GUM 48 hr access standard maintained. Rapid access chest pain standard (2 wk) maintained. 	Chief Operating Officer
	1.4 Continue to improve outpatient booking systems.	 Hospital short notice cancellations reduced so that less than 20% of total are short notice (35% in Feb). DNA rate reduced to less than 10% (12% in Feb). Hospital initiated cancellations reduced to less than 15% of appointments made in month (16% in Feb). 	Chief Operating Officer
	1.5 Improve patient flow from admission through discharge to home care / after care.	 Acute delayed discharges reduced to less than 4% of acute beds (5% in Feb.) Average hospital length of stay maintained at less than 4.5 days (4.4 in Feb). Numbers of very long stay patients (>28 days) reduced to 150 or less (187 in Feb). Reduced readmissions within 30 days (baseline to be set in line with national guidance). 	Chief Operating Officer

Strategic Objecti	ve Annual Objective 2011/12	Measure of Success	Lead Director(s)
2. High Quality Care	2.1 Improve reported levels of patient satisfaction.	 Establish systems to seek patient/carer/user views that ensure all groups are represented. Establish reporting and feedback systems of patient views at the Trust, Division, Directorate and Department level. To ensure action plans exist and are delivered against areas of dissatisfaction/requiring improvement. To have a list of priority patient experience improvement themes/topics and corporately plan and deliver the action. Ensure external views are fed into internal feedback systems. To deliver CQUIN target for patient experience improvement. To measure behaviours against Trust Promises. To develop an approach to 'customer care' training. 	Chief Nurse (with all Execs)
	2.2 Continue to embed Customer Care promises.	 Refresh the customer care promise action plan in line with the feedback from Hot Topics. Regular analysis of patient survey results and complaints by customer care promises. Revised recruitment, induction and appraisal processes focusing on customer care. 	Head of Communications & Engagement

Strategic Objective	Annual Objective 2011/12	Measure of Success	Lead Director(s)
	2.3 Improve the care we provide to vulnerable adults.	 Ensure systems and processes for vulnerable adults are embedded in all clinical areas – including Deprivation of Liberty, Safeguarding, and Mental Health. Deliver level 1 and 2 training targets. Relevant policies are in place. Delivery of targets set within dementia action plan. Establishment of domestic violence training. Achievement of standards/rules of the Mental Health Act. CQC and NHSLA standards met. Nutrition CQUIN achieved. Falls and pressure damage targets achieved. 	Chief Nurse
	2.4 Make improvements in A & E services.	 Build on the work from 2010/11 in respect of integration. Ensure that newly developed systems become embedded and continue to support safer and more responsive care. Ensure that the agreed financial investments lead to the successful recruitment of high quality Clinical staff (Medical and Nursing). Implement systems to monitor and manage performance in respect of the new ED quality standards. 	Medical Director
	2.5 Make improvements in Trauma and Orthopaedic services.	 18 week waiting time standard achieved for orthopaedics (c. 70% in 18 weeks in Feb). Workforce plan agreed and delivered for T&O wards. Improved service line position for T&O. 	Chief Operating Officer

Strategic Objective	Annual Objective 2011/12	Measure of Success	Lead Director(s)
		• Improved outpatient performance (reduced cancellations, short notice cancellations and review rates).	
	2.6 Make improvements in Stroke services.	 Stroke dashboard fully populated and incorporated into the Quality Management Framework. Ensure that performance remains in the top Quartile nationally. Continued improvements in KPIs for Stroke and TIA pathways. Ensure robust management structure for stroke services including clarity on reporting lines and accountability. Develop an option appraisal in partnership with commissioners to ensure optimal configuration of Acute and rehabilitation components of stroke/TIA services and pathways. 	Medical Director
	2.7 Embed the Quality and Safety Strategy incorporating the FT Quality Governance Framework.	 Achieve the plan developed to ensure effective implementation of the Quality and Safety Strategy. Positive outcomes to support the Trust's top 3 quality related priorities. 	Director of Governance (with all Execs)
	2.8 Improve and heighten awareness of the need to report and learn from incidents.	 Annual rate of incident reporting increased at least 10% on previous year. Improved position with the NRLS report as benchmarked against similar size Trusts. Reduced number of incidents that cause harm, of a similar nature and / or within the same environment / location. 	Director of Governance

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Strategic Objective	Annual Objective 2011/12	Measure of Success	Lead Director(s)
	2.9 Deliver the CQUIN targets.	 Targets to be finalised but will include: VTE prevention Improving patient experience Alcohol abuse prevention Smoking cessation Nutrition assessment on admission End of life care – choice of place to die Mortality reviews Enhanced recovery Stroke discharge Medicines management Health Visiting response times Falls Assessment Access to chemotherapy out of hospital Improving access to organs for transplant Avoiding preventable blindness in neonates Improving neonatal care pathways 	Chief Nurse/ Medical Director/ Chief Operating Officer
3. Care Closer to Home	 3.1 Ensure a successful integration of adult and children's community services that has benefits for patients. 3.2 Deliver the agreed changes in activity required as part of the Right Care Right Here programme. 	 Transfer successfully completed in April. Agreed benefits realisation plan in place by end Q1. Integration / benefits realisation delivered as planned. Decommissioning plan agreed with commissioners (value = £16m). Plan successfully delivered by end of the 	Chief Operating Officer (with CN) Chief Operating Officer
	3.3 Play a key role in the local community, actively promoting healthy lifestyles and health education.	 Development and approval of health promotion strategy. Delivery of health promotion / education LiA and resulting action plan, involving all key stakeholders. 	Head of Communications & Engagement

Strategic Objective	Annual Objective 2011/12	Measure of Success	Lead Director(s)
		 Launch of involvement website to promote healthy lifestyles. Lead the development of a RCRH health promotion and education strategy. Participate in joint venture tender for lifestyle services. 	
	3.4 Develop a local response to national plans for Health Visiting.	 Implementation plan supported by PCT/SHA. Clear recruitment plans. Increase University commissions. Review of team skill mix. Retention plan in place. New models of care developed, including family partnerships. 	Chief Nurse
	3.5 Make fuller use of the facilities at Rowley Regis Community Hospital to provide care closer to home.	 Launch of new intermediate care unit in June. Agree and deliver plan for services at Rowley in 2011/12. Increased numbers of outpatient clinics scheduled at Rowley. 	Chief Operating Officer
4. Good Use of Resources	4.1 Deliver a £21.1m CIP and produce detailed plans to deliver a £20m annual CIP for a further three years.	 Presentation of the line by line CIP plan for the next financial year as assessed for quality and risk, deliverability and presented to the Finance and Performance Committee as part of the Trust Board's approval of the overall plan. Continuation of the robust monitoring and management of the plan via the Performance Management Board including tracking of replacement schemes, Full year/part year effects and any shifts from recurrent 	Director of Finance & Performance Management (with all Execs)

Strategic Objective	Annual Objective 2011/12	Measure of Success	Lead Director(s)
		 categories to non-recurrent. Develop and agree the basis of allocating operational targets as part of 3 year CIP, ensuring capacity and expertise is developed so that plans are expressed in QUiPP and QuEP categories making use of all internal and external benchmarking data, e.g. SLR. Completion target to be consistent with commencement of strategic CIP work, end of Q1. Integration of the plan within overall financial modelling including explicit crossmodel audit trails of the impact of CIPs within the external and internal financial models (e.g. LTFM, LTSM, FIMS) 	
	4.2 Achieve a £2m surplus.	 Prepare a detailed financial plan with sufficient income based resources to meet anticipated expenditure in accordance with operating framework imperatives, capacity plans and risk reserves. Ensure that Board reporting is clear between the DH target surplus and IFRS based bottom line results that take account of on-balance sheet treatment of long term contracts Ensure that variations in the plan are reported at the earliest opportunity together with corrective mitigating plans as developed and implemented through the Performance Management Board. 	Director of Finance & Performance Management

Str	ategic Objective	Annual Objective 2011/12	Measure of Success	Lead Director(s)
		4.3 Reduce premium rate working.	 Premium rate working reduced by £1.8m compared with 2010/11 outturn. Theatre utilisation improved: <20% late starts, <25% early finishes, average of >3.5 cases per list). 	Chief Operating Officer
		4.4 Develop plans to improve the service line position of the Trust.	 Identify three services. Evaluate baseline position. Develop improvement plan for each service. 	Director of Strategy & Organisational Development
5.	21 st Century Facilities	5.1 Begin to Procure a new hospital.	 OJEU notice placed. GVD executed. Clarity on Deed on Safeguard achieved. 	Director of Estates/ New Hospital Project Director
		5.2 Continue to improve current facilities.	 Updated Estates Strategy. Capital programme on plan. Satisfactory environmental assessments (CQC, Hygiene Code, PEAT etc). 	Director of Estates/ New Hospital Project Director
		5.3 Develop detailed plans for the development of the community estate.	 RCRH Community Facilities Programme Team embedded. Programme for development agreed. Initial projects commenced. 	Director of Estates/ New Hospital Project Director
6.	An Effective Organisation	6.1 Obtain approval to become a Foundation Trust.	 Develop a detailed project plan. Ensure delivery of all milestones in the project plan. Secure any additional support required for the application including stakeholder support. 	Director of Strategy & Organisational Development

Strategic Objective	Annual Objective 2011/12	Measure of Success	Lead Director(s)
	6.2 Deliver a set of Organisational Development activities including a stronger voice for front line staff.	 Develop an OD framework and action plan to support FT application. Deliver a model of staff engagement and incentive system. 	Director of Strategy & Organisational Development
	6.3 Develop our clinical systems and processes to reduce variability and ensure safe, error free care.	 Continue diagnostic project in respect of Clinical Back Office Systems. Establish Project Board to deliver on Paperlite and Clinical Back Office Projects. Relevant processes (including SBAR for reliable clinical handover, "kitemarking" clinical offices and departments for information standards & root cause analysis) developed and embedded in all clinical departments. 	Medical Director
	6.4 Improve staff satisfaction, health and wellbeing.	 System of gathering staff views throughout the year. Identify actions arising from staff views. Publish staff survey results. Regular communications to staff. Health and Wellbeing action plan – delivery against timescales. Reduction in sickness absence. Measurable improvements in survey results. Links to OD/OTF plans around staff engagement and ownership. 	Chief Nurse

Strategic Objective	Annual Objective 2011/12	Measure of Success	Lead Director(s)
	6.5 Agree an IT strategy including an affordable route to procurement of an Electronic Patient Record.	 Programme board set up and running. Option appraisal complete. Decision-making process agreed and underway. 	Medical Director
	6.6 Continue to develop and implement the Trust's approach to sustainability and transport and access.	 Carbon Management Plan agreed. Sustainability action plan on target. Review and update travel plan. 	Director of Estates/ New Hospital Project Director
	6.7 Develop a training plan that reflects service needs, is resourced and supports the workforce plan.	 Trust Training Plan developed by May. Funding to support plan agreed June/July. LBR and JIF funding identified. Commissions with higher education institutions agreed. L&D Committee monitoring of plan. Plan clearly linked to workforce plan due September. Learning Hub/Health tech proposal written and presented to relevant parties. 	Chief Nurse

2.2 Service Development Plans

Our plans for 2011/12 are designed to ensure delivery of the Annual Objectives. This section provides an overview of the most significant service developments included within these plans.

2.2.1 Activity Levels

The table below sets out planned activity levels for 2011/12 – 2013/14 based on the agreed LDP for 2011/12 and the assumptions in our Long-Term Financial Model.

000's of cases					
	Plan 10/11	Forecast Outturn 10/11	2011/12 Plan*	2012/13 Forecast	2013/14 Forecast
Elective	58.4	60.9	62.4	60.3	60.7
Non-elective	62.2	66.2	62.4	58	58.1
Unbundled	17.6	19.8	14.2	14.2	14.2
Outpatients	552.4	595.8	609.3	582.8	545.1
A&E	227.0	214.1	219.2	226.5	230
Rehab OBDs	21.5	23.6	23.2	23.2	23.2
Neonatal OCDs	10.8	10.0	11.3	11.3	11.3

Clinical Activity

* 2011/12 Plan is draft activity prior to PCT disinvestment proposals being formalised (by 31st March). This should reduce some of the inconsistency between 2010-11 plan and LTSM figures for 2012-13 onwards.

As part of the Right Care Right Here programme and our contractual agreement for 2011/12 with our main commissioners, a comprehensive programme of service redesign is being developed. This will also include targeted plans to reduce some aspects of activity in our hospitals and provide more activity closer to people's homes.

2.2.2 Right Care Right Here

Our priorities for 2011/12 include continuing to work closely with primary care colleagues to support further moves to the levels of work agreed through the RCRH Programme. The LDP also commits us to this priority. The following are some of the key changes we will be working on:

- Implementing new care pathways for agreed conditions including Cardiology. These will allow patients to receive more of their ongoing care from the primary care team and so closer to home, with ongoing support to the primary care team from the specialist hospital team. This will also reduce the number of follow-up hospital appointments.
- Implementing a new model of intermediate care in the inpatient beds at Rowley Regis Hospital that focuses on enhanced assessment and re-ablement in order to ensure more people can return to their own homes, with support from a community service if needed, rather than being admitted to a long term care home.

• Further development of the Urgent Care Centres and supporting care pathways especially in relation to mental health, children's respiratory conditions, chest pain, musculoskeletal pain and raising the public's awareness of these services as alternatives to attending A&E.

2.2.3 Quality & Efficiency Programme

2010/11 saw the first year of our three year Quality and Efficiency Programme (QUEP). The programme is designed to ensure continued improvement in quality of service and productivity and support the development of our cost improvement programme.

In 2011/12 the programme will consist of 16 projects addressing:

- Improvements to Outpatients, Theatres and utilisation of our beds in order to improve patient experience, quality of care and make the best use of our clinical staffing.
- Demand management and decommissioning, working closely with primary care, to deliver on commitments to changes in models of care in preparation for the new hospital.
- Realising the benefits from the transfer of the Sandwell Community Services to the Trust including better communication between staff, improved quality of patient referrals, shared access to clinical data, standardisation of assessments and reduced duplication.
- Workforce improvements aimed at ensuring effectiveness of our staff, developing new roles, reviewing and standardising practice and appropriate staff deployment. Cost savings will also be sought through reduced sickness absence, reduced use of bank and agency staffing and reduced premium rate working.
- Improvement to clinical administration systems, accurate coding and counting of patient activity, analysis of service line reporting data and development of service line management.
- Estates rationalisation to make the best use of our buildings and save costs where possible.

2.2.4 CQUIN Targets

As part of the LDP with commissioners the Trust is agreeing a range of Commissioning for Quality and Innovation (CQUIN) targets. In accordance with the NHS Operating Framework for 2011/12 the total value of the CQUIN scheme for 2011/12 is 1.5% of total contract value.

The targets for 2011/12 include –

Nationally mandated targets for adult acute services:

- Reducing avoidable death, disability and chronic ill health from Venousthromboembolism : VTE prevention
- Patient Experience Improve responsiveness to personal needs of patients (improving outcomes from patient surveys)

Local agreement - targets still to be finalised:

- Alcohol abuse prevention health promotion intervention
- Smoking cessation health promotion intervention
- Alcohol and smoking educating staff to promote health
- Nutrition assessment on admission
- End of life care choice of place to die
- Mortality reviews
- Enhanced recovery
- Stroke discharge
- Medicines management missed doses

Community Services targets:

- Smoking cessation
- End of life care choice of place to die
- Improving patient experience outcomes from patient surveys
- Health Visiting response times
- Falls assessment

Specialised Services targets have a total value to the Trust of £316,965 including the 2 national targets above plus:

- Access to chemotherapy out of hospital increasing the number of chemotherapy deliveries made at home or in community setting
- Improving access to Organs for Transplant
- Avoiding preventable blindness in neonates : Screening for Retinopathy of Prematurity (ROP)
- Improving neonatal care pathways

2.3 Operating Resources Required to Deliver our Annual Plan

This section of the plan sets out the Trust's finance, workforce and capital plans for 2011/12.

2.3.1 Finance

The table below summarises the Trust's financial plan for 2011/12 – 2013/14.

Summary Financial Plan 2011/12 – 2013/14

Category	2008/9	2009/10	2010/11 Forecast Outturn	2011/12 Plan	2012/13 Plan	2013/14 Plan
	£m	£m	£m	£m	£m	£m
NHS Clinical Income	317.2	342.6	341.3	370.4	350.2	345.6
Non NHS Clinical Income	1.8	2.5	2.3	2.2	3.6	3.8
Other Income	40.2	39.7	40.2	40.6	40.6	40.9
Total Income	359.2	384.8	383.8	413.2	394.4	390.3
Total Costs	(332.6)	(353.9)	(359.9)	(389.4)	(369.3)	(364.4)
Operating Surplus (EBITDA)	26.6	30.9	23.9	23.8	25.1	25.9
Depreciation, Amortisation, Interest and Impairments	(14.8)	(52.6)	(21.3)	(15.6)	(15.3)	(15.5)
PDC Dividend	(9.3)	(6.9)	(5.8)	(5.8)	(6.0)	(6.3)
Net Surplus / (Deficit)	2.5	(28.6)	(3.2)	2.4	3.8	4.1
IFRS/Impairment Adjustments		35.9	5.2	(0.6)	(0.5)	(0.5)
Net Surplus/(Deficit) for DoH Target		7.3	2.0	1.8	3.3	3.6

The Local Delivery Plan

The LDP (local delivery plan) for 2011/12 encompasses the activity, finance and contract terms that underpin the income anticipated in the new financial year.

The LDP agreement sought to address:

- The full year effect of decommissioning specific activity in 2010/11 carrying forward into 2011/12. This includes procedures of limited clinical value, reductions in new:review outpatient ratios and reductions in consultant to consultant referrals.
- The impact of activity performance in excess of the RCRH trajectories and the pace at which all parties must work to get back on track.
- The basis for formulating activity estimates for 2011/12 (rolling averages versus trend data).

The final contract agreement is planned to be in force as from 1 April 2011. The contract settlement includes a continuation of the transitional financial framework resources to recognise the lagging nature of fixed and semi-fixed cost release as activity reduces.

Income has been modelled at a level slightly below the current year's forecast in cash terms owing to the tariff deflator (£380m versus £384m respectively, excluding the additional community services set to transfer in). CQUIN funding remains at 1.5% in total.

The activity that underpins the 2010/11 income is based on RCRH trajectories and a mix of existing trends. Consequently, the work on de-commissioning specific cohorts of activity continues and will be incorporated in the final price activity matrix.

An estimate has been made regarding other non patient related income sources (educational levies and research) as formal notification is yet to be received.

Expenditure Plans and Cost Improvement Plan

Expenditure Plans are based on start point budgets, activity related changes, the implementation of cost improvement plans, regulatory pressures, wage and other contractual increases and agreed developments with commissioning bodies. An overall picture of Income and Expenditure is presented above. This shows total income as £413,199,000 (inclusive of £33,007,000 TCS transfer) which after costs results in a surplus of £1,807,000. The income position is now based upon agreed values for those PCT contracts overseen by Sandwell PCT (i.e. general and acute services for West Midlands PCTs). Final confirmation of other income budgets is not yet complete, e.g. specialised services and meetings continue in this regard.

This year's plan contains less flexibility when compared with 2010/11. This reflects a challenging CIP target within the tariff (4.0%) coupled with additional local savings plans.

Delivering the cost improvement target savings of £21.1m (inclusive of TCS) is one of the key central programmes for the forthcoming year. The present rigorous system of tracking and scrutinising the content and implementation risks (complete with mitigating actions) shall continue to ensure maximum delivery.

2.3.2 Workforce

The table below sets out a summary of our workforce plans for 2011/12.

Budgeted WTE by Staff Group

Category	April 2010	March 2011	April 2012
		projected	projected
Medical	777	788	788
Managers	237	279	270
Administrative and Estates	1,216	1,397	1,349
Nursing and Midwifery / Healthcare Assistants and Support	3,146	3,530	3,437
Scientific Therapeutic and Technical	1,049	1,195	1,165
TOTAL	6,425	7,189	7,009

Note: WTEs for March 2011 and April 2012 include staff transferring from Sandwell Community Health Services, currently employed by Sandwell PCT.

2.3.3 Capital Programme

The table below summarises the Trust's Capital Programme for 2011/12. The capital programme totals £24.1m including additional resource for the land purchase for the new hospital.

	£000
Capital Resources	
Internally Generated Cash (depreciation)	13,500
NHS Capital Loans	10,600
Total Resources	24,100
Capital Expenditure	
Right Care, Right Here - Land Acquisition	13,000
Statutory Standards/Fire/DDA/ Estates/ Security	3,000
Medical Equipment	700
IT Programmes	500
Capitalised Salaries	475
Other Slippage and Retentions B/F	300
Digital Mammography	1,818
Carbon Management	500
Ophthalmology & Plaster Room, SGH	500
E-Rostering	450
BMEC Accommodation Changes	90
A&E IT System Changes	225
Ward Refurbishment D11	500
Ward Refurbishments other	500
Vehicle Replacement	450
Pharmacy Robotics	430
Other Schemes	662
Total Expenditure	24,100
Under/(Over) Commitment against CRL	0

Capital Programme 2011/12

The capital programme is dominated by the acquisition of land in Grove Lane as part of the RCRH new hospital project. Statutory standards, medical equipment and IT programmes are continuations of ongoing schemes.

3. Risk Analysis – MS TO DISCUSS/AGREE WITH EXECS

The Trust has a well-established system for identifying and managing risk to the delivery of our services and the achievement of our objectives. At this stage the plan contains a high level assessment of the major risks to delivery of our plan.

The risks have been scored in line with the Trust's standard approach to risk assessment based on a scale of 1-5 for impact and likelihood.

Risk	Score (Impact x Likeli- hood)	R/A/G	Lead Director	Mitigating Action	Post Mitigation Score	R/A/G
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

4. Membership

4.1 Membership Report

During the year, the membership of the Trust has been largely stable, as shown in the figures below. This year the Trust has been focused on engaging with young people, the trust has attended school careers fairs and has hosted careers fair's as a way of recruiting younger people as members.

The size of our membership and expected movements in 2011/12 are set out in the table below.

Public constituency	Last Year 2010/11	Next Year (estimated) 2011/12
At year start (April 1)	7,542	7504
New members	166	700
Members leaving	209	200
At year end (March 31)	7504	8000
Staff constituency	Last Year	Next Year (estimated)
At year start (April 1)	6,485 (eligible members)	6,684
New members	685	1148
Members leaving	486	476
At year end (March 31)	6,684	7,356

Membership size and movement

Analysis of current membership (based on 7,540 public members as at February 2010) of total public constituencies (the wider West Midlands) is shown in the table below.

Public constituency	Number of members	Eligible membership
Age (years):		
0-16	433	428,612
17-21	482	332,660
22+	6589	3,768,599
Not Known		
Ethnicity:		
White	4353	4,674,296
Mixed	128	73,225
Asian or Asian British	1734	385,573
Black or Black British	804	104,032
Other	189	30,182
Not Known	296	
Socio-economic groupings:		
ABC1	2820	1,913,858
C2	1235	685,541
D	1560	794,461
E	1873	700,084

Public constituency	Number of members	Eligible membership
Gender:		
Male	2902	2,575,111
Female	4455	2,692,197
Not Known	147	

4.2 Membership Commentary

Engaging with members continues to be a priority for the Trust through a variety of Communications methods. Members will this year receive a quarterly newsletter as the volume of information the Trust wishes to share with our members has grown considerably. In addition the Trust will also be launching a new Members website where members will be able to easily access information about engagement events, talk with other members and once we become a Foundation Trust will also enable Members to communicate effectively with their Governors. Work will progress throughout 2011/12 to further improve methods of communication in line with Governor and Members needs.

Over the last 12 months the Trust has had a series of successful engagement events including the AGM, careers events and Health talks which have attracted large number of members. In November 2010 the Trust invited members to an event which focused on discussing what members would like to get involved in over the next 12 months. Members indicated they would like more Health talks focused on current health issues which are prominent in our area for example Tuberculosis and Heart Disease. The trust will also be setting up further focus groups around prominent health issues.

5. Monitoring our Performance

The Trust has in place a Performance Management Framework that is continually developing. Key elements of the Framework include:

- Monthly review of performance on a wide-range of measures by Executive Team and Trust Management Board;
- Monthly oversight through Finance & Performance Committee chaired by a Non-Executive Director;
- Monthly reports to Trust Board;
- Quarterly review of Divisional performance by Executive Team;
- Quarterly review of Clinical directorate performance by Divisional management teams;
- Quarterly report to Trust on progress with corporate objectives.

We will continue to use this established system to ensure the successful achievement of our objectives for 2011/12.

Sandwell and West Birmingham Hospitals

NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Final Draft Financial Plan
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Robert White, Director of Finance and Performance Mgt
DATE OF MEETING:	31 March 2011

SUMMARY OF KEY POINTS:

This paper presents the final 2011/12 draft financial plan for consideration and approval by the Trust Board.

The financial plan was reviewed and scrutinised by the Finance & Performance Management Committee on 24th March 2011.

The forecast of income and expenditure is consistent with wider health economy plans culminating in an agreed budget surplus target of just over £1.8m based on a turnover of £413.2m.

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

Approval	Receipt and Noting	Discussion
Х		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to:

RECEIVE the final draft budget

APPROVE the 11/12 Budget as part of the 3 year financial plan as recommended by the Finance & Performance Management Committee

AGREE to receive in-year monitoring of financial performance

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Delivery of CIP plan and financial surplus target.
Annual priorities	Supports achievement of strategic and operational objectives
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

Financial	Х	Provides the basis for delivering volumes and quality patient care within predefined resources
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

The Finance & Performance Management Committee has considered the draft plan during January to March 2011.

Sandwell & West Birmingham Hospitals NHS Trust

Paper to the Trust Board Thursday 31st March 2011

2011/12 Budget & Medium Term Financial plan

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Sandwell & West Birmingham Hospitals NHS Trust

Paper to the Trust Board Thursday 31st March 2011

2011/12 Budget & Medium Term Financial plan

1.0 Introduction

This paper presents the final draft budget plan for 2011/12 – 2013/14 which provides detailed plans for 2011/12 and financial planning estimates for year 2 and 3. These documents have been reviewed in detail by the Finance & Performance Management Committee on 24th March 2011. The plan has been compiled in accordance with the statutory duties of an NHS Trust. All supporting schedules will be brought together in a 'Budget Book' complete with summarised CIP (cost improvement plan) schemes. The financial assumptions and forecasts are presented to the Trust Board for approval. A 'Foreword' is to appear at the beginning of the Budget Book. The suggested draft is as follows:

Foreword

At the time of writing the Trust is on course to deliver a surplus of £2,038,000 in 2010/11. This was the value of the surplus agreed by the Board in March 2010 (in accordance with the DH target) and the organisation can be proud of itself for continuing to deliver high quality healthcare to its patients within the resources available to it. In certain areas budgetary pressures are present as a result of responding to patient care demands during the busy winter period and maintaining waiting times for planned/elective care. The Trust and its partners are acutely aware that the funding position in the health economy is set to change and a range of system levers will be introduced in 2011/12 that seek to reduce hospital based activity in favour of community/primary care alternatives.

The Trust is well placed to respond to these challenges given the RCRH (right care, right here) partnership and its plans to devolve activity to the community and concentrate inpatient and specialist acute services. It is important in the period of transition that costs are effectively managed and quality is maintained and improved. The Budget Book plan contains challenging targets in this respect and all staff members have a role to play in ensuring delivery of 'value for money' services. The efficiencies required and streamlining of services will only be achieved through the joint efforts of all stakeholders. This is vital for ensuring effective, safe, clean and efficient services to patients.

Roger Trotman Chair Finance & Performance Management Committee Robert White Director of Finance & Performance Mgt

2.0 Planning Context

2.1 High Level Control Totals

For as long as the Trust remains within the performance management remit of the West Midlands SHA (Strategic Health Authority) it must adopt high level control totals involving surplus results and capital spending limits. The SHA has previously issued multi-year surplus control totals and broadly speaking these have not changed (the next page shows a summary of PCT target surpluses and NHS Trusts in the Black Country which are subject to change). Irrespective of the corporate form (Foundation Trust or NHS Trust), the department of health requires the delivery of surpluses. This approach fosters financial stability and other associated benefits such as:

- future investment (predominately a conversion into capital spending where additional Capital Resource Limit is granted)
- strengthening of the Statement of Financial Position (balance sheet) as organisations prepare for self-governing status
- creating sufficient surpluses to counteract the effects of an adverse risk

The SHA must share out its overall underspending target and for PCTs & Trusts this is decreasing over time. Consequently, there is a downward trend in the value of surplus targets for non Foundation Trust Hospitals and PCTs. The table overleaf shows Black Country provider Trusts, followed by PCT budgeted positions (*please note: The Dudley Group of Hospitals NHS Foundation Trust does not fall under the SHA for performance management purposes*).

BLACK COUNTRY	Surplus £000s					
Provider	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Dudley and Walsall Mental Health Partnership NHS Trust	- 7,355	850	850	350	351	349
Sandwell and West Birmingham Hospitals NHS Trust	7,262	2,038	1,807	2,000	2,011	2,023
Sandwell Mental Health NHS and Social Care Trust	121	465	544	538	561	589
The Royal Wolverhampton Hospitals NHS Trust	8,374	9,249	8,992	7,804	6,043	6,683
The Dudley Group of Hospitals NHS Foundation Trust	656	243	935	1,872	2,329	2,716
Walsall Hospitals NHS Trust	1,994	3,933	2,499	2,100	1,981	1,919

Organisation Name	Cluster	Org Code	2011-12 Control Total Target	
			G	
			£000	
Coventry PCT	ARDEN	5MD	£5,000	
Warwickshire PCT	ARDEN	5PM	£1,000	
			£6,000	
South Birmingham PCT	BIR/SOL	5M1	£1,000	
Heart of Birmingham PCT	BIR/SOL	5MX	£9,000	
Birmingham East & North PCT	BIR/SOL	5PG	£1,000	
Solihull PCT	BIR/SOL	TAM	£1,000	
			£12,000	
Walsall PCT	BLK CO	5M3	£1,000	
Wolverhampton PCT	BLK CO	5MV	£10,000	
Dudley PCT	BLK CO	5PE	£1,000	
Sandwell PCT	BLK CO	5PF	£1,000	
			£13,000	
North Staffordshire PCT	STAFF	5PH	£1,000	
Stoke PCT	STAFF	5PJ	£1,000	
South Staffordshire PCT	STAFF	5PK	£1,000	
			£3,000	
Herefordshire PCT	W MER	5CN	£1,000	
Shropshire County PCT	W MER	5M2	£1,000	
Telford and Wrekin PCT	W MER	5MK	£1,000	
Worcestershire PCT	W MER	5PL	£1,000	
			£4,000	
			000.000	
Total PCTs			£38,000	

PCT Control Totals (subject to change during March 2011)

Plans continue to be finalised, but at present the PCTs make up the majority of the SHA's contribution to the central underspend, which is estimated to be approximately £55m.

West Midlands Capital Allocations

The table below is an excerpt from SHA planning documents. They are draft plans at present, but if maintained, are helpful to the Trust in that the provider element has risen (given our recent request for additional capital resources).

		2010-11		2011-12		
	PCT	Trust	PCT	Trust		
	£m	£m	£m	£m		
WM	66	122	40	140		
England	864	1549	505	1374		

Within our Health Economy, Sandwell PCT's final budgetary plan is expected to be at breakeven or a small surplus whereas as Heart of Birmingham PCT is expected to deliver a planned underspend of £9.0m. The Trust's target surplus target £1.8m, sits within the context of a challenging cost improvement programme (£20m). Activity reductions agreed as part of the LDP are made possible through the transitional financial framework agreed by RCRH partners. This is especially important given the nature of fixed cost behavior in the short to medium term.

2.2 DH planning timetable 2011/12

The Trust and its PCT partners were successful in meeting the schedule of deadlines for agreement of the 2011/12 LDP*. The associated patient care is to be delivered in the context of the published and emerging performance management framework for the NHS together with Monitor's compliance regime. A summary of these two schedules of indicators is appended to this report. (*LDP – Local Delivery Plan refers to the schedule of services, activity and prices agreed [excluding prices governed by the national tariff] between Trusts and Commissioners).

Month	w/c	Previously Notified Requirements	Post Submission New Requirements	Operating Framework New Requirements
January 2011	3rd Jan	(6/7) Cluster Quarterly Reviews	(4) Author Plan workshop	
	10th Jan		(10) Cluster CEO and SHA report	
	17th Jan	(21) LTSM resubm'n	(21) Cluster System Plan Resubm'n	(18,19) Review Fin Strategy with Clusters (21) FIMS & Perf Measures
	24th Jan	(27) Region System Plan to DH		1st weekly call To discuss contract issues
February 2011	31st Jan			2nd weekly call
	7th Feb			3rd weekly call
	14th Feb		(18) Cluster System Plan Resubm'n	4th weekly call
	21st Feb			5th weekly call Contract agreement
March 2011	28th Feb			Conciliation/ Arbit'n
	7th March			Conciliation/ Arbit'n
	14th March		(18) Final System Plan	Conciliation/ Arbit'n
			Contract agreement	(16) FIMS& Perf Measures
				(18) Final Signed Con't
	21st March			(25) Final Regional
				System Plan to DH

The detailed timeline for the next 3 month planning period is as follows:

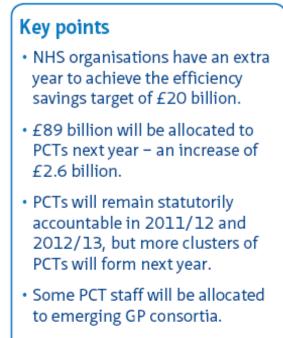
The Trust and PCTs reached agreement on overall resource and activity volumes on 25th February 2011 and have now to resolve detailed contracting terms during March 2011.

Much of the modeling was undertaken against the previous 'road test' tariff. Similar to discussions in Feb/Mar 2010, the LDP negotiations explored measures aimed at better

managing demand for acute services, which was as much linked to preparing for reduced funding settlements as it was ensuring partners were on course to meet the trajectories within the RCRH (Right Care, Right Here) programme. This culminated in a range of variations to standard contract terms. At the time of writing, the Trust and coordinating PCT are working through the detail of the agreement and therefore the Head of Terms will be shared when complete.

3.0 <u>The Operating Framework</u>

The operating framework was published on 15th December 2010 and many of its features have been circulated within the Trust. The NHS Confederation published a summary with the key points being:



- Alterations in tariff and non-tariff prices for providers are outlined.
- SHAs will hold back 2 per cent of PCTs' allocations to ensure funds are available to meet the costs of change.
- An outcomes framework has been published containing outcome goals to help focus on health improvements achieved.

Source: January 2011, Issue 212, NHSConfed

The OF presents the financial constraints within which the NHS will be expected to operate in 11/12 and future years. Key financial and business elements include the following:

• 31 new quality standards being developed by NICE

- £20 billion efficiency savings required across the NHS for reinvestment over the spending review period
- every PCT needs to ensure that 2%of recurrent funding is only ever committed nonrecurrently, this resource being held by SHAs with PCTs being required to submit business cases
- average growth in recurrent allocations for PCTs is 2.2% with a minimum growth of 2.0%
- a national efficiency requirement of 4% and the uplift for pay and price inflation of 2.5%
- tariff prices for 2011/12 reflect the 4% efficiency requirement with 2% embedded in tariff design with the remaining 2% offsetting the pay and prices uplift
- prices for services outside the scope of the national tariffs to reflect a reduction of 1.5%
- in 2011/12 hospitals will not be reimbursed for emergency readmissions within 30 days
 of discharge following an elective admission and all other readmissions within 30 days
 of discharge will be subject to locally agreed thresholds, set to deliver a 25% reduction,
 where possible. There is an expectation that local arrangements will put in manage the
 risk associated with this pronouncement
- to drive efficiency further in the tariff, the way in which long stays in hospital are funded is changed by introducing a five-day trim point floor so that relatively short stays do not attract a long stay payment
- all tariffs are set at 1% below the average as an initial step in pricing policy to set tariffs below the national average level
- the change to the calculation of trim points, setting tariffs below the average and the expansion of best practice tariffs mean that a 2% efficiency requirement has been "embedded" into the tariff
- the 30% marginal tariff rate for emergency admissions, above a contractual baseline, introduced in 2010/11, will continue in 2011/12 as an incentive for providers and commissioners to work together to minimise the number of avoidable emergency admissions to hospital (again 2008/09 being the baseline year).

The Trust's annual planning document describes other aspects of the Operating Framework and therefore this paper focuses on the financial aspects only.

4.0 Financial Plan 11/12

This year's round of financial planning has been the most challenging yet as the Trust and its partners move into a period of significantly reduced growth. Achievement of the cost improvement programme is therefore vital for ensuring the Trust delivers efficient services whilst maintaining and improving quality. The impact of moving acute services to a more appropriate community/primary care setting requires continuous monitoring and managing against the assumptions in the RCRH programme and the overall affordability of the Trust.

Following a period of intensive planning, a surplus income and expenditure position has been identified which includes agreed income agreements, a cost improvement programme that exceeds national efficiency levels as well as the impact of Sandwell PCT's community services becoming part of the Trust.

4.1 Income assessment:

The previously reported funding gap was closed as part of the 2011/12 LDP negotiation round. This was largely driven by competing views of the amount of patient care activity required next year together with a range of non-PbR cost funding requirements to address expenditure which cannot in the long term, be supported from the general financial reserves of the Trust.

At the time of writing the Trust is working through its coordinating commissioner to resolve a funding issue in respect of Breast screening services for Birmingham East and North PCT and the route to resolution will identified shortly.

The LDP agreement sought to address:

- The full year effect of decommissioning specific activity in 10/11 carrying forward into 2011/12. This includes procedures of limited clinical value, reductions in new:review outpatient ratios and reductions in consultant to consultant referrals
- The impact of activity performance in excess of the RCRH trajectories and the pace at which all parties must work to get back on track
- The basis for formulating activity estimates for 11/12 (rolling averages versus trend data)
- Pathology services and the prices charged
- Consultation services (non face to face)
- Breast Screening services
- Gynae-oncology service costs
- Commissioning community bed capacity
- Plastic surgery and other specialist top-ups
- Coding and counting changes
- Interventional radiology
- MPI
- Non consultant led activity

The final agreement will be shared with the F&PMC.

The contract settlement includes a continuation of the transitional financial framework resources (\pounds 10.3m in 11/12) to recognise the lagging nature of fixed and semi-fixed cost release as activity reduces.

Income has been modeled at a level slightly below the current year's forecast in cash terms owing to the tariff deflator (£380m vs £384m respectively, excluding transferring-in community services).

CQUIN (commissioning for quality and innovation) funding remains at 1.5% of total contract values.

The activity that underpins the 2010/11 income is based on RCRH trajectories and a mix of existing trends. Consequently, the work on de-commissioning specific cohorts of activity continues and will be incorporated in the final price activity matrix.

An estimate has been made regarding other non patient related income sources (educational levies and research) and formal notification is yet to be received.

4.2 Expenditure Plans (including key schedules) and Cost Improvement Plan

Expenditure Plans are based on startpoint budgets, activity related changes, the implementation of cost improvement plans, regulatory pressures, wage and other contractual increases and agreed developments with commissioning bodies. An overall picture of Income and Expenditure is presented at **appendix 1**. This shows total income as £413,199,000 (inclusive of £33,007,000 TCS transfer) and expenditure of £411,392,000 based on SHA control totals, resulting in a surplus of £1,807,000. The income position is now based upon agreed values for those PCT contracts overseen by Sandwell PCT (i.e. general and acute services for West Midlands PCTs). Final confirmation of other income budgets is not yet complete, e.g. specialised services and meetings continue in this regard.

This year's plan contains less flexibility when compared with 2010/11. This reflects a challenging CIP target within the tariff (4.0%) coupled with additional local savings plans. Reserve allocations are now frozen in value terms although the detailed distribution will undergo further internal review based on annual plan submissions, CIP performance and affordability positions.

A number of reserves have been established through a combination of reinvested cost savings, inflation within tariff and non-tariff prices and discrete investment decisions by the PCTs. These reserves will be applied to cost of living uplifts for lower paid staff, agenda for change and medical staffing increments, national insurance employer cost rises, inflationary costs associated with blood products, energy and clinical negligence premiums paid to central bodies.

As a general point, any non-recurrent slippage owing to a delay in implementing various schemes reverts to the control of the accountable officer (CEO). A significant risk of increased energy costs has arisen owing to very recent world events.

This has not been specifically budgeted for and owing to the timing, will likely represent an initial call on risk/management of change reserves. Obviously, these events were not foreseen and they could present a cost pressure of as much as £1.4m. Further information will be brought to F&PMC in due course.

Any reserves linked to pay awards and costs occurring from 1 April 2011 onwards will be allocated to budgets from the outset. Other reserves are subject to further scrutiny and will be held pending these reviews. The bulk of the divisional costs pressures are committed to meeting activity related pressures currently in the system. They are not therefore discretionary.

4.3 Financial Appendices

Each of the financial appendices is described overleaf.

Appendix 1 – Income and Expenditure

This schedule shows the financial plan in the context of prior year outturn performance. Care is required when making comparisons as some years such as 2009/10 contain one-off income not replicated in other years. Unlike in previous years the schedule shows pay and nonpay quantums after the allocation of reserves. This provides a basis for comparison notwithstanding the comment above and shows a cessation of the annual growth in income and expenditure. A memorandum column has been added to disclose the element of TCS income and costs.

Appendix 2 – Service Level Agreements

This schedule holds SLA values for PCTs and other income sources. The Sandwell and HoB figures are subject to minor adjustment following the final format of Heads of Terms (i.e. they may be adjusted further for items held in PCT reserves). However, the schedule of income does represent the latest estimate of income which in turn supports the expenditure base.

Appendix 3 – Divisional Startpoint Budgets

This schedule summarises the divisional rollover budgets as set against CIP targets. The process of sign-off of these control totals is underway.

Appendix 4 – Divisional Workforce Budgets

This schedule charts the whole time equivalent budgets contained in pay budgets prior to the allocation of in year reserves associated with developments.

Appendix 5 – Statement of Financial Position (Balance Sheet)

The schedule includes new borrowings and the impact of the capital programme on fixed asset carrying values along with the main categories of assets and liabilities. It has been stated on the basis of International Financial Reporting Standards.

Appendix 6 – Draft Capital Programme

The Draft capital plan for 2011/12 shows a significant investment in Land as part of the overall acquisition. A separate paper has been presented to the acute hospital project board explaining the timing of resources and the details of these are not repeated here. In summary, the Trust is placing itself in a position such that it has sufficient resources to undertake further land transactions as and when it effects the GVD (general vesting declaration).

The balance of the programme represents the outcome of the capital planning process and many of the schemes are subject to further business case approvals.

Appendix 7 – Cash Flow

The cashflow reflects all movements of cash (both revenue and capital) and assumes a degree of borrowing contingent upon progress with land acquisition.

Appendix 8 – Budget Reserves

These reserves are established to meet unavoidable pressures associated with pay awards and nonpay inflation. Other reserve allocations are also shown. As part of its financial strategy, the Trust is preparing to create underlying surpluses as part of RCRH. In the transition period these can be used non-recurrently. The presentation at this point is provisional as there are some immediate risks regarding energy that have been referred to earlier in the paper.

Appendix 9 – CIP

The cost improvement plan (£21.2m, inclusive of TCS) has been the subject of separate reports to the Finance & Performance Management Committee. The schedule at appendix 9 confirms the delivery values set for 2011/12 which in turn support the financial plan targets. The TCS element will be forwarded to the committee. Progress currently stands at approximately 80% and closure meetings are scheduled for March.

Appendix 10 – Sensitivity

This section describes a range of financial planning risks and how they would be managed in the event they materialised.

5.0 <u>Acute Hospital Project - related costs</u>

Both income and expenditure plans are excluded at this stage for the costs associated with the RCRH acute project fees. Separate financial arrangements are in place via the SHA and PCT for the funding of the programme and resources are available to meet the 2011/12 forecast expenditure. This will result in additional income and expenditure over and above the current draft plan levels.

6.0 Financial Planning Risks

- A risk arising each year is demand risk, especially where this results in higher than planned activity. The risk for the Trust is both operational (achieving access targets) and financial (additional income sufficient to cover increases in capacity principally staffing costs). Longer term, the risk of unmanaged growth in the secondary care threatens the success of the RCRH programme and all of its objectives. Consequently, a modified set of contract terms were agreed with PCT partners (Sandwell & HoB only) aimed at creating incentives workable for both primary and secondary clinicians.
- Efficiency risk may materialize where any deviation occurs in delivery of the CIP plan. Contingency reserves exist for non-recurrent risk but the full year effect of the programme needs to be delivered during 2011/12.
- Risks to the current favourable performance for control of infection measures and cleaning regimes. This is a complex risk especially as there are plans by regulatory authorities to lower the number of allowable cases of infection, but the Trust has invested heavily in this area in recent years.
- A rise in medical emergencies presents a risk given the continuation of the 30% tariff rate for activity above 08/09 outturn. The Division of Medicine has an ambitious plan to introduce greater coverage of the acute physician model such that the need for downstream bed capacity is mitigated.
- The introduction of GP Commissioners and wider competition introduces new risks. However, for the Trust's current catchment area its RCRH programme directs the changes in activity and will be incorporating any GPCC changes as part of tracking RCRH trajectories.

- General unforeseen cost rises could include anything from energy, to medical consumables through to additional capacity changes. The nature of the contracting terms assists in reducing reliance on the acute sector and this coupled with a degree of contingency reserves provides some mitigation. The Trust's approach to procurement of goods and services is changing and confidence regarding long term pricing agreements is one such feature.
- Constraints placed on the amount of available capital is a risk. Early indications are that the Trust may receive the capital resource limit (CRL) it is seeking which is important given planned land purchases during the year. Any shortfall will create the need to review the current programme and reassess priorities.
- The LDP contractual terms are designed to deal with the decision by the DH that hospitals should not be paid for readmissions. Specific guidance is awaited on how this is to be applied, but the resources are to be ring-fenced locally for use in mitigating the impact.

7.0 <u>Next Steps</u>

In terms of setting budgets, the next steps include but are not limited to:

- Conversion of contract activity targets to divisional targets
- Summarisation of the CQUIN schemes to F&PMC once agreed
- Divisional startpoint budget and CIP sign-off
- LTFM submitted to the SHA at the end of March 2011.

8.0 <u>Summary and Recommendations</u>

The Trust is in the process of working through detailed contractual terms as part of the LDP settlement. The plan as presented includes agreed decommissioning plans (£16m) in order to remain in line with RCRH trajectories as backed by transitional financial framework monies to meet fixed and semi-fixed delayed cost release.

Given the degree of volatility within NHS funding generally, it is important that the £21m CIP is fully delivered as the ability to respond centrally to operational or regulatory risks is reduced, albeit a reserve has been established for the management of change.

A number of risks will need to be addressed as described earlier in the document and due consideration is being given to issues within the corporate risk register, RCRH risk register and assurance framework.

The Trust Board is asked to:

RECEIVE the final draft budget

APPROVE the 11/12 Budget as part of the 3 year financial plan as recommended by the Finance & Performance Management Committee

AGREE to receive in-year monitoring of financial performance

Robert White Director of Finance & Performance Management 24th March 2011

Financial Plan 2011/2012

Income & Expenditure Position Actual, Forecast and Plan

	Accounts Mar - 07 £000's	Accounts Mar - 08 £000's	Accounts Mar - 09 £000's	Accounts Mar - 10 £000's	Forecast Mar - 11 £000's	Outline Mar - 12 £000's	TCS Mar - 12 £000's
INCOME							
Main Commissioner Contracts	271,388	290,081	296,695	327,369	334,492	363,777	31,718
Other SLA Income				6,043	6,840	6,582	0
Market Forces Factor	15,977	18,499	20,458	-	0	0	0
Total Category A Income	287,365	308,580	317,153	342,552	341,332	370,359	31,718
Non NHS Clinical Income							
Private Patient Income	234	134	132	164	175	162	0
Other Non Protected Income	1,420	1,031	1,712	2,375	2,140	2,055	0
Total	1,654	1,165	1,844	2,539	2,315	2,217	0
Other Income							
Education and Training	19,297	16,874	17,062	18,473	17,639	17,147	0
Research & Development	1,285	1,082	1,303	1,889	1,747	1,012	0
Other Income	17,935	20,774	21,799	19,321	20,762	22,464	1,289
Total	38,517	38,730	40,164	39,683	40,148	40,624	1,289
TOTAL INCOME	327,536	348,475	359,161	384,774	383,795	413,199	33,007
EXPENDITURE Base Position							
Pay	(220,244)	(219,686)	(238,675)	(252,557)	(259,322)	(281,162)	-27,383
Non Pay	(80,990)	(95,484)	(93,929)	(101,341)	(100,537)	(108,215)	-5,624
TOTAL OPERATING COSTS	(301,234)	(315,170)	(332,604)	(353,898)	(359,859)	(389,377)	(33,007)
EBITDA	26,302	33,305	26,557	30,876	23,936	23,822	0
Profit / loss on asset disposals	(114)	(101)	(109)	(102)	(100)	0	0
Fixed Asset impairments	()	(3,346)	0	(36,463)	(5,650)	0	0
Depreciation & Amortisation	(14,632)	(15,725)	(15,587)	(13,913)	(13,307)	(13,582)	0
Total interest receivable	803	1,664	1,048	80	85	83	0
Total interest payable on Loans and Leases	(12)	(442)	(104)	(2,179)	(2,417)	(2,156)	0
PDC Dividend	(8,948)	(8,831)	(9,258)	(6,945)	(5,784)	(5,803)	0
NET SURPLUS/(DEFICIT)	3,399	6,524	2,547	(28,646)	(3,237)	2,364	0
IFRS/Impairment Related Adjustments				35,906	5,275	(557)	0
SURPLUS/(DEFICIT) FOR DOH TARGET	3,399	6,524	2,547	7,260	2,038	1,807	0

Financial Plan 2010/2011

Patient Related Service Level Agreements

Commissioner	Total SLA Value £000	TCS Value £000
Sandwell PCT	182,756	
Heart of Birmingham tPCT Associated PCTs	89,184 65,091	407 476
West Midlands Specialised Services (including repatriated services)	24,416	0
Wales	51	0
Non Contracted Activity	2,279	0
Total	363,777	31,718

Financial Plan 2011/2012

Divisional Pay and Non Pay Base Budgets and Cost Improvement Targets

Division	Pay £000	Non Pay Budget £000	Total Expenditure £000	CIP Target £000
Chief Executive	1,811	519	2,330	123
Estates	3,470	8,695	12,164	628
Facilities	17,267	7,268	24,534	990
Finance	3,806	750	4,556	234
Governance	2,203	562	2,766	144
Workforce	4,368	573	4,941	190
IM&T/Patient Process	3,236	1,172	4,408	214
Imaging	13,535	3,719	17,254	801
Medicine & Emergency Care	64,348	23,074	87,422	5,417
Nursing & Therapies	7,588	709	8,297	458
Pathology	14,066	6,454	20,520	884
Strategy/Operations	13,188	1,546	14,734	791
Surgery B	16,897	5,816	22,713	1,465
Surgery A, Anaesthetics & Critical Care	50,627	12,254	62,881	4,262
Womens & Childrens	32,428	4,036	36,464	2,069
SHCS: Childrens Services	2,752	565	3,317	142
SHCS: Other Services	24,631	5,059	29,690	1,029
Other	2,938	34,774	37,713	1,331
TOTAL	282,097	152,318	434,415	21,171

Notes

Budgets Based on Month 11 Rollover

Other includes National Poisons Information, Research and Development, Post Graduate Centre, clinical negligence costs, deprecaition charges and other Corporate Services.

Financial Plan 2011/2012

Divisional Workforce Budgets (Whote Time Equivalents)

Division	Mar-11	April	May	June	July	August	September	October	November	December	January	February	March
Facilities	769.45	756.45	756.45	756.45	753.45	753.45	753.45	753.45	753.45	753.45	753.45	753.45	753.45
Estates	104.92	102.92	102.92	102.92	102.92	102.92	102.92	102.92	102.92	102.92	102.92	102.92	102.92
Operations/Strategy	443.88	432.16	432.16	432.16	432.16	432.16	432.16	432.16	432.16	432.16	432.16	432.16	432.16
Chief Executive	24.63	24.13	24.13	24.13	24.13	24.13	24.13	24.13	24.13	24.13	24.13	24.13	24.13
Finance	95.45	91.95	91.95	91.95	91.95	91.95	91.95	91.95	91.95	91.95	91.95	91.95	91.95
Governance	65.45	63.45	63.45	63.45	63.45	63.45	63.45	63.45	63.45	63.45	63.45	63.45	63.45
Workforce	127.03	123.73	123.73	123.73	123.73	123.73	123.73	123.73	123.73	123.73	123.73	123.73	123.73
IM&T	97.51	96.51	96.51	96.51	96.51	96.51	96.51	96.51	96.51	96.51	96.51	96.51	96.51
Imaging	297.08	297.08	297.08	297.08	292.36	292.36	292.36	292.36	292.36	292.36	292.36	292.36	292.36
Medicine & Emergency Care	1,524.93	1,516.84	1,516.84	1,506.63	1,506.63	1,506.63	1,506.63	1,506.63	1,506.63	1,506.63	1,506.63	1,506.63	1,506.63
Nursing & Therapies	244.10	231.10	231.10	231.10	231.10	231.10	231.10	231.10	231.10	231.10	231.10	231.10	231.10
Pathology	350.17	346.98	346.98	346.98	346.98	346.98	346.98	346.98	346.98	346.98	346.98	346.98	346.98
Surgery A, Anaesthetics & Critical Care	1,090.66	1,070.32	1,067.82	1,057.99	1,054.89	1,054.89	1,054.89	1,054.89	1,054.89	1,054.89	1,054.89	1,054.89	1,054.89
Surgery B	352.13	359.00	359.00	359.00	359.00	359.00	359.00	359.00	359.00	359.00	359.00	359.00	359.00
Womens & Childrens	776.74	751.69	751.69	751.69	751.69	751.69	751.69	750.69	750.69	750.69	750.69	750.69	750.69
Community Services	768.92	722.59	722.59	722.59	722.59	722.59	722.59	722.59	722.59	722.59	722.59	722.59	722.59
Other	56.00	56.00	56.00	56.00	56.00	56.00	56.00	56.00	56.00	56.00	56.00	56.00	56.00
TOTAL	7,189.05	7,042.90	7,040.40	7,020.36	7,009.54	7,009.54	7,009.54	7,008.54	7,008.54	7,008.54	7,008.54	7,008.54	7,008.54

Financial Plan 2011/2012

Statement of Financial Position

		<u>Opening Balance</u> <u>as at 1st April</u> <u>2011</u> <u>£000</u>	<u>Balance as at</u> <u>31st March 2012</u> <u>£000</u>
Non Current Assets	Property, Plant and Equipment	201,205	212,381
	Property, Plant and Equipment (PFI) Trade and Other Receivables	18,262 1,350	17,604 1,350
Current Assets	Inventories	3,450	3,350
	Trade and Other Receivables	19,143	16,830
	Investments	0	0
	Cash	18,012	12,431
Current Liabilities	Trade and Other Payables	(39,041)	(33,274)
	Loans	0	(2,000)
	PFI and Finance Leases	(1,606)	(1,160)
	Provisions for Liabilities and Charges	(5,000)	(5,000)
Non Current Liabilities	Trade and Other Payables	0	0
	Loans	0	(6,000)
	PFI and Finance Leases	(30,864)	(29,704)
	Provisions for Liabilities and Charges	(2,150)	(2,150)
		182,761	184,659
Financed by: Taxpayers Equity	Public Dividend Capital	160,231	160,231
	Retained Earnings	(25,496)	(23,172)
	Revaluation Reserve	36,250	36,250
	Donated Asset Reserve	1,675	1,249
	Other Reserves	10,101	10,101
		182,761	184,659

Sandwell & West Birmingham Hospitals

Financial Plan 2011/2012

Draft Capital Programme

		2011/12 £000
Capital Resources	Internally Generated Cash (depreciation) Additional CRL	13,500 10,600
Total Resources		24,100
Brought Forward Commitments	Capitalised Salaries Other Slippage and Retentions B/F	475 300
	Total Brought Forward	775
Ongoing Schemes	Statutory Standards and Estates Risk Related Expenditure IT Programmes Medical Equipment	3,000 500 700
	Total Ongoing Schemes	4,200
Land	Land Purchases	13,000
Other Schemes	Digital Mammography Final Phase Carbon Management Plan (incorporating estate rationalisation) Ophthalmology and Plaster Room SGH E-Rostering (CIP related) BMEC - Clinical/General Accommodation Changes B/F A&E IM&T System Changes Paeds/Wards/Refurbishment (addresses siderooms/cubicles) Digital Dictation/OPD Improvements D11 and Other Wards (supported by stat strandards) Vehicle Replacement GTS, PTS Pharmacy Robotics TCS Related Capital Risk Reserve Available for Other Business Cases Potential Slippage on Land (£13.0m vs £10.4m) Balance of Baseline Programme Supporting GL Initial Feasibility Work on Retained Assets	1,818 500 500 450 90 225 500 100 500 450 430 200 362 (2,600) 2,300 300
Total Expenditure		24,100
Net under/(Over) Spend Against Capi	tal Resources	0

Sandwell & West Birmingham Hospitals

Financial Plan 2011/2012

Cash Flow

						Per	iod					
	April	Мау	June	July	August	September	October	November	December	January	February	March
Opening Balance	18,012	18,207	18,452	18,572	18,692	18,813	16,031	16,151	15,967	15,783	15,600	15,417
EBITDA	1,982	1,982	1,982	1,982	1,982	1,982	1,982	1,982	1,982	1,982	1,982	1,982
Other increases/(decreases) to reconcile to profit/(loss) from operations	(36)	(36)	(36)	(36)	(36)	(36)	(36)	(36)	(36)	(36)	(36)	(36)
Operating cash flows before movements in working capital	1,946	1,946	1,946	1,946	1,946	1,946	1,946	1,946	1,946	1,946	1,946	1,946
Novement in Working Capital												
Increase)/decrease in Inventories	0	0	0	0	0	0	0	0	0	0	0	100
Increase)/decrease in Trade and Other Receivables, Current	292	501	304	304	304	304	304	0	0	0	0	0
Increase)/decrease in Trade and Other Payables and Accruals, Current	(412)	(572)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)
Increase/(decrease) in working capital	(120)	(71)	(196)	(196)	(196)	(196)	(196)	(500)	(500)	(500)	(500)	(400)
Increase/(decrease) in Non Current Provisions	0	0	0	0	0	0	0	0	0	0	0	0
Net cash inflow/(outflow) from operating activities	1,826	1,876	1,750	1,750	1,750	1,750	1,750	1,446	1,446	1,446	1,446	1,546
Cash flow from investing activities												
Capital Spend	(2,008)	(2,008)	(2,008)	(2,008)	(2,008)	(2,008)	(2,008)	(2,008)	(2,008)	(2,008)	(2,008)	(2,008)
PFI residual interest	0	0	0	0	(_,000)	0	(_,000)	(_,000)	0	(_,000)	0	(_,000)
Cash receipt from asset sales	0	0	0	0	0	0	0	0	0	0	0	0
	Ū	0	0	0	0	0	0	0	0	0	0	0
Net cash inflow/(outflow) from investing activities	(2,008)	(2,008)	(2,008)	(2,008)	(2,008)	(2,008)	(2,008)	(2,008)	(2,008)	(2,008)	(2,008)	(2,008)
Cash Flow before Financing	(182)	(133)	(258)	(258)	(258)	(258)	(258)	(562)	(562)	(562)	(562)	(462)
Cash flow from financing activities												
Public Dividend Capital received	0	0	0	0	0	0	0	0	0	0	0	0
Public Dividend Capital repaid	0	0	0	0	0	0	0	0	0	0	0	0
Dividends paid	0	0	0	0	0	(2,902)	0	0	0	0	0	(2,902)
nterest (paid) on loans and leases	(4)	(4)	(3)	(3)	(3)	(3)	(2)	(2)	(2)	(2)	(1)	(1)
nterest element of PFI Unitary Charge	(159)	(159)	(159)	(159)	(159)	(159)	(159)	(159)	(159)	(159)	(159)	(159)
nterest received on cash and cash equivalents	7	7	7	7	7	7	6	6	6	6	6	6
Drawdown of loans and leases	667	667	667	667	667	667	667	667	667	667	667	667
Repayment of loans and leases	(134)	(134)	(134)	(134)	(134)	(134)	(134)	(134)	(134)	(134)	(134)	(134)
Aovement in Other grants/Capital received	0	0	0	0	0	0	0	0	0	0	0	0
let cash inflow/(outflow) from financing	377	378	378	378	378	(2,523)	378	378	378	378	379	(2,523)
let cash outflow/inflow	195	245	120	120	120	(2,781)	120	(184)	(184)	(184)	(183)	(2,985)
Closing Balance	18,207	18,452	18,572	18,692	18,813	16,031	16,151	15,967	15,783	15,600	15,417	12,431

APPENDIX 8

Sandwell & West Birmingham Hospitals NHS Trust

Financial Plan 2011/2012

Reserves

INFLATION	Total £000
Pay Award AfC Other Incremental Drift SAS Contract Issues Local Discretionary Points National insurance Increases Inflation: Blood Inflation: Energy CNST (based on actual proposed charge)	
TOTAL	5,133

OTHER RESERVES	Total £000
RCRH Transition Fund Same Sex Accommodation ED Action Plan Maternity Reconfiguration Other Corporate Cost Pressures Divisional Cost Pressures Service Developments: Breast Screening Income Changes Other	
TOTAL	22,537
TOTAL RESERVES	27,670

Sandwell & West Birmingham Hospitals

Financial Plan 2011/2012

Divisional Summary Cost Improvement Programme

	2011/12 TARGET	PAY £000	NON PAY £000	INCOME £000	TOTAL £000	2011-12 (Under)/Over Achievement £000	Recurrent Value of 2011-12 Schemes £000	Recurrent (Under)/Over Achievement £000
OPERATIONAL DIVISIONS								
Imaging	801	351	170	280	801	0	809	8
Medicine & Emergency Care	5,417	4,543	245	630	5,417	1	5,432	15
Nursing & Therapies	458	491	0	0	491	32	491	C
Pathology	884	196	515	174	885	2	885	C
Surgery A, Anaesthetics & Critical Care	4,262	2,837	1,010	418	4,264	2	4,377	113
Surgery B	1,465	1,203	194	68	1,465	0	1,553	88
Womens & Child Health	2,069	1,756	233	80	2,069	0	1,989	(80)
SCHS: Childrens Services	142	114	28	0	142	0	142	C
SCHS: Childrens Services	1,029	823	206	0	1,029	0	1,029	C
CORPORATE AREAS								
Chief Executive	123	53	77	0	130	7	130	C
Strategy/Operations	791	433	353	5	791	0	791	C
Facilities	990	500	105	375	980	(10)	1,070	90
Estates	628	250	200	180	630	2	630	C
Finance	234	127	27	80	234	0	234	C
Governance	144	66	25	55	146	2	146	C
Postgraduate Centre	55	0	0	55	55	1	55	C
Workforce	190	151	0	40	191	1	191	C
IM&T	214	63	154	0	217	3	217	C
Corporate	1,276	0	1,276	0	1,276	0	1,276	C
TOTAL	21,171	13,956	4,817	2,439	21,214	43	21,447	234

Sandwell & West Birmingham Hospitals

Financial Plan 2011/2012

Risk and Sensitivity Analysis

		Mitigating	Actions
Area of Risk/Sensitivity	Financial Effect	Value	Details
	£000	£000	
	2000	2000	
20% reduction in CIP delivery	(4,234)	1,562	Delivered corporately through release of contingency reserves in the absense of operational replacement schemes
		1,221	Delay/review implementation of discretionary/developmental spending
		1,451	Contingency CIP programme inacted
PbR Data Challenges	(1,000)	500	Environment does not promote overperformance, but to the extent this occurs in certain lines, the OH contrib.used.
		500	
			Implementation of wider LDP agreement on activity management designed to reduce risks
GP Commissioning Consortia	(2,500)	2,500	Interlinked plans into RCHR trajectories mitigates risk as do moves of activity in terms of counting towards
	(_//	_,	agreed decommissiong targets
Underlying Inflationary Pressures	(5,133)	(5,133)	
Energy related risk (world developments)	(1,400)	(1,400)	There is a very real risk of energy cost rises owing to events in Japan and the middle east, it is likely that risk
	(1,100)	(1,100)	reserves wil be utilised towards these costs in the short term
	(272)		
Other Category C Income under performs by 1%	(372)	372	Impose additional CIP on divisions affected by reduction
AfC Incremental Growth 10% higher than budget	(60)	60	Utilisation of other pay related reserves
1 ward additional capacity required for whole year	(850)	850	Capacity would only be opened in response to increased demand therefore generating additional income although
	, , , , , , , , , , , , , , , , , , ,		with 30% marginal rates, this is unlikely to cover full costs, advance recruitment to resolve bank/agency useage
			and improve rostering will assist in mitigating this risk
Risk from no payment arising from readmissions	(3,000)	(3,000)	This relates to national guidance concerning emergency admissions within 30 days of a previous elective or
	(-,,	(-,,	emergency admission. The LDP contract is being utlised to identify compliant schemes aimed at system
			improvements that avoids the need for such transactions.
Unforeseen divisional cost pressures	(1,000)	800	Use of cost pressure reserve
omoreseen amisional cost pressures	(1,000)	200	
Other Unforeseen Events	(2,000)	1,562	Use of contingency reserve
	(2,000)	438	
		.50	

Financial Plan 2011/2012

Medium Term Financial Plan: Extract from Long Term Financial Model

	Plan Mar-12	Forecast Mar-13	Foreo Mar-
Units			
£m unless otherwise stated			
All amounts shown here are nominal			
e Statement			
NHS Acute Activity Revenue			
Elective revenue (long and short stay)	57.8	51.8	51.
Non-Elective revenue	96.7	93.4	92.
Outpatient	71.0	65.8	61.
A&E	17.7	17.7	17.
Other NHS	121.5	103.1	103
NHS Acute Activity Revenue, Total	364.7	331.7	327
PBR (Clawback)/ Relief	0.0	0.0	0.0
NHS Clinical Revenue, Total	364.7	331.7	327
Non NHS Clinical Revenue	504.7	551.7	527
Private patient revenue	0.2	0.0	0.0
Other non-NHS clinical revenue (incl. CRU)	2.1	3.6	3.1
Non NHS Clinical Revenue, Total	2.1	3.6	3.8
Other Operating income	2.2	5.0	5.0
Research and Development income	1.0	1.1	1.1
Education and Training income	1.0	24.1	24.
PFI Specific income	0.0	0.0	24.
Other Operating Income	28.2	33.8	34.
Other Operating income, Total	46.3	59.0	59.
Operating Revenue and Income, Total	413.2	394.4	390
Operating Expenses	(277.7)	(252.0)	(245
Employee benefits expense	(277.7) (27.3)	(253.8)	(245
Drug expense Clinical supplies		(28.1) (39.7)	(29)
Clinical supplies Non Clinical Supplies	(36.5) (47.0)	(39.7) (46.4)	(39) (48)
PFI operating expenses	(1.0)	(40.4)	(40)
Other Operating expenses	0.0	0.0	0.0
Operating Expenses, Total	(389.4)	(369.3)	(364
		25.4	
EBITDA Surplus (Deficit) from Operations margin	23.8 <i>6%</i>	25.1 <i>6%</i>	25 . <i>7%</i>
	•••		
Non-Operating income			_
Gain/(loss) on asset disposals	0.0	0.0	0.0
Gain/(loss) on asset disposals Income from NHS Charitable Funds	0.0	0.0	0.0
Gain/(loss) on asset disposals Income from NHS Charitable Funds Other Non-Operating income			
Gain/(loss) on asset disposals Income from NHS Charitable Funds	0.0	0.0 0.0	0.0
Gain/(loss) on asset disposals Income from NHS Charitable Funds Other Non-Operating income Non-Operating income, Total Non-Operating expenses	0.0	0.0	0.0
Gain/(loss) on asset disposals Income from NHS Charitable Funds Other Non-Operating income Non-Operating income, Total Non-Operating expenses Interest expense on overdrafts and working capital facilities	0.0 0.1	0.0 0.4	0. (
Gain/(loss) on asset disposals Income from NHS Charitable Funds Other Non-Operating income Non-Operating income, Total Non-Operating expenses Interest expense on overdrafts and working capital facilities Interest expense on loans and leases	0.0 0.1 (2.2)	0.0 0.4 (2.3)	0. (2.3
Gain/(loss) on asset disposals Income from NHS Charitable Funds Other Non-Operating income Non-Operating income, Total Non-Operating expenses Interest expense on overdrafts and working capital facilities Interest expense on loans and leases Depreciation and Amortisation	0.1 (2.2) (13.6)	0.0 0.4 (2.3) (13.3)	0.4 (2.3 (13.
Gain/(loss) on asset disposals Income from NHS Charitable Funds Other Non-Operating income Non-Operating income, Total Non-Operating expenses Interest expense on overdrafts and working capital facilities Interest expense on loans and leases Depreciation and Amortisation PDC Dividend	0.1 (2.2) (13.6) (5.8)	0.0 0.4 (2.3) (13.3) (6.0)	0.4 (2.3 (13) (6.3
Gain/(loss) on asset disposals Income from NHS Charitable Funds Other Non-Operating income Non-Operating income, Total Non-Operating expenses Interest expense on overdrafts and working capital facilities Interest expense on loans and leases Depreciation and Amortisation PDC Dividend Impairment Losses (Reversals) net	0.1 (2.2) (13.6)	0.0 0.4 (2.3) (13.3)	0.4 (2.3 (13.
Gain/(loss) on asset disposals Income from NHS Charitable Funds Other Non-Operating income Non-Operating income, Total Non-Operating expenses Interest expense on overdrafts and working capital facilities Interest expense on loans and leases Depreciation and Amortisation PDC Dividend Impairment Losses (Reversals) net Other Non-Operating expenses	0.1 (2.2) (13.6) (5.8) 0.0	0.0 0.4 (2.3) (13.3) (6.0) 0.0	0.4 (2.3 (13. (6.3 0.0
Gain/(loss) on asset disposals Income from NHS Charitable Funds Other Non-Operating income Non-Operating income, Total Non-Operating expenses Interest expense on overdrafts and working capital facilities Interest expense on loans and leases Depreciation and Amortisation PDC Dividend Impairment Losses (Reversals) net	0.1 (2.2) (13.6) (5.8)	0.0 0.4 (2.3) (13.3) (6.0)	0.4 (2.3 (13) (6.3
Gain/(loss) on asset disposals Income from NHS Charitable Funds Other Non-Operating income Non-Operating income, Total Non-Operating expenses Interest expense on overdrafts and working capital facilities Interest expense on loans and leases Depreciation and Amortisation PDC Dividend Impairment Losses (Reversals) net Other Non-Operating expenses	0.1 (2.2) (13.6) (5.8) 0.0	0.0 0.4 (2.3) (13.3) (6.0) 0.0	0.4 (2.3 (133 (6.3 0.0
Gain/(loss) on asset disposals Income from NHS Charitable Funds Other Non-Operating income Non-Operating income, Total Non-Operating expenses Interest expense on overdrafts and working capital facilities Interest expense on loans and leases Depreciation and Amortisation PDC Dividend Impairment Losses (Reversals) net Other Non-Operating expenses Non-Operating expenses, Total	0.0 0.1 (2.2) (13.6) (5.8) 0.0 (21.5)	0.0 0.4 (2.3) (13.3) (6.0) 0.0 (21.3)	0. (2. (13) (6. 0. (21)
Gain/(loss) on asset disposals Income from NHS Charitable Funds Other Non-Operating income Non-Operating income, Total Non-Operating expenses Interest expense on overdrafts and working capital facilities Interest expense on loans and leases Depreciation and Amortisation PDC Dividend Impairment Losses (Reversals) net Other Non-Operating expenses Non-Operating expenses, Total Surplus (Deficit) before Tax	0.0 0.1 (2.2) (13.6) (5.8) 0.0 (21.5) 2.3	0.0 0.4 (2.3) (13.3) (6.0) 0.0 (21.3) 3.8	0. (2. (13 (6. 0. (21) (21)

APPENDIX 11 CONT

Sandwell & West Birmingham Hospitals NHS Trust

Financial Plan 2011/2012

Medium Term Financial Plan: Extract from Long Term Financial Model

	Plan	Forecast	Forecast
	Mar-12	Mar-13	Mar-14
<u>Units</u>			
£m unless otherwise stated			
All amounts shown here are nominal			
alance sheet			
ASSETS, NON CURRENT			
Property, Plant and Equipment and intangible assets, Net	212.4	207.9	206.1
Property, plant & equipment (PFI)	17.6	16.9	16.1
PFI Other Assets	0.0	0.0	0.0
Investments, Non-Current	0.0	0.0	0.0
Trade and Other Receivables, Net, Non-Current (including prepayments)	1.4	1.4	1.4
Other Assets, Non-Current	0.0	0.0	0.0
Assets, Non-Current, Total	231.3	226.1	223.5
ASSETS, CURRENT			
Inventories	3.4	3.3	3.2
NHS Trade Receivables, Current	10.6	9.9	10.9
Non NHS Trade Receivables, Current	(0.1)	0.2	0.7
Other Receivables, Current	2.6	2.6	2.6
Other Financial Assets, Current (e.g. accrued income)	2.8	2.8	2.8
Prepayments, Current, PFI related	0.0	0.0	0.0
Prepayments, Current, non-PFI related	0.9	0.9	0.9
Cash and Cash Equivalents	12.4	20.2	17.0
Other Assets, Current	0.0	0.0	0.0
Assets, Current, Total	32.6	39.9	38.1
ASSETS, TOTAL	263.9	266.0	261.6
LIABILITIES, CURRENT			
Bank Overdraft and Working Capital Facility	0.0	0.0	0.0
Interest-Bearing Borrowings, Current (including accrued interest)	(2.0)	(2.0)	(2.0)
Deferred Income, Current	(8.5)	(8.5)	(8.5)
Provisions, Current	(5.0)	(5.0)	(5.0)
Trade Payables, Current	(13.9)	(15.4)	(10.9)
Other Payables, Current	0.0	0.0	0.0
Capital Payables, Current	(0.8)	(0.8)	(0.8)
Accruals, Current	(9.9)	(9.9)	(9.9)
Payments on Account	0.0	0.0	0.0
Finance Leases, Current	(0.2)	0.0	0.0
PDC dividend creditor, Current	0.0	0.0	0.0
Other Liabilities, Current	(1.1)	(1.6)	(1.0)
Liabilities, Current, Total	(41.4)	(43.1)	(38.0)
NET CURRENT ASSETS (LIABILITIES)	(8.8)	(3.3)	0.0
	(0.0)	(0.0)	

LIABILITIES, NON CURRENT

Interest-Bearing Borrowings, Non-Current	(6.0)	(4.0)	(2.0)
Deferred Income, Non-Current	0.0	0.0	0.0
Provisions, Non-Current	(2.2)	(2.2)	(2.2)
Trade and Other Payables, Non-Current	0.0	0.0	0.0
Finance Leases, Non-current	(0.0)	(0.0)	(0.0)
Other Liabilities, Non-Current	(29.7)	(28.7)	(27.7)
Liabilities, Non-Current, Total	(37.9)	(34.8)	(31.8)
TOTAL ASSETS EMPLOYED	184.7	188.0	191.7
TAXPAYERS' EQUITY			
Public dividend capital	160.2	160.2	160.2
Retained Earnings (Accumulated Losses)	(23.2)	(19.4)	(15.2)
Charitable Funds	0.0	0.0	0.0
Donated asset reserve	1.2	0.8	0.4
Revaluation reserve	36.3	36.3	36.3
Miscellaneous Other Reserves	10.1	10.1	10.1
TOTAL TAXPAYERS EQUITY	184.7	188.0	191.7

<u>KPIs</u>			
NHS Trade Receivable Days	10.5	10.8	12.0
Non NHS Trade Receivable Days	21.3	17.8	21.0
Trade Payable Days	44.8	47.9	33.0

Financial Plan 2011/2012

Medium Term Financial Plan: Extract from Long Term Financial Model

	Plan	Forecast	Foreca
	Mar-12	Mar-13	Mar-1
Units			
£m unless otherwise stated			
All amounts shown here are nominal			
Cash flow			
EBITDA	23.8	25.1	25.9
Other increases/(decreases) to reconcile to profit/(loss) from operations	(0.4)	(0.4)	(0.4
Operating cash flows before movements in working capital	23.4	24.6	25.5
Movement in working capital:			
(Increase)/decrease in Inventories	0.1	0.1	0.1
(Increase)/decrease in NHS Trade Receivables	2.0	0.7	(1.0
(Increase)/decrease in Non NHS Trade Receivables	0.3	(0.2)	(0.6
(Increase)/decrease in other Receivables	0.0	0.0	0.0
(Increase)/decrease in Other financial assets (e.g. accrued income)	0.0	0.0	0.0
(Increase)/decrease in Prepayments	0.0	0.0	0.0
(Increase)/decrease in Other assets	0.0	0.0	0.0
Increase/(decrease) in Deferred Income & Payments on account	0.0	0.0	0.0
Increase/(decrease) in Provisions	0.0	0.0	0.0
Increase/(decrease) in Trade Payables	0.0	1.5	(4.5
Increase/(decrease) in Other Payables	0.0	0.0	0.0
Increase/(decrease) in PDC Dividend Creditor			
Increase/(decrease) in accruals	(6.0)	0.0	0.0
Increase/(decrease) in Other liabilities	(0.0)		0.0
Increase/(decrease) in working capital	(3.6)	2.0	(5.9
Increase/(decrease) in Non Current Provisions	0.0	0.0	0.0
Net cash inflow/(outflow) from operating activities	19.8	26.6	19.
Cash flow from investing activities			
Property, plant and equipment expenditure	(24.1)	(8.1)	(10.
Proceeds on disposal of property, plant and equipment	0.0	0.0	0.0
Other cash flows from investing activities, e.g. expenditure or proceeds from Investments & Dividends	0.0	0.0	0.0
Net cash inflow/(outflow) from investing activities	(24.1)	(8.1)	(10.
CF before Financing	(4.3)	18.5	8.6
Cash flow from financing activities			
Public Dividend Capital received	0.0	0.0	0.0
Public Dividend Capital repaid	0.0	0.0	0.0
Dividends paid	(5.8)	(6.0)	(6.3
Interest (paid) on Loans and Leases	(5.8) (1.9)	(8.0) (1.9)	(0.3
Interest (paid) on bank overdrafts and working capital facilities	(1.5)	(1.9)	(2.0
Interest received on Cash and Cash equivalents	0.1	0.4	0.4
Drawdown of Loans and Leases	0.1 8.0	0.4 0.0	0.4
Repayment of Loans and Leases			
Other cash flows from financing activities	(1.6)	(3.2)	(3.0
Net cash inflow/(outflow) from financing	(1.3)	(10.7)	(11.
net tash hinow/ (outhow) nom mancing	(1.3)	(10.7)	(11.)
Taxes paid	0.0	0.0	0.0
Net cash outflow/inflow	(5.6)	7.8	(3.2

Financial Plan 2011/2012

Medium Term Financial Plan: Extract from Long Term Financial Model

		Pla		
		Mar	-12 Mar-13	Mar-14
Linita				
<u>Units</u> £m unless otherwise stated				
All amounts shown here are nominal				
All amounts shown here are nonlinal				
Key Ratios				
Data				
Revenue		413	3.2 394.4	390.3
Revenue available for debt service		23		26.3
Annual dividend payable		5.		6.3
Annual Debt Service		3.		5.3
Annual Interest payable		2.		2.3
Debt		38		32.7
PBC Ratios				
Dividend Cover		3.7		3.8x
Interest Cover		11.		11.5x
Debt Service Cover		6.3		5.0x
Debt Service to Revenue		0.9	0% 1.4%	1.4%
Tior 1 Toot	Limite			
<u>Tier 1 Test</u> Minimum Dividend Cover	<u>Limits</u> 1.0x	TR	UE TRUE	TRUE
Minimum Interest Cover	3.0x	TR		TRUE
Minimum Debt Service Cover	2.0x	TR		TRUE
Maximum Debt Service to Revenue	2.5%	TR		TRUE
	2.370			INCL
Tier 1 PBC ratio test passed		TR	UE TRUE	TRUE
	Lingite			
Tier 2 Test Minimum Dividend Cover	<u>Limits</u> 1.0x	тр		трис
Minimum Dividend Cover Minimum Interest Cover	1.0x 2.0x	TRI TRI		TRUE TRUE
Minimum Debt Service Cover	2.0x 1.5x	TR		TRUE
Maximum Debt Service Cover Maximum Debt Service to Revenue	1.5x 10.0%	TR		TRUE
Maximum Debt Service to Revenue	10.0%			TRUE
Tier 2 PBC ratio test passed		TR	UE TRUE	TRUE
Dielensting				
Risk rating				
Metric				
EBITDA margin		5.8	6.4%	6.6%
EBITDA, % achieved		283		100.0%
ROA		4.3		5.4%
I&E surplus margin		0.6		1.1%
Liquid ratio		17		20.3
-1				_ • • •

Extract from the 2011/12 Monitor Compliance Guidance

Area	Proposed measures, thresholds, weightings and monitoring periods for 2011/12	Threshold (1)	Weighting	Monitoring Period
Safety	Clostridium difficile – meeting the Clostridium difficile objective	0	1.0	Quarterly
Safety	MRSA – meeting the MRSA objective (2)	0	1.0	Quarterly
Quality	All cancers: 31-day wait for second or subsequent treatment (3), comprising either:		1.0	Quarterly
	surgery anti cancer drug treatments radiotherapy	94% 98% 94%		
Quality	All cancers: 62-day wait for first treatment (4), comprising either:		1.0	Quarterly
	from urgent GP referral to treatment from consultant screening service referral from fast track consultant upgrade	85% 90% 85%		
Patient Experience	Referral to treatment waiting times – admitted (95 th percentile) (5)	23 weeks	1.0	Quarterly
Patient Experience	Referral to treatment waiting times – non-admitted (95 th percentile) (5)	18.3 weeks	1.0	Quarterly
Quality	All cancers: 31-day wait from diagnosis to first treatment (6)	96%	0.5	Quarterly
Quality	Cancer: two week wait from referral to date first seen (7), comprising either:		0.5	Quarterly
	all cancers for symptomatic breast patients (cancer not initially suspected)	93% 93%		
Quality	A&E (8): Total time in A&E (95 th percentile) Time to initial assessment (95 th percentile) Time to treatment decision (median) Unplanned reattendance rate Left without being seen	4 hours 15 minutes 60 minutes 5% 5%	0.5 0.5 0.5 0.5 0.5	Quarterly
Quality	Stroke indicator (9)	TBC	0.5	Quarterly
Quality	100% enhanced Care Programme Approach (CPA) patients (10), comprising either: receiving follow-up contact within seven days of discharge having formal review within 12 months	95% 95%	1.0	Quarterly
Quality	Minimising delayed transfers of care (11)	<= 7.5%	1.0	Quarterly
Quality	Admissions to inpatients services had access to crisis resolution home treatment teams (12)	90%	1.0	Quarterly
Quality	Meeting commitment to serve new psychosis cases by early intervention teams (13)	95%	0.5	Quarterly
Effectiveness	Data completeness: identifiers (14)	99%	0.5	Quarterly
Effectiveness	Data completeness: outcomes (15)	50%	0.5	Quarterly
Quality	Category A call -emergency response within 8 minutes (16)	75%	1.0	Quarterly
Quality	Category A call – ambulance vehicle arrives within 19 minutes (16)	95%	1.0	Quarterly
Patient experience	Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability (17)	N/A	0.5	Quarterly

Appendix 2 – governance indicators (table 1)

Integrated performance measures for national oversight

	Headline measures	Supporting measures	
Quality (Safety, Effectiveness & Patient Experience)	 HCAI measure (MRSA & CDI) Patient experience survey² Referral to Treatment waits (95th percentile measures) MSA breaches A&E Quality Indicators (5 measures)¹ Ambulance quality (Cat A response times) Cancer 2 week, 62 day waits (2 aggregate measures) Emergency Readmissions 	MRSA – delivery of objective VTE Risk assessment VTE Risk assessment Water Risk assessment VTE Risk assessment Water Risk assessment Referral b Treatment waits (median wait measures) Cervical screening Referral to Treatment waits (median wait measures) Cervical screening Referral to Treatment waits (median wait measures) Community services Referral to Treatment waits (median wait measures) Commonity of objective Water Risk assessment Stroke Indicator Cares breaks Stroke Indicator Cares breaks Cares breaks Cares breaks Stroke Indicator Stroke Indicator Cares breaks Stroke Indicator Stroke Inditing Stroke Indicator Str	
Resources (Finance, Capacity & Activity)	 Finandal forecast outturn & performance against plan Finandal performance score for NHS Trusts³ Delivery of running cost targets Progress on delivery of QIPP savings Acute Bed Capacity Non elective FFCEs Numbers walting on an Incomplete Referral to Treatment pathway Health visitor numbers Workforce productivity 	Total pay costs Year to date financial position Year to date financial position Underlying financial position of PCTs and NHS Trusts Delayed position Underlying financial position of PCTs and NHS Trusts Delayed Transfers of Care (Acute & MH) Delayed Transfers of Care (Acute & MH) Other referrals to hospital Other referrals for a first outpatient attendances Ambulance Urgent & Emergency Journeys Clinical staff numbers Redundancy numbers	
Reform (Commissioner, Provider & building capability and partnership)	 FT pipeline Transforming Community Services (TCS) successfully achieved GP Consortia progress and transfer of relevant functions NHS CB/LAs Establishment of PCT clusters Choice Information to Patients Competition 	Provider development: % of orgs progressing along pipeline to milestones agreed between SHA, trust and DH	

1 Sultes of measures - a drop in performance on a single indicator may not trigger intervention as long as there has been no worsening in performance of the sulte overall.

2 Monitored through local data collections as well as national annual survey 3 The finance domain score for NHS Trusts in the NHS Performance Framework.

Sandwell and West Birmingham Hospitals

NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Research & Development Department Report
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Professor Carl Clarke, Director of Research & Development
DATE OF MEETING:	31 March 2011

SUMMARY OF KEY POINTS:

- 1) Standardised reporting arrangements for Committee members detailing research activity, recruitment status and additional support requirements introduced.
- 2) Transparent 2011-2012 bid for financial support to Birmingham & Black Country Comprehensive Local Research Network (BBC CLRN) submitted requesting £1.22 million (19% increase on 2010-11 funding).
- 3) Support, in the form of research nurse and data manager time, is being provided to a number of established and new disciplines to increase the amount of research being undertaken including rheumatology, ophthalmology, stroke, dermatology, colorectal surgery, diabetes.
- 4) The availability and uptake of local GCP training has increased
- 5) Implementation of the NIHR Research Support Service initiative is ongoing. Members of the Department are also acting as local representatives for the implementation of the new NIHR Research & Development Management Information System Co-ordinated System for Gaining NHS Permissions (RDMIS CSP)
- 6) The Trust Lead Research Nurse, three Band 6 Research Nurses, two Band 5 Research Nurse and three Band 3 Data Managers were appointed in January / February 2011.
- 7) Lack of office accommodation for R & D Department requires urgent attention.
- 8) Appointment of R&D Finance Officer urgently required

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

Approval	Receipt and Noting	Discussion
	Х	

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	6.3 Implement the next stages of our new clinical research strategy
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	х	
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Last considered by the Trust Board at its meeting in August 2010.

SWBTB (3/11) 067 (a) Sandwell and West Birmingham Hospitals

Trust-Wide Governance Committees

Report to:	Governance Board April 2011		
Report of:	Research & Development		
Report by:	Professor Carl E Clarke		
Subject:	Progress report for the period July 2010 to March 2011		
MEETINGS HELD			
	1. 26 th October 2010		
During the reporting	2. 7 th December 2010		
period the Committee met on the following dates:	3. 25 th January 2011		
on the following dates.	4.		
	5.		
2010-11 OBJECTIVES			
Provide an update on progress made in achieving the agreed	 To define the structure and function of the R&E Committee. Standardised reporting arrangements for Committee members detailing research activity, recruitment status and 		
annual objectives for the	additional support requirements introduced.		
Committee	 To provide a transparent system of funding for research throughout the Trust 		
[Only a summary position statement is required against each objective as more detailed information will have been submitted for inclusion in the quarterly Annual Governance Development Plan updates]	Transparent 2011-2012 bid for financial support to Birmingham & Black Country Comprehensive Loca Research Network (BBC CLRN) submitted requesting £1.22 million (19% increase on 2010-11 funding). NIHR Industry Costings Template adopted for costing of al Commercial research studies.		
	 To continue to increase the quantity of research undertaken in the Trust 		
	Support, in the form of research nurse and data manage time, is being provided to a number of established and new disciplines to increase the amount of research being undertaken including rheumatology, ophthalmology stroke, dermatology, colorectal surgery, diabetes.		
	 To continue to increase the quality of research undertaker in the Trust The availability and uptake of local GCP training has increased 		
	 To strengthen and streamline systems within the R&E Department Implementation of the NIHR Research Support Service initiative is on-going. Members of the Department are also acting as local representatives for the implementation o the new NIHR Research & Development Managemen Information System Co-ordinated System for Gaining NHS Permissions (RDMIS CSP) To develop a pool of Research Nurses, Allied Health 		

KEY ISSUES Key issues that the Committee wants to bring to the attention of the Governance Board should be listed. Where possible, solutions or suggestions should be put forward for any problems or areas of concern raised.	 Professionals and other research support staff within the Corporate Team The Trust Lead Research Nurse, three Band 6 Research Nurses, two Band 5 Research Nurse and three Band 3 Data Managers were appointed in January / February 2011. 7. General Comments: 1. The efficiency of the R&D Department is currently being compromised by the fact that since January the single office that the department inhabited in Arden House, designed to accommodate four staff members, is currently accommodating five members of staff. A solution to the problem is under consideration. 2. To continue to develop the transparent system of funding for R&D throughout the Trust there is a requirement for dedicated finance support for the R&D Department. In collaboration with the Finance Department a designated R&D Finance Officer will be appointed in the near future. 3. 	
	5.	
QUALITY STANDARDS Include details of: • national, regional or local quality standards • monitoring information considered by the Committee and/or collected • corporate, divisional and directorate-level performance in relation to quality standards • the Trust's performance compared with other similar organisations [NB: Indicators tracked at	2010-11 at 980. Recruitment has not been as high a anticipated and it is estimated that the Trust will only recru 910 (93%) participants by the end of the financial year.	
directorate-level will be included in the QMF]		
POLICIES, PROCEDURES, PRO Provide details of any <u>new</u> policies being developed or <u>existing</u> ones that are	The first stage of the implementation of the NIHR Research Support Services initiative is the R&D Operational Capability Statement (RDOCS). The RDOCS is appended for Trust Board consideration.	

being reviewed.					
QUALITY IMPROVEMENTS CONSULTATION AND PATIEN	QUALITY IMPROVEMENTS CONSULTATION AND PATIENT INVOLVEMENT				
Provide information on how the Committee has involved services users and their relatives in its work or intends to do so.	The	Committee includes a lay member			
EDUCATION, TRAINING, LEARNING AND CONTINUOUS PROFESSIONAL DEVELOPMENT ATTACHMENTS					
	1.	SWBHT RDOCS v1			
List any documents that	2.	SWBHT R&D RDOCS SOP v1			
are attached to this report.	3.				
	4.				

Completed returns to be emailed to simon.grainger-payne@swbh.nhs.uk a week before the schedule date of presentation to the Governance Board



Research & Development Department

Standard Operating Procedure

Manage R&D Operational Capability Statement	
Version:	1.0
Effective Date:	1 st April 2011
Author:	Sinead Baxter, RM&G Manager
Approved by:	Jocelyn Bell, Head of R&D

Revision Chronology:	Effective Date	Reason for change
Version 1.0	1 st April 2011	

1. PURPOSE AND CONTEXT

- 1.1. This Standard Operating Procedure (SOP) describes the procedures the R&D Office within a NHS Organisation use when managing the content of the R&D Operational Capability Statement.
- 1.2. The R&D Operational Capability Statement (the 'Statement') provides a board level operational framework which empowers a R&D Office to undertake the management of R&D within the Organisation. The NIHR expects that all Organisations intending to sponsor or participate in research have a R&D Operational Capability Statement.
- 1.3. The outcome is that the R&D Office does its work by reference to a Board approved R&D Operational Capability Statement.
- 1.4. The Statement provides information that enables:
 - a. The R&D Office to undertake a rapid assessment using the Participating Trust Planning Tool and / or Study Sponsor Planning Tool.
 - b. Sponsors, Research Teams and NIHR Networks to work with R&D Offices to make the NHS Permission process predictable, quick and effective.
 - c. The Board to set the Organisation's management framework for R&D and to plan developments and investments in research capability.
- 1.5. The Statement does not replace the Research & Development Strategy 2009-2011.
- 1.6. The Statement provides an operational overview of capabilities and lists of contact points and Internal Agreements. The Statement can be shared with Networks, Industry, Researchers and Sponsors. It is a tool to improve collaboration and effectiveness in research activities.
- 1.7. The Statement provides an operational overview of the clinical services, facilities and resources available to support R&D in the Organisation. It includes an overview of collaborations and partnerships with other Organisations in providing these resources.
- 1.8. The Board is accountable for the R&D Operational Capability Statement. The R&D Office is responsible for maintaining the Statement. The Board periodically reviews the Statement and makes it available to anyone who needs it.

For the Board

- 1.9. The Statement sets out how the Board plans to meet its research related responsibilities / requirements / principles as stated in:
 - a. Department of Health Research Governance Framework for Health and Social Care.
 - b. Medicines for Human Use (Clinical Trials) Regulations (as Sponsoring Organisation or Participating Organisation).
 - c. Operating Framework for the NHS in England.
 - d. Quality Accounts.
 - e. Handbook to NHS Constitution.
 - f. Clinical investigation of medical devices for human subjects ISO 14155.
 - g. Other relevant guidance and regulations.
- 1.10. It specifies the management and governance responsibilities delegated to the R&D Office, enabling the Organisation to meet its Sponsor or Participating (host) research site responsibilities. Some of these responsibilities may be devolved to Networks or to other

Organisations providing related support.

1.11. The NIHR recommends that the R&D Operational Capability Statement is underpinned by a R&D Development Plan. The plan will set out a development path for building operational capability and achieving increased research activity as set out in the Organisation's R&D Strategy and the NHS Operating Framework.

For the R&D Office

- 1.12. The Statement gives the R&D Office an approved management framework, supporting timely and efficient decisions whether to support a particular research Study. It empowers the R&D Office to undertake its responsibilities with support from staff within clinical and other service departments in the Organisation.
- 1.13. In particular it summarises key decisions already taken by the Board regarding participation in or sponsoring of studies and provides access to key contacts in the Organisation who support such decisions. This information is used during Study Sponsoring / Participating Planning Tool for each Study.
- 1.14. The Statement includes an escalation procedure so that the R&D Office can quickly seek appropriate authorisation when it is unclear how to apply the guidance in the Statement.
- 1.15. It provides information on planned or agreed R&D development needs required to support governance and delivery of studies including training of staff or other investments.

For Sponsors, Research teams and NIHR Networks

- 1.16. It summarises the facilities and research capability of the Organisation, enabling others to avoid proposing studies that the Organisation is unable to support.
- 1.17. It facilitates collaborative working and efficiency by improving information sharing regarding the Organisation's capability and capacity to support different types of research in differing roles e.g. Participant Identification Centre, Employing Organisation, and Organisation Providing Care.

	FROCEDO		
	Responsibilit v	Undertaken by	Activity
1	R&D Office	Head of R&D	Review the Research Strategy or other Organisation documents for goals / missions / objectives and the time frames.
2	R&D Office	RM&G Manager /Head of R&D	Conduct an 'As Is' assessment to document the current capabilities of the Organisation in each of the areas outlined in the Guideline.
3	R&D Office	RM&G Manager /Head of R&D	Conduct consultation (appropriate to the R&D activities of the Organisation) with the relevant stakeholders in the development of the Statement.
4	R&D Office	RM&G Manager /Head of R&D	Liaise with Clinical Support Services and other services in order to agree, document and sign off established processes and Internal Agreements that support research.
5	R&D Office	RM&G Manager /Head of R&D	Review draft content with relevant service managers.
6	R&D Office	RM&G Manager /Head of R&D	Complete R&D Operational Capability Statement using pro- forma.

2. PROCEDURE

Page 3 of 4

	Responsibilit y	Undertaken by	Activity
7	R&D Office	Head of R&D	Obtain agreement of the Lead / Director of R&D.
8	Lead/Director of R&D	Director of R&D	Obtain Board approval.
9	R&D Office	Head of R&D	Ensure there is an agreed process for review and update of the Statement by the Board (on an annual basis and when changes are required to be made to the Statement).

3. SUPPORTING MATERIAL

SWBHT Research & Development Strategy 2009-2011

4. ADDITIONAL INFORMATION

- 4.1. R&D Operational Capability Statement (see separate Excel document).
- 4.2. List of planned and actual studies for the Organisation (Information held within R&D Office on ReDa database)

NIHR Guideline B01 R&D Operational Capability Statement

Version History

Version number RDOCS 001	Valid from 01/02/2011	Valid to 31/01/2012	Date approved	Approved by xxx	Updated by rrr
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Contents

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Organisation R&D Management Arrangements

Information on key of	contacts
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Organisation Details		
Name of Organisation	Sandwell & West Birmingham Hospitals NHS Trust	
R&D Lead / Director (with responsibility for reporting	Professor Carl E. Clarke (Director of Research & Development)	
on R&D to the Organisation Board)		
R&D Office details:		
Name:	Research & Development	
Address:	Arden House, City Hospital, Dudley Road, B18 7QH	
Contact Number:	0121 507 4946	
Contact Email:	jocelyn.bell@nhs.net	
Other relevant information:		
Key Contact Details e.g. Research Governance Lea	ad, NHS Permissions Signatory contact details	
Contact 1:		
Role:	Head of Research & Development	
Name:	Dr Jocelyn Bell	
Contact Number:	0121 507 4946 / 07773 426989	
Contact Email:	jocelyn.bell@nhs.net	
Contact 2:		
Role:	RM&G Manager	
Name:	Sinead Baxter	
Contact Number:	0121 507 4092 / 07976 499420	
Contact Email:	sinead.baxter@nhs.net	
Contact 3:		
Role:	Trust Lead Research Nurse	
Name:	Frances Lloyd	
Contact Number:	0121 507 4946 / 07976 499240	
Contact Email:	frances.lloyd1@nhs.net	

Add further contacts by selecting and then **copying** the five Excel **rows** (ie whole rows) above for Contact, role, name, number and email.

Then select the **blank row** under the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.) <u>Go to top of document</u>

Information on staffing of the R&D Office

Whole Time	Comments
Equivalent	indicate if shared/joint/week days in office etc
0.2	
1	
1	
1	
1	
0.8	
1	Post currently in development
	Equivalent 0.2 1 1 1 1 1 0.8

Add lines in the table as required by selecting and then copying a whole Excel row which is a part of the table (note: select and copy the row not cells in the row). Then select a row in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.) Go to top of document

Information on reporting structure in organisation (include information on any relevant committees, for example, a Clinical Research Board / Research Committee / Steering Committee.) **Reporting Structures**

SWBH NHS Trust Research & Development Committee exercises research governance functions on behalf of the Trust. The R&D Committee meets quarterley and has health professional, organisational representative and lay membership. The R&D Committee has oversight of decisions on sponsorship of research and NHS Permission powers delegated to the Director and Head of R&D in order to facilitate more rapid granting of permission for research to be undertaken.

Add lines in the table as required by selecting and then copying a whole Excel row which is a part of the table (note: select and copy the row not cells in the row). Then select a row in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.) Go to top of document

Information on Research Networks supporting/working with the Organisation.

Information on how the Organisation works with the Comprehensive Local Research Network (CLRN), Primary Care Research Network (PCRN), Topic Specific Clinical Research Networks (TCRN). Research Networks

	Research Network (name/location)	Role/relationship of the Research Network eg host Organisation		
I	Birmingham & the Black Country CLRN (BBC CLRN)	The Trust is a member orgainsation of the BBC CLRN. The CLRN provides RM&G funding, information and of research nurses and support staff working in various specialties. The CLRN also funds some Investigator		
		of research nurses and support staff working in various specialties. The CLRN also funds some Investigator		
Pan Birmingham Cancor Posoarch Notwork		The Trust is a member organisation of the PBCRN. The Trust employs a research nurse and data manager		
	(PBCRN)	The trust is a member organisation of the PBCICN. The trust employs a research hurse and data manager		
	West Midlands Medicines for Children Research	MCRN network funded nurses support paediatric trials in the Trust		
	Network			
	West Midlands Stroke Research Network	Stroke research network funded nurses support stroke trials in the Trust		

Add lines in the table as required by selecting and then copying a whole Excel row which is a part of the table (note: select and copy the row not cells in the row). Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.) Go to top of document

Information on collaborations and partnerships for research activity (e.g. Biomedical Research Centre/Unit, Other NHS Organisations, Higher Education Institutes, Industry) Current Collaborations / Partnerships

	Details of Collaboration / Partnership (eg		Email a			
Organisation Name	University/Organisation Joint Office,	Contact Name				
Organisation Name	external provider of pathology services to	to				
	Organisation, etc, effective dates)					

nd advice. The Trust employs, with CLRN funding, a number or time. er to support cancer trials with funding from the PBCRN.

Contact Number ddress

University of Birmingham	University employed research staff work within the Trust. The Trust sponsors a number of research project run by University employed staff.	Bredan Laverty	b.w.laverty@bham.ac.uk	0121 414 7151
Aston University	University employed research staff work within the Trust. The Trust sponsors a number of research project run by University employed staff.	Nichola Seare	n.seare@aston.ac.uk	0121 204 3325
Birmingham Clinical Trials Unit	Sponsors some studies, and also coordinates a number of trials	Michelle Burgess	bctu@bham.ac.uk	0121 405 9100

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row). Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.) Go to top of document

Organisation Study Capabilities

Information on the types of studies that can be supported by the Organisation to the relevant regulatory standards

Types of Studies Organisation has capabilities in (please tick applicable)							
	CTIMPs	Clinical Trial of a	Other Clinical	Human Tissue:	Study Administering	Qualitative Study	OTHER
	(indicate Phases)	Medical Device	Studies	Tissue Samples	Questionnaires		
				Studies			
As Sponsoring Organisation	Х	Х	\checkmark	\checkmark			
As Participating Organisation	√ Phases 2-4	\checkmark	\checkmark	\checkmark			
As Participant Identification Centre	√ Phases 2-4						

Add lines in the table as required by selecting and then copying a whole Excel row which is a part of the table (note: select and copy the row not cells in the row). Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.) Go to top of document

Which licences does the organisation hold which may be relevant to research?

Organisation Licences			
Licence Name	Licence Details	Licence Start Date (if applicable)	Licence End Date (if applicable)
Example: Human Tissue Authority Licence			

Add lines in the table as required by selecting and then copying a whole Excel row which is a part of the table (note: select and copy the row not cells in the row). Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.) Go to top of document

PCT ONLY: Information on the practices which are able to conduct research

Number/notes on General Practitioner (GP) Practices

Add lines in the table as required by selecting and then copying a whole Excel row which is a part of the table (note: select and copy the row not cells in the row). Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.) Go to top of document

Organisation Services

Information on key clinical services contacts and facilities/equipment which may be used in studies for supporting R&D governance decisions across the organisation.

Service Department	Specialist facilities that may be provided	Contact Name	Contact email	Contact number	Details of any internal agreement
	(eg number/type of scanners)	within Service			templates
		Department			and other comments
Pathology		Jonathan Berg	jonathanberg@nhs.net	0121 507 5353	
Imaging		to be confirmed			
Pharmacy	Clinical Trials Pharmacist	Julie Simpson	julie1.simpson@nhs.net	0121 507 3550	
Histology		Diane Edwards	diane.edwards@nhs.net	0121 507 4260	
Haematology		Jackie Martin	jackie.martin2@nhs.net	0121 507 5363	
Biochemistry		Vanessa Lane	vanessalane@nhs.net	0121 507 6027	

Add lines in the table as required by selecting and then copying a whole Excel row which is a part of the table (note: select and copy the row not cells in the row). Then select a row in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.) Go to top of document

Information on key management contacts for supporting R&D governance decisions across the organisation.

Management Support e.g. Finance, Legal Service	s, Archiving				
Department	Specialist services	Contact Name	Contact email	Contact number	Details of any
	that may be	within Service			internal agreement
	provided	Department			templates
Contracts		Dr Jocelyn Bell	jocelyn.bell@nhs.net	0121 507 4946	
Finance		Paul North	paulnorth@nhs.net	0121 507 5217	
HR		Ms Del Radway	del.radway@nhs.net	0121 507 6688	
Statistical support		Dr Andrew Blann	a.blann@bham.ac.uk	0121 507 5076	

Organisation R&D Interests

Information on the areas of research interest to the Organisation

Organisation R&D Areas of Interest				
Area of Interest	Details	Contact Name	Contact Email	Contact Number
Cancer		Dr Daniel Rea	d.w.rea@bham.ac.uk	0121 507 5241
Cardiology		Professor Greg Lip	g.y.h.lip@bham.ac.uk	0121 507 5080
Diabetes		Dr Douglas Robertson	doug.robertson@nhs.net	0121 507 3907
Ophthtalmology		Professor Philip Murray	p.i.murray@bham.ac.uk	0121 507 6851
Neurology		Professor Carl Clarke	c.e.clarke@bham.ac.uk	0121 507 4073
Stroke		Dr David Nicholls	david.nicholl@nhs.net	0121 507 4588
Rheumatology		Professor Caroline Gordon	p.c.gordon@bham.ac.uk	0121 507 5793
Gastroenterology (Upper GI)		Dr Nigel Trudgill	nigel.trudgill@nhs.net	0121 507 3080
Endocrinology		Dr Elizabeth Hughes	elizabeth.hughes@westmidlands.	nhs.uk 0121 507 3426

Add lines in the table as required by selecting and then copying a whole Excel row which is a part of the table (note: select and copy the row not cells in the row). Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.) Go to top of document

Information on Local / National Specialty group membership within the Organisation which has been shared with the CLRN

Specialty Group Membership (Local and National)					
National / Local	Specialty Group	Specialty Area (if only specific areas	Contact Name	Contact Email	Contact Number
Local	Priority Area Lead	Ophthalmology	Miss Saaeha Rauz	s.rauz@bham.ac.uk,	0121 507 6849 /
		Ophinainology	Prof Jon Gibson	j.m.gibson@aston.ac.uk	6806
Local	Priority Area Lead	Immunology and Inflammation	Professor Caroline	p.c.gordon@bham.ac.uk	0121 507 5793
			Gordon		
National	Priority Area Lead	Immunology and Inflammation	Professor Caroline	p.c.gordon@bham.ac.uk	0121 507 5793
National		initiation and initiation	Gordon		
Local	Priority Area Lead	Cardiovascular	Professor Gregory	g.y.h.lip@bham.ac.uk	0121 507 5080
			Lip		
			Professor	c.d.buckley@bham.ac.uk	0121 507 5793
Local	Priority Area Lead	Musculoskeletal	Christopher		
			Buckley		
			Professor	c.d.buckley@bham.ac.uk	0121 507 5793
National	Priority Area Lead	Musculoskeletal	Christopher		
			Buckley		

Add lines in the table as required by selecting and then copying a whole Excel row which is a part of the table (note: select and copy the row not cells in the row). Then select a row in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.) Go to top of document

Organisation R&D Planning and Investments

Planned Investment			
Area of Investment (e.g. Facilities, Training, Recruitment, Equipment etc.)	Description of Planned Investment	Value of Investment	Indicative dates
Recruitment, Equipment etc.)			

Organisation R&D Standard Operating Procedures Register

Standard Operating Procedures		
SOP Ref Number	SOP Title	SOP Details
R&D Standard Operating Procedures currently in		
preparation / review		

Add lines in the table as required by selecting and then copying a whole Excel row which is a part of the table (note: select and copy the row not cells in the row). Then select a row in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.) Go to top of document

Information on the processes used for managing Research Passports Indicate what processes are used for managing Research Passports

Research Passports are manged and issued by the Research & Development Department in accordance to current guidance.

Add lines in the table as required by selecting and then copying a whole Excel row which is a part of the table (note: select and copy the row not cells in the row). Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.) Go to top of document

Information on the agreed Escalation Process to be used when R&D governance issues cannot be resolved through normal processes

Escalation Process

R&D governance issues that cannot be resolved by the Head and Director of R&D would be escalated to the Director of Governance and Medical Director with re

Valid from	Valid to

esponsibility for research.		

Planned and Actual Studies Register

The Organisation should maintain or have access to a current list of planned and actual studies which its staff lead or collaborate in.

Comments

The Trust R&D Department records and maintains information for all studies on the ReDa Database. This is mangaged within the R&D Department.

Add lines in the table as required by selecting and then copying a whole Excel row which is a part of the table (note: select and copy the row not cells in the row). Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.) Go to top of document

Other Information

For example, where can information be found about the publications and other outcomes of research which key staff led or collaborated in? Other Information (relevant to the capability of the Organisation)

Sandwell and West Birmingham Hospitals

NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Risk Management Report – Q3 2010/11	
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance	
AUTHOR:	Allison Binns, Head of Risk Management David Sullivan, Lead for Complaints Dally Masaun, Head of Health and Safety Nayna Patel, Lead for PALS	
DATE OF MEETING:	31 March 2011	

SUMMARY OF KEY POINTS:

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

Key incident statistics:

- There were 2097 reported incidents (2127 in Q3 2009/10)
- Reported clinical incidents increased from 1380 in Q3 2009/10 to 1434 in Q3 2010/11
- Reported health & safety incidents fell from 747 in Q3 2009/10 to 663 in Q3 2010/11
- There were 105 incident forms received relating to red incidents (5% of the total), compared with 59 in Q3 2009/10 (3% of the total)

Key complaints statistics:

• Total complaints: 201 (245 in Q3 2009/10), a decrease of 18%

Key claims statistics:

Total claims: 29 (39 in Q3 2009/10).

Key PALS statistics:

Total enquiries to PALS team: 980 compared with 1600 in the same quarter 2009/10

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Governance Board on 4 March 2011 and Governance and Risk Management Committee on 24 March 2011.



Risk Management Report

Quarter 3 - 2010-2011

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



Q3 Risk Management Report

Integrated Risk, Complaints and Claims Report: Quarter 3 2010/11

1. Overview

This report highlights key risk activity including:

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

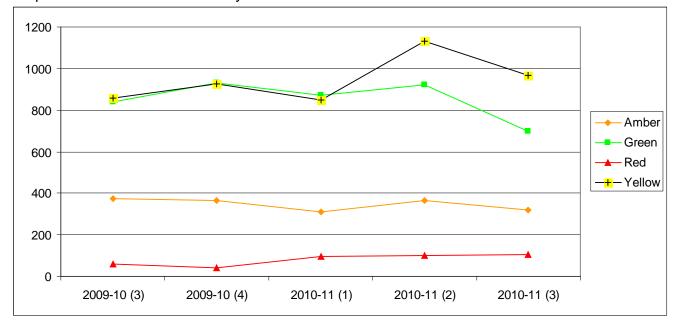
2. Introduction

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

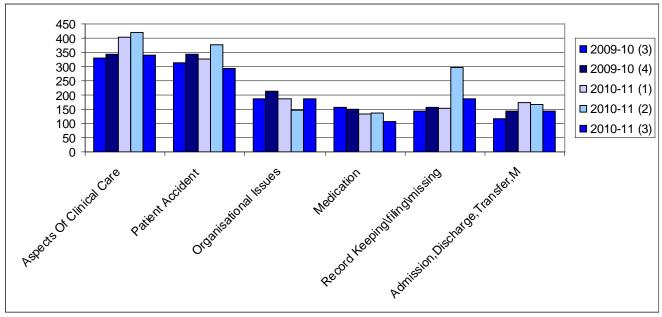
3. Key Issues

3.1 Review of Quarter 3 Incident Data

- There were 2097 reported incidents (2127 in Q3 2009/10)
- Reported clinical incidents increased from 1380 in Q3 2009/10 to 1434 in Q3 2010/11
- Reported health & safety incidents fell from 747 in Q3 2009/10 to 663 in Q3 2010/11
- There were 105 incident forms received relating to red incidents (5% of the total), compared with 59 in Q3 2009/10 (3% of the total),

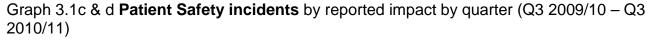


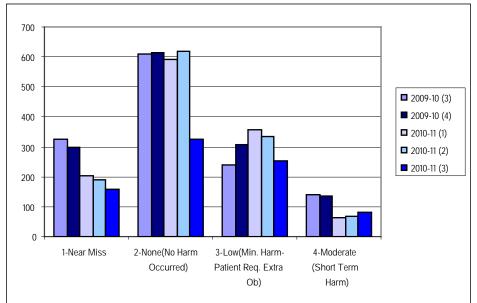
Graph 3.1a - Incident Trends by risk score Q3 2009/10 – Q3 2010/11

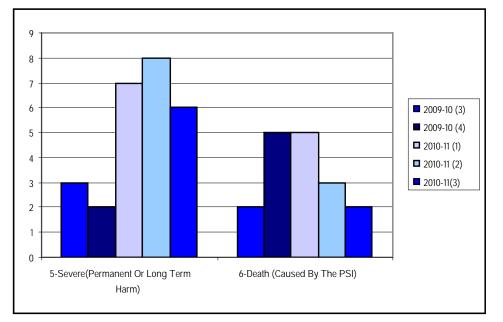


Graph 3.1b - Top 6 reported clinical incidents by quarter (Q3 2009/10 - Q3 2010/11)

The top 6 most frequently reported categories remain the same as Q2 2010/11. Compared to the last quarter, there has been a fall in all cause groups with the exception of organisational issues.







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

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

	Near Miss	None (No Harm Occurred)	Low (Min. Harm- Patient Req. Extra Ob)	Moderate (Short Term Harm)	Severe (Permanent Or Long Term Harm)	Death (Caused By The PSI)
Medicine	77	176	153	35	4	2
Surgery A	25	45	54	22	1	
Surgery B	2	10	9	2		
Women & Child Health	36	89	29	17	1	
Development/Cancer	1			1		
Facilities/Nursing &						
Therapy	1	1				
Imaging	3	2	5	3		
Pathology	7		2			
Operations	4	2	1			

Table 3.1 Patient Safety incidents by reported impact by division within Q3 2010/11

3.2 Complaints

During the reporting period the complaints team dealt with 201 new complaint contacts, which is a reduction (-18%) over the same quarter for the previous year (245).

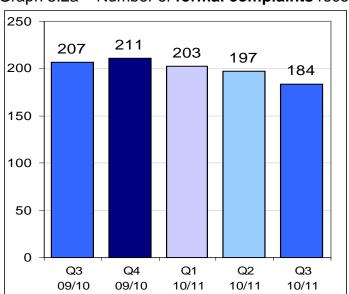
First contact complaint: where the Trust's substantive (i.e. initial) response has not yet been made.

Link complaint: the complainant has received the substantive response to their complaint but has returned as they remain dissatisfied/or require additional clarification.

Types of Contact	No	
Formal Complaints	184	Formal complaints with negotiated timescales
Can't Accept	0	Concerns not addressed (due to time elapsed since incident etc)
General Query/Feedback	2	Not dealt with formally (concerns/query addressed via letter)
GP/intra NHS Concerns	0	Concerns raised by GPs or other NHS organisations/staff members
Dealt with informally	0	Not dealt with formally (concerns/query addressed via phone or meeting)
Under Review	0	Pathway not finalised (e.g. reviewing records to establish whether a complaint can still be reviewed given time elapsed)
Withdrawn	15	Complaints are typically withdrawn if a relative has made the complaint, but patient consent cannot be obtained. Occasionally complaints are withdrawn as the complainant changes their mind about taking their concerns forward.

Table 3.2a Types of **Contact** during Q3 2010-11

The Trust dealt with 184 formal complaints, compared with 207 in the same quarter in 2009/10. This may in part reflect lower levels of PALS referrals into the formal complaints process (i.e. 21 referrals received for the corresponding reporting period last year compared to 4 received during Q3 this year).



Graph 3.2a - Number of formal complaints received by quarter

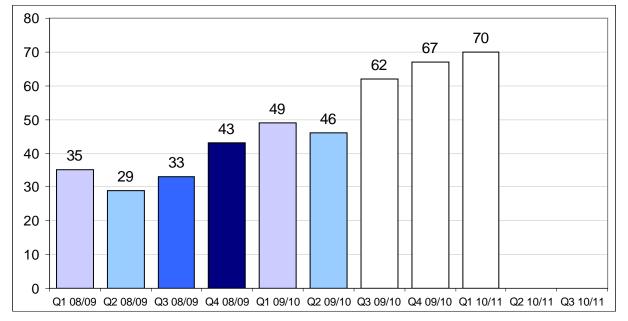
SWBTB (3/11) 055 (a)

The Trust received 25 "link" (follow-up) contacts during the quarter. Of these, 17 complainants raised concerns about the Trust's previous complaint investigation; 4 wished to attend a local resolution meeting and 4 asked for some further information. All "link" contacts are now tracked and categorised from receipt. However, this feature was not available for the same quarter last year.

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

So far the deadlines for 20% (37 cases) of complaints have been re-negotiated. Some of these timescales have had to be extended more than once. In total there have been 36 recorded date changes. This compares with a finalised figure of 41% (88 cases, 178 changes) for the same reporting period last year. However, as 72% of cases received during the present reporting period are still open (and thus potentially subject to further renegotiation), it would not be appropriate to directly compare the figures.

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

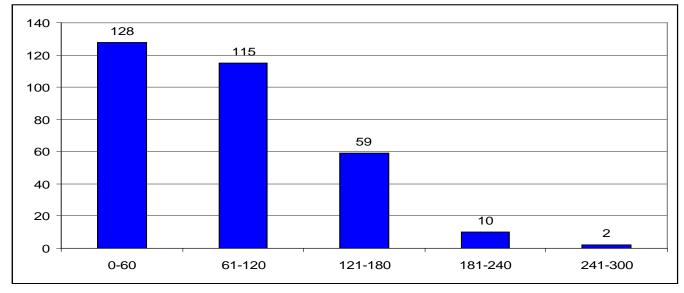


Graph 3.2b Trend of average response times in days

The graph above shows a marked lengthening of average response times from October 2009 onwards (Quarter 3 2009/10), which appears to be linked with the introduction of the new NHS Complaints Procedure in April 2009, coupled with an increase in complaints generally. It should also be noted that the Trust was an early adopter of the proposed revised complaints arrangements from April 2008, which featured a move away from the statutory 25 working day targets towards negotiated timescales.

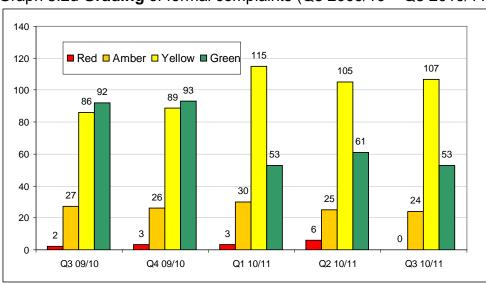
SWBTB (3/11) 055 (a)

Figures from quarter 3 2009/10 onwards are provisional only, as the chart represents only those cases that have received a substantive response. The final figure for that and subsequent quarters will increase as additional overdue cases are included. Both Q2 2010/11 and Q3 2010/11 have not been re-produced at all due to the large number of open cases.



Graph 3.2c Active complaints grouped by 60 day intervals at the end of Q3 2010/11

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

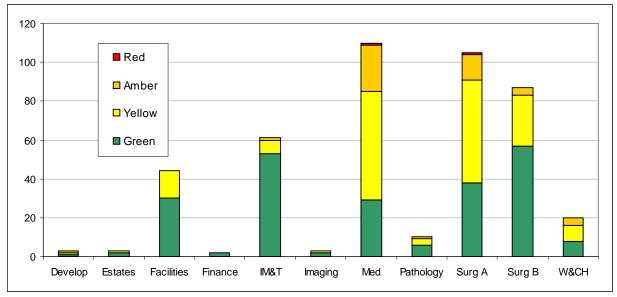


Graph 3.2d Grading of formal complaints (Q3 2009/10 - Q3 2010/11)

Key lessons learned for complaints during Q3 are attached at Appendix 1.

Action Plan Completion

All divisions are required to submit a copy of a completed action plan to the Complaints Department following the finalising of the Trust's investigation and response to the complainant. Monthly reports are being issued to relevant divisional managers containing details of any action plans yet to be submitted. The graph below is a breakdown by division of action plans currently outstanding for complaints responded to up until the 31st December 2010. The chart shows how many of each grade is outstanding.



Graph 3.2e Number of **action plans outstanding** by divisional lead (responses to end of Q3 2010/11)

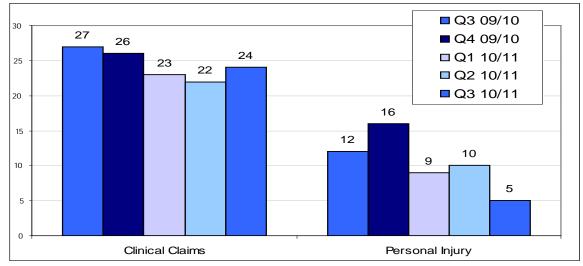
Referral of Complaints to the Health Service Ombudsman

Three cases were referred to the Ombudsman during the reporting period. The Ombudsman declined to investigate one case. Two other cases were referred back for efforts at additional local resolution.

3.3 Claims

The claims received are as follows:





Of the 24 clinical claims received, there were 5 that had a reported clinical incident related to the case. 12 claimants had already raised their concerns via the complaints procedure.

Of the 5 personal injury claims received, there were 3 that had a reported clinical incident related to the case. No claimants had previously raised their concerns via the complaints procedure. However, personal injury claims typically relate to staff injuries (this applies to 4 of the 5 claims here) and staff are not able to raise their concerns via the NHS complaints procedure.

Category	Clinical Claims	Personal Injury Claims
Burns/scalds/reactions	1	-
Delay In Treatment	1	-
Dissatisfied With Treatment	6	-
Failure Or Delay In Diagnosis	6	-
Failure to Obtain Consent	1	-
Failure to Recognise Complications	1	-
Fall/slip	-	2
Infection – MRSA	-	-
Lacerations/Sores	2	-
Lack of Care	-	-
Late Diagnosis and Treatment	1	-
Lifting/moving/handling	-	1
Moving/falling Objects	-	1
Needlestick	-	1
Operation Carried Out Negligently	1	-
Treatment Carried Out Negligently	4	-

Table 3.3a **Categories** of claims

At present the Trust has 248 Clinical claims and 89 personal injury claims at various stages of the legal process.

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

Status	Clinical Claims	Personal Injury
Disclosure Of Records*	165	3
Early Stages	1	1
Letter Of Claim	21	56
Letter Of Response	4	0
Liability Admitted	5	14
Liability Being Assessed	6	4
Liability Denied	6	1

Q3 Risk Management Report

Status	Clinical Claims	Personal Injury
Negotiate Settlement	10	4
Part 36 Offer	8	1
Proceedings Issued/served	6	1
Settlement Made	16	4

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

Division	Clinical Claims	Personal Injury Claims
Estates	-	19
Facilities	-	26
IM&T	-	2
Imaging	3	3
Medicine	57	18
Not Clear	9	-
Operations	-	1
Pathology	3	1
Surgery A	71	10
Surgery B	22	3
W&CH	83	5
Workforce	-	1

I ADIE J.J. UIAIIIIS DV DIECIUIAIE/DIVISIUII (EXCIUUES IECOIUS UISCIUSUIE)	Table 3.3c Claims by	Directorate/Division	(excludes records disclosure)
--	----------------------	----------------------	-------------------------------

Table 3.3d **Ongoing** claims by category

Category	Clinical Claims	Personal Injury Claims
Burns/scalds/reactions	6	5
Defective Equipment	1	3
Delay In Treatment	14	-
Dissatisfied With Treatment	51	-
Failure Or Delay In Diagnosis	74	-
Failure To Obtain Consent	1	-
Failure To Recognise Complications	13	-
Failure to Warn of Risk	-	1

Q3 Risk Management Report

Category	Clinical Claims	Personal Injury Claims
Fall/slip	6	36
Head Injury	-	1
Infection - MRSA	1	-
Infection - Other	-	1
Lacerations/sores	4	-
Lack Of Care	3	1
Late Diagnosis And Treatment	4	-
Lifting/moving/handling	2	12
Moving/falling objects	-	13
Needlestick	-	11
Not clear	1	-
Operation Carried Out Negligently	33	-
Stress	-	1
Treatment Carried Out Negligently	34	-
Violence & Aggression	-	4

3.3 Aggregated analysis

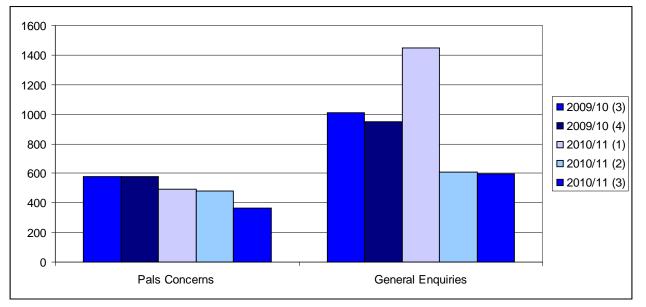
Details of key lessons learned are included at Appendix 1.

4. PALS

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

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

Graph 4.1a Trends of number of **enquiries** received (Q3 2009-10 to Q3 2010-11)



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

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

Table 4.1a **Top 11 categories** of issues raised with PALS Q3 2010-11

Category breakdown	Number of contacts
Appointment Cancellation	14
Appointment Delay	14
Attitude of staff – Nurse	13
Delay in Surgery	13
Communication Written	13
Compliment to Wards/Departments	16
Discharge arrangements	17
Complaint advice	27
Complaint process	26
Complaint referral	13
Complaint Handling	1
Complaint response time	3
General advice	28
Information	38

Top 3 categories reported in quarter 3 from PALS specific enquiries

- Formal Complaint Advice/Process/Referral/ Complaint Handling
- General Enquiries
- Clinical Treatment

70 enquiries 66 enquiries

nent 58 enquiries

Compliments

During quarter 3, sixteen compliments were received in the following areas:

NHS treatment	1
PALS	1
Oncology (BTC)	1
Coronary Care (Sandwell)	1
Walkden Unit	1
Immunology (City)	1
Discharge Planners (City)	1
Occupational Therapy (Sandwell)	1
Lyndon 1	1
D27	1
Lyndon 2	1
Cardiology	1
Tissue Viability (Sandwell)	1
Anti-coagulant Service (Sandwell)	1
Newton 3	1

5. Recommendations

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

Lessons Learned Q3 2010/11

1. Incidents

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

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

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

Learning from Experience: Case Example	es
Incident	Action Taken / Good practice noted
Medication omission in a patient with learning disabilities who was refusing to eat or take regular drugs.	Policy and training to emphasise and distinguish between capacity and compliance
Emergency caesarean section for offensive liquor led to baby with low apgars and transfer to neonatal unit – no consultant ward round	Reconfiguration will mean that 2 consultants will be on duty at same time to ensure ward rounds happen.
A 26 year old patient with known AV malformation and epileptic, attended A & E via ambulance with sudden headache, vomiting & was unresponsive. An urgent CT scan performed showed a large intracranial bleed. 29/40, baby delivered by C-section and now discharged. Mother RIP.	Good communication between ITU and Obstetrics Good communication between Obstetrics and family Good communication between Neonates and family
Patient referred in December 2009 with irregular vaginal bleeding and a suspicious looking cervix. Seen urgently in the Gynaecology Outpatient Clinic but no physical examination was performed. Request for 3 month appointment was made but appointment was not arranged in a timely manner and patient next seen in September 2010. The patient was diagnosed with an aggressive form of Cervical Cancer in October 2010.	Introduce process to ensure all consultants in OPD review referrals, supervise & agree junior doctors management plans

2. Complaints

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

Learning from Experience: Case Examples			
Complaint	Action Taken		
A lady was concerned about delays in a Pain Clinic held in a local health centre. The delays had been caused by staff waiting for medical records to arrive from Trust sites.	Records are now transported on the morning of the clinic by a dedicated driver.		
A relative was concerned that there was a lack of facilities for breaking bad news.	An area has been identified for a counselling room and a PEAT bid for funding submitted.		
A lady was concerned that, when she attended for her appointment, she was informed that she had been booked onto the wrong clinic	To minimise the risk of future administrative errors, a larger triage stamp has been ordered to ensure the patient's pathway is clearer on the referral documentation.		
A mother felt that her son's medical team failed to diagnose a collapsed lung.	Although the overall clinical management of the lady's son was appropriate, a further chest x-ray prior to introducing CPAP would have helped the medical staff to understand that the condition of the patient's lungs was worsening. The Clinical Director has discussed the case with the consultant team.		

3. Claims

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

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

SWBTB (3/11) 054

Sandwell and West Birmingham Hospitals

NHS Trust

TRUST BOARDDOCUMENT TITLE:Patient Satisfaction Survey ResultsSPONSORING DIRECTOR:Rachel Overfield, Chief NurseAUTHOR:Rachel Overfield, Chief NurseDATE OF MEETING:31 March 2011

SUMMARY OF KEY POINTS:

The purpose of the report is to present to the Trust Board the results of the Q3 report from the Trust led patient surveys. Surveys are given to patients (or carers) during their stay to be completed before discharge. The report highlights the key issues arising from these as well as the positive areas.

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

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to note the contents of the attached report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Trust Management Board on 22 March 2011.

Report Title	Patient Experience – Patient Satisfaction Survey Results
Meeting	Trust Board
Author	Rachel Overfield, Chief Nurse
Date	31.03.11

Attached is the Q3 report from the Trust led in-patient surveys. Surveys are given to patients (or carers) during their stay to be completed before discharge. 5 CQUIN indicator questions are included in the surveys to give some indication of what the national survey may say.

Key Issues

- Low response rate from some areas.
- 5 CQUIN areas for the quarter only improved in one area.
- 86% of patients said that the overall experience was excellent or good, although there was a decrease in 'excellent' response.
- Continue to have problems with representation from all ethnic backgrounds.
- A large number of patients do not know who their Consultant is.
- Although patients did not view wards as unclean it is clear that they thought improvements could be made.
- Noise at night bothers around 30% of patients.
- Discussion of dietary needs and meal choice.
- Access to written information.
- Waiting for take home medications and side effects to look out for.
- Access to Chaplains.
- Complaints information.

Positive Areas

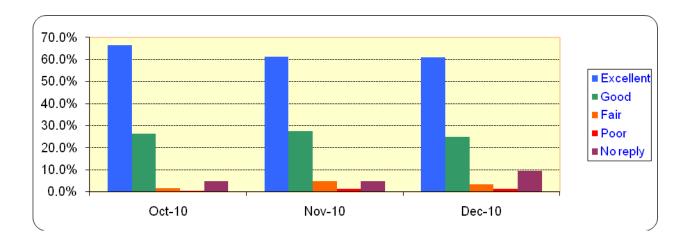
- Concerns were listened to.
- Information to carers on discharge.
- Long term condition management.
- Involvement in care.
- Access to medical staff.
- Able to ask questions.
- Assistance with meals.
- Assistance with hygiene.
- Being made to feel welcome.
- Being treated with kindness.
- Privacy, dignity and respect.

PATIENT SATISFACTION SURVEY- ADULT INPATIENTS TRUSTWIDE – Quarter III (Oct – Dec 2101)

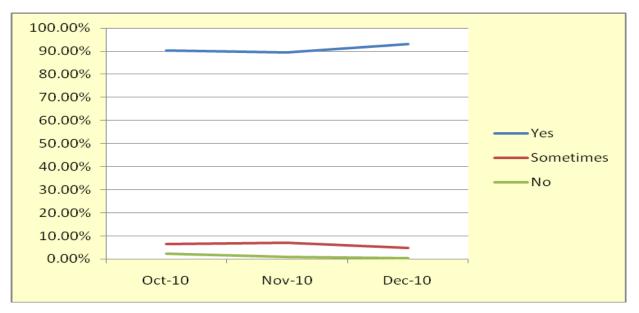
Base – 607 patients

- Results of the surveys received back from the wards for the months Oct Dec 2010
- Some patients did not reply to all the questions in the survey but the base total used for calculations was the overall total which reflects in some of the percentages below.

OVERALL CARE AS RATED BY THE PATIENTS AND HOW IT MOVED OVER QTR III:



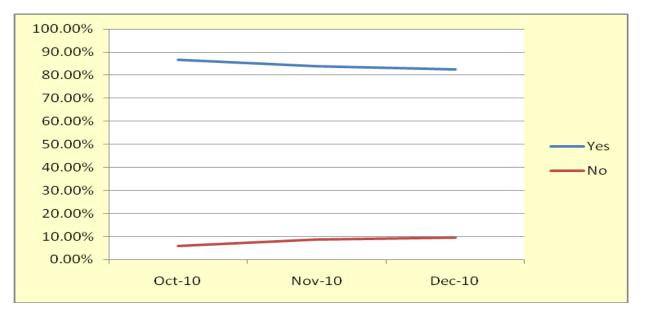
THE 5 CQUIN INDICATORS AND THEY MOVED OVER QTR IIIWas your privacy respected when discussing your condition and treatment?Yes.553Sometimes.553No.37Colspan="2">6.1%No.71.2%



Did the staff listen to your worries and fears?		
Yes	439	72.3%
No	19	3.1%
Not needed	116	19.1%

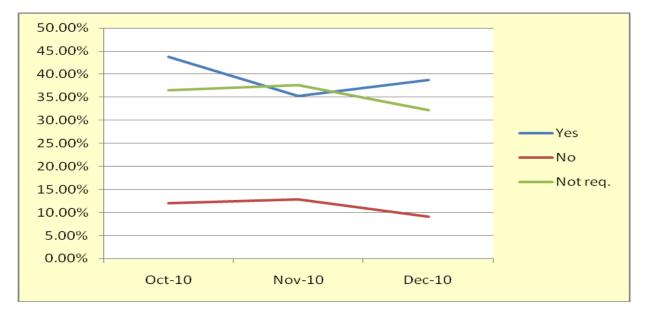
Were you involved as much as you wanted to be in decisions about your care and treatment?

No	50	8.2%

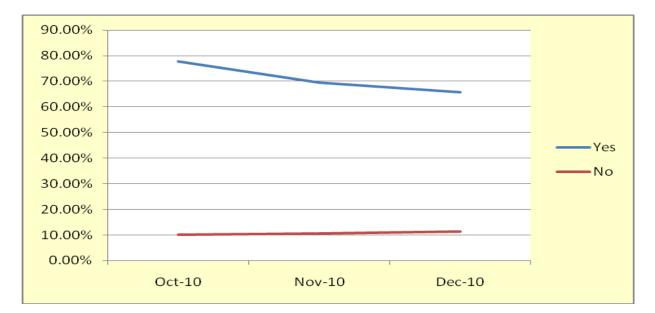


Did the staff tell you about medication side effects to watch out for when you went home? Yes. 236 38.9%

165	. 200	30.970
No	. 68	11.2%
Not required	. 214	35.3%



Were you told whom to contact if you were worried about your condition or treatment after you left the hospital?		
Yes	427	70.3%
No	65	10.7%



THE FULL SURVEY

PATIENT PROFILE		
Are you	Q3 Oct-D	Dec 2011
Total number of surveys received:	607 (Base)	
Male	238	39.2%
Female	324	53.4%
What is your age?		
Under 18	4	0.7%
18 to 24	48	
25 to 44	153	25.2%
45 to 60	146	24.1%
Over 60	236	38.9%
Do you have any of the following:	7	1
Learning disabilities	31	5.1%
Mental health needs	27	4.4%
Which of the following best describes your ethnic background?		
White - British	381	62.8%
White - Irish	22	3.6%
White – European	6	1.0%
White – any other white b/g	0	0.0%
Mixed-White & Black Caribbean	9	1.5%
Mixed-White & Black African	4	0.7%
Mixed-White & Asian	5	0.8%
Mixed- any other mixed b/g	1	0.2%
Asian/Asian Brit – Indian	46	7.6%
Asian/Asian Brit – Pakistani	37	6.1%
Asian/Asian Brit – Bangladeshi	10	1.6%
Asian/Asian Brit-any oth Asian b/g	7	1.2%

))
Black/Blk Brit-Caribbean	43	7.1%
Black/Blk Brit-African	7	1.2%
Black/Blk Brit – Any other Blk b/g	4	0.7%
Other Ethnic Group - Chinese	5	0.8%
Other Ethnic group	6	1.0%
Do not want to stated	2	0.3%
Were you provided with a language interpreter if you needed one?	۷.	0.370
Yes	17	2.8%
No	67	11.0%
	-	
Not Applicable	471	77.6%
PRIVACY & DIGNITY		
Were you treated with respect and dignity while you were on this ward?		
Yes, always	548	90.3%
Yes, sometimes	43	7.1%
No	2	0.3%
During your stay on this ward, did you ever share a sleeping area (room	or bay) v	vith
patients of the opposite sex?		
Yes	49	8.1%
No	550	90.6%
On this ward, did you ever have to use the same bathroom or shower are	ea with p	atients
of the opposite sex?		-
Yes	28	4.6%
No	563	92.8%
Was your privacy respected when discussing your condition and treatm	ent? (CQ	UIN)
Yes	553	91.1%
Sometimes	37	6.1%
No	7	1.2%
Were you given enough privacy when being examined or treated?		
Yes	580	95.6%
Sometimes	14	2.3%
No	5	0.8%
ABOUT DOCTORS, NURSES & OTHER STAFF		
When you arrived at this unit/ward, were you made to feel welcome by the	he staff?	
Yes	564	92.9%
No	16	2.6%
Did you know the name of the consultant treating you?		•
Yes	414	68.2%
No	146	24.1%
Did the doctors talk in front of you as if you were not there?		
Yes	41	6.8%
Sometimes	66	10.9%
No	466	76.8%
Did the nurses talk in front of you as if you were not there?		•
Yes, always	30	4.9%
Yes, Sometimes	57	9.4%
No	486	80.1%
Did you have confidence and trust in the doctors examining and treating	you?	
Yes, always	524	86.3%
Yes, sometimes	46	7.6%
No	8	1.3%
Did you have confidence and trust in the nurses treating and caring for y		
Yes, always	524	86.3%

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Yes, sometimes	50	8.2%
No	4	0.7%
Were the staff kind and caring while looking after you?		
Yes, always	525	86.5%
Yes, sometimes	46	7.6%
No	4	0.7%
THE WARD ENVIRONMENT		
How clean was the ward/room that you were in?		
Very Clean	503	82.9%
Fairly Clean	74	12.2%
Not at all clean	0	0.0%
Do you think the toilets and bathrooms in your ward were:		
Very Clean	433	71.3%
Fairly Clean	131	21.6%
Not at all clean	9	1.5%
As a patient on this ward, were you satisfied with your hygiene arrangements (washing & toileting)?		
Yes, always	510	84.0%
Sometimes	48	7.9%
No	16	2.6%
Were you bothered by noise from hospital staff at night?		
Yes	50	8.2%
Sometimes	133	21.9%
No	380	62.6%
If it was needed to transfer you to another ward during your stay, was this well managed		
and were you kept informed?		
Yes	248	40.9%
No	23	3.8%
Not Applicable	283	46.6%

FOOD & DRINK

Did a nurse discuss your dietary needs (food & drink) when you were admitted to this ward?

Yes	256	42.2%
No	104	17.1%
Not needed	204	33.6%
During your stay in hospital, did you have access to enough drinks?		
Yes	534	88.0%
No	29	4.8%
Did you have enough choices for your meals?		
Yes	480	79.1%
No	73	12.0%
Did you get what you ordered?		
Yes	468	77.1%
No	66	10.9%
Did you get help to eat your meals when required?		
Yes	72	11.9%
No	19	3.1%
Not Needed	477	78.6%
		•

YOUR TREATMENT & CARE

Were you have the linformed about your treatment and ears by the staff?					
Were you kept well informed about your treatment and care by the staff?		75.00/			
Yes, always	461	75.9%			
Yes, sometimes	92	15.2%			
No	16	2.6%			
Did you receive information (leaflets, etc) about your condition or treatm		45.00/			
Yes	273	45.0%			
No	117	19.3%			
Not required	183	30.1%			
Was this information in a language/format you could easily understand?					
Yes	264	43.5%			
No	11	1.8%			
Not applicable	279	46.0%			
Did you have chances to ask questions about your treatment or care?					
Yes	535	88.1%			
No	37	6.1%			
Did the staff listen to your worries and fears? (CQUIN)					
Yes	439	72.3%			
No	19	3.1%			
Not needed	116	19.1%			
Did your family or someone close have the opportunity to talk to a docto	-				
to?	i ii tiioy	nantoa			
Yes	325	53.5%			
No	53	8.7%			
Not needed	195	32.1%			
	195				
Were you involved as much as you wanted to be in decisions about your	ooro on				
Were you involved as much as you wanted to be in decisions about your	care and	ł			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN)					
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes	511	84.2%			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes	511 50	84.2% 8.2%			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes	511 50 diabetes	84.2% 8.2%			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes. No If you have a long-term condition that you manage at home, for example were you supported and enabled to continue to manage this during your	511 50 diabetes	84.2% 8.2%			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes	511 50 diabetes hospital	84.2% 8.2%			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes No If you have a long-term condition that you manage at home, for example were you supported and enabled to continue to manage this during your stay? Yes	511 50 diabetes hospital	84.2% 8.2% , 24.5%			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes. No If you have a long-term condition that you manage at home, for example were you supported and enabled to continue to manage this during your stay? Yes. No	511 50 diabetes hospital 149 17	84.2% 8.2% , 24.5% 2.8%			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes. No If you have a long-term condition that you manage at home, for example were you supported and enabled to continue to manage this during your stay? Yes. No No No No No No No No No No applicable	511 50 diabetes hospital 149 17 390	84.2% 8.2% , , , , , , , , , , , , , , , , , , ,			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes. No If you have a long-term condition that you manage at home, for example were you supported and enabled to continue to manage this during your stay? Yes. No No No No applicable. Do you think that the hospital staff did everything they could to help con	511 50 diabetes hospital 149 17 390 trol your	84.2% 8.2% , 24.5% 2.8% 64.3% pain?			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes. No If you have a long-term condition that you manage at home, for example were you supported and enabled to continue to manage this during your stay? Yes. No No No No applicable. Do you think that the hospital staff did everything they could to help con Yes, always.	511 50 diabetes hospital 149 17 390 trol your 470	84.2% 8.2% , 24.5% 2.8% 64.3% pain? 77.4%			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes. No If you have a long-term condition that you manage at home, for example were you supported and enabled to continue to manage this during your stay? Yes. No No No No applicable. Do you think that the hospital staff did everything they could to help con	511 50 diabetes hospital 149 17 390 trol your	84.2% 8.2% , 24.5% 2.8% 64.3% pain?			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes No If you have a long-term condition that you manage at home, for example were you supported and enabled to continue to manage this during your stay? Yes No No No No applicable Do you think that the hospital staff did everything they could to help con Yes, always. Sometimes No	511 50 diabetes hospital 149 17 390 trol your 470	84.2% 8.2% , 24.5% 2.8% 64.3% pain? 77.4%			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes No If you have a long-term condition that you manage at home, for example were you supported and enabled to continue to manage this during your stay? Yes No No No No applicable Do you think that the hospital staff did everything they could to help con Yes, always. Sometimes No	511 50 diabetes hospital 149 17 390 trol your 470 42	84.2% 8.2% 24.5% 2.8% 64.3% pain? 77.4% 6.9%			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes No If you have a long-term condition that you manage at home, for example were you supported and enabled to continue to manage this during your stay? Yes No No No No No No No No No applicable Do you think that the hospital staff did everything they could to help con Yes, always Sometimes	511 50 diabetes hospital 149 17 390 trol your 470 42 9	84.2% 8.2% , 24.5% 2.8% 64.3% pain? 77.4% 6.9% 1.5%			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes No If you have a long-term condition that you manage at home, for example were you supported and enabled to continue to manage this during your stay? Yes No No No No applicable Do you think that the hospital staff did everything they could to help con Yes, always. Sometimes No	511 50 diabetes hospital 149 17 390 trol your 470 42 9	84.2% 8.2% , 24.5% 2.8% 64.3% pain? 77.4% 6.9% 1.5%			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes No If you have a long-term condition that you manage at home, for example were you supported and enabled to continue to manage this during your stay? Yes No No No applicable Do you think that the hospital staff did everything they could to help con Yes, always. Sometimes No No	511 50 diabetes hospital 149 17 390 trol your 470 42 9	84.2% 8.2% , 24.5% 2.8% 64.3% pain? 77.4% 6.9% 1.5%			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes No If you have a long-term condition that you manage at home, for example were you supported and enabled to continue to manage this during your stay? Yes No No No tapplicable Do you think that the hospital staff did everything they could to help con Yes, always. Sometimes No Not required	511 50 diabetes hospital 149 17 390 trol your 470 42 9 54	84.2% 8.2% 24.5% 2.8% 64.3% 64.3% 64.3% 6.9% 1.5% 8.9%			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes. No If you have a long-term condition that you manage at home, for example were you supported and enabled to continue to manage this during your stay? Yes. No No No No No No No No No No applicable No applicable No Sometimes. No No required ABOUT YOUR DISCHARGE If there were delays in your going home after being discharged from the	511 50 diabetes hospital 149 17 390 trol your 470 42 9 54	84.2% 8.2% 24.5% 2.8% 64.3% 64.3% 64.3% 6.9% 1.5% 8.9%			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes. No If you have a long-term condition that you manage at home, for example were you supported and enabled to continue to manage this during your stay? Yes. No No No No No No No No No applicable. Do you think that the hospital staff did everything they could to help con Yes, always. Sometimes. No Not required. ABOUT YOUR DISCHARGE If there were delays in your going home after being discharged from the were the reasons? (Tick all that apply)	511 50 diabetes hospital 149 17 390 trol your 470 42 9 54 hospital,	84.2% 8.2% 24.5% 2.8% 64.3% pain? 77.4% 6.9% 1.5% 8.9% what			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes Yes No If you have a long-term condition that you manage at home, for example were you supported and enabled to continue to manage this during your stay? Yes Yes No No applicable Do you think that the hospital staff did everything they could to help con Yes, always Sometimes No No required ABOUT YOUR DISCHARGE If there were delays in your going home after being discharged from the were the reasons? (Tick all that apply) Waiting for transport	511 50 diabetes hospital 149 17 390 trol your 470 42 9 54 hospital, 50	84.2% 8.2% 24.5% 2.8% 64.3% 64.3% 64.3% 6.9% 1.5% 8.9% 8.9% what 8.2%			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes No If you have a long-term condition that you manage at home, for example were you supported and enabled to continue to manage this during your stay? Yes Yes No No No No No No No No No applicable Do you think that the hospital staff did everything they could to help con Yes, always Sometimes No Not required ABOUT YOUR DISCHARGE If there were delays in your going home after being discharged from the were the reasons? (Tick all that apply) Waiting for transport Waiting for medicines to take home	511 50 diabetes hospital 149 17 390 trol your 470 42 9 54 54 hospital, 50 143	84.2% 8.2% 24.5% 2.8% 64.3% 64.3% 64.3% 6.9% 1.5% 8.9% 8.9% 8.9% what 8.2% 23.6%			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes No If you have a long-term condition that you manage at home, for example were you supported and enabled to continue to manage this during your stay? Yes Yes No No Sometimes No No Sometimes No No Not required ABOUT YOUR DISCHARGE If there were delays in your going home after being discharged from the were the reasons? (Tick all that apply) Waiting for transport Waiting for medicines to take home Delay in discharge planning from staff.	511 50 diabetes hospital 149 17 390 trol your 470 42 9 54 hospital, 50 143 16	84.2% 8.2% 24.5% 2.8% 64.3% pain? 77.4% 6.9% 1.5% 8.9% 1.5% 8.9% what 8.2% 23.6% 2.6%			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes No If you have a long-term condition that you manage at home, for example were you supported and enabled to continue to manage this during your stay? Yes Yes No No applicable Do you think that the hospital staff did everything they could to help con Yes, always Sometimes No Not required ABOUT YOUR DISCHARGE If there were delays in your going home after being discharged from the were the reasons? (Tick all that apply)	511 50 diabetes hospital 149 17 390 trol your 470 42 9 54 hospital, 50 143 16 42	84.2% 8.2% 24.5% 2.8% 64.3% pain? 77.4% 6.9% 1.5% 8.9% 1.5% 8.9% 4.5% 2.6% 2.6% 2.6% 6.9%			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes No If you have a long-term condition that you manage at home, for example were you supported and enabled to continue to manage this during your stay? Yes Yes No No Sometimes No No Sometimes No No Starge for transport Waiting for medicines to take home. Delay in discharge planning from staff. Other No delay.	511 50 diabetes hospital 149 17 390 trol your 470 42 9 54 hospital, 50 143 16	84.2% 8.2% 24.5% 2.8% 64.3% pain? 77.4% 6.9% 1.5% 8.9% 1.5% 8.9% 4.2% 8.2% 23.6% 2.6%			
Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes No If you have a long-term condition that you manage at home, for example were you supported and enabled to continue to manage this during your stay? Yes Yes No No Yes No No Starpe Yes No No applicable Do you think that the hospital staff did everything they could to help con Yes, always Sometimes No No Not required ABOUT YOUR DISCHARGE If there were delays in your going home after being discharged from the were the reasons? (Tick all that apply) Waiting for transport Waiting for medicines to take home Delay in discharge planning from staff. Other No delay. <td< td=""><td>511 50 diabetes hospital 149 17 390 trol your 470 42 9 54 54 hospital, 50 143 16 42 253</td><td>84.2% 8.2% 2.8% 64.3% 64.3% 64.3% 6.9% 1.5% 8.9% 1.5% 8.9% 4.5% 2.6% 2.6% 6.9% 41.7%</td></td<>	511 50 diabetes hospital 149 17 390 trol your 470 42 9 54 54 hospital, 50 143 16 42 253	84.2% 8.2% 2.8% 64.3% 64.3% 64.3% 6.9% 1.5% 8.9% 1.5% 8.9% 4.5% 2.6% 2.6% 6.9% 41.7%			
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Were you involved as much as you wanted to be in decisions about your treatment? (CQUIN) Yes No If you have a long-term condition that you manage at home, for example were you supported and enabled to continue to manage this during your stay? Yes Yes No No Yes No No Starpe Yes No No applicable Do you think that the hospital staff did everything they could to help con Yes, always Sometimes No No Not required ABOUT YOUR DISCHARGE If there were delays in your going home after being discharged from the were the reasons? (Tick all that apply) Waiting for transport Waiting for medicines to take home Delay in discharge planning from staff. Other No delay. <td< td=""><td>511 50 diabetes hospital 149 17 390 trol your 470 42 9 54 54 hospital, 50 143 16 42 253</td><td>84.2% 8.2% 2.8% 64.3% 64.3% 64.3% 6.9% 1.5% 8.9% 1.5% 8.9% 4.5% 2.6% 2.6% 6.9% 41.7%</td></td<>	511 50 diabetes hospital 149 17 390 trol your 470 42 9 54 54 hospital, 50 143 16 42 253	84.2% 8.2% 2.8% 64.3% 64.3% 64.3% 6.9% 1.5% 8.9% 1.5% 8.9% 4.5% 2.6% 2.6% 6.9% 41.7%			

3WDTD (3/11	/	/	
When leaving the hospital were you given written or printed information	about wl	hat you	
should or should not do?			
Yes	291	47.9%	
No	52	8.6%	
Not required	148	24.4%	
Did the staff explain how to take and purpose of the medicines you were	aiven to	take at	
home in a way you could understand?	J		
Yes	387	63.8%	
No	10	1.6%	
Not required	93	15.3%	
Were you given clear written or printed information about your medicine		10.070	
Yes	350	57.7%	
No		23.6%	
Not required			
Did the staff tell you about medication side effects to watch out for when	i you wei	nt	
home? (CQUIN)			
Yes	236		
<u>No</u>	68	11.2%	
Not required	214	35.3%	
Were you told whom to contact if you were worried about your condition or treatment			
after you left the hospital? (CQUIN)			
Yes	427	70.3%	
No	65	10.7%	
Did the doctors or nurses give your family or someone close to you all the	he inform	nation	
they needed to help care for you?			
Yes	235	38.7%	
No	39	6.4%	
Not required	249	41.0%	
	275	11.070	
ABOUT YOUR HOSPITAL EXPERIENCE			

Did you have access to spiritual care/chaplains during your stay?			
87	14.3%		
67	11.0%		
408	67.2%		
Not required40867.2%When you were in this hospital, did you see posters or leaflets explaining how to			
279	46.0%		
270	44.5%		
No27044.5%If you needed to raise concerns about your care or treatment, were these listened to			
and responded to appropriately?			
231	38.1%		
30	4.9%		
293	48.3%		
Not applicable29348.3%Overall, how would you rate the care you received on this ward/unit:5			
380	62.6%		
159	26.2%		
21	3.5%		
7	1.2%		
	67 408 100 to 279 270 stened 231 30 293 380		

Sandwell and West Birmingham Hospitals

NHS Trust

TRUST BOARD		
DOCUMENT TITLE: National Cancer Survey		
SPONSORING DIRECTOR:	Jessamy Kinghorn, Head of Communications and Engagement	
AUTHOR:	Jessamy Kinghorn, Jenny Donovan	
Date of meeting:	31 March 2011	

SUMMARY OF KEY POINTS:

This report contains the results of the National Cancer Patient Experience Survey 2010, including how the Trust performs in comparison to other NHS trusts providing cancer services.

It is based on the views of 526 of the Trust's patients, the largest group responding being breast cancer patients of which there were 153.

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

Approval	Receipt and Noting	Discussion
	Х	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

NOTE the contents of the report

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Trust Management Board on 22 March 2011.

Sandwell and West Birmingham Hospitals

NHS Trust

Trust Board

National Cancer Patient Experience Survey 2010

31st March 2011

Introduction

This report contains the results of the National Cancer Patient Experience Survey 2010, including how the Trust performs in comparison to other NHS trusts providing cancer services. The survey included all adult patients (aged 16 and over) with a primary diagnosis of cancer who had been admitted to an NHS hospital as an inpatient or as a day case patient, and had been discharged between 1st January 2010 and 31st March 2010.

The results are based on the views of 526 of the Trust's patients, the largest group responding being breast cancer patients of whom there were 153. There were more than twice as many breast cancer patients as any other individual specialty.

Key findings

The report shows that Sandwell and West Birmingham Hospitals NHS Trust was in the top 20% of trusts for:

- Patient given written information about the type of cancer they had
- Possible side effects explained in an understandable way
- Patient given the name of the CNS in charge of their care
- Admission date not changed by hospital
- Staff gave complete explanation of what would be done
- Patient given written information about the operation
- Got understandable answers to important questions all/most of the time
- Patient's family definitely had opportunity to talk to doctor
- Staff told patient who to contact if worried post discharge
- Family definitely given all information needed to help care at home
- Patient never thought they were given conflicting information
- Given the right amount of information about condition and treatment

The report shows that SWBH was in the lowest 20% of trusts for:

- First appointment no more than 4 weeks after referral
- Patient thought they were seen as soon as necessary
- Patient completely understood the explanation of what was wrong
- Nurses did not talk in front of patient as if they were not there
- Waited no longer than 30 minutes for OPD appointment to start
- GP practice staff definitely did everything they could to support patient
- Patient did not feel that they were treated as 'a set of cancer symptoms'

Key specialty specific results

The specialties where enough patients responded in order to facilitate analysis by specialty were: Breast, Colorectal / Lower Gastro, Lung, Prostate, Gynaecological, Haematological and Urological cancers. Results across the specialties varied considerably, with the range of results being far greater than the range of average results nationally.

- There was a 39% variation for patients who said they were definitely involved in decisions about which treatment they should have with haematology receiving the poorest result and colorectal / lower gastro the best. Nationally the range between the best (prostate) and poorest specialty (also haematology) for this question was 6%.
- The greatest range was a 40% variation for patients who said the hospital gave them information on how to get financial help, with urology receiving the poorest result and lung cancer the best.

The report shows that breast cancer patients are consistently more positive about their experience than any other group of patients, both within the Trust and when compared to other breast cancer patients nationally.

The report also showed that Haematological patients are the least positive, and they generally rated their experiences lower than the national average.

The full survey, including national comparisons and specialty breakdown, is attached.

Next steps

The survey report has been circulated to the relevant leads for each cancer specialty to develop action plans.



National Cancer Patient Experience Programme

2010 National Survey

Sandwell and West Birmingham Hospitals NHS Trust

Pre Publication December 2010

The National Cancer Patient Experience Survey Programme is being undertaken by Quality Health on behalf of the Department of Health



Introduction

The Cancer Reform Strategy (CRS) published in 2007 set out a commitment to establish a new NHS Cancer Patient Experience Survey programme. The 2010 National Cancer Patient Experience Survey was designed to monitor national progress on cancer care; and to provide information that could be used to drive local quality improvements; and to help gather vital information on the *Transforming Inpatient Care* Programme, the *National Cancer Survivorship* Initiative and the *National Cancer Equality* Initiatives.

Participating Trusts

158 acute hospital NHS Trusts providing cancer services took part in the survey. Primary Care Trusts, some of whom provide cancer services, were excluded from the survey, as were some specialist hospital Trusts because of very low patient numbers.

Patients selected to take part

The survey included all adult patients (aged 16 and over) with a primary diagnosis of cancer who had been admitted to an NHS hospital as an inpatient or as a day case patient, and had been discharged between 1st January 2010 and 31st March 2010.

Patients eligible for the survey were taken from Trust patient administration systems; the inclusion criteria were that the patient had an International Classification of Disease (ICD10) code of C00-99 (excluding C44) or D05. The types of cancer patients included in the 2010 survey included, for the first time, significant numbers with rarer cancers as well as patients in the "Big 4" cancer groups – i.e. breast, prostate, lung, and colorectal/Lower GI.

Trust samples were checked rigorously for duplicates and patient lists were also deduplicated nationally to ensure that patients did not receive multiple copies of the questionnaire.

Survey method

Postal surveys were sent to patients' home addresses following their discharge. Up to two reminders were sent to non-responders. A freepost envelope was included for their replies. Patients could call a free telephone line to ask questions, complete the questionnaire verbally, or to access an interpreting service.

Response rate

A total of 109,477 patients who had received treatment for cancer during January to March 2010 were included in the national sample for the Cancer Patient Experience Survey. These patients fell into 13 different cancer groups.

1005 eligible patients from this Trust were sent a survey, and 526 questionnaires were returned completed. This represents a response rate of 65% once deceased patients and questionnaires returned undelivered had been accounted for. The national response rate was 67% (67,713 respondents).

Percentage scores

The questions in the cancer survey have been summarised as the percentage of patients who reported a positive experience. For example, "Percentage of patients who were given a complete explanation of their diagnostic tests" and "Percentage of patients who said that nurses did NOT talk in front of them as if they were not there". Neutral responses, such as "Don't know" and "I did not need an explanation" are not included in the denominator when computing the score.

The higher the score, the better the Trust's performance.

Trusts with small numbers of respondents or small numbers in particular tumour groups

Some Trusts have relatively small numbers of cancer patients, so the total number of respondents to the survey may be low despite the high response rate. Reports for these Trusts have been completed in the normal way, but the results for these Trusts need to be treated with caution. It is important to recognise however, that the low numbers of respondents in these Trusts is simply the result of low numbers of cancer patients being treated.

In almost all Trusts, there were tumour groups where the number of respondents was less than 20; this is particularly true of tumour groups representing rarer cancers. Where numbers of respondents in a particular tumour group is less than 20, we have used the convention of leaving the relevant cell blank. This is further explained in the introduction to the tumour group tables in this report.

Benchmark charts

Percentage scores are displayed on benchmark bar charts in the following section. Each bar represents the range of results across all Trusts that took part in the survey for one question. The bar is divided into:

- a red section: scores for the lowest-scoring 20% of Trusts
- a green section: scores for the highest-scoring 20% of Trusts
- an amber section: scores for the remaining 60% of Trusts.

The black circle represents the score for this Trust. For example, if the circle is in the green section of the bar, it means that the Trust is among the top 20% of Trusts in England for that question. The line on either side of the circle shows the 95% confidence interval (the amount of uncertainty surrounding the Trust's score).

The table below each benchmarking chart represents the Trust score for each question in the first column (represented by the black circle on the benchmarking chart). The confidence intervals in columns two and three are shown on the chart as the black line running through the Trust score. The fourth and fifth columns represent the upper threshold for the lowest scoring 20% and the lower threshold for the highest scoring 20% (i.e. the end of the red section and the beginning of the green section on the chart). The sixth column displays the highest Trust's score for this question and the seventh column displays the number of respondents who gave this answer for this question. The eighth column displays a '+' alongside any question where the Trust's score falls within the lowest 20% of Trust scores for that question.

Further information

Full details of the survey method are in the National Report of the Cancer Patient Experience Survey 2010, which is available at www.quality-health.co.uk; and further details of survey development, nationally agreed methodology, and cognitive testing are also available at www.quality-health.co.uk.

Who responded to the survey at this Trust?

526 patients responded to the survey from the Trust. The tables below show the numbers of patients from each tumour group and the age and sex distribution of these patients.

Respondents by tumour group

Tumour Group	Number of respondents*
Breast	153
Colorectal / Lower Gastrointestinal	58
Lung	27
Prostate	47
Brain/Central Nervous System	4
Gynaecological	78
Haematological	61
Head and Neck	7
Sarcoma	5
Skin	6
Upper Gastrointestinal	12
Urological	61
Other	7

* These figures will not match the numerator for all questions in the 'comparisons by tumour group' section of this report because not all questions were answered by all responders.

Age and sex

The survey asked respondents to give their year of birth. This information has been amalgamated into 6 age bands. 22 people did not provide their gender or age. Of the 504 who did, the age and gender distribution for the Trust was as follows:

	16-25	26-35	36-50	51-65	66-75	75+	Missing	Total
Men	2	3	13	36	78	47	7	186
Women	1	9	52	134	76	31	15	318
Total	3	12	65	170	154	78	22	504

Trust results

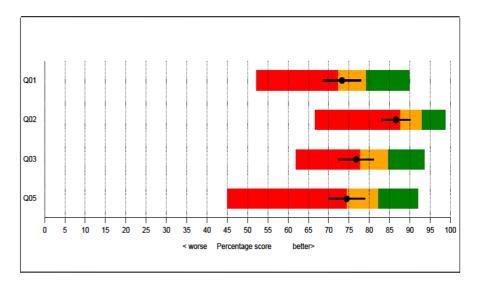
Seeing your GP

Saw GP once/twice before being told had to go to hospital

First appointment no more than 4 weeks after referral

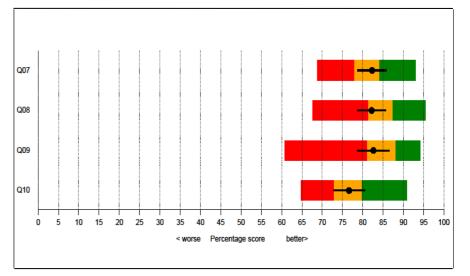
Patient thought they were seen as soon as necessary

Patient's health got better or remained about the same while waiting



Questi	on	Percentage for this Trust	Lower 95% confidence interval	Upper 95% confidence interval	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Highest Trust's percentage score	Number of responders for this Trust	Scored % in lowest 20% of Trusts
Q1	Saw GP once/twice before being told had to go to hospital	73%	69%	78%	72%	79%	90%	348	
Q2	First appointment no more than 4 weeks after referral	87%	83%	90%	88%	93%	99%	342	+
Q3	Patient thought they were seen as soon as necessary	77%	72%	81%	78%	85%	94%	366	+
Q5	Patient's health got better or remained about the same while waiting	74%	70%	79%	74%	82%	92%	364	

Diagnostic tests



Staff gave complete explanation of purpose of test(s)

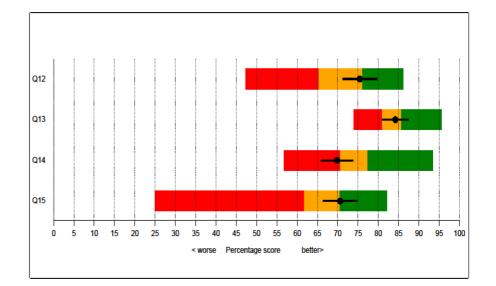
Staff explained completely what would be done during test

Given easy to understand written information about test

Given complete explanation of test results in understandable way

Questi	on	Percentage for this Trust	Lower 95% confidence interval	Upper 95% confidence interval	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Highest Trust's percentage score	Number of responders for this Trust	Scored % in lowest 20% of Trusts
Q7	Staff gave complete explanation of purpose of test(s)	82%	79%	86%	78%	84%	93%	440	
Q8	Staff explained completely what would be done during test	82%	79%	86%	81%	87%	95%	455	
Q9	Given easy to understand written information about test	83%	79%	87%	81%	88%	94%	351	
Q10	Given complete explanation of test results in understandable way	77%	73%	80%	73%	80%	91%	466	

Finding out what was wrong with you



Patient told they could bring a friend when first told they had cancer

Patient felt they were told sensitively that they had cancer

Patient completely understood the explanation of what was wrong

Patient given written information about the type of cancer they had

Questi	on	Percentage for this Trust	Lower 95% confidence interval	Upper 95% confidence interval	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Highest Trust's percentage score	Number of responders for this Trust	Scored % in lowest 20% of Trusts
Q12	Patient told they could bring a friend when first told they had cancer	75%	71%	80%	65%	76%	86%	411	
Q13	Patient felt they were told sensitively that they had cancer	84%	81%	87%	81%	86%	96%	513	
Q14	Patient completely understood the explanation of what was wrong	70%	66%	74%	71%	77%	93%	511	+
Q15	Patient given written information about the type of cancer they had	71%	66%	75%	62%	70%	82%	459	

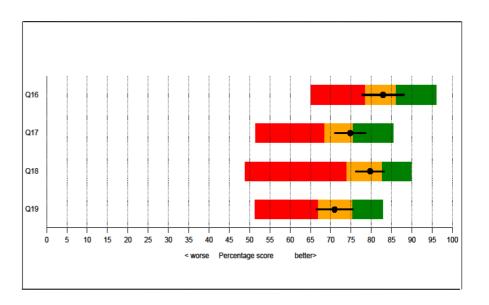
Deciding the best treatment for you

Patient given a choice of different types of treatment

Possible side effects explained in an understandable way

Patient given written information about side effects

Patient definitely involved in decisions about which treatment



Questi	on	Percentage for this Trust	Lower 95% confidence interval	Upper 95% confidence interval	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Highest Trust's percentage score	Number of responders for this Trust	Scored % in lowest 20% of Trusts
Q16	Patient given a choice of different types of treatment	83%	78%	88%	79%	86%	96%	199	
Q17	Possible side effects explained in an understandable way	75%	71%	79%	68%	75%	85%	489	
Q18	Patient given written information about side effects	80%	76%	83%	74%	83%	90%	484	
Q19	Patient definitely involved in decisions about which treatment	71%	66%	75%	67%	75%	83%	389	

Clinical Nurse Specialist

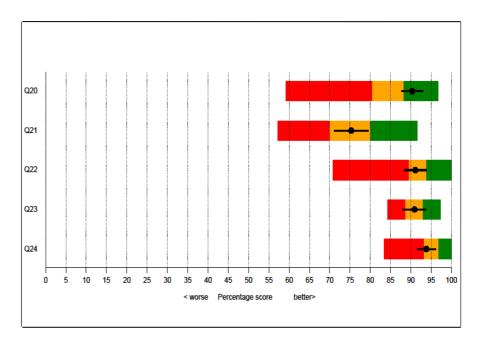
Patient given the name of the CNS in charge of their care

Patient finds it easy to contact their CNS

CNS definitely listened carefully the last time spoken to

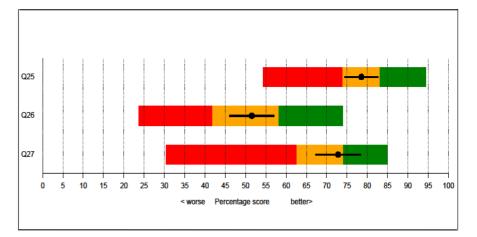
Get understandable answers to important questions all/most of the time

Last time seen, time spent with CNS about right



Questi	on	Percentage for this Trust	Lower 95% confidence interval	Upper 95% confidence interval	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Highest Trust's percentage score	Number of responders for this Trust	Scored % in lowest 20% of Trusts
Q20	Patient given the name of the CNS in charge of their care	90%	88%	93%	81%	88%	97%	487	
Q21	Patient finds it easy to contact their CNS	75%	71%	80%	70%	80%	92%	393	
Q22	CNS definitely listened carefully the last time spoken to	91%	88%	94%	90%	94%	100%	427	
Q23	Get understandable answers to important questions all/most of the time	91%	88%	94%	89%	93%	97%	385	
Q24	Last time seen, time spent with CNS about right	94%	92%	96%	93%	97%	100%	421	

Support for people with cancer



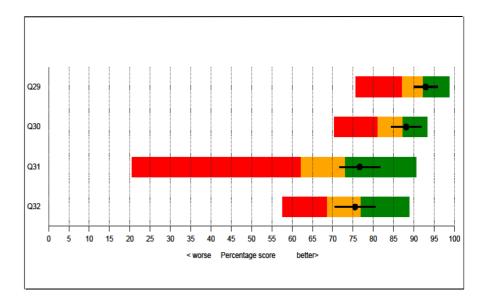
Hospital staff gave information about support
groups

Hospital staff gave information on getting financial help

Hospital staff told patient they could get free prescriptions

Questi	ion	Percentage for this Trust	Lower 95% confidence interval	Upper 95% confidence interval	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Highest Trust's percentage score	Number of responders for this Trust	Scored % in lowest 20% of Trusts
Q25	Hospital staff gave information about support groups	79%	74%	83%	74%	83%	94%	387	
Q26	Hospital staff gave information on getting financial help	52%	46%	57%	42%	58%	74%	324	
Q27	Hospital staff told patient they could get free prescriptions	73%	67%	78%	63%	74%	85%	250	

Operations



Admission date not changed by hospital

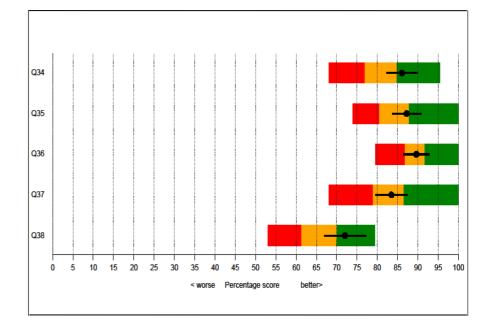
Staff gave complete explanation of what would be done

Patient given written information about the operation

Staff explained how operation had gone in understandable way

Ques	tion	Percentage for this Trust	Lower 95% confidence interval	Upper 95% confidence interval	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Highest Trust's percentage score	Number of responders for this Trust	Scored % in lowest 20% of Trusts
Q29	Admission date not changed by hospital	93%	90%	96%	87%	92%	99%	296	
Q30	Staff gave complete explanation of what would be done	88%	84%	92%	81%	87%	93%	294	
Q31	Patient given written information about the operation	77%	72%	82%	62%	73%	91%	274	
Q32	Staff explained how operation had gone in understandable way	76%	71%	80%	69%	77%	89%	290	

Hospital doctors



Got understandable answers to important questions all/most of the time

Patient had confidence and trust in all doctors treating them

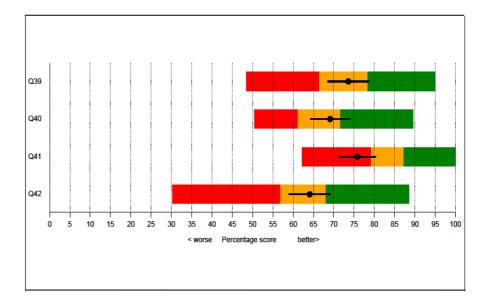
Patient thought doctors knew enough about how to treat their cancer

Doctors did not talk in front of patient as if they were not there

Patient's family definitely had opportunity to talk to doctor

Questi	ion	Percentage for this Trust	Lower 95% confidence interval	Upper 95% confidence interval	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Highest Trust's percentage score	Number of responders for this Trust	Scored % in lowest 20% of Trusts
Q34	Got understandable answers to important questions all/most of the time	86%	82%	90%	77%	85%	95%	309	
Q35	Patient had confidence and trust in all doctors treating them	87%	84%	91%	80%	88%	100%	337	
Q36	Patient thought doctors knew enough about how to treat their cancer	90%	86%	93%	87%	92%	100%	338	
Q37	Doctors did not talk in front of patient as if they were not there	83%	80%	87%	79%	86%	100%	339	
Q38	Patient's family definitely had opportunity to talk to doctor	72%	67%	77%	61%	70%	79%	297	

Ward nurses



Got understandable answers to important questions all/most of the time

Patient had confidence and trust in all ward nurses

Nurses did not talk in front of patient as if they were not there

Always / nearly always enough nurses on duty

Questi	on	Percentage for this Trust	Lower 95% confidence interval	Upper 95% confidence interval	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Highest Trust's percentage score	Number of responders for this Trust	Scored % in lowest 20% of Trusts
Q39	Got understandable answers to important questions all/most of the time	74%	69%	79%	67%	78%	95%	292	
Q40	Patient had confidence and trust in all ward nurses	69%	64%	74%	61%	72%	90%	337	
Q41	Nurses did not talk in front of patient as if they were not there	76%	71%	80%	79%	87%	100%	335	+
Q42	Always / nearly always enough nurses on duty	64%	59%	69%	57%	68%	89%	334	

Hospital care and treatment

Patient did not think hospital staff deliberately misinformed them

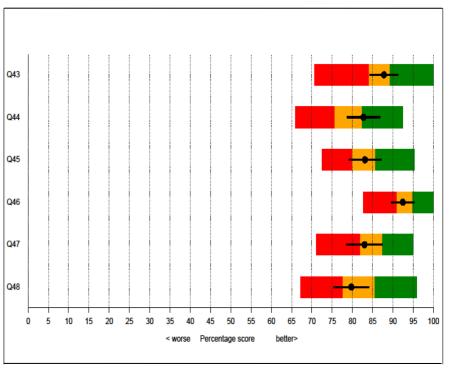
Patient never thought they were given conflicting information

Always given enough privacy when discussing condition or treatment

Always given enough privacy when being examined or treated

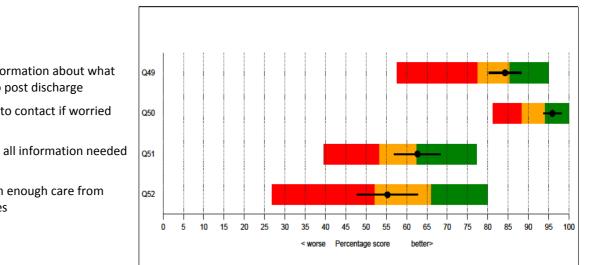
Hospital staff did everything to help control pain all of the time

Always treated with respect and dignity by staff



Questi	on	Percentage for this Trust	Lower 95% confidence interval	Upper 95% confidence interval	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Highest Trust's percentage score	Number of responders for this Trust	Scored % in lowest 20% of Trusts
Q43	Patient did not think hospital staff deliberately misinformed them	88%	84%	91%	84%	89%	100%	336	
Q44	Patient never thought they were given conflicting information	83%	79%	87%	76%	82%	92%	336	
Q45	Always given enough privacy when discussing condition or treatment	83%	79%	87%	80%	86%	95%	337	
Q46	Always given enough privacy when being examined or treated	92%	90%	95%	91%	95%	100%	331	
Q47	Hospital staff did everything to help control pain all of the time	83%	79%	87%	82%	87%	95%	276	
Q48	Always treated with respect and dignity by staff	80%	75%	84%	78%	86%	96%	331	

Information given to you before leaving hospital and home support



Given clear written information about what should / should not do post discharge

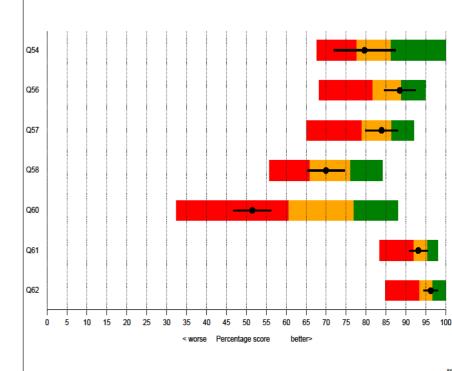
Staff told patient who to contact if worried post discharge

Family definitely given all information needed to help care at home

Patient definitely given enough care from health or social services

Questi	on	Percentage for this Trust	Lower 95% confidence interval	Upper 95% confidence interval	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Highest Trust's percentage score	Number of responders for this Trust	Scored % in lowest 20% of Trusts
Q49	Given clear written information about what should / should not do post discharge	84%	80%	88%	78%	85%	95%	317	
Q50	Staff told patient who to contact if worried post discharge	96%	94%	98%	89%	94%	100%	320	
Q51	Family definitely given all information needed to help care at home	63%	57%	68%	53%	62%	77%	276	
Q52	Patient definitely given enough care from health or social services	55%	48%	63%	52%	66%	80%	170	

Hospital care as a day patient / outpatient



Staff definitely did everything to control side effects of radiotherapy

Staff definitely did everything to control side effects of chemotherapy

Staff definitely did everything they could to help control pain

Hospital staff definitely gave patient enough emotional support

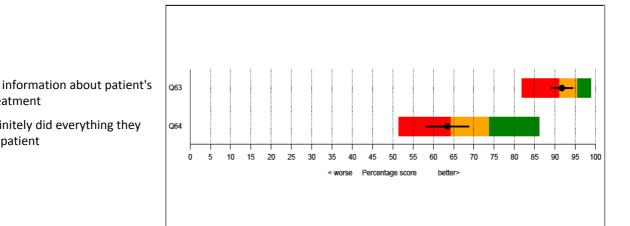
Waited no longer than 30 minutes for OPD appointment to start

Patient thought doctor spent about the right amount of time with them

Doctor had the right notes and other documentation with them

Questi	on	Percentage for this Trust	Lower 95% confidence interval	Upper 95% confidence interval	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Highest Trust's percentage score	Number of responders for this Trust	Scored % in lowest 20% of Trusts
Q54	Staff definitely did everything to control side effects of radiotherapy	80%	72%	87%	78%	86%	100%	108	
Q56	Staff definitely did everything to control side effects of chemotherapy	88%	85%	92%	82%	89%	95%	260	
Q57	Staff definitely did everything they could to help control pain	84%	80%	88%	79%	86%	92%	311	
Q58	Hospital staff definitely gave patient enough emotional support	70%	65%	75%	66%	76%	84%	376	
Q60	Waited no longer than 30 minutes for OPD appointment to start	51%	47%	56%	61%	77%	88%	435	+
Q61	Patient thought doctor spent about the right amount of time with them	93%	91%	95%	92%	95%	98%	464	
Q62	Doctor had the right notes and other documentation with them	96%	94%	98%	93%	97%	100%	450	

Care from your general practice



Questi	ion	Percentage for this Trust	Lower 95% confidence interval	Upper 95% confidence interval	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Highest Trust's percentage score	Number of responders for this Trust	Scored % in lowest 20% of Trusts
Q63	GP given enough information about patient's condition and treatment	92%	89%	94%	91%	96%	99%	412	
Q64	Practice staff definitely did everything they could to support patient	63%	58%	69%	64%	74%	86%	323	+

GP given enough information about patient's condition and treatment

Practice staff definitely did everything they could to support patient

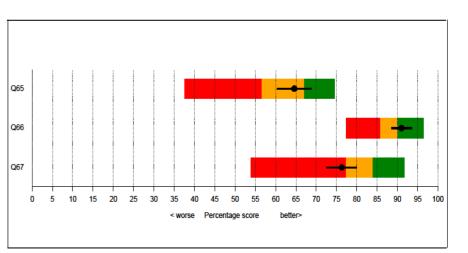
Your overall NHS care

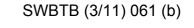
Hospital and community staff always worked
well together

Given the right amount of information about condition and treatment

Patient did not feel that they were treated as 'a set of cancer symptoms'

Questi	on	Percentage for this Trust	Lower 95% confidence interval	Upper 95% confidence interval	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Highest Trust's percentage score	Number of responders for this Trust	Scored % in lowest 20% of Trusts
Q65	Hospital and community staff always worked well together	65%	60%	69%	57%	67%	74%	486	
Q66	Given the right amount of information about condition and treatment	91%	89%	94%	86%	90%	96%	501	
Q67	Patient did not feel that they were treated as 'a set of cancer symptoms'	76%	73%	80%	77%	84%	92%	502	+





Comparisons by tumour group for this Trust

The following tables show the Trust and the national percentage scores for each question broken down by tumour group. Where a cell in the table is blank this indicates that the number of patients in that group was below 20 and too small to display.

Seeing your GP

	before bein	1. Saw GP once/twice efore being told had o go to hospital		Q2. First appointment no more than 4 weeks after referral		thought een as soon Y	Q5. Patient's health got better or remained about the same while waiting	
Cancer type	This Trust	National	This Trust	National	This Trust	National	This Trust	National
Breast	91%	92%	91%	96%	72%	83%	83%	91%
Colorectal / Lower Gastro	59%	70%	82%	88%	73%	78%	77%	74%
Lung								
Prostate	85%	77%	85%	86%	94%	84%	80%	88%
Brain / CNS								
Gynaecological	65%	71%	90%	90%	73%	77%	64%	72%
Haematological	55%	62%	84%	90%	77%	81%	57%	66%
Head & Neck								
Sarcoma								
Skin								
Upper Gastro								
Urological	88%	81%	81%	88%	83%	83%	88%	87%
Other Cancers								
All cancers	73%	75%	87%	90%	77%	81%	74%	78%

Diagnostic tests

	Q7. Staff ga complete ex of purpose of	planation	Q8. Staff ex completely would be do test	what	Q9. Given ea understand information	written	Q10. Given explanation results in an understand	of test
Cancer type	This Trust	National	This Trust	National	This Trust	National	This Trust	National
Breast	90%	83%	90%	85%	87%	85%	84%	79%
Colorectal / Lower Gastro	81%	82%	77%	85%	88%	88%	77%	79%
Lung	83%	80%	100%	86%			73%	76%
Prostate	83%	83%	85%	86%	88%	87%	71%	77%
Brain / CNS								
Gynaecological	83%	76%	80%	81%	84%	83%	78%	73%
Haematological	69%	81%	73%	84%	63%	82%	65%	73%
Head & Neck								
Sarcoma								
Skin								
Upper Gastro								
Urological	84%	80%	79%	84%	88%	86%	75%	76%
Other Cancers								
All cancers	82%	81%	82%	84%	83%	85%	77%	76%

Finding out what was wrong with you

	Q12. Patient told th could bring a friend when first told they had cancer		Q13. Patien were told se that they ha	ensitively	Q14. Patien completely the explana what was w	understood tion of	Q15. Patient given written information about the type of cancer they had		
Cancer type	This Trust	National	This Trust	National	This Trust	National	This Trust	National	
Breast	87%	78%	91%	87%	80%	79%	79%	71%	
Colorectal / Lower Gastro	72%	75%	79%	83%	64%	78%	73%	65%	
Lung	80%	73%	85%	81%	63%	75%	57%	61%	
Prostate	77%	69%	85%	83%	67%	78%	85%	75%	
Brain / CNS									
Gynaecological	63%	63%	72%	80%	69%	73%	51%	61%	
Haematological	73%	65%	90%	82%	49%	58%	75%	71%	
Head & Neck									
Sarcoma									
Skin									
Upper Gastro									
Urological	72%	65%	85%	81%	77%	77%	78%	63%	
Other Cancers									
All cancers	75%	71%	84%	83%	70%	74%	71%	66%	

Deciding the best treatment for you

	Q16. Patien choice of dif types of trea	fferent	Q17. Possib effects expla understanda	ained in an	Q18. Patien written info about side e	rmation	Q19. Patien involved in about which	decisions
Cancer type	This Trust	National	This Trust	National	This Trust	National	This Trust	National
Breast	91%	87%	84%	75%	90%	88%	78%	72%
Colorectal / Lower Gastro	95%	82%	71%	76%	83%	81%	83%	73%
Lung			88%	75%	85%	83%	81%	72%
Prostate	81%	89%	69%	71%	70%	77%	69%	74%
Brain / CNS								
Gynaecological	100%	81%	77%	75%	80%	83%	73%	73%
Haematological	68%	78%	62%	70%	69%	77%	44%	68%
Head & Neck								
Sarcoma								
Skin								
Upper Gastro								
Urological			66%	67%	70%	68%	71%	70%
Other Cancers								
All cancers	83%	83%	75%	72%	80%	79%	71%	71%

Clinical Nurse Specialist

	Q20. Patie the name CNS in cha their care	of the		to contact listened carefully understandable seen,		easy to contact listened carefully understandable seen, tim eir CNS the last time answers to with CNS spoken to important right		answers to important questions all/most		e spent
Cancer type	This Trust	National	This Trust	National	This Trust	National	This Trust	National	This Trust	National
Breast	92%	93%	70%	72%	94%	91%	95%	91%	93%	94%
Colorectal / Lower Gastro	88%	87%	85%	78%	98%	93%	96%	92%	98%	96%
Lung	100%	91%	70%	75%	83%	91%	90%	89%	80%	93%
Prostate	93%	81%	84%	71%	89%	91%	82%	90%	97%	95%
Brain / CNS										
Gynaecological	92%	88%	74%	72%	91%	91%	90%	90%	95%	95%
Haematological	88%	81%	62%	77%	86%	92%	84%	91%	90%	95%
Head & Neck										
Sarcoma										
Skin										
Upper Gastro										
Urological	83%	69%	90%	75%	88%	92%	87%	90%	95%	96%
Other Cancers										
All cancers	90%	84%	75%	75%	91%	91%	91%	91%	94%	95%

Support for people with cancer

	Q25. Hospit gave inform about suppo	ation	Q26. Hospit gave inform getting fina	ation on	Q27. Hospit patient they free prescrip	/ could get
Cancer type	This Trust	National	This Trust	National	This Trust	National
Breast	87%	86%	56%	53%	79%	61%
Colorectal / Lower Gastro	70%	78%	50%	46%	72%	74%
Lung	88%	84%	68%	71%		
Prostate	88%	78%	43%	35%		
Brain / CNS						
Gynaecological	72%	79%	55%	52%	64%	61%
Haematological	76%	77%	55%	52%	67%	74%
Head & Neck						
Sarcoma						
Skin						
Upper Gastro						
Urological	57%	60%	28%	26%		
Other Cancers						
All cancers	cancers 79% 79%		52%	50%	73%	68%

Operations

	Q29. Admiss not changed hospital		Q30. Staff gave complete explanation of what would be done Q31. Patient giv written informa about the opera		rmation	Q32. Staff explained how operation had gone in understandable way		
Cancer type	This Trust	National	This Trust	National	This Trust	National	This Trust	National
Breast	96%	94%	90%	86%	88%	77%	77%	72%
Colorectal / Lower Gastro	93%	90%	90%	84%	76%	66%	80%	76%
Lung								
Prostate								
Brain / CNS								
Gynaecological	85%	89%	88%	85%	70%	71%	75%	76%
Haematological								
Head & Neck								
Sarcoma								
Skin								
Upper Gastro								
Urological	92%	85%	92%	84%	72%	65%	82%	72%
Other Cancers								
All cancers	93%	89%	88%	85%	77%	68%	76%	73%

Hospital Doctors

	Q34. Got understar answers t important questions of the tim	o t all/most	Q35. Patie confidenc trust in al treating t	e and I doctors	Q36. Patie thought d knew eno about hov their canc	loctors ough w to treat	Q37. Doct not talk ir patient as were not	front of if they	Q38. Patio family def had oppo talk to do	initely rtunity to
Cancer type	This Trust	National	This Trust	National	This Trust	National	This Trust	National	This Trust	National
Breast	88%	83%	93%	84%	91%	91%	93%	88%	85%	68%
Colorectal / Lower Gastro	90%	83%	84%	85%	93%	90%	75%	80%	71%	65%
Lung										
Prostate										
Brain / CNS										
Gynaecological	93%	82%	89%	83%	92%	89%	89%	86%	67%	66%
Haematological	64%	81%	72%	80%	77%	85%	73%	82%	62%	68%
Head & Neck										
Sarcoma										
Skin										
Upper Gastro										
Urological	82%	79%	85%	85%	88%	91%	73%	80%	60%	59%
Other Cancers										
All cancers	86%	81%	87%	84%	90%	89%	83%	83%	72%	66%

Ward Nurses

	Q39. Got understand answers to questions a the time	important	confidence and trust in talk in fro		talk in front as if they we	Q41. Nurses did not talk in front of patient as if they were not there		Q42. Always / nearly always enough nurses on duty	
Cancer type	This Trust	National	This Trust	National	This Trust	National	This Trust	National	
Breast	84%	74%	81%	66%	81%	86%	71%	62%	
Colorectal / Lower Gastro	77%	71%	50%	63%	70%	80%	52%	58%	
Lung									
Prostate									
Brain / CNS									
Gynaecological	64%	72%	61%	64%	74%	84%	57%	61%	
Haematological	64%	74%	60%	67%	72%	85%	56%	60%	
Head & Neck									
Sarcoma									
Skin									
Upper Gastro									
Urological	66%	73%	73%	70%	76%	83%	69%	65%	
Other Cancers									
All cancers	74%	73%	69%	66%	76%	83%	64%	62%	

Hospital care and treatment

	Q43. Patient did not think hospital staff deliberately misinformed them		Q44. Patient thought the given conflic information	y were cting	Q45. Always given enough privacy when discussing condition or treatment		
Cancer type	This Trust	National	This Trust	National	This Trust	National	
Breast	94%	90%	92%	80%	91%	84%	
Colorectal / Lower Gastro	79%	86%	72%	77%	82%	82%	
Lung							
Prostate							
Brain / CNS							
Gynaecological	85%	86%	77%	78%	80%	81%	
Haematological	71%	85%	63%	74%	72%	84%	
Head & Neck							
Sarcoma							
Skin							
Upper Gastro							
Urological	92%	87%	84%	82%	75%	82%	
Other Cancers							
All cancers	88%	87%	83%	79%	83%	82%	

	Q46. Always given enough privacy when being examined or treated		Q47. Hospit everything t control pain time	o help	Q48. Always treated with respect and dignity by staff		
Cancer type	This Trust	National	This Trust	National	This Trust	National	
Breast	95%	93%	89%	88%	86%	83%	
Colorectal / Lower Gastro	95%	93%	78%	84%	73%	80%	
Lung							
Prostate							
Brain / CNS							
Gynaecological	95%	93%	85%	85%	79%	81%	
Haematological	78%	93%			74%	84%	
Head & Neck							
Sarcoma							
Skin							
Upper Gastro							
Urological	90%	92%	82%	82%	78%	82%	
Other Cancers							
All cancers	92%	93%	83%	85%	80%	82%	

Information given to you before you left hospital and home support

	Q49. Given written info about what should not o discharge	rmation should /	Q50. Staff to who to cont worried pos	act if	if given all information		Q52. Patient definitely given enough care from health or social services	
Cancer type	This Trust	National	This Trust	National	This Trust	National	This Trust	National
Breast	91%	88%	99%	95%	73%	57%	53%	59%
Colorectal / Lower Gastro	77%	78%	93%	92%	62%	57%	73%	67%
Lung								
Prostate								
Brain / CNS								
Gynaecological	75%	83%	98%	92%	54%	55%	59%	54%
Haematological	86%	80%	96%	95%	59%	63%		
Head & Neck								
Sarcoma								
Skin								
Upper Gastro								
Urological	86%	79%	91%	86%	58%	55%		
Other Cancers								
All cancers	84%	82%	96%	92%	63%	58%	55%	60%

Hospital care as a day patient / outpatient

	Q54. Staff d did everythi control side radiotherap	ing to effects of	Q56. Staff d did everythi control side chemothera	ing to effects of	Q57. Staff definitely did everything they could to help control pain		Q58. Hospital staff definitely gave patient enough emotional support	
Cancer type	This Trust	National	This Trust	National	This Trust	National	This Trust	National
Breast	84%	85%	95%	85%	89%	85%	76%	69%
Colorectal / Lower Gastro			83%	85%	77%	84%	66%	73%
Lung			87%	86%			76%	74%
Prostate							63%	72%
Brain / CNS								
Gynaecological			96%	88%	86%	84%	75%	69%
Haematological			78%	86%	85%	85%	59%	74%
Head & Neck								
Sarcoma								
Skin								
Upper Gastro								
Urological					70%	77%	66%	71%
Other Cancers								
All cancers	80%	82%	88%	85%	84%	83%	70%	71%

	Q60. Waited no longer than 30 minutes for OPD appointment to start		Q61. Patient doctor spen right amoun with them	t about the	Q62. Doctor had the right notes and other documentation with them		
Cancer type	This Trust	National	This Trust	National	This Trust	National	
Breast	40%	63%	93%	92%	98%	94%	
Colorectal / Lower Gastro	48%	69%	94%	95%	98%	95%	
Lung	59%	71%	92%	94%	91%	95%	
Prostate	87%	74%	97%	93%	100%	94%	
Brain / CNS							
Gynaecological	47%	65%	90%	95%	96%	95%	
Haematological	36%	61%	83%	95%	88%	96%	
Head & Neck							
Sarcoma							
Skin							
Upper Gastro							
Urological	77%	76%	100%	95%	100%	95%	
Other Cancers							
All cancers	51%	68%	93%	94%	96%	95%	

Care from your general practice

	Q63. GP give information patient's co treatment	about	Q64. Practice staff definitely did everything they could to support patient		
Cancer type	This Trust	National	This Trust	National	
Breast	94%	95%	70%	68%	
Colorectal / Lower Gastro	91%	93%	68%	70%	
Lung					
Prostate	97%	93%	81%	73%	
Brain / CNS					
Gynaecological	89%	93%	58%	66%	
Haematological	90%	94%	54%	66%	
Head & Neck					
Sarcoma					
Skin					
Upper Gastro					
Urological	90%	93%	54%	71%	
Other Cancers					
All cancers	92%	93%	63%	69%	

Your overall NHS care

	Q65. Hospital and community staff always worked well together		Q66. Given amount of i about condi treatment	nformation	Q67. Patient did not feel that they were treated as 'a set of cancer symptoms'		
Cancer type	This Trust	National	This Trust	National	This Trust	National	
Breast	69%	61%	94%	89%	80%	78%	
Colorectal / Lower Gastro	55%	61%	93%	89%	77%	82%	
Lung	77%	65%	89%	88%	70%	79%	
Prostate	73%	63%	95%	87%	78%	81%	
Brain / CNS							
Gynaecological	62%	59%	85%	87%	78%	80%	
Haematological	55%	63%	88%	90%	68%	82%	
Head & Neck							
Sarcoma							
Skin							
Upper Gastro							
Urological	67%	64%	86%	87%	76%	84%	
Other Cancers							
All cancers	65%	61%	91%	88%	76%	80%	



The National Cancer Patient Experience Survey was undertaken by Quality Health, which specialises in measuring patients' experiences of hospital, primary care and mental health services, using this information to improve the quality of health care and the responsiveness of health services to patients and service users' needs.

Quality Health works with all acute hospitals in England, all independent providers of hospital care, and all Health Boards in Scotland using rigorous survey methods to evaluate the quality of services to patients, the outcomes of operative procedures and health gain, and establish the views of NHS staff. Quality Health also works for healthcare system providers in the Middle East and in Wales and Northern Ireland.

Quality Health is an approved contractor for the Care Quality Commission survey programmes of patients and staff in the NHS and also undertakes data collection and survey systems for the National Patient Reported Outcomes programme on behalf of the Department of Health. Quality Health has headquarters in North Derbyshire.

Further information on the National Cancer Patient Experience Survey programme and the 2010 survey can be obtained at <u>www.quality-health.co.uk</u>

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Sandwell and West Birmingham Hospitals

NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Survey of women's experiences of maternity services 2010
SPONSORING DIRECTOR:	Jessamy Kinghorn, Head of Communications and Engagement
AUTHOR:	Jessamy Kinghorn, Head of Communications and Engagement
DATE OF MEETING:	31 March 2011

SUMMARY OF KEY POINTS:

This report contains the results of the Survey of women's experiences of maternity services 2010, including how the Trust performs in comparison to other NHS trusts providing maternity services.

It is based on the views of 146 women.

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

Approval	Receipt and Noting	Discussion
	Х	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

NOTE the contents of the report

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Trust Management Board on 22 March 2011.

Trust Board

Experiences of Maternity patients - 2010

31st March 2011

Introduction

This report contains the results of the National Survey of women's experiences of maternity services 2010, including how the Trust performs in comparison to other NHS trusts providing maternity services. It is based on the views of 146 women who gave birth at the Trust during February 2010 and were asked for their views during April to August 2010.

The report also contains the results of a Trust commissioned survey to compare the experiences of women having low-risk births before the Trust had a midwife-led unit, with the experiences of women who used the midwife-led Serenity Birth Centre after it opened in May 2010.

National survey - Key findings

Patients rated the Trust in the top 20% of trusts nationally for midwives and other carers giving them consistent advice. **However**, the report shows that there are a number of key areas where the Trust was rated the national average in the opinion of patients.

- Choice of having baby at home
- Reasons for downs syndrome test explained
- Ability to move around during labour
- How soon any necessary stitches are done after birth
- Skin to skin contact after birth
- Confidence and trust in staff during birth
- Partner or companion made welcome
- Patient left alone at a time when it worried them
- Patient spoken to in a way they could understand
- Overall rating of care during labour and birth
- Appropriate length of stay in hospital after birth
- Treated with kindness and understanding after birth

The women surveyed in the national survey gave birth more than a year ago. The Trust has been working on a plan to improve maternity services, which has included significant investment, the opening of the Serenity Birth Centre, and the reconfiguration of the service in January 2011, since this survey was carried out. The results of the survey of women having low-risk births pre- and post- the opening of the Serenity Birth Centre are summarised and the full document is attached.

Serenity Birth Centre survey – Key findings

The opening of the Serenity Birth Centre in May 2010 was a significant part of the plans to improve maternity services.

A report was commissioned by the Trust to look at the views of women who had low-risk births between February and May 2010 and could have used a birth centre if that option had been available, and women who used the Serenity birth centre after it opened in May 2010. The survey was analysed independently by IDA (Independent Data Analysis Limited), and their report is attached. It shows a substantial improvement in the experiences of low risk women. The highlights are shown below:

	<u>% 'very good' or 'all the time'</u>				
Aspects:	<u>'Pre'</u>	<u>Serenity</u>			
Overall rating of experience:	22%	83%			
Rating of quality of care:	31%	78%			
Confidence in midwives?	63%	85%			
Information given:	22%	56%			
Cleanliness of delivery room:	44%	90%			
Made to feel welcome:	31%	81%			
Feel staff listened to me:	38%	72%			
Polite, courteous, respectful	50%	81%			
Kept informed?:	28%	77%			
Staff valued my point of view?	34%	73%			
Staff were caring and kind?	44%	85%			
Staff kept me involved?	34%	71%			
Staff went the 'extra mile'?	9%	53%			
Delivery suite environment:	31%	90%			
Delivery suite facilities:	28%	88%			

Next steps:

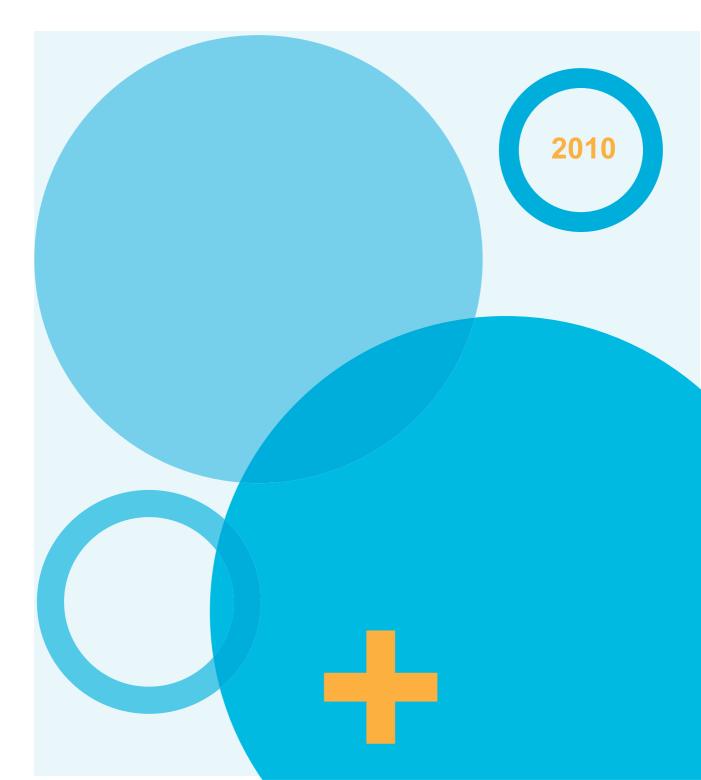
The survey findings of both the National survey and the survey commissioned by the Trust have been distributed to the Clinical Director for Maternity and the Head of Midwifery. They have also been discussed at Trust Management Board. The results will be used as part of the evaluations of the Serenity Birth Centre and the reconfiguration of maternity services.

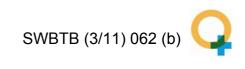
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Listening to patients

a e a es ha s a s NHS Trust National Maternity Survey a a e e e



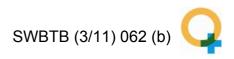


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background

The National Patient Survey (NPS) programme was introduced in 2001 by the Department of Health. The first survey, of acute inpatients in all relevant Trusts in England, was undertaken in early 2002.

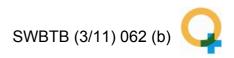
The Department novated the survey programme to the Healthcare Commission, and then to the Care Quality Commission (CQC), which has set out a rolling programme of patient and service user surveys in various settings covering all types of NHS Trusts.

Other national surveys for National Service Framework programmes have been rolled out to cover cancer, older people, diabetes, and coronary heart disease. A programme of national staff surveys also began in Autumn 2003. Quality Health runs the National Cancer Survey Programme for DH and is responsible for mobilising NHS and IS providers for the National PROMs programme.

The content of the national patient surveys is determined nationally, as is the content of the covering letters that are sent to patients. A national MREC approval letter covers the ethical issues. Send-out is normally undertaken on the Trust's behalf by their approved contractor under approved data security arrangements. Quality Health is accredited to ISO 27001 and 9001, IGSoC 7, and has been witness tested by the Department of Health.

All national data is collated by the Survey Co-ordination Centre, which is responsible for publishing national comparative data. The comparative data displayed in this report is derived from all the Trusts surveyed by Quality Health.





introduction

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The National Maternity Survey was undertaken for Sandwell and West Birmingham Hospitals NHS Trust between April and August 2010.

All women aged 16 and over who had given birth during February were surveyed. Where Trust samples did not reach a minimum of 250, women who had given birth in January were included. Samples were checked on three separate occasions through DBS and Trust internal checks, to ensure that no women or babies who had died were surveyed. Stillbirths, infants who had been adopted or taken in to care, and concealed pregnancies, were excluded from Trusts samples under the national arrangements.

RESPONSE RATE

146 completed surveys were returned from the sample of 429. A group of 9 women were excluded from the sample for the following reasons:

- Moved/not known at this address
 8
- Subsequent death of baby
- Ineligible

The response rate for Sandwell and West Birmingham Hospitals NHS Trust was 35% (146 usable responses from a final sample of 420).

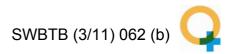
REPORT CONTENTS

This Report contains sections that describe the results from the survey, and sets out the full results in the same format as they appear in the questionnaire. It provides comparisons of the Trust results against those of other Trusts undertaking the Survey (headed Trust and All). In these comparisons, after each result there is an indicator showing whether the Trust's performance is more positive than (7) or not so positive as (k) the national mean score (by 5% or more), or if scores are about average (–).

This Report also shows the results from questions in the survey which are covered by the National Service Framework standards, and pulls together all the Report's conclusions and action points into an Executive Summary.

The questionnaire provided space for respondents to write their own comments about any aspect of their care. The comments received are set out in a separate supplement to this Report. These comments have been anonymised as far as it is possible to do so by the removal of names or other identifying features where these have been included.





NSF standards & NIHCE guidelines

The National Service Framework for Children, Young People and Maternity Services, first published in 2004, establishes clear standards for promoting the health and well-being of children, young people and mothers; and for providing high quality services which meet their needs.

There are 11 standards in the NSF, the last of which covers maternity services and looks at the requirements of women and their babies during pregnancy, birth and after the birth. This is Standard 11: 'Women have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies'.

Standards 1 to 5 also address some issues which are of relevance to maternity services and care, for example, low uptake of antenatal and postnatal support by younger women (Standard 4); involvement of fathers (Standards 1 and 3); and child health promotion (Standard 1).

The NSF includes a number of markers of good practice many of which relate to questions in the Maternity Survey. This report sets out these markers at the end of each section, indicates how the Trust is performing in relation to other Trusts on relevant questions, and provides action points.

There are also a number of NIHCE (National Institute for Health and Clinical Excellence) Guidelines in relation to antenatal care. These are also included where they relate to questions in the survey. There is some overlap between these and the Royal College of Obstetricians and Gynaecologists / Royal College of Midwives / Royal College of Anaesthetists and Royal College of Paediatrics and Child Health Standards for Maternity Care, first published in 2008, containing 30 individual standards covering the different stages of motherhood.

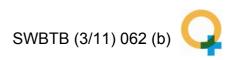


The Present Shape of Maternity Services

When considering the management recommendations in this report, Trusts will want to take account of the policy context and also the present shape of maternity services in England. The factual base set out below is useful context to the survey findings in 2010:

- In 2008–9, 57% of deliveries were conducted by midwives, (source: NHS Information Centre), compared to 39% undertaken by hospital doctors.
- Just under a quarter of deliveries in England were by caesarean section in 2008–9, of which around half were emergencies and the rest preplanned, a notable rise from under 3% in the 1950s and 12% in 1990– 91. The World Health Organization's target is for no more than 10-15% of deliveries to be by caesarean section.
- In recent years, midwifery-led units have been established which provide women with the option to give birth with little or no medical intervention. Where these are situated on the same site as a consultant unit, women can quickly be transferred if there are complications.
- A maternity-specific workforce planning tool Birthrate Plus recommends a ratio of one midwife for every 29.5 women as the minimum standard necessary to achieve one-to-one care in established labour. The Royal College of Midwives (RCM) recommends using this indicator at national and / or regional level.
- The most recent figures from the Nursing and Midwifery Council show there were 35,305 midwives registered to practise in the UK in 2008.
- According to the RCM's evidence submission to the Pay Review Body in 2008, there was a shortage of approximately 5,000 whole time equivalent midwives in England alone.
- In May 2008 there were 1,676 relevant consultants in post (number of NHS whole time equivalents = 1,574), 1,138 specialist registrars and 1,406 senior house officers according to The Royal College of Obstetricians and Gynaecologists' annual census of the workforce. The College believes around 400 more consultants are needed for England and Wales. The European Working Time Directive has impacted on maternity services, as it restricts junior doctors to working 48 hours a week. There are particular difficulties in recruiting to posts in paediatric and maternity services because of the need to have specialty-specific clinical skills immediately available 24 hours a day.
- The Government is committed to more choice in maternity care through the creation of new maternity networks.





executive summary

This section pulls together the conclusions and action points from each section of the Report to give an overview of the Trust's results and areas for consideration for action planning.

Early Pregnancy

CONCLUSIONS:

Trust scores in comparison to other Trusts on issues relating to care at the start of pregnancy are less positive.

Trust scores on issues relating to care at the start of pregnancy are mixed compared to 2007.

ACTION:

- Increase the number of women who are given a choice of where to have their baby including the choice of a home birth.
- Ensure that information is given about the choices available to women on where to have their baby.
- Ensure that all women who need one are given a copy of The Pregnancy Book.
- Ensure that all women are given information about the NHS Choices website.

Antenatal Check-ups

CONCLUSIONS:

Trust scores in comparison to other Trusts on issues relating to antenatal check-ups are more positive.

Trust scores on issues relating to antenatal check-ups have improved compared to 2007.

ACTION:

- Ensure that women are given as much choice as is possible about where they have their antenatal check-ups and who will do them.
- Increase continuity of care from midwives so that women see the same midwife as often as possible.
- Look at ways of increasing the continuity of care from hospital doctors so that women see the same doctor as often as possible.



Tests and Scans

CONCLUSIONS:

Trust scores in comparison to other Trusts on issues relating to tests and scans are less positive.

The Trust score on being offered a test for Down's syndrome has remained about the same.

ACTION:

- Ensure that all women have a choice about whether they have a screening test for Down's syndrome.
- Take action to improve explanations about the reasons for testing for Down's syndrome.
- Ensure that women get clear explanations about the reasons for dating scans and mid-trimester scans and feel they have a choice about having these scans.

During Pregnancy

CONCLUSIONS:

Trust scores in comparison to other Trusts on issues relating to care during pregnancy are less positive.

Trust scores on issues relating to care during pregnancy have improved compared to 2007.

ACTION:

- Ensure that all women are given a contact number in case they are worried during their pregnancy.
- Ensure that both verbal and written information is easily understood by women, and that all the information and explanations required are given.
- Ensure that all women are treated with respect and dignity, kindness and understanding during their pregnancy.
- Ensure that women are involved as much as possible in decisions about their care.



Antenatal Classes

CONCLUSIONS:

Trust scores in comparison to other Trusts on issues relating to antenatal classes are less positive.

Trust scores on issues relating to antenatal classes have improved compared to 2007.

ACTION:

- Review the provision of NHS antenatal classes given the high proportion of women not attending NHS classes and in particular, those not attending any classes at all.
- Examine alternative times and places for classes given the number of women saying they were not convenient.
- Ensure that women are told when partners / others can attend classes with them.
- Ensure that there are enough classes to meet women's needs.

During Labour

CONCLUSIONS:

Trust scores in comparison to other Trusts on issues relating to labour are less positive.

The Trust score on getting the pain relief wanted has remained about the same.

ACTION:

- Ensure that women are given a choice as far as is possible about whether they are induced.
- Examine ways of increasing the number of women able to move around and choose the position that makes them most comfortable during labour.
- Ensure that women are given pain relief in a timely manner to meet their needs.



The Baby's Birth

CONCLUSIONS:

Trust scores in comparison to other Trusts on issues relating to the birth of the baby about the same.

Trust scores on issues relating to the birth of the baby have improved compared to 2007.

ACTION:

• Consider whether the Trust's level of caesarean sections can be brought down.

The Staff

CONCLUSIONS:

Trust scores in comparison to other Trusts on issues relating to the staff are less positive.

Trust scores on issues relating to the staff have improved compared to 2007.

ACTION:

- Ensure that women are cared for by the same midwives as far as is possible during labour and the birth of their baby and if possible by midwives they have met previously.
- Ensure that husbands and partners are able to be present for the whole of labour and the birth of the baby if requested.
- Examine reasons why some women feel they are left alone at times which they find worrying.
- Ensure that both verbal and written information is easily understood by women, and that all the information and explanations required are given.
- Ensure that all women are treated with respect and dignity, kindness and understanding during labour and the birth of their baby.
- Examine ways of increasing the number of women who feel involved in decisions about their care during labour and the birth of their baby.
- Investigate why ratings for care during labour are generally less positive than elsewhere.



Post-natal Hospital Care

CONCLUSIONS:

Trust scores in comparison to other Trusts on issues relating to hospital care after the birth are mixed.

Trust scores on issues relating to hospital care after the birth have fallen back compared to 2007.

ACTION:

- Examine reasons why some women think their stay in hospital was too short.
- Ensure that women are given all the information they require about their own recovery after the birth of their baby.
- Ensure that all babies have a newborn examination before discharge.
- Ensure that both verbal and written information is easily understood by women, and that all the information and explanations required are given.
- Ensure that all women are treated with respect and dignity, kindness and understanding during their postnatal stay in hospital.

Feeding Baby

CONCLUSIONS:

Trust scores in comparison to other Trusts on issues relating to feeding baby are less positive.

Trust scores on issues relating to feeding baby have improved compared to 2007.

ACTION:

- Ensure that women have infant feeding discussed with them during their pregnancy by midwives.
- Ensure that women are given full support and encouragement, practical help and consistent advice about feeding their baby, particularly in relation to breast feeding.
- Look at ways of increasing the number of women breast feeding their babies.



Care at Home After Birth

CONCLUSIONS:

Trust scores in comparison to other Trusts on issues relating to care at home after the birth are less positive.

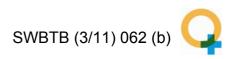
Trust scores on issues relating to care at home are mixed compared to 2007.

ACTION:

- Ensure that women have a contact number in case they are worried by anything when at home after the baby's birth.
- Review the number and frequency of midwives visits in the light of respondents' views.
- Review the provision of information about looking after baby in the light of the number of women who say they either did not get information or that they only got it to some extent.
- Ensure that all women have postnatal check-ups for their own health.







characteristics

The characteristics of the women who responded to the survey from Sandwell and West Birmingham Hospitals NHS Trust were as follows:

1. PREVIOUS PREGNANCIES

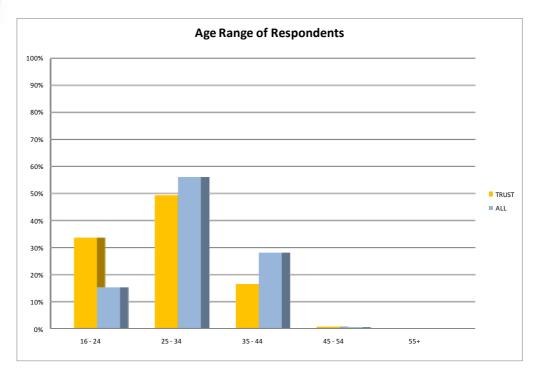
Women were asked if they had had a previous pregnancy; 59% said that they had. 67% said they had one or two babies before the birth that was the subject of this survey; 24% had had three or more.

2. THIS PREGNANCY

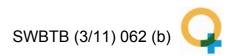
Women were also asked if they had had a single baby in this most recent pregnancy, or a multiple birth. 100% said they had had a single baby, no women had had twins, and no women had had triplets, quads or more.

3. AGE RANGE

34% of respondents were aged between 16 and 24; 17% aged 35 or over.



* Women aged under 16 having babies were excluded from the samples supplied by Trusts, however, a number of respondents stated that their age was under 16.



4. OTHER FAMILY MEMBERS

69% of the women were living with a husband or partner; and 10% said they lived alone.

5. ETHNIC GROUP

41% of the women were White British; 35% of the respondents were from Asian backgrounds (Indian, Pakistani, Bangladeshi or other), and 14% were from Black backgrounds (Caribbean, African or other).

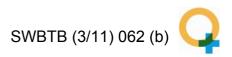
Women were asked what language they spoke most often at home. 73% said they spoke English; 17% spoke an Asian language (e.g. Hindi, Gujarati, Punjabi, Urdu, Sylheti, Bengali, Chinese, Thai); 1% spoke an African language (e.g. Swahili, Hausa, Yoruba) and 4% spoke another language (including British sign language).

6. LONG-STANDING CONDITIONS

9% of women said they had a long-standing physical or mental health condition. Of these women, 4 (25%) said this problem or disability definitely affected their everyday activities; 63% said they had no difficulty with any of the issues mentioned.







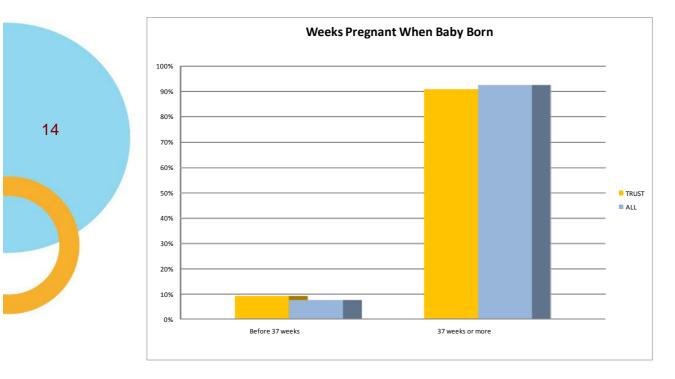
about the baby

1. TIME BABY WAS BORN

Women were asked at what time of day their baby was born; 49% said the baby was born in the day time (between 6 am and 6 pm), 51% said it was born at night time (between 6 pm and 6 am).

2. LENGTH OF PREGNANCY

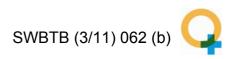
As the chart shows, 91% of women said their pregnancy lasted 37 weeks or more. 13 babies were born prematurely (under 37 weeks).



3. THE BABY'S WEIGHT

Babies are considered to have a low birth weight if they weigh less than 2,500 grams. Women were given the option of expressing their baby's weight in either grams or pounds and ounces.

89% of the babies weighed 2,500 grams / 5lb 8oz or more at birth; 8% weighed less than 2,500 grams / 5lb 8oz.



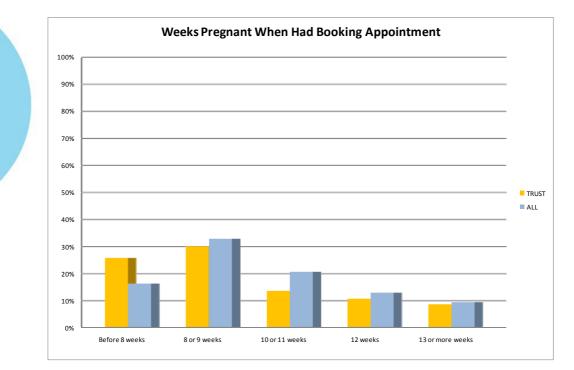
early pregnancy

1. HEALTH PROFESSIONAL FIRST SEEN

73% of women saw their GP / family doctor first about their pregnancy care; 19% saw a midwife.

2. BOOKING APPOINTMENTS

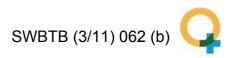
Women were asked how many weeks pregnant they were when they had their booking appointment (the appointment where they were given their pregnancy notes). The chart shows how many weeks pregnant women were when they had this appointment. 54% said they were between 8 and 12 weeks pregnant; 9% were 13 or more weeks pregnant.



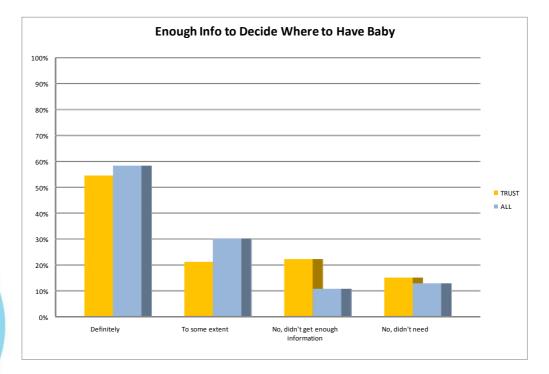
3. CHOICE ABOUT WHERE TO HAVE BABY

77% of women said they were given a choice about where they could have their baby at the start of their pregnancy; 3% said they could not have a choice for medical reasons. 47% of women said they were given a choice of having their baby at home.





The chart shows the proportion of women who had a choice about where to have their baby who felt that they got enough information from a midwife or doctor to help them make a decision on this issue. Of those who wanted it, 54% said they definitely got enough information; 22% said they did not get enough information.



4. GIVEN THE PREGNANCY BOOK

65% of women said that they were given a copy of The Pregnancy Book; 2% said they already had one. 29% were not given one.

5. INFORMATION ABOUT NHS CHOICES

Women were asked if they were given information about the NHS Choices website; 28% said they were given this information.





NSF Good Practice & NIHCE Guidelines

- The option for women to access a midwife as the first point of contact is widely publicised (NSF).
- Each pregnant woman has two visits early in pregnancy with a midwife who can advise her on her options for care on the basis of an in-depth knowledge of local services (NSF).
- The range of antenatal, birth and post birth care services available locally constitutes real choice for women, including home births (NSF).
- Each woman receives an initial assessment of her needs and agrees a care plan with the midwife which takes into account the type of birth, expected length of stay in hospital [if appropriate] and the timing of her transfer home (NSF).
- Pregnant women should be offered evidence-based information and support to enable them to make informed decisions regarding their care (NIHCE).
- All first time pregnant women should be offered 'The Pregnancy Book' by their carer (NIHCE).
- Maternity services should have a system in place whereby women carry their own case notes (NIHCE).

COMPARISONS WITH OTHER TRUSTS IN 2010

		Trust	All	Com
~	Saw a midwife first about pregnancy care	19%	26%	K
~	Had a choice about where could have the baby	77%	78%	-
~	Was given a choice of having baby at home	47%	70%	Ľ
~	Definitely got enough information to help decide where to have baby	54%	58%	-
~	Not given a copy of The Pregnancy Book	29%	21%	Ľ
~	Given Information about NHS Choices website	28%	22%	7

COMPARISONS WITH PREVIOUS YEAR

		2007	2010	Com
~	Saw a midwife first about pregnancy care	17%	19%	-
~	Had a choice about where could have the baby	78%	77%	-
~	Was given a choice of having baby at home	20%	47%	7
~	Not given a copy of The Pregnancy Book	20%	29%	Ľ

2007

2010

Com

CONCLUSIONS:

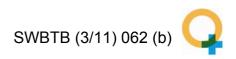
Trust scores in comparison to other Trusts on issues relating to care at the start of pregnancy are less positive.

Trust scores on issues relating to care at the start of pregnancy are mixed compared to 2007.

ACTION:

- Increase the number of women who are given a choice of where to have their baby including the choice of a home birth.
- Ensure that information is given about the choices available to women on where to have their baby.
- Ensure that all women who need one are given a copy of The Pregnancy Book.
- Ensure that all women are given information about the NHS Choices website.

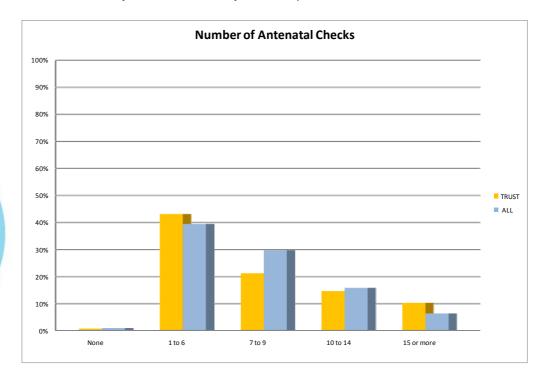




antenatal check-ups

1. NUMBER OF CHECK UPS

Women were asked how many antenatal check-ups they had during their pregnancy. The chart shows the number of women who said they had. 1 woman said they did not have any check-ups.



2. CHOICE OF WHERE CHECK-UPS TOOK PLACE

36% of women said they were given a choice about where their antenatal check-ups took place; 58% said they were not given a choice.

3. WHICH HEALTH PROFESSIONALS WERE SEEN

Women were asked which health professionals they saw for their check-ups. 89% saw midwives; 6% saw GPs; 31% saw hospital doctors; and 1% saw someone else.

4. SEEING THE SAME MIDWIFE

20% of women who saw a midwife more than once said they saw the same midwife every time they had an antenatal check-up, a further 40% said they saw the same one most of the time. No women said they never saw a midwife.

NSF Good Practice & NIHCE Guidelines

- All women are offered the support of a named midwife throughout pregnancy (NSF).
- Antenatal care should be provided by a small group of carers with whom the woman feels comfortable. There should be continuity of care throughout the antenatal period (NIHCE).
- Antenatal care should be readily and easily accessible to all women and should be sensitive to the needs of individual women and the local community (NIHCE).
- Early in pregnancy all women should receive appropriate written information about the likely number, timing and content of antenatal appointments (NIHCE).

COMPARISONS WITH OTHER TRUSTS IN 2010

		Trust	All	Com
~	Given a choice about where to have antenatal check-ups	36%	23%	7
~	Saw the same midwife every time or most of the time for antenatal check-ups	60%	59%	Ĩ
COI	MPARISONS WITH PREVIOUS YEAR			

		2007	2010	Com
~	Given a choice about where to have antenatal check-ups	28%	36%	7
~	Saw the same midwife every time or most of the time for antenatal check-ups	51%	60%	7

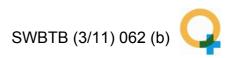
CONCLUSIONS:

Trust scores in comparison to other Trusts on issues relating to antenatal check-ups are more positive.

Trust scores on issues relating to antenatal check-ups have improved compared to 2007.

ACTION:

- Ensure that women are given as much choice as is possible about where they have their antenatal check-ups and who will do them.
- Increase continuity of care from midwives so that women see the same midwife as often as possible.
- Look at ways of increasing the continuity of care from hospital doctors so that women see the same doctor as often as possible.



tests and scans

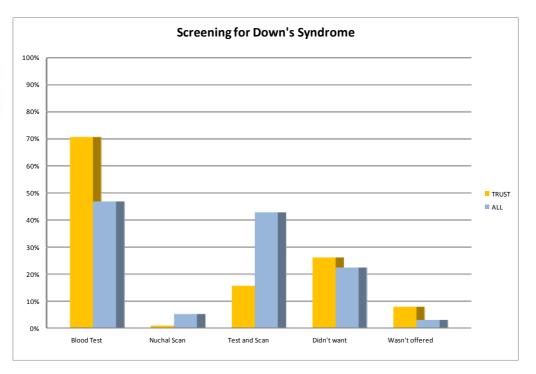
1. DATING SCANS

Women were asked if they had had a dating scan between 8 to 14 weeks of pregnancy. 90% said that they did have such a scan.

77% said the reason for having the scan was definitely explained clearly to them; 4% said it was not explained clearly.

2. TESTING FOR DOWN'S SYNDROME

Women were asked if they had had a blood test or nuchal scan to check whether their baby might have Down's syndrome. The chart shows the proportion of women who had had such tests.



26% of women said they did not want to be screened for Down's syndrome; 8% said they were not offered a test.

70% said the reasons for having such a test were definitely explained clearly to them; 9% said they were not explained clearly.

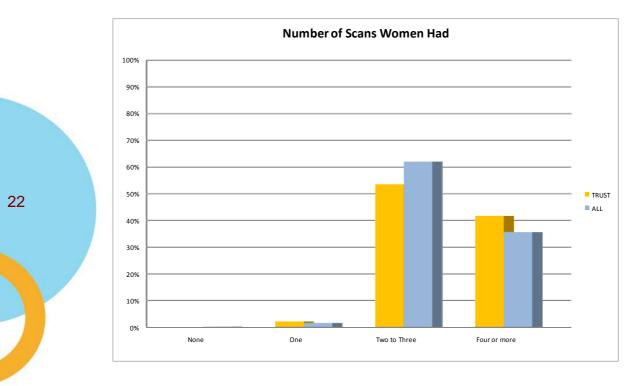
3. 20 WEEK SCANS

Women were asked if they had had a mid-trimester or anomaly scan at 20 weeks of pregnancy. 94% of the women said that they did have such a scan.

77% said the reason for having this scan was definitely explained clearly to them; 3% said it was not explained clearly.

4. OVERALL NUMBER OF SCANS

The chart shows the number of ultrasound scans that women said they had had during their pregnancy.



NSF Good Practice & NIHCE Guidelines

- A comprehensive high quality antenatal screening and diagnostic service ... is offered to all women (NSF).
- Antenatal tests and screening are offered to women as options (with the purpose and consequence of each test explained) rather than as a routine part of the process of being pregnant (NSF).
- Where women request or decline services or treatment, their decision is respected (NSF).
- Pregnant women should be offered screening for Down's Syndrome (NIHCE).

COMPARISONS WITH OTHER TRUSTS IN 2010

		Trust	All	Com
~	Reason for dating scan clearly explained	77%	75%	•
~	Not offered a screening test for Down's Syndrome	8%	3%	K
~	Reasons for having test for Down's syndrome clearly explained	70%	76%	Ľ
~	Reason for having mid-trimester scan clearly explained	77%	79%	-

COMPARISONS WITH PREVIOUS YEAR

		2007	2010	Com	
~	Not offered a screening test for Down's syndrome	7%	8%		

CONCLUSION:

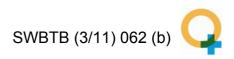
Trust scores in comparison to other Trusts on issues relating to tests and scans are less positive.

The Trust score on being offered a test for Down's syndrome has remained about the same.

ACTION:

- Ensure that all women have a choice about whether they have a screening test for Down's syndrome.
- Take action to improve explanations about the reasons for testing for Down's syndrome.
- Ensure that women get clear explanations about the reasons for dating scans and mid-trimester scans and feel they have a choice about having these scans.





during pregnancy

1. CONTACT NUMBERS

Women were asked whether they had the name and telephone number of a midwife that they could contact if they were worried during their pregnancy. 92% said that they did have a contact number; 11 women (8%) did not have one.

Of those women contacting a midwife, 75% said they were always given the help they needed.

2. INFORMATION AND COMMUNICATION

78% of women said they were always spoken to in a way that they could understand; 4% said that they were not.

3. ATTITUDE

65% were always involved enough in decisions about their care; 8% were not.

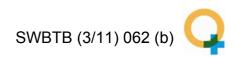
NSF Good Practice & NIHCE Guidelines

- All women are able to contact a midwife day or night at any stage in pregnancy if they have concerns (NSF).
- Every women who is experiencing problems in early pregnancy has access to an Early Pregnancy Unit (NSF).

COMPARISONS WITH OTHER TRUSTS IN 2010

		Trust	All	Com
~	Had the name and telephone number of a midwife to contact if worried	92%	93%	1
~	Always given the help needed by midwife	75%	72%	-
~	Always spoken to in a way they could understand	78%	83%	Ľ
~	Always involved enough in decisions about care	65%	73%	Ľ
~	Rating of care during pregnancy excellent / v good	75%	76%	





COMPARISONS WITH PREVIOUS YEAR

		2007	2010	Com	
~	Had the name and telephone number of a midwife to contact if worried	88%	92%	•	
~	Always spoken to in a way they could understand	67%	78%	7	
~	Rating of care during pregnancy excellent / v good	64%	75%	7	

CONCLUSION:

Trust scores in comparison to other Trusts on issues relating to care during pregnancy are less positive.

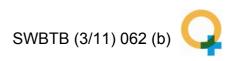
Trust scores on issues relating to care during pregnancy have improved compared to 2007.

ACTION:

- Ensure that all women are given a contact number in case they are worried during their pregnancy.
- Ensure that both verbal and written information is easily understood by women, and that all the information and explanations required are given.
- Ensure that all women are treated with respect and dignity, kindness and understanding during their pregnancy.
- Ensure that women are involved as much as possible in decisions about their care.





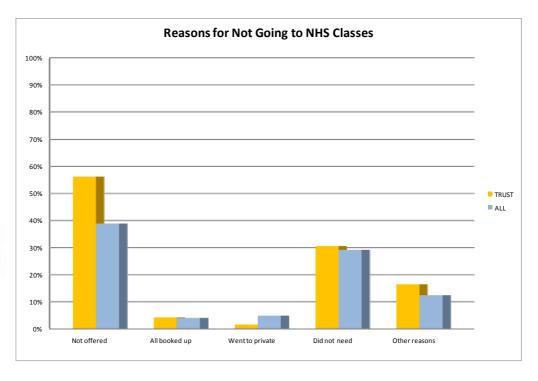


antenatal classes

1. ATTENDING CLASSES

26

40% of women attended antenatal classes provided by the NHS. The chart shows the reasons women did *not* attend NHS antenatal classes.



NSF Good Practice & NIHCE Guidelines

• Pregnant women should be offered opportunities to attend antenatal classes (NIHCE).

COMPARISONS WITH OTHER TRUSTS IN 2010

		Trust	All	Com
~	Attended antenatal classes provided by the NHS	40%	57%	Ľ
~	Not offered any antenatal classes	56%	39%	Ľ

COMPARISONS WITH PREVIOUS YEAR

		2007	2010	Com
~	Attended antenatal classes provided by the NHS	36%	40%	•
~	Not offered any antenatal classes	61%	56%	7

QUALITY HEALTH - 2010 NATIONAL MATERNITY SURVEY

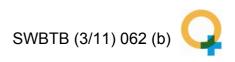
CONCLUSION:

Trust scores in comparison to other Trusts on issues relating to antenatal classes are less positive.

Trust scores on issues relating to antenatal classes have improved compared to 2007.

ACTION:

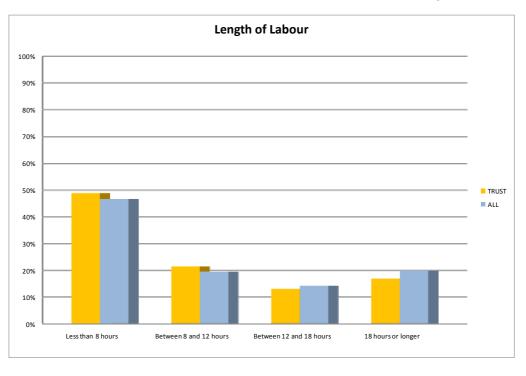
- Review the provision of NHS antenatal classes given the high proportion of women not attending NHS classes and in particular, those not attending any classes at all.
- Examine alternative times and places for classes given the number of women saying they were not convenient.
- Ensure that women are told when partners / others can attend classes with them.
- Ensure that there are enough classes to meet women's needs.



during labour

1. HOW LONG LABOUR LASTED

The chart shows how long labour lasted for respondents to the survey. 49% said it lasted Less than 8 hours; 17% said it lasted 18 hours or longer.





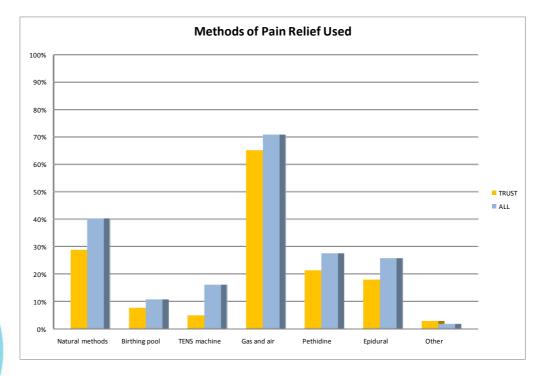
2. MOVING AROUND AND CHOOSING POSITION

Of those women who could move around 56% said that they were able to move around and choose the position that made them most comfortable for most of the time during their labour. 12% were not able to move around or choose position.



3. PAIN RELIEF

The forms of pain relief used by women are shown in the chart. 8% did not use any pain relief.



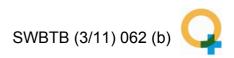
Of those women who wanted pain relief 59% said they definitely got the pain relief they wanted; 9% said they did not. 4% said it was not possible to have pain relief (e.g. because there was not enough time).

NSF Good Practice & NIHCE Guidelines

- Can have furniture easily re-arranged to allow for mobility and different birth positions (NSF).
- Women have a choice of methods of pain relief during labour, including non-pharmacological options (NSF).
- Women with uncomplicated pregnancies should be offered induction of labour beyond 41 weeks. From 42 weeks, women who decline induction of labour should be offered increased antenatal monitoring (NIHCE).

COMPARISONS WITH OTHER TRUSTS IN 2010

		Trust	All	Com
~	Able to move around and choose position that was most comfortable most of the time	56%	64%	Ľ
~	Definitely got the pain relief wanted	59%	65%	K



COMPARISONS WITH PREVIOUS YEAR

	2007	2010	Com
Definitely got the pain relief wanted	60%	59%	-

CONCLUSION:

~

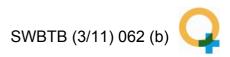
Trust scores in comparison to other Trusts on issues relating to labour are less positive.

The Trust score on getting the pain relief wanted has remained about the same.

ACTION:

- Ensure that women are given a choice as far as is possible about whether they are induced.
- Examine ways of increasing the number of women able to move around and choose the position that makes them most comfortable during labour.
- Ensure that women are given pain relief in a timely manner to meet their needs.





the baby's birth

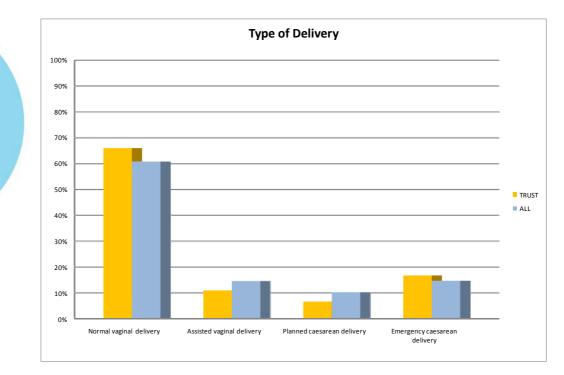
1. WHERE THE BABY WAS BORN

97% of women said their baby was born in hospital; 2% said the baby was born in a birth centre or maternity unit separate from hospital. 2% of women had a home birth.

2. KIND OF DELIVERY

31

66% of women said they had a normal vaginal delivery; 23% had a caesarean (either planned or emergency). The chart shows the proportion of women who had each type of delivery.



3. WHERE WOMEN GAVE BIRTH

95% of women gave birth on a bed, no women gave birth on the floor, and 2 women (2%) in a water or birthing pool.

24% of women said they gave birth sitting, or sitting supported by pillows; 39% said they were lying or lying supported by pillows; and 24% said they were lying with their legs supported in stirrups.

4. EPISIOTOMIES AND TEARS

Of those women who had stitches for either an episiotomy or a tear 52% had these done within 20 minutes; 15% waited more than 1 hour.

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5. SKIN CONTACT WITH BABY

Women were asked if they had skin to skin contact with their baby shortly after the birth. 2 women (1%) said they did not want skin contact with their baby. Of those that wanted and could have skin contact, 76% said they did have this contact.

NSF Good Practice & NIHCE Guidelines

- Promote the normalcy of childbirth i.e. they replicate a home-like ambience (NSF).
- In all out-of-hospital labours / births, the midwife is responsible for transfer [if this is required] and continues to care for the woman on transfer where possible (NSF).
- All staff have up to date skills and knowledge to support women who choose labour without pharmacological intervention, including the use of birthing pools, and in the position of their choice (NSF).
- Clinical interventions, including elective caesarean section, are only performed if there is clinical evidence of expected benefits of these to the mother and / or baby (NSF).
- When considering a caesarean section there should be discussion on the benefits and risks of CS compared with virginal birth specific to the woman and her pregnancy. Maternal request is not on its own an indication for CS (NIHCE).

COMPARISONS WITH OTHER TRUSTS IN 2010

		Trust	All	Com	
~	Delivery was by caesarean section	23%	25%	-	
~	Was stitched within 20 minutes of baby being born	52%	56%	-	

COMPARISONS WITH PREVIOUS YEAR

Was stitched within 20 minutes

	2007	2010	Com
of baby being born	46%	52%	7

CONCLUSION:

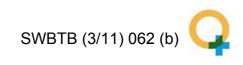
Trust scores in comparison to other Trusts on issues relating to the birth of the baby about the same.

Trust scores on issues relating to the birth of the baby have improved compared to 2007.

ACTION:

• Consider whether the Trust's level of caesarean sections can be brought down.





the staff

1. DIFFERENT MIDWIVES

Women were asked if they had met any of the staff who looked after them during their labour and the birth of their baby before they went into labour; 36% said that they had met them, 61% had not met any of them.

2. CONFIDENCE AND TRUST

68% of women definitely had confidence and trust in the staff caring for them during their labour and birth; 4% did not have confidence and trust.

3. HUSBANDS, PARTNERS AND COMPANIONS

Women were asked if they had a partner or a companion with them during their labour and delivery if they were made welcome by staff; 75% said they definitely were made welcome.

4. BEING LEFT ALONE

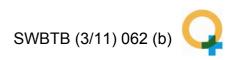
Women were asked if they felt they and their husbands or partners were left alone by midwives or doctors at a time when it worried them. 14% said they felt left alone during labour, 11% felt left alone shortly after the birth, and 7% felt left alone both during labour and shortly after the birth. 69% said they did not feel left alone.

5. CARE DURING LABOUR AND BIRTH

78% of women said they were always spoken to in a way that they could understand; 5% said that they were not.

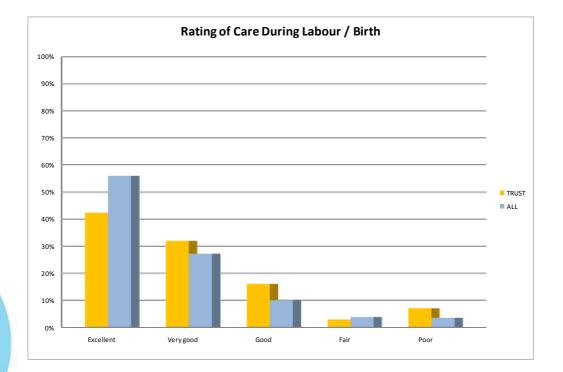
64% felt they were always involved enough in decisions about their care; 6% did not feel involved.





6. OVERALL RATING OF CARE

As the chart shows, 42% of women rated the care they received during labour and the birth of their baby as excellent; 10% rated it as only fair or poor.



NSF Good Practice

- Every woman is able to choose the most appropriate place and professional to attend her during childbirth.
- Maternity services develop the capacity for every woman to have a designated midwife to provide care for them when in established labour for 100% of the time.
- Birth environments are welcoming to fathers and other birthing partners.
- Maternity services staff [should] have the core competencies set out under NSF Standard 3 which are relevant to maternity services.

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COMPARISONS WITH OTHER TRUSTS IN 2010

		Trust	All	Com
~	Had met some of the staff before going into labour who were present during labour or the birth	36%	25%	7
~	Definitely had confidence and trust in staff	68%	73%	Ľ
~	Partner or companion definitely made welcome by staff	75%	83%	K
~	Not left alone by midwives or doctors at a time when it was worrying	69%	78%	Ľ
~	Always spoken to in a way that could be understood	78%	82%	Ľ
~	Always involved in decisions about care	64%	70%	Ľ
~	Care received during labour / birth excellent / v good	74%	83%	Ľ

COMPARISONS WITH PREVIOUS YEAR

		2007	2010	Com
~	Had met some of the staff before going into labour who were present during labour or the birth	27%	36%	7
~	Definitely had confidence and trust in staff	58%	68%	7
~	Not left alone by midwives or doctors at a time when it was worrying	61%	69%	7
~	Always spoken to in a way that could be understood	75%	78%	1
~	Care received during labour / birth excellent / v good	72%	74%	1



CONCLUSION:

Trust scores in comparison to other Trusts on issues relating to the staff are less positive.

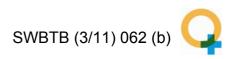
Trust scores on issues relating to the staff have improved compared to 2007.

ACTION:

- Ensure that women are cared for by the same midwives as far as is possible during labour and the birth of their baby and if possible by midwives they have met previously.
- Ensure that husbands and partners are able to be present for the whole of labour and the birth of the baby if requested.
- Examine reasons why some women feel they are left alone at times which they find worrying.
- Ensure that both verbal and written information is easily understood by women, and that all the information and explanations required are given.
- Ensure that all women are treated with respect and dignity, kindness and understanding during labour and the birth of their baby.
- Examine ways of increasing the number of women who feel involved in decisions about their care during labour and the birth of their baby.
- Investigate why ratings for care during labour are generally less positive than elsewhere.



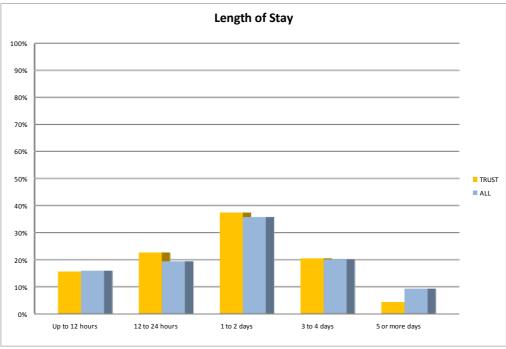




post-natal hospital care

1. LENGTH OF STAY

The chart shows the length of stay that women had in hospital after the birth of their baby.



* The figures in this chart are recalculated after combining the responses in both hours and days from the questionnaire

11% of women felt that this length of stay was too long; 17% thought it was too short, and 66% said it was about right.

2. INFORMATION AND EXPLANATIONS

61% of women said they were always given the information or explanations they needed; 9% said they were not.

3. ATTITUDES

37

59% were always treated with kindness and understanding; 8% were not.

NSF Good Practice

• Professionals are skilled in sharing concerns and choices with parents as part of the emerging diagnosis.

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COMPARISONS WITH OTHER TRUSTS IN 2010

		Trust	All	Com
~	Length of stay in hospital was about right	66%	70%	-
~	Woman definitely given enough information about her own recovery after the baby's birth	44%	43%	1
~	Always given the information or explanations needed	61%	51%	7
~	Always treated with kindness and understanding	59%	59%	1

COMPARISONS WITH PREVIOUS YEAR

		2007	2010	Com
~	Length of stay in hospital was about right	65%	66%	-
~	Always given the information or explanations needed	65%	61%	1
~	Always treated with kindness and understanding	65%	59%	K

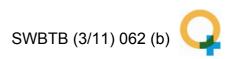
CONCLUSION:

Trust scores in comparison to other Trusts on issues relating to hospital care after the birth are mixed.

Trust scores on issues relating to hospital care after the birth have fallen back compared to 2007.

ACTION:

- Examine reasons why some women think their stay in hospital was too short.
- Ensure that women are given all the information they require about their own recovery after the birth of their baby.
- Ensure that all babies have a newborn examination before discharge.
- Ensure that both verbal and written information is easily understood by women, and that all the information and explanations required are given.
- Ensure that all women are treated with respect and dignity, kindness and understanding during their postnatal stay in hospital.



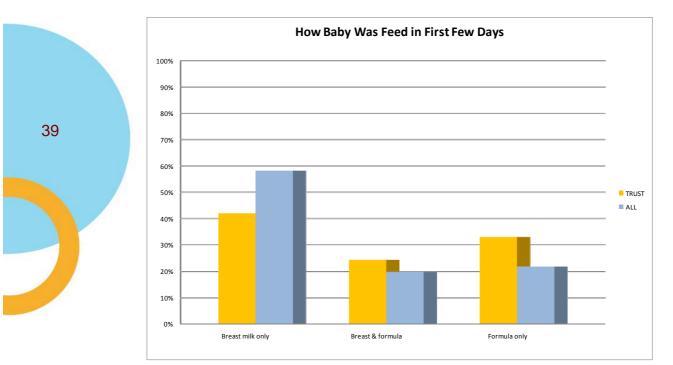
feeding baby

1. DISCUSSIONS ABOUT FEEDING

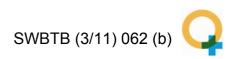
55% of women said that a midwife discussed infant feeding with them during their pregnancy; 15% said that they did not.

2. HOW BABY WAS FED

The chart shows how babies were fed in the first few days after their birth.



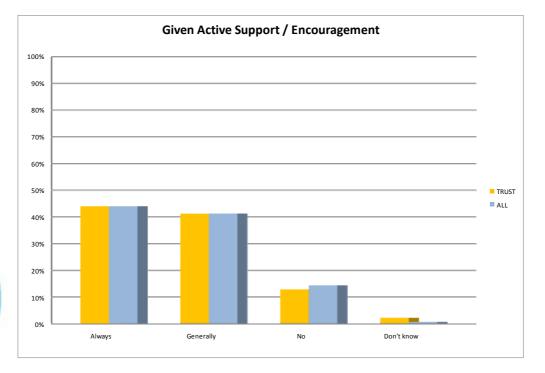
27% of women said that they put their baby to the breast at least once; 73% did not.



3. CARE FROM MIDWIVES ABOUT FEEDING

44% of women who wanted it said they always got consistent advice about feeding their baby from midwives and other carers; 17% said they did not.

The chart shows the proportion of women who felt they always got active support and encouragement with feeding their baby.

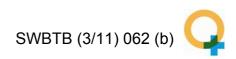


NSF Good Practice

- Information on breast feeding is timely, consistent and reflects best practice standards.
- Support for breast feeding is a routine part of antenatal care, birth and post-natal care, with particular support for mothers who have had a multiple birth or have a premature or sick baby.

COMPARISONS WITH OTHER TRUSTS IN 2010

		Trust	All	Com
~	During pregnancy, infant feeding discussed by midwife	55%	56%	1
~	Baby put to breast at least once	27%	25%	-
~	Baby fed breast milk only in first few days	42%	58%	Ľ
~	Given consistent advice by midwives and other carers	44%	37%	7
~	Given active support and encouragement by midwives and other carers	44%	44%	-



COMPARISONS WITH PREVIOUS YEAR

		2007	2010	Com
~	Baby fed breast milk only in first few days	39%	42%	-
~	Given consistent advice by midwives and other carers	39%	44%	7
~	Given active support and encouragement by midwives and other carers	42%	44%	•

CONCLUSION:

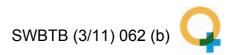
Trust scores in comparison to other Trusts on issues relating to feeding baby are less positive.

Trust scores on issues relating to feeding baby have improved compared to 2007.

ACTION:

- Ensure that women have infant feeding discussed with them during their pregnancy by midwives.
- Ensure that women are given full support and encouragement, practical help and consistent advice about feeding their baby, particularly in relation to breast feeding.
- Look at ways of increasing the number of women breast feeding their babies.





care at home after birth

1. CONTACT NUMBER

Women were asked if they had the name and telephone number of a midwife or health visitor that they could contact if they were worried when they were at home after the birth of their baby. 94% said that they did have a contact number; 4% did not.

Of those women who contacted a midwife or health visitor, 75% said they were always given the help they needed.

2. HOME VISITS BY MIDWIVES

Women were asked if they had been visited at home by a midwife. none said they were not offered a visit; a further 1% said their baby was in a neonatal unit so they did not get a visit.

99% said they were visited at home; no women saw the midwife in a clinic.

3. NUMBER OF VISITS

77% of women said they had been visited up to 4 times; 4% were visited 7 times or more.

29% would have liked to have seen a midwife more often; 64% saw a midwife as much as they wanted.

4. POSTNATAL CHECK-UPS

78% of women said they had had a postnatal check-up of their own health around 4-8 weeks after the birth of their baby; 22% said they had not had a check-up.

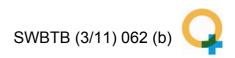
5. HEALTH INFORMATION AND ADVICE

Women were asked if they were given enough information about their own recovery; 44% said that they definitely were.

Of those women who said they needed it, 42% said they were definitely given enough information about emotional changes they might experience.

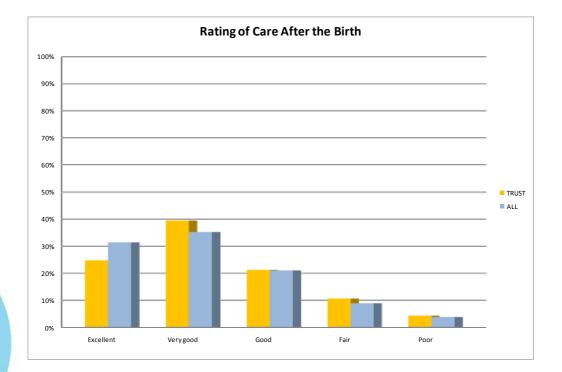
Women were asked if they were given information or offered advice from a health professional about contraception; 91% said that they were.





6. RATING OF CARE AFTER THE BIRTH

The chart shows how women rated the care they received after the birth of their baby.



NSF Good Practice

- All women leaving hospital or in the community, receive support from a community-based co-ordinating health professional.
- Local policies ensure that women are discharged from the maternity service according to their individual needs and those of their babies.
- All women receive a structured needs assessment in the post natal period, using a recognised assessment tool which enables health professionals to systematically identify, record and promote the health and well-being of the mother and her baby.
- Arrangements are in place for support in the community for teenage parents, including the provision of contraceptive advice and treatment.

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COMPARISONS WITH OTHER TRUSTS IN 2010

		Trust	All	Com
~	Had contact number for a midwife or health visitor if worried when at home after the baby's birth	94%	95%	-
~	Have been visited at home by a midwife since the baby's birth	99%	98%	•
~	Saw the midwife as much as wanted	64%	75%	Ľ
~	Received help and advice from health professionals about feeding baby	43%	52%	K
~	Received help and advice from health professionals about baby's health and progress	62%	64%	•
~	Woman had postnatal check up for own health	78%	89%	Ľ
~	Definitely given enough information about own recovery	44%	43%	-
~	Definitely given enough information about emotional changes	42%	43%	•
~	Given information or advice about contraception	91%	90%	-
~	Care after birth excellent / v good	64%	67%	-

COMPARISONS WITH PREVIOUS YEAR

		2007	2010	Com
~	Had contact number for a midwife or health visitor if worried when at home after the baby's birth	94%	94%	-
~	Saw the midwife as much as wanted	62%	64%	-
~	Received help and advice from health professionals about feeding baby	64%	43%	K
~	Received help and advice from health professionals about baby's health and progress	64%	62%	1
~	Woman had postnatal check up for own health	83%	78%	Ľ
~	Given information or advice about contraception	92%	91%	-
~	Care after birth excellent / v good	57%	64%	7





CONCLUSION:

Trust scores in comparison to other Trusts on issues relating to care at home after the birth are less positive.

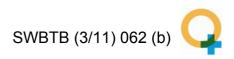
Trust scores on issues relating to care at home are mixed compared to 2007.

ACTION:

- Ensure that women have a contact number in case they are worried by anything when at home after the baby's birth.
- Review the number and frequency of midwives visits in the light of respondents' views.
- Review the provision of information about looking after baby in the light of the number of women who say they either did not get information or that they only got it to some extent.
- Ensure that all women have postnatal check-ups for their own health.







national findings

The key overall national findings, taken from data in the Trusts that Quality Health surveyed, are set out below.

Women are in some senses being given real choices on their maternity care, but on some issues choice is there for only a minority. Examples are:

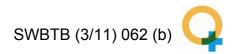
- Nearly 8 in 10 women are being offered a choice of where to have their baby.
- 7 in 10 women said they were given a choice of whether to have their baby at home, a significantly better score than in 2007, when less than half say they were offered a choice of having their baby at home.
- Relatively few women (23%) were being given choices about where their antenatal care would be located.
- Only about 1 in 5 women (22%) were given information about the NHS Choices website, the gateway to information on a wide range of NHS services.

Availability of the Pregnancy book is patchy, with only 71% saying they were given one. 1 in 5 women said they were not given one.

It is clear that the vast majority of women are receiving the care that is supposed to happen at clear markers during their pregnancy. For example:

- More than 9 in 10 women (94%) had a dating scan.
- The 20 week scan was almost universal (98% of women said they had one).
- Almost all women (93%) had the name and telephone number of a midwife they could call if they were worried.
- The prevalence of antenatal classes is by no means universal:
 - $\sim\,$ Of those women who thought they needed to attend them, 39% said they were not offered any. In 2007, almost 1 in 4 women said they were not offered any.
 - $\sim 41\%$ of all women said they did not need to attend antenatal classes or did not do so for a particular reason.
 - ~ Take up of antenatal classes was low amongst certain social groups (see below).

Caesarean rates varied widely from Trust to Trust, with an overall national rate of 25% (10% "elective", 15% emergency).



On the overall ratings of care, (on information, being treated with kindness and understanding, respect and dignity, given information etc.), women are consistently less positive about postpartum care as distinct from antenatal and intrapartum care. At the postpartum stage, 1 in 7 women overall said care was only fair or poor.

The incidence of breast feeding varied widely. In Trusts with high concentrations of white women who left education at 16 or earlier, a majority of women were using formula milk in the first few days as distinct from breast feeding. The lowest incidence of breast feeding is amongst young, white, less well educated women and the highest rates are amongst Asian and black women and amongst older white women. The overall proportion of mothers feeding baby with breast milk only in the first few days after the birth was 58%.

In terms of check-ups on their own and baby's health:

- Almost all women were visited by a midwife at home after the birth (98%).
- Most women (89%) said they had a check-up of their own health.
- Significant minorities of women said they were not given advice about the baby's health and progress.

Almost all women were given advice about contraception (90%) but a significant minority (1 in 5) were not given information about emotional changes that might occur after the birth.

• Demographic and Other Variables:

There are a range of variables that can influence the survey results (e.g. ethnicity, age), and some of the most important findings from our analysis of the national dataset are set out below.

The most important findings from the 2010 survey are that, although most women have experiences of maternity care which are positive, there are concentrations of women where that experience is different and in many ways less positive. Quality Health has run statistical significance tests on our national dataset which demonstrate a number of key findings.



Ethnic Minority Women

On many separate items in the survey, women from ethnic minority backgrounds are significantly less likely to receive a service which they rated positively or which can be defined as in line with national policy and good practice. Some of the most important items on which ethnic minority women receive a less good service, or are potentially more at risk, are:

- They are more likely to have premature babies
- They have lower birth weight babies
- They are less likely to see a professional for first contact within 12 weeks
- They are less likely to be given a choice of where to have their baby
- They are less likely to have a dating scan or a 20 week scan
- They are less likely to be offered a test for down's syndrome
- They are less likely to attend nhs antenatal classes
- They are less likely to get the pain relief they wanted
- They are less likely to get stitches done within 20 minutes
- They are less likely to have skin to skin contact with baby shortly after birth
- They are less likely to have trust and confidence in the staff
- They are less likely to feel involved in their care
- They are far less likely to say that they saw a midwife post partum as much as they wanted
- They are far less likely to rate their care as excellent or very good at any stage, i.e. Antenatal, intrapartum, or postnatal

However, there are some issues on which women from ethnic minority backgrounds are more likely to be positive about aspects of their care. Examples of these items are as follows:

- Being given a copy of the pregnancy book
- Being given information about the NHS Choices website
- Being given a choice about where to have their antenatal care
- Being given the explanations they needed about their care and treatment after the birth
- Having discussions on infant feeding, and getting consistent advice and active support on breast feeding
- Being given enough advice on their own recovery and on their emotional needs

Age of the Mother

Age of the mother is also a strong variable, reflecting data from other NHS surveys. It is clear that the 2010 Maternity survey identifies areas where younger mothers have different and often less positive attitudes than older mothers, which in most cases are congruent with the findings of the 2007 survey.

Mothers aged 20 and under were significantly less likely to be positive about maternity care than were older women, especially those aged over 32. The key issues on which women under 20 (described here as "younger women") were less positive are as follows:

- Younger women were the most likely to first see a health professional after 12 weeks; older women presented earlier; and younger women were also more likely to have a booking appointment after 12 weeks.
- Younger women were less likely to be given a choice of having a home birth.
- Younger women were the most likely not to have any antenatal check-ups at all; and were less likely to have a dating scan or a 20 week scan. Only 28% of mothers aged 20 and under said they had attended an NHS antenatal class. Younger women were also less likely to have a postnatal check of their own health than were older women.
- Younger women had less positive attitudes to midwifery care in general, especially being given the help they needed, understanding information they were given, etc.
- Younger women were less likely to rate care as excellent or very good at antenatal, intrapartum, and post natal stages.
- One of the most significant findings about younger women is that they are far less likely to breast feed than are older women. Only 33% of women aged 20 and under breast fed their baby in the first few days.

Mothers Not Living With a Partner

As in 2007, there were some fundamental differences between women who were living with a partner and those who were in some other kind of domestic arrangement. Women who lived with their partners were generally more positive and likely to access NHS care earlier and more effectively.

There was, however, no real evidence of compensatory intervention being given by the NHS in respect of this group of women – for example they were less likely to see midwives post partum as much as they wanted, and less likely to have a personal check-up of their own health at that point.



Mothers living with a partner were generally more positive about maternity care. They were:

- More likely to present for a first appointment within 12 weeks
- More likely to say they were given a choice of a home birth
- Far more likely to have antenatal checks
- More likely to have a dating scan and a 20 week scan
- More likely to say they were offered a Down's test
- Far more likely to say they attended NHS antenatal classes
- More likely to say they had skin to skin contact with their baby shortly after the birth
- More likely to say they had contact with a midwife after the birth
- Far more likely to say they saw a midwife as much as they wanted after leaving hospital
- Much more likely to rate care as very good at antenatal, intrapartum and post partum stages

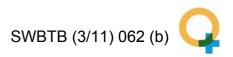
It is clear that the group of women who did not have partners are more at risk as a group than women with partners. They are more likely to present late; have less contact with services during the pregnancy; and have less contact with midwives after the birth.

Mothers With Long Term Health Conditions

It is clear from our analysis of the national data that mothers with long term health conditions (e.g. deafness, blindness, physical conditions, learning disabilities, mental health conditions, illnesses such as cancer, diabetes etc) are less positive about some aspects of maternity care, and are not picked up by the NHS system as readily, as women without LTCs.

Some of the key significant findings are these:

- Women with LTCs have a higher tendency to give birth before 37 weeks
- Fewer women with LTCs said they got all the help they needed during pregnancy and fewer felt as involved as they wanted to be in decision making
- Fewer women with LTCs attended NHS antenatal classes
- Fewer women with LTCs breast fed their baby in the first few days after the birth but more of them were given advice on feeding afterwards
- Fewer women with LTCs saw a midwife as much as they wanted after the birth



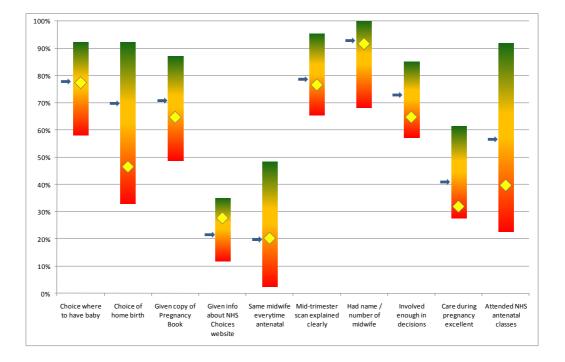
key scores in 2010

Set out below are a series of charts which show the range of responses on some key questions in the survey. Quality Health has chosen these questions as being representative of key issues in maternity care.

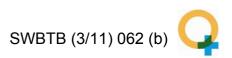
The charts show three things:

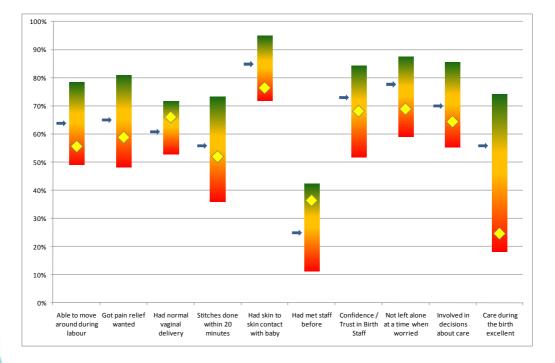
- The **range of scores** achieved by all Trusts surveyed by Quality Health on a particular group of questions. The range is graded from green to red.
- The **national mean score** achieved by all Trusts for each of the questions. This is shown as a blue arrow pointing toward each scale.
- Your Trust's score on each key question. This is shown on the scale as a yellow diamond.

The national mean score and your Trust's score is shown without any weighting or standardisation of the data.



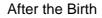
During Pregnancy

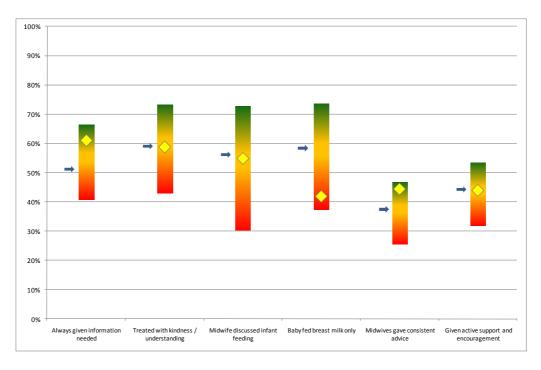


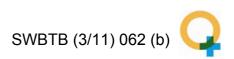


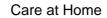
During Labour & Birth

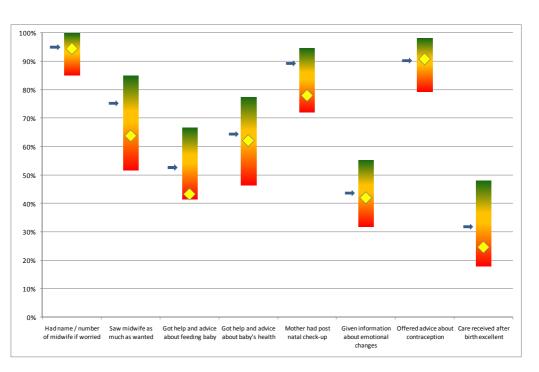








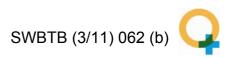




CONCLUSIONS

The conclusions that we can reach from these key scores are as follows:

- The range of performance between Trusts on some questions is extremely wide, for example scores on whether women attended NHS antenatal classes range from 23% to 92%; scores on women being given a choice of a home birth range from 33% to 92%. It is clear from this that there is a huge variation in policy and practice between Trusts.
- It is clear that the range of scores from Trust to Trust is smaller on some issues than others. For example, the range on being given the name / number of a midwife to call if worried is very small (15 point spread). On other issues the range is extraordinarily wide.
- There is strong evidence from international studies quoted in the NIHCE Guidelines (Clinical Guidelines on C Section, April 2004, page 2, ISBN 1 904752 02 0) that it is in hospitals with strong multidisciplinary teams, positive attitudinal scores, strong leadership, and a commitment to evidence based programmes, that care is at its best.



survey results

This section of the report sets out the full results¹ from the National Maternity Survey ordered in exactly the same way as in the survey questionnaire sent to women.

• HOW TO READ THE COLUMNS OF FIGURES

The results are shown firstly in absolute numbers then as percentages. The first pair of columns show the results for the Trust in 2007; the second pair of columns show the results from 2010, and the third pair of columns show the results from all the hospitals where Quality Health undertook the National Maternity Survey in 2010 (ALL).

The purpose of presenting the figures in this way is to give direct, at-a-glance, comparisons between the Trust's performance in 2007 and 2010, and between the Trust and other Trusts in the UK in 2010.

On some questions there are no results in the 2007 columns. This is because the question is either a new question this year or because the question has been substantially changed and is therefore not comparable with the 2010 question.

CONVENTIONS

The percentages are calculated after excluding those women who did not answer that particular question. All percentages are rounded to the nearest whole number. When added together, the percentages for all answers to a particular question may not total 100% because of this rounding.

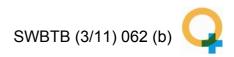
The 'Missing' figures show the number of women who did not reply to a particular question. In some cases, the 'Missing' figure is quite high because it includes women who did not answer that question or group of questions because it was not applicable to their circumstances (e.g. question B5).

On some questions there are also some figures which are italicised. The percentages on these questions have been recalculated to exclude responses where the question was not applicable to the woman's circumstances. For example, questions such as B4, where both those not answering (Missing) and those saying they were not given a choice about where to have their baby are excluded from the percentage calculations.

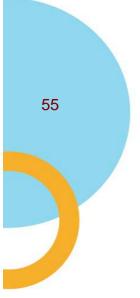
• CHANGES MADE TO THE DATA

There are a number of questions which are 'routed' (i.e. where women are directed to a subsequent question depending on their answer to the lead question). Sometimes there are conflicts in the answers that women give to these questions and the data is corrected to account for this. For example, if answers 2, 3 or 4 in question B4 are ticked and the woman goes on to answer questions B5 or B6 etc., then any data between question B4 and question B7 (where the woman was directed) will be deleted as these questions should not have been answered.

¹ Question A2 is not shown in these results as it only asked for the date that the respondent filled in the questionnaire.



There were also a number of questions where women were asked to write in specific information e.g. how many weeks pregnant they were when the baby was born. All of these questions have been scaled to provide statistical information for the Trust on these issues.



DATES AND YOUR BABY

A single baby 189 99% 142 100% 7469 98% Twins 1 1% 0 0% 130 2% Triplets quads or more 0 0% 0 0% 2 0% Missing 2 4 59 59 59 A3 What time was your baby born? 59 59 59 Early morning (12:01am-6.00am) 0 0% 38 28% 1907 25% Morning (6:01am-12:00 noon) 0 0% 37 27% 2026 27% Afternoon (12:01pm-6:00pm) 0 0% 30 22% 1928 25%	
Triplets quads or more 0 0% 0 0% 2 0% Missing 2 4 59 59 59 A3 What time was your baby born? 0 0% 38 28% 1907 25% Morning (6:01am-12:00 noon) 0 0% 37 27% 2026 27%	
Missing 2 4 59 A3 What time was your baby born? Early morning (12:01am-6.00am) Morning (6:01am-12:00 noon) 0 0% 38 28% 1907 25% 0 0% 37 27% 2026 27%	
A3 What time was your baby born? Early morning (12:01am-6.00am) 0 0% 38 28% 1907 25% Morning (6:01am-12:00 noon) 0 0% 37 27% 2026 27%	
Early morning (12:01am-6.00am)00%3828%190725%Morning (6:01am-12:00 noon)00%3727%202627%	
Morning (6:01am-12:00 noon) 0 0% 37 27% 2026 27%	
Afternoon (12:01pm 6:00pm) 0 00% 30 22% 1028 25%	
Evening / Night (6:01pm-12:00 midnight) 0 0% 32 23% 1703 23%	
Missing 192 9 96	
A4 Roughly how many weeks pregnant were you when your baby was born?	
Before I was 37 full weeks pregnant 0 0% 13 9% 574 8%	
When I was 37 weeks pregnant or more 0 0% 129 91% 7007 92%	
Missing 192 4 79	
A5 How much did your baby weigh at birth?	
Less than 2500g / 2.5kg (Less than 5 pounds 8 ounces) 0 0% 11 8% 384 5%	
2500g / 2.5kg or more (5 pounds 8 ounces or more) 0 0% 124 89% 7131 94%	
Don't know / Can't remember 0 0% 4 3% 42 1%	
Missing 192 7 103	

AN	TENATAL CARE	Total	SWBT	B_(3/1	1,062	(þ) Total	All
B1	Who was the first health professional you saw when you thought you were pregnant? GP / family doctor	154	81%	103	73%	5215	69%
	Midwife	33	17%	27	19%	2004	26%
	Other	2	1%	11	8%	354	5%
	Missing	3		5		87	
B2	Roughly how many weeks pregnant were you when you first saw this health professional about your pregnancy care?						
	Before I was 7 full weeks pregnant	0	0%	78	55%	3907	52%
	When I was 7 to 12 weeks pregnant	0	0%	46	33%	3144	41%
	When I was more than 12 weeks pregnant	0	0%	10	7%	379	5%
	Don't know / Can't remember	0	0%	7	5%	148	2%
	Missing	192		5		82	
B3	Roughly how many weeks pregnant were you when you had your 'booking' appointment (the appointment where you were given your pregnancy notes)?						
	Before I was 8 full weeks pregnant	0	0%	36	26%	1227	16%
	When I was 8 or 9 weeks pregnant	0	0%	42	30%	2480	33%
	When I was 10 or 11 weeks pregnant	0	0%	19	14%	1559	21%
	When I was 12 weeks pregnant	0	0%	15	11%	972	13%
	When I was 13 or more weeks pregnant	0	0%	12	9%	705	9%
	Don't know / Can't remember	0	0%	16	11%	612	8%
	Missing	192		6		105	
B4	At the start of your pregnancy did you have a choice about where you could have your baby?						
	Yes	144	78%	106	77%	5459	78%
	No	32	17%	27	20%	1243	18%
	No but this was not possible for medical reasons	6	3%	4	3%	520	7%
	Don't Know / Can't remember	9 1	5%	4 5	3%	<i>320</i> 118	5%
	Missing	I		5		110	
B5	Were you given a choice of having your baby at home? Yes	34	20%	47	47%	3493	70%
	No	120	70%	45	45%	1118	22%
	No but this was not possible for medical reasons	17	9%	6	6%	487	9%
	Don't Know / Can't remember	18	10%	9	9%	361	7%
	Missing	3		39		2201	
B6	Did you get enough information from a midwife or doctor to help you decide where to have your baby?						
	Yes definitely	0	0%	49	54%	2784	58%
	Yes to some extent	0	0%	19	21%	1438	30%
	No	0	0%	20	22%	512	11%
	No but I did not need this information	0	0%	16	15%	703	13%
	Don't know / Can't remember	0	0%	2	2%	46	1%
	Missing	192		40		2177	

AN	ENATAL CARE	Total	SWBT	Brotal1	12062	(þ) Total	All
B7	Before your baby was born, did you plan to have your baby at home?						
	Yes	0	0%	10	7%	527	7%
	No	0	0%	128	93%	7035	93%
	Missing	192		8		98	
B8	Were you given a copy of The Pregnancy Book?						
	Yes	123	69%	88	65%	4968	71%
	No	36	20%	40	29%	1459	21%
	No I already had one Don't Know / Can't remember	13 19	7% 11%	3 8	2% 6%	565 584	7% 8%
	Missing	19	1170	0 7	0%	364 84	0%
B9	Were you given information about the NHS Choices website?						
	Yes	0	0%	38	28%	1680	22%
	No	0	0%	80	58%	4222	56%
	Not sure / Don't know	0	0%	19	14%	1673	22%
	Missing	192		9		85	
B10	Roughly how many antenatal check-ups did you have in total?						
	None	0	0%	1	1%	72	1%
	1 to 6	0	0%	59	43%	2974	39%
	7 to 9	0	0%	29	21%	2241	30%
	10 to 14	0	0%	20	15%	1192	16%
	15 or more Don't know / Can't remember	0	0% 0%	14 14	10% 10%	474 601	6% 8%
	Missing	0 192	0%	9	10%	106	070
		102		Ũ		100	
B11	During your pregnancy were you given a choice about where your antenatal check-ups would take place?						
	Yes	51	28%	50	36%	1741	23%
	No	124	67%	81	58%	5457	73%
	Don't Know / Can't remember	10 7	5%	8 7	6%	312	4%
	Missing	1		1		150	
B12	Which of the following health professionals did you see for your antenatal check-ups?						
a.	Midwife	0	0%	129	89%	7255	96%
а.	Missing	192	070	16	0070	333	0070
_							
b.	GP (Family doctor)	0	0%	8	6%	1329	18%
	Missing	192		137		6259	
C.	Hospital doctor	0	0%	45	31%	2955	39%
	Missing	192	- / 0	100	/ 0	4633	
d.	Other	0	0%	2	1%	121	2%
	Missing	192		143		7467	

ANTENATAL CARE	Total	SWART	B (3/1	12062	(þ) Total	All
B13 If you saw a midwife for your antenatal check-ups, did you see the same one every time?						
Yes every time	34	18%	28	20%	1489	20%
Yes most of the time	61	33%	55	40%	2887	39%
No	89	48%	54	39%	2963	40%
I only saw a midwife once	1	1%	3	2%	74	1%
I did not see a midwife	0	0%	0	0%	38	1%
Don't Know / Can't remember	1	1%	1	1%	33	0%
Missing	6		5		176	
B14 Did you have a 'dating scan'? This takes place between 8-14 weeks of pregnancy.						
Yes	0	0%	128	90%	7130	94%
No	0	0%	7	5%	355	5%
Don't know / Can't remember	0	0%	7	5%	91	1%
Missing	192		4		84	
B15 Was the reason for this scan clearly explained to you?	0	00/	400	770/	5000	750/
Yes definitely Yes to some extent	0	0% 0%	106 21	77% 15%	5606	75%
No	0 0	0% 0%	21 6	15% 4%	1331 342	18% 5%
Don't know / Can't remember	0	0%	5	4%	342 149	5% 2%
Missing	192	0 /0	8	4 /0	232	2 /0
Missing	132		0		202	
B16 Did you have any screening tests (a blood test or nuchal scan) to check whether your baby might have Down's syndrome?						
Yes a blood test only	99	64%	72	71%	2711	47%
Yes a nuchal scan only	5	3%	1	1%	300	5%
Yes a nuchal scan and a blood test	34	22%	16	16%	2478	43%
No I didn't want a screening test for Down's Syndrome	35	19%	36	26%	1667	22%
No I wasn't offered any screening test for Down's syndrome	11	7%	8	8%	172	3%
Don't Know / Can't remember	5	3%	5	5%	134	2%
Missing	3		8		198	
B17 Were the reasons for having a screening test for Down's syndrome clearly explained to you?						
Yes definitely	0	0%	96	70%	5653	76%
Yes to some extent	0	0%	19	14%	1232	17%
No	0	0%	12	9%	368	5%
Don't know / Can't remember	0	0%	10	7%	164	2%
Missing	192		9		243	
B18 Did you have a scan at around 20 weeks of pregnancy? This may have been called a '20 week' scan, or an 'anomaly' scan or a 'mid-trimester' scan.						
Yes	0	0%	135	94%	7434	98%
No	0	0%	3	2%	82	1%
Don't know / Can't remember	0	0%	5	3%	61	1%
Missing	192		3		83	

B19 Was the reason for this scan clearly explained to you? 0 0% 108 77% 594.8 79% Yes to some extent 0 0% 4 3% 256 3% No 0% 4 3% 955 1% Don't know / Can't remember 0 0% 4 3% 955 1% Missing 192 5 188 188 0% 4 3% 955 1% No 0 0% 4 3% 955 1% 2% 1% 2% 1% 2% 1% 2% 1% 2% 1% 2% 1% 2% 1% 2% 1% 2% 1% 2% 1% 2% 1% 2% 1% 2% 1% 2% 1% 2% 1% 2% 1% 1% 2% 1% 1% 2% 1% 1% 1% 1% 1% 1% 1% 1% 1% 1% 1% 1% 1% 1% 1% 1% 1% 1% 1% <td< th=""><th>ANTENATAL CARE</th><th>Total</th><th>SWBT</th><th></th><th>1,062</th><th>(þ) Total</th><th>All</th></td<>	ANTENATAL CARE	Total	SWBT		1,062	(þ) Total	All
Yes definitely 0 0% 108 77% 5948 79% Yes to some extent 0 0% 25 18% 1243 16% No 0 0% 4 3% 955 1% Don't know / Can't remember 0 0% 4 3% 955 1% Missing 192 5 118 18 18 B20 Roughly how many ultrasound scans did you have in total during this pregnancy? None 0 0% 3 2% 115 2% None 0 0% 77 53% 4691 62% 706 9% 76 15 16 9% Don't know / Can't remember 0 0% 64 3% 56 1% 15 2% 7065 93% 706 93% 10 11 8% 474 6% 20 777 52% 16 1% 16 1% 21% 775 93% 16 1%	B19 Was the reason for this scan clearly explained to you?						
No 0 0% 4 3% 256 3% Don't know / Can't remember 0 0% 4 3% 95 1% B20 Roughty how many ultrasound scans did you have in total during this pregnancy? 0 0% 0 0% 16 0% None 0 0% 3 2% 115 2% None 0 0% 77 53% 4691 62% Four or more 0 0% 64 3% 56 1% Missing 192 2 86 1% 132 2% 66 3% No 0 0% 64 3% 16 9% 63 1% Don't know / Can't remember 0 0% 14 1% 44 1% Missing 1 169 88% 132 9% 705 93% No 0 0% 74 7% 77 77 77 77 </th <th></th> <th>0</th> <th>0%</th> <th>108</th> <th>77%</th> <th>5948</th> <th>79%</th>		0	0%	108	77%	5948	79%
Don't know / Can't remember Missing 0 192 0% 5 1% 5 1% 5 B20 Roughly how many ultrasound scans did you have in total during this pregnancy? 0 0% 0 0% 16 0% None 0 0% 0 0% 15 2% 15 2% None 0 0% 0 0% 16 0% 0% 43 2% 155 2% 2% 156 2% 5% 0% 0 0% 43 2% 169 8% 4591 6% 0% 0% 4 3% 56 1% B21 During your pregnancy did you have the name and telephone number of a midwife you could contact if you were worried? 11 8% 474 6% 0% 0% 11 1% 44 1% Missing 1 1% 44 1% 1% 1% 1% 1% 2% 77 1% 2% 77 1% 2% 77 1% 2% 1%<	Yes to some extent	0	0%	25	18%	1243	16%
Missing 192 5 118 B20 Roughly how many ultrasound scans did you have in total during this pregnancy? None 0 0% 0 0% 15 0% None 0 0% 3 2% 115 2% 155 2% 155 2% 155 2% 155 2% 155 2% 155 2% 155 2% 155 2% 155 2% 160 0% 60 0% 4691 62% 60% 00 42% 2686 36% 160 18% 160 0% 461 62% 66% 18% 172 2 86 18% 191 0% 11 8% 474 6% 0% 0% 11 8% 474 1% 16% 00 11 8% 474 1% 16% 00 11 8% 474 1% 16% 00 11 1% 2% 765 3% 22% 16% </td <td>No</td> <td>0</td> <td>0%</td> <td>4</td> <td>3%</td> <td>256</td> <td>3%</td>	No	0	0%	4	3%	256	3%
B20 Roughly how many ultrasound scans did you have in total during this pregnancy? None 0 0% 0 0% 115 0% None 0 0% 3 2% 115 2% Orne 0 0% 73 2% 115 2% Two to Three 0 0% 77 53% 4691 62% Four or more 0 0% 60 42% 2596 3% Don't know / Can't remember 0 0% 60 43% 56 1% Missing 192 2 86 1% 3% 56 1% Yes 169 88% 132 92% 7065 93% No 1 1 8 474 6% 50 Don't Know / Can't remember 19 10% 11 8% 474 6% No 0 0% 74 75% 4219 72% 72% Yes sometimes 0 0% 71 17% 1288 22% 5% 16 <td< td=""><td>Don't know / Can't remember</td><td>0</td><td>0%</td><td>4</td><td>3%</td><td>95</td><td>1%</td></td<>	Don't know / Can't remember	0	0%	4	3%	95	1%
during this pregnancy? 0 0% 0 0% 16 0% None 0 0% 3 2% 115 2% Two to Three 0 0% 60 42% 2% 26% Four or more 0 0% 40 42% 2696 36% Don't know / Can't remember 0 0% 41 3% 56 1% Missing 192 2 2 86 1%	Missing	192		5		118	
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Four or more 0 0% 60 42% 26% 36% Don't know / Can't remember 192 2 86 1% B21 During your pregnancy did you have the name and telephone number of a midwife you could contact if you were worried? 5 1% 3 Yes 169 88% 132 9% 7065 93% No 19 10% 11 8% 474 6% Don't Know / Can't remember 3 2% 1 1% 44 1% Missing 1 2 77 77 77 77 77 B22 If you contacted a midwife, were you given the help you needed? 0 0% 74 75% 4219 72% Yes sometimes 0 0% 74 75% 4219 72% 75% 4219 72% 75% 4219 72% 75% 4219 72% 75% 4219 72% 75% 4219 72% 75% 4219 72% 75% 4219 72% 75% 4219 72% 75% 4219 <t< td=""><td>One</td><td>0</td><td>0%</td><td>3</td><td>2%</td><td>115</td><td>2%</td></t<>	One	0	0%	3	2%	115	2%
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Missing 1 2 77 B22 If you contacted a midwife, were you given the help you needed? - <td>No</td> <td>19</td> <td>10%</td> <td>11</td> <td>8%</td> <td>474</td> <td>6%</td>	No	19	10%	11	8%	474	6%
B22 If you contacted a midwife, were you given the help you needed? Yes always 0 0% 74 75% 4219 72% Yes sometimes 0 0% 17 17% 1288 22% No 0 0% 8 8% 320 5% I did not contact a midwife 0 0% 44 31% 1735 23% Missing 192 3 98 98 98 98 98 B23 Thinking about your antenatal care, were you spoken to in a way you could understand? 78% 111 78% 6288 83% Yes sometimes 48 26% 24 17% 1117 15% No 8 4% 6 4% 136 2% Don't know / Can't remember 4 2% 1 1% 38 1% Missing 9 4 81 16 24 1619 22% No 0 0% 90 65% 5462 73% 73% Yes always 0 0%	Don't Know / Can't remember	3	2%	1	1%	44	1%
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I did not contact a midwife 0 0% 44 31% 1735 23% Missing 192 3 98 98 98 B23 Thinking about your antenatal care, were you spoken to in a way you could understand? 58 58 58 58 58 83% Yes always 123 67% 111 78% 6288 83% Yes sometimes 48 26% 24 17% 1117 15% No 8 4% 6 4% 136 2% Don't know / Can't remember 4 2% 1 1% 38 1% Missing 9 4 811 1% 38 1% Pes always 9 4 81 1% 38 1% Missing 9 4 81 1% 38 1% B24 Thinking about your antenatal care, were you involved enough in decisions about your care? 9 0 65% 5462 73% Yes sometimes 0 0% 0% 0% 37 27% 1619 <td>Yes sometimes</td> <td>0</td> <td>0%</td> <td>17</td> <td>17%</td> <td>1288</td> <td>22%</td>	Yes sometimes	0	0%	17	17%	1288	22%
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I did not want / need to be involved 0 0% 2 1% 56 1% Don't know / Can't remember 0 0% 1 1% 89 1%	•	0	0%	37	27%	1619	22%
Don't know / Can't remember 0 0% 1 1% 89 1%	No	0	0%	11	8%	348	5%
	I did not want / need to be involved	0	0%	2	1%	56	1%
Missing 192 5 86	Don't know / Can't remember	0	0%	1	1%	89	1%
	Missing	192		5		86	

ANTENATAL CARE	Total	S₂‱₽¯	Г <mark>В- (3/</mark> 1	1,20,62	(þ) Total	All
B25 Overall, how would you rate the care received during your pregnancy?						
Excellent	54	29%	46	32%	3126	41%
Very good	65	35%	62	43%	2604	34%
Good	37	20%	22	15%	1220	16%
Fair	26	14%	8	6%	468	6%
Poor	5	3%	6	4%	141	2%
Missing	5		2		101	
B26 During your pregnancy, did you attend any antenatal classes provided by the NHS?						
Yes	37	36%	29	40%	2321	57%
No I was not offered any classes	63	61%	41	56%	1572	39%
No they were all booked up	3	3%	3	4%	159	4%
No I attended other antenatal classes (e.g. NCT)	3	2%	2	1%	355	5%
No I did not need to attend the classes	53	28%	43	30%	2182	29%
No I did not attend for some other reasons	28	15%	23	16%	923	12%
Missing	5		5		148	

YO	UR LABOUR AND THE BIRTH OF YOUR BABY	Total	SWA	Г <mark>В- (3/</mark> 1 тота і	1,062	(þ) Total	All
C1	Roughly how long did your labour last?						
	Less than 8 hours	0	0%	64	49%	3130	47%
	8 hours or longer but less than 12 hours	0	0%	28	21%	1304	19%
	12 hours or longer but less than 18 hours	0	0%	17	13%	950	14%
	18 hours or longer	0	0%	22	17%	1328	20%
	Missing	192		15		948	
C2	During your labour, were you able to move around and choose the position that made you most comfortable?						
	Yes most of the time	0	0%	65	56%	3727	64%
	Yes some of the time	0	0%	38	32%	1624	28%
	No not at all	0	0%	14	12%	501	9%
	No but it was not possible to move around	0	0%	10	8%	831	12%
	Missing	192		19		977	
C3	During your labour and birth, did you use any of the following to help relieve the pain?						
a.	Natural methods (e.g. breathing massage)	49	26%	42	29%	3079	40%
	Missing	143		104		4581	
b.	Water or a birthing pool	4	2%	11	8%	814	11%
	Missing	188		135		6846	
C.	TENS Machine (with pads on your back)	5	3%	7	5%	1222	16%
	Missing	187		139		6438	
d.	Gas and air (breathing through a mask)	124	65%	95	65%	5420	71%
	Missing	68		51		2240	
e.	Injection of pethidine or a similar painkiller	54	28%	31	21%	2100	27%
	Missing	138		115		5560	
f.	Epidural or similar (injection in your back given by an anaesthetist)	28	15%	26	18%	1965	26%
	Missing	164		120		5695	
g.	Other	1	1%	4	3%	125	2%
	Missing	191		142		7535	
h.	l did not use any pain relief	13	7%	12	8%	430	6%
	Missing	179		134		7230	
C4	During your labour and birth, did you feel you got the pain relief you wanted?						
	Yes definitely	76	60%	67	59%	3800	65%
	Yes to some extent	35	28%	35	31%	1544	26%
	No	11	9%	10	9%	449	8%
	No but it was not possible to have any pain relief (e.g. there was not	20	13%	5	4%	539	8%
	time)						
	l did not want any pain relief	5	3%	6	5%	282	4%
	Don't know / Can't remember	4	3%	2	2%	38	1%
	Missing	41		21		1008	

YO	UR LABOUR AND THE BIRTH OF YOUR BABY	Total	SWAT	B-(3/1	12062	(þ) Total	All
C5	Where was your baby born? In hospital In a birth centre/maternity unit separate from hospital At home Other Missing	157 4 0 31	98% 2% 0% 0%	123 2 2 0 19	97% 2% 2% 0%	6632 273 204 7 544	93% 4% 3% 0%
C6	Thinking about the birth of your baby, what kind of delivery did you have? (If you had twins or more than two babies this time, please fill in this question about the baby which was born first)						
	A normal vaginal delivery An assisted vaginal delivery (e.g. with forceps or ventouse suction cup) A planned caesarean delivery An emergency caesarean delivery Missing	0 0 0 192	0% 0% 0%	91 15 9 23 8	66% 11% 7% 17%	4596 1096 770 1102 96	61% 14% 10% 15%
C7	Where did you give birth? On a bed On the floor In water or in a birthing pool Other Missing	130 1 1 1 59	98% 1% 1% 1%	106 0 2 3 35	95% 0% 2% 3%	5137 239 228 127 1929	90% 4% 4% 2%
C8	What position were you in when your baby was born? Sitting / sitting supported by pillows On my side Standing squatting or kneeling Lying / lying supported by pillows Lying with legs in stirrups Other Missing	42 3 48 32 2 62	32% 2% 37% 25% 2%	26 8 6 42 26 0 38	24% 7% 6% 39% 24% 0%	1031 260 684 1827 1739 137 1982	18% 5% 12% 32% 31% 2%
C9	If you had an episiotomy (cut) or tear requiring stitches, how long after your baby was born were the stitches done? I did not have an episiotomy (cut) or a tear I did not have stitches Within 20 minutes 20 minutes to 1 hour More than 1 hour Don't know / Can't remember Missing	26 27 27 24 6 2 80	23% 24% 46% 41% 10% 3%	35 11 27 10 8 7 48	36% 11% 52% 19% 15% 13%	1390 497 1944 981 397 156 2295	26% 9% 56% 28% 11% 4%
C10	Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth? Yes No No but this was not possible for medical reasons I did not want skin to skin contact with my baby Missing	0 0 0 192	0% 0% 0%	100 31 8 2 5	76% 24% 6% 1%	5741 1030 643 159 87	85% 15% 8% 2%

YOUR LABOUR AND THE BIRTH OF YOUR BABY	Total	SWAFT	Br (3/1	1)2062	(þ) Total	All
C11 Had you met any of the staff who cared for you during your labour and birth before you went into labour?						
Yes	50	27%	52	36%	1925	25%
No	131	70%	87	61%	5574	73%
Don't know / Can't remember	7	4%	4	3%	103	1%
Missing	4		3		58	
C12 Did you have confidence and trust in the staff caring for you during your labour and birth?						
Yes definitely	110	58%	98	68%	5536	73%
Yes to some extent	74	39%	37	26%	1708	22%
No	4	2%	6	4%	313	4%
Don't know / Can't remember	1	1%	3	2%	35	0%
Missing	3		2		68	
C13 If you had a partner or a companion with you during your labour and delivery, were they made welcome by the staff?						
Yes definitely	0	0%	102	75%	6194	83%
Yes to some extent	0	0%	27	20%	1085	14%
No	0	0%	5	4%	170	2%
I did not have a partner or a companion with me	0	0%	8	6%	109	1%
Don't know / Can't say	0	0%	2	1%	48	1%
Missing	192		2		54	
C14 Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you?						
Yes during labour	32	17%	19	14%	873	12%
Yes shortly after the birth	27	14%	15	11%	451	6%
Yes during labour and shortly after the birth	14	7%	9	7%	310	4%
No not at all	115	61%	95	69%	5852	78%
Missing	4		8		174	
C15 Thinking about your care during labour and birth, were you spoken to in a way you could understand?						
Yes always	140	75%	112	78%	6257	82%
Yes sometimes	41	22%	23	16%	1064	14%
No	4	2%	7	5%	224	3%
Don't know / Can't remember	2	1%	2	1%	54	1%
Missing	5		2		61	
C16 Thinking about your care during labour and birth, were you involved enough in decisions about your care?						
Yes always	0	0%	92	64%	5232	70%
Yes sometimes	0	0%	38	27%	1748	23%
No	0	0%	8	6%	436	6%
I did not want / need to be involved	0	0%	1	1%	91	1%
Don't know / Can't remember	0	0%	5	3%	85	1%
Missing	192		2		68	

YOUR LABOUR AND THE BIRTH OF YOUR BABY

C17 Overall, how would you rate the care received during your

labour and birth?						
Excellent	78	42%	61	42%	4206	56%
Very good	57	30%	46	32%	2043	27%
Good	25	13%	23	16%	746	10%
Fair	21	11%	4	3%	280	4%
Poor	6	3%	10	7%	255	3%
Missing	5		2		130	

CA	RE IN HOSPITAL AFTER BIRTH (POSTNATAL CARE)	Total	SWBI	FB-(3/1	1,062	(þ) Total	All
D1	How long did you stay in hospital after your baby was born?						
	Up to 12 hours	0	0%	22	15%	1158	16%
	More than 12 hours but less than 24 hours	0	0%	32	23%	1410	19%
	1 to 2 days	0	0%	53	37%	2603	36%
	3 to 4 days	0	0%	29	20%	1460	20%
	5 or more days	0	0%	6	4%	675	9%
	Missing	192		4		354	
D2	Looking back, do you feel that the length of your stay in hospital after the birth was:						
	Too long	27	15%	16	11%	1147	16%
	Too short	28	15%	24	17%	852	12%
	About right	120	65%	94	66%	5121	70%
	Not sure / Don't remember	11	6%	8	6%	189	3%
	Missing	6		4		351	
D3	Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?						
	Yes always	119	65%	86	61%	3717	51%
	Yes sometimes	48	26%	42	30%	2657	36%
	No	15	8%	13	9%	917	13%
	Don't know / Can't remember	1	1%	2	1%	36	0%
	Missing	9		3		333	
D4	Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?						
	Yes always	118	65%	84	59%	4293	59%
	Yes sometimes	48	26%	47	33%	2410	33%
	No	16	9%	11	8%	581	8%
	Don't know / Can't remember	0	0%	1	1%	25	0%
	Missing	10		3		351	

FEE	EDING YOUR BABY	Total	SWBT	Brotal1	1 2062	(þ) Total	All
E1	During your pregnancy did your midwife discuss infant feeding with you?						
	Yes definitely	0	0%	79	55%	4234	56%
	Yes to some extent	0	0%	37	26%	2047	27%
	No	0	0%	22	15%	1158	15%
	Don't know / Can't remember	0	0%	6	4%	117	2%
	Missing	192		2		104	
E2	In the first few days after the birth how was your baby fed?						
	Breast milk (or expressed breast milk) only	74	39%	60	42%	4391	58%
	Both breast and formula (bottle) milk	52	28%	35	24%	1496	20%
	Formula (bottle) milk only	62	33%	47	33%	1654	22%
	Not sure	0	0%	1	1%	12	0%
	Missing	4		3		107	
E3	Did you ever put your baby to the breast (even if it was only once)?						
	Yes	0	0%	13	27%	427	25%
	No	0	0%	35	73%	1250	75%
	Missing	192		98		5983	
E4	Thinking about feeding your baby (breast or bottle) did you feel that midwives and other carers gave you consistent advice?						
	Yes always	69	39%	64	44%	2690	37%
	Yes generally	70	40%	53	37%	3046	42%
	No	35	20%	24	17%	1514	21%
	Don't know	3	2%	3	2%	54	1%
	I didn't want or need this	8	4%	1	1%	257	3%
	Missing	7		1		99	
E5	Did you feel that midwives and other carers gave you active						
	support and encouragement?		10 0 (
	Yes always	75	42%	62	44%	3250	44%
	Yes generally	65 20	37%	58	41%	3047	41%
	No Dep't know	36	20%	18	13%	1056	14%
	Don't know	1	1% 2%	3	2% 1%	44 150	1% 2%
	I didn't want or need this Missing	5 10	3%	2 3	170	158 105	2%
	Missing	10		3		105	

CARE AT HOME AFTER THE BIRTH		Total	SWAT	B-(3/1	1 ,062	(þ) Total	All
F1	When you were at home after the birth of your baby did you have the name and telephone number of a midwife or health visitor you could contact if you were worried?						
	Yes	177	94%	137	94%	7155	95%
	No	10	5%	6	4%	349	5%
	Don't know / Can't remember	2	1%	2	1%	51	1%
	Missing	3		1		105	
F2	If you contacted a midwife or health visitor, were you given the help you needed?						
	Yes always	0	0%	76	75%	3992	75%
	Yes sometimes	0	0%	20	20%	1089	21%
	No	0	0%	5	5%	224	4%
	I did not contact a midwife or health visitor	0	0%	42	29%	2215	29%
	Missing	192		3		140	
F3	Since your baby's birth have you been visited at home by a midwife?						
	Yes	0	0%	143	99%	7410	98%
	No I visited the midwife or saw a midwife in a clinic	0	0%	0	0%	48	1%
	No I was not offered a visit	0	0%	0	0%	21	0%
	No I was visiting or staying near my baby in a neonatal unit (NNU NICU SCBU)	0	0%	1	1%	71	1%
	No for another reason	0	0%	1	1%	12	0%
	Missing	192		1		98	
F4	How many times in total did you see a midwife after you went home?						
	1 - 2	0	0%	28	20%	1778	24%
	3 - 4	0	0%	82	58%	3926	53%
	5 - 6	0	0%	24	17%	1215	16%
	7 times or more	0	0%	6	4%	444	6%
	Don't know / Can't remember	0	0%	2	1%	83	1%
	Missing	192		4		214	
F5	Would you have liked to have seen a midwife						
	More often	58	31%	41	29%	1594	22%
	Less often	13	7%	10	7%	290	4%
	I saw a midwife as much as I wanted	117	62%	90	64%	5524	75%
	Missing	4		5		252	
F6	In the six weeks after the birth of your baby did you receive help and advice from health professionals about feeding your baby?						
	Yes definitely	109	64%	58	43%	3443	52%
	Yes to some extent	109 41	04% 24%	50 48	43% 36%	3443 2218	32 <i>%</i> 34%
	No	41 19	24% 11%	40 28	30 <i>%</i> 21%	2218 907	34 <i>%</i> 14%
	Did not need any	17	9%	20 10	21 <i>%</i> 7%	907 937	12%
	Missing	6	570	2	770	155	12/0
		0		2		100	

CAF	RE AT HOME AFTER THE BIRTH	Total	SWA	Brotal1	1)20102	(þ) Total	AII
F7	In the six weeks after the birth of your baby did you receive help and advice from health professionals about your baby's health and progress?						
	Yes definitely	112	64%	87	62%	4666	64%
	Yes to some extent	49	28%	43	31%	2240	31%
	No	13	7%	10	7%	385	5%
	Did not need any	13	7%	2	1%	234	3%
	Missing	5		4		135	
F8	Did you have a postnatal check-up of your own health? (Around 4-8 weeks after the birth)						
	Yes	158	83%	110	78%	6655	89%
	No	32	17%	31	22%	861	11%
	Missing	2		5		144	
F9	Were you given enough information about your own recovery after the birth?						
	Yes definitely	0	0%	62	44%	3164	43%
	Yes to some extent	0	0%	46	33%	2893	39%
	No	0	0%	29	21%	1258	17%
	No but I did not need this information	0	0%	2	1%	155	2%
	Don't know / Can't remember	0	0%	3	2%	55	1%
	Missing	192		4		135	
F10	Were you given enough information about any emotional changes you might experience after the birth?						
	Yes definitely	0	0%	58	42%	3112	43%
	Yes to some extent	0	0%	40	29%	2620	37%
	No	0	0%	37	27%	1355	19%
	No but I did not need this information	0	0%	2	1%	368	5%
	Don't know / Can't remember	0	0%	3	2%	69	1%
	Missing	192		6		136	
F11	Were you given information or offered advice from a health professional about contraception?						
	Yes	174	92%	129	91%	6789	90%
	No	14	7%	8	6%	629	8%
	Don't know / Can't remember	2	1%	5	4%	109	1%
	Missing	2		4		133	
F12	Overall, how would you rate the care received after the birth?						
	Excellent	57	30%	35	25%	2347	31%
	Very good	49	26%	56	39%	2636	35%
	Good	35	19%	30	21%	1569	21%
	Fair	28	15%	15	11%	659	9%
	Poor	18	10%	6	4%	278	4%
	Missing	5		4		171	

YO	J AND YOUR HOUSEHOLD	Total	SWA	F <mark>B- (3/</mark> 1	1,062	(þ) Total	AII
G1	Have you had a previous pregnancy? Yes No Missing	115 73 4	61% 39%	82 58 6	59% 41%	4231 3297 132	56% 44%
G2	How many babies have you given birth to before this pregnancy?						
	None	8	7%	7	8%	444	10%
	1-2	87	75%	56	67%	3383	80%
	3 or more	21	18%	20	24%	425	10%
	Missing	76		63		3408	
G3	Age:						
	16 - 24	50	29%	45	34%	1105	15%
	25 - 34	87	51%	66	49%	4060	56%
	35 - 44	34	20%	22	16%	2035	28%
	45 - 54	0	0%	1	1%	40	1%
	55+	0	0%	0	0%	5	0%
	Missing	21		12		415	
G4	Whe do you live with now?						
64	Who do you live with now? I live alone (with or without my baby / children)	0	0%	14	10%	567	8%
	With a partner/husband/boyfriend (with or without any children)	0	0%	96	69%	6401	86%
		-					
	With family members other than a partner/husband/boyfriend (e.g.	0	0%	26	19%	425	6%
	parents)	0	00/	0	4.07	~~~	00/
	With friends	0	0%	2	1%	22	0%
	Other Missing	0	0%	1 7	1%	39 206	1%
	Missing	192		1		206	
G5	What language do you speak most often at home?						
05	English	128	74%	100	73%	6557	88%
	Other European language	8	5%	7	5%	325	4%
	Asian Language	31	18%	23	17%	317	4%
	African language	4	2%	20	1%	131	2%
	Other including British Sign Language	2	1%	5	4%	99	1%
	Missing	19	.,,	9	. / 0	231	. , 0
	.			-		÷.	

YOU AND YOUR HOUSEHOLD

All

G6 Do you have any of the following long-standing conditions?

a.	Deafness or severe hearing impairment Missing	0 192	0%	1 145	1%	48 7612	1%
b.	Blindness or partially sighted Missing	0 192	0%	1 145	1%	22 7638	0%
c.	A long-standing physical condition Missing	0 192	0%	2 144	1%	143 7517	2%
d.	A learning disability Missing	0 192	0%	2 144	1%	56 7604	1%
e.	A mental health condition Missing	0 192	0%	2 144	1%	127 7533	2%
f.	A long-standing illness such as cancer HIV diabetes chronic heart desease or epilepsy	0	0%	5	3%	143	2%
	Missing	192		141		7517	
g.	No I do not have a long-standing condition Missing	0 192	0%	118 28	81%	6734 926	88%
G7	Does this condition(s) cause you difficulty with any of the following?						
a.	Everyday activities that people your age can usually do Missing	0 0	0%	4 12	25%	144 404	26%
b.	At work in education or training Missing	0 0	0%	2 14	13%	99 449	18%
c.	Access to building streets or vehicles Missing	0 0	0%	1 15	6%	29 519	5%
d.	Reading or writing Missing	0 0	0%	4 12	25%	54 494	10%
e.	People's attitudes to you because of your condition Missing	0 0	0%	1 15	6%	56 492	10%
f.	Communicating mixing with others or socialising Missing	0 0	0%	0 16	0%	86 462	16%
g.	Any other activity Missing	0 0	0%	1 15	6%	63 485	11%
h.	No difficulty with any of these Missing	0 0	0%	10 6	63%	261 287	48%

YOU AND YOUR HOUSEHOLD

G8 To which of these ethnic groups would you say you belong?

British	76	41%	57	41%	5729	77%
Irish	1	1%	2	1%	50	1%
Any other White background	9	5%	5	4%	580	8%
White and Black Caribbean	6	3%	3	2%	33	0%
White and Black African	0	0%	1	1%	25	0%
White and Asian	1	1%	0	0%	26	0%
Any other mixed background	0	0%	0	0%	37	0%
Indian	31	17%	18	13%	198	3%
Pakistani	17	9%	23	17%	160	2%
Bangladeshi	7	4%	3	2%	59	1%
Any other Asian background	2	1%	5	4%	96	1%
Caribbean	12	7%	13	9%	81	1%
African	16	9%	6	4%	301	4%
Any other Black background	1	1%	0	0%	12	0%
Chinese	3	2%	1	1%	56	1%
Any other ethnic group	2	1%	2	1%	39	1%
Missing	8		7		178	

Patient survey report 2010



Survey of women's experiences of maternity services 2010 Sandwell and West Birmingham Hospitals NHS Trust

The national survey of women's experiences of maternity services 2010 was designed, developed and co-ordinated by the Surveys Co-ordination Centre for the NHS Patient Survey Programme at Picker Institute Europe.



making patients' views count

National NHS patient survey programme Survey of women's experiences of maternity services 2010

The Care Quality Commission

The Care Quality Commission is the independent regulator of health and adult social care services in England. We also protect the interests of people whose rights are restricted under the Mental Health Act.

Whether services are provided by the NHS, local authorities, private companies or voluntary organisations, we make sure that people get better care. We do this by:

- Driving improvement across health and adult social care.
- Putting people first and championing their rights.
- Acting swiftly to remedy bad practice.
- Gathering and using knowledge and expertise, and working with others.

Survey of women's experiences of maternity services 2010

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

This report shows the results of the second survey of maternity services provided by NHS trusts in England. It shows how each trust scored on a number of questions in the survey, compared with national average results¹. The report enables you to understand the trust's performance, and to identify areas where it needs to improve.

Results for each trust are also displayed in the CQC 'Care Directory', where it is possible to see whether a trust performed 'better' or 'worse' than the majority of other trusts. National overall results for the 2010 survey compared with the results for the 2007 survey are also available, alongside an explanation of the key issues. These documents were produced by the Surveys Co-ordination Centre at Picker Institute Europe.

A similar survey of women using maternity services was also carried out in 2007. These surveys are part of a wider programme of NHS patient surveys, which cover a range of topics including mental health services, adult inpatient and outpatient services, and ambulance services. To find out more about our programme, please visit our website (see 'further information' section).

About the survey

The second survey of maternity services involved 142 NHS acute trusts and 2 primary care trusts (PCTs). We received responses from over 25,000 women, a response rate of 52%. Women were eligible for the survey if they had a live birth between 1-28 February 2010 and were aged 16 years or older². Women who had a home birth were also eligible.

Interpreting the report

For each of the 19 survey questions reported here, individual responses were converted into scores on a scale of 0 to 100. A score of 100 represents the best possible response. Therefore, the higher

¹This report provides results for 19 questions where care is provided by NHS acute trusts in England. We do not include the remaining questions that relate to care provided by the local primary care trust; however results for these questions have been provided directly to those trusts.

²Some trusts with a small number of women delivering in February would have also included women who gave birth in January 2010. For further details on women excluded from the survey, please see the survey guidance manual at: <u>http://www.nhssurveys.org/Filestore//documents/Maternity_Survey_Guidance_2010_v7.pdf</u>

the score for each question, the better the trust is performing³.

Please note: the scores are **not percentages**, so a score of 80 does not mean that 80% of people who have used services in the trust have had a particular experience (e.g. ticked 'Yes' to a particular question), it means that the trust has scored 80 out of a maximum of 100. A 'scored' questionnaire showing the scores assigned to each question is available on our website (see further information' section).

Please also note that it is not appropriate to score all questions within the questionnaire for benchmarking purposes. This is because not all of the questions assess the trusts in any way, or they may be 'filter questions' designed to filter out respondents to whom following questions do not apply. An example of such a question would be C6: "Thinking about the birth of your baby, what kind of delivery did you have?"

The graphs included in this report display the scores for this trust, compared with national benchmark scores. Each bar represents the range of results for each question across all trusts that took part in the survey. In the graphs, the bar is divided into three sections:

- The red section (left hand end) shows the scores for the 20% of trusts with the lowest scores.
- The green section (right hand end) shows the scores for the 20% of trusts with the highest scores.
- The orange section (middle section) represents the range of scores for the remaining 60% of trusts.

A white diamond represents the score for this trust. If the diamond is in the green section of the bar, for example, it means that the trust is among the top 20% of trusts in England for that question. The line on either side of the diamond shows the amount of uncertainty surrounding the trust's score, as a result of random fluctuation⁴.

Since the score is based on a sample of women in a trust rather than all women who have given birth, the score may not be exactly the same as if everyone had been surveyed and had responded. Therefore we calculate a confidence interval⁵ as a measure of how accurate the score is. We can be 95% certain that if everyone in the trust had been surveyed, the 'true' score would fall within this interval.

³Trusts have differing profiles of maternity service users; for example, one trust may have more 'first time' mothers than another. This is significant because it strongly influences women's experiences and could potentially lead to a trust's results appearing better or worse than if they had a slightly different profile of maternity service users. To account for this, we 'standardise' the data. Results have been standardised by parity (whether women have given birth previously) and age of respondent, to ensure that no trust will appear better or worse than another because of its respondent profile. This helps to ensure that each trust's age-parity profile reflects the national age-parity distribution (based on all of the respondents to the survey). It therefore enables a more accurate comparison of results from trusts with different profiles of maternity service users.

⁴If a score is on the 'threshold' for the highest scoring 20% of trusts (if the white diamond is on the line separating green and orange), this means that the score is one of the highest 20% of scores for that question. Similarly, trusts with scores on the threshold for the lowest scoring 20% of trusts are included in this lowest 20% of scores.

⁵A confidence interval is an upper and lower limit within which you have a stated level of confidence that the true mean (average) lies somewhere in that range. These are commonly quoted as 95% confidence intervals, which are constructed so that you can be 95% certain that the true mean lies between these limits. The width of the confidence interval gives some indication of how cautious we should be; a very wide interval may indicate that more data should be collected before making any conclusions.

When considering how a trust performs, it is very important to consider the confidence interval surrounding the score. If a trust's average score is in one colour, but either of its confidence limits are shown as falling into another colour, this means that you should be more cautious about the trust's result because, if the survey was repeated with a different random sample of patients, it is possible their average score would be in a different place and would therefore show as a different colour.

The white diamond (score) is not shown for questions answered by fewer than 30 people because the uncertainty around the result would be too great. When identifying trusts with the highest and lowest scores and thresholds, trusts with fewer than 30 respondents have not been included.

At the end of the report you will find the data used for the charts and background information about the patients that responded.

Notes on specific questions

Question B5: "Were you given a choice of having your baby at home?" This question was only answered by women who answered 'yes' to question B4 (At the start of your pregnancy did you have a choice about where you could have your baby?").

Questions C2 and C4: "During your labour, were you able to move around and choose the position that made you most comfortable?" and "During your labour and birth, did you feel you got the pain relief you wanted?" were not answered by women who had a planned caesarean.

Questions D2, D3 and D4: "Looking back, do you feel that the length of your stay in hospital after the birth was...", "Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?" and "Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?" were not answered by women who had a home birth and did not go to hospital.

Further information

Full details of the methodology of the survey can be found at: http://www.nhssurveys.org/

More information on the programme of NHS patient surveys is available on the patient survey section of the website at:

http://www.cqc.org.uk/patientsurveys.cfm

The results for each trust will also be available under the organisation search tool of the CQC website:

<u>http://caredirectory.cqc.org.uk/caredirectory/searchthecaredirectory.cfm</u> (Enter a postcode or organisation name, then scroll down to 'What people said about this trust')

Results, questionnaire and scoring for the 2010 survey of women's experiences of maternity services can be found at: http://www.cqc.org.uk/maternitysurvey2010.cfm

Results from the 2007 survey of maternity services can be found at: <u>http://www.cqc.org.uk/maternityservices2007</u>

Survey of women's experiences of maternity services 2010 Sandwell and West Birmingham Hospitals NHS Trust

Care during pregnancy (Antenatal Care)

Were you given a choice of having your baby at home?

Dating scan: was the reason for this scan clearly explained to you?

Were the reasons for having a screening test for Down's syndrome clearly explained to you?

20 week scan: was the reason for this scan clearly explained to you?

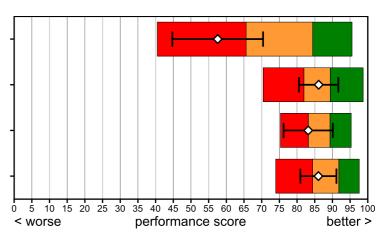
Labour and birth

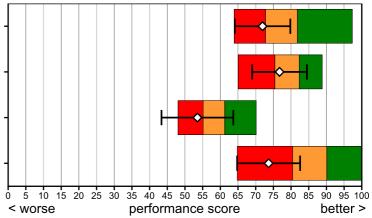
During labour, could you move around and choose the most comfortable position?

During labour and birth, did you get the pain relief you wanted?

If you had a cut or tear requiring stitches, how soon after the birth were the stitches done?

Did you have skin to skin contact with your baby shortly after the birth?





	Best performing 20% of trusts	\diamond	This trust (vertical lines show amount of uncertainty as a result of random	
	Intermediate 60% of trusts		fluctuation)	
	Worst performing 20% of trusts			
This trust's results are not shown if there were fewer than 30 respondents.				

Survey of women's experiences of maternity services 2010 Sandwell and West Birmingham Hospitals NHS Trust

Staff during labour and birth

Did you have confidence and trust in the staff caring for you during the labour and birth?

If you had a partner or a companion with you during your labour and delivery, were they made welcome by the staff?

Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you?

Thinking about your care during labour and birth, were you spoken to in a way you could understand?

Thinking about your care during labour and birth, were you involved enough in decisions about your care?

Overall, how would you rate the care received during your labour and birth?

Care in hospital after the birth (Postnatal care)

Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?

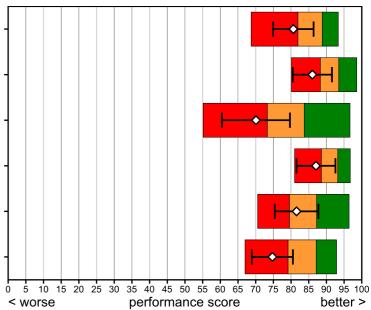
After the birth of your baby, were you given the information or explanations you needed?

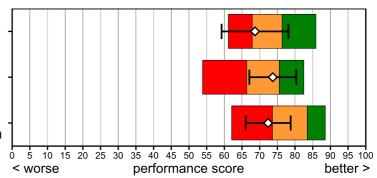
After the birth of your baby, were you treated with kindness and understanding?

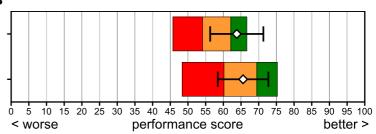
Feeding the baby during the first few days

Did you feel that midwives and other carers gave you consistent advice?

Did you feel that midwives and other carers gave you active support and encouragement?







This trust (vertical lines show amount of uncertainty as a result of random fluctuation)

Worst performing 20% of trusts

Best performing 20% of trusts

Intermediate 60% of trusts

This trust's results are not shown if there were fewer than 30 respondents.

SWBTB (3/11) 062 (c) Survey of women's experiences of maternity services 2010							
Sandwell and West Birmingham Hospitals NHS Trust	Scores for this NHS trust	Interval Lower	Upper 95% Confidence	Threshold for the lowest scoring 20% of NHS Trusts	Threshold for the highest scoring 20% of NHS Trusts	Highest score achieved (all trusts)	Number of respondents (this trust)
Care during pregnancy (Antenatal Care)							
B5 Were you given a choice of having your baby at home?	58	45	70	66	84	96	90
B15 Dating scan: was the reason for this scan clearly explained to you?	86	81	92	82	89	99	129
B17 Were the reasons for having a screening test for Down's syndrome clearly explained to you?	83	76	90	83	89	95	124
B19 20 week scan: was the reason for this scan clearly explained to you?	86	81	91	84	92	98	133
Labour and birth							
C2 During labour, could you move around and choose the most comfortable position?	72	64	80	73	82	97	112
C4 During labour and birth, did you get the pain relief you wanted?	77	69	84	75	82	89	106
C9 If you had a cut or tear requiring stitches, how soon after the birth were the stitches done?	54	43	64	55	61	70	44
C10 Did you have skin to skin contact with your baby shortly after the birth?	74	65	83	80	90	100	128
Staff during labour and birth							
C12 Did you have confidence and trust in the staff caring for you during the labour and birth?	81	75	86	82	89	93	137
C13 If you had a partner or a companion with you during your labour and delivery, were they made welcome by the staff?	86	80	92	88	94	99	130
C14 Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you?	70	60	80	73	84	97	134
C15 Thinking about your care during labour and birth, were you spoken to in a way you could understand?	87	82	93	89	93	97	138
C16 Thinking about your care during labour and birth, were you involved enough in decisions about your care?	82	75	88	80	87	96	134
C17 Overall, how would you rate the care received during your labour and birth?	75	69	81	79	87	93	140
Care in hospital after the birth (Postnatal care)							
D2 Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?	69	59	78	68	76	86	131
D3 After the birth of your baby, were you given the information or explanations you needed?	74	67	80	66	76	82	137
D4 After the birth of your baby, were you treated with kindness and understanding?	72	66	79	74	83	89	138

Su	rvey of women's experiences of maternity ser	vices	S۱ 2 01 s	//BTE 0	3 (3/1	1) 06	2 (c)	
Saı Tru	ndwell and West Birmingham Hospitals NHS ist	Scores for this NHS trust		Upper 95% Confidence	Threshold for the lowest scoring 20% of NHS Trusts	Threshold for the highest scoring 20% of NHS Trusts	Highest score achieved (all trusts)	Number of respondents (this trust)
Fee	eding the baby during the first few days							
E4	Did you feel that midwives and other carers gave you consistent advice?	64	56	71	54	62	67	138
E5	Did you feel that midwives and other carers gave you active support and encouragement?	66	58	73	60	69	75	134

SWBTB (3/11) 062 (c) Survey of women's experiences of maternity services 2010 Sandwell and West Birmingham Hospitals NHS Trust

Background information

-		
The sample	This trust	All trusts
Number of respondents	145	25488
Response Rate (percentage)	35	52
Demographic characteristics	This trust	All trusts
Percentage of mothers	(%)	(%)
First-time	46	(70)
Who have previously given birth	54	51
Age group (percentage)	(%)	(%)
Aged 16-18	4	1
Aged 19-24	27	13
Aged 25-29	23	23
Aged 30-34	28	33
Aged 35 and over	18	29
Ethnic group (percentage)	(%)	(%)
White	44	84
Mixed	3	2
Asian or Asian British	34	7
Black or Black British	13	4
Chinese or other ethnic group	2	1
Not known	4	2

Summary Report

on the

Serenity Maternity Unit Survey

for

Sandwell and West Birmingham Hospitals



Prepared by: Client contacts: Peter Jackling, IDAC 04 February 2011 (version 1) Jessamy Kinghorn

SWBH Serenity Maternity Unit Survey

Introduction and objectives:	Page 3
Summary	Page 4
Methodology:	Page 5
Sample structure and response rate:	Page 6
Main findings:	
- Ratings and experiences	Page 7
- Comments about the experience	Page 17

1. Introduction and Objectives:

In May 2010 Sandwell and West Birmingham Hospitals Trust opened a new maternity unity at City hospital: Serenity. As part of the Trust's efforts to establish satisfaction with their services at both City and Sandwell hospitals, research has been done among mothers of babies born both before and after the opening of the new unit.

The two key research objectives were:

- To establish patient opinions and levels of satisfaction with the maternity services provided by the Trust
- To establish the impact the new Serenity unit has had on patient opinions and satisfaction.

32 completed questionnaires were returned from patients prior to the new unit, and 78 from patients following the opening of the unit. These have all been included for analysis. However, the very small number of 'pre' respondents means that comparisons should be treated with some caution.

This report summarises the main survey findings, which in tabular form have been analysed in full for each question in the questionnaires, cross-profiled by (where given): hospital, how far into pregnancy when admitted, whether it was the first baby, birth aides used, overall satisfaction with the care provided, and age groups. For each question the tabulations show numbers and percentages giving each answer.

For questions with open-ended text, the verbatim answers have been coded for analysis. The full detailed tabulations have been provided in advance.

2. Conclusions / Executive Summary:

The survey findings indicate levels of satisfaction before and after the new unit was opened, and indicate a substantial improvement in satisfaction with the overall quality of care perceived.

Although the bases are quite low, the message is consistent and clear: patients who have been through Serenity as very significantly happier and more satisfied, overall and on every aspect, and would want to return.

	<u>% 'very good' or 'all the time'</u>				
Aspects:	<u>'Pre'</u>	<u>Serenity</u>			
Overall rating of experience:	22%	83%			
Rating of quality of care:	31%	78%			
Confidence in midwives?	63%	85%			
Information given:	22%	56%			
Cleanliness of delivery room:	44%	90%			
Made to feel welcome:	31%	81%			
Feel staff listened to me:	38%	72%			
Polite, courteous, respectful	50%	81%			
Kept informed?:	28%	77%			
Staff valued my point of view?	34%	73%			
Staff were caring and kind?	44%	85%			
Staff kept me involved?	34%	71%			
Staff went the 'extra mile'?	9%	53%			
Delivery suite environment:	31%	90%			
Delivery suite facilities:	28%	88%			

Patients in Serenity also reported feeling less afraid during their labour.

Things to work on: maintaining these high standards. Some mentioned poor aftercare, insufficient support for breastfeeding, a long wait in triage, insufficient or unclear information, or thought they were sent home too soon.

3. Methodology:

The survey was conducted during November 2010 to January 2011, after the opening of the Serenity unit, based on 283 patients from the old unit and 309 from the new unit. Responses are lower among patients at the old unit since they were contacted much longer after their hospital stay.

Patients were given a freepost reply envelope and a sheet offering to translate the survey into any of 31 languages if required. They were asked to complete the questionnaire within three weeks of receipt, and to post the forms direct to SWBH using FREEPOST envelopes supplied. No reminders were sent. In a covering which explained the purposes of the research, patients were given assurances about confidentiality, that the analysis would be done on an anonymous basis, and that in accordance with the Data Protection Act there would be no come back to them unless they specifically request it.

From the 592 sent out, 32 pre and 78 post Serenity completed questionnaires were received in time for analysis, response rates of 11% pre and 25% for Serenity. The latter is reasonable for such surveys and would provide 95% confidence limits of \pm 9% points at the 50% level.

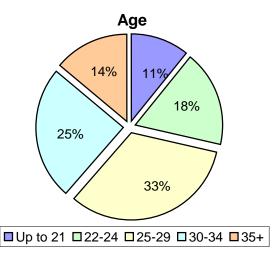
Responses have been entered and analysed on an anonymous basis by IDA to produce the aggregated tabulated results and listings of verbatim responses to open questions, in accordance with the code of conduct of the Market Research Society. In this report comments are made when there are significant differences between responses in different profile groups. However, it should be noted that some of the groups (especially Ethnicity) are quite small and so differences may not be statistically significant.

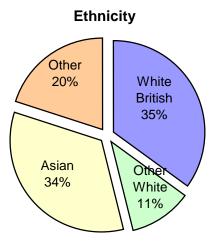
The questionnaire was designed by SWBH and would take under 15 minutes to complete.

4. Sample Profile:

Among patients attending before Serenity was opened, two thirds went to Sandwell, where they had planned to have their baby. All patients after October 2010 went to City hospital, again, as planned, among nearly all.

Mothers entering hospital to have their baby have an average age of 28 – slightly less when it is their first. Across both samples. nearly two thirds of mothers are aged under 30.





In terms of ethnicity, across both samples there is a culturally diverse mix, with roughly equal numbers of White British patients and those of Asian background.

Also across samples, a few, 3%, say they consider themselves disabled, but do not say what form that takes. Asked their sexual orientation, 40% did not wish to state, 56% said they are heterosexual, and 5% were bisexual. On religion, a quarter did not wish to state. A third said they were Christians, 26% Islamic, 4% Sikh, 3% Atheists, and 7% 'other'.

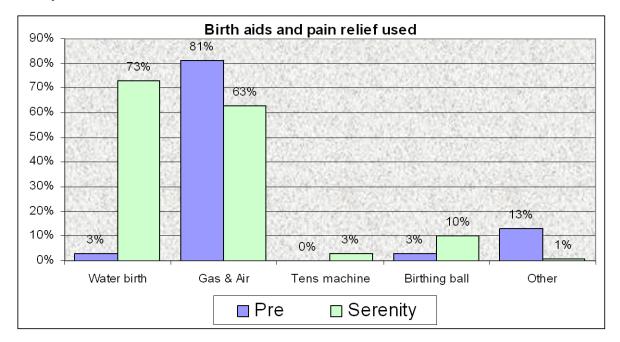
5. Main findings:

In both samples, the majority (about three-quarters) of patients arrived by car, the rest by taxi, or a few by emergency ambulance. Most were at least 38 weeks into their pregnancy – all were at least 36 weeks in. Irrespective of the unit, patients say that their baby was delivered on average 13-14 hours after going into labour, and for about half this was their first baby.

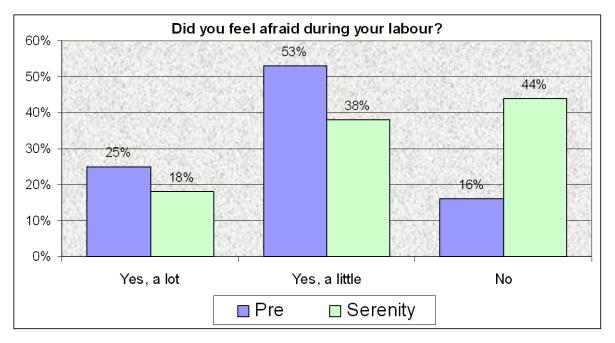
Waiting time to see a midwife was slightly longer among patients at the new unit (average nearly 10 minutes, with 12% waiting longer than 20 minutes, a few more than an hour) than before Serenity opened (average 6 minutes).

Roughly half of maternity patients say they had a birth plan, especially those for whom it was their first, and most (77% pre, 90% post) felt that their midwives tried to keep to the plan. Keeping to the birth plan contributes to overall satisfaction: 97% of those who were very satisfied with their care had a birth plan which was kept to.

Water births are greatly used among patients in Serenity, hardly ever before, whilst the use of Gas & Air has declined somewhat, although it is still used in nearly two thirds of cases. 10% now use a birth ball.

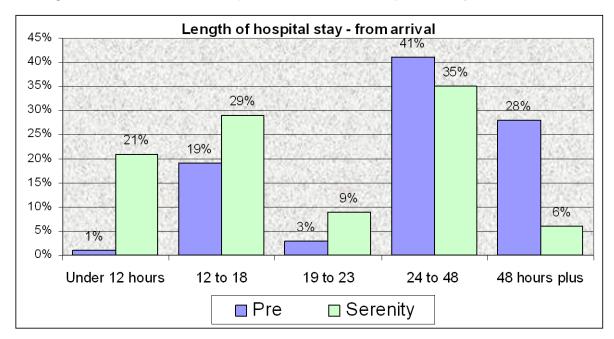


Patients using Serenity are considerably less likely to report **feeling afraid** during their labour, although, naturally, first-time mothers still tend to be the more apprehensive. 44% of mothers using Serenity said they did not feel at all afraid, compared with 16% before.



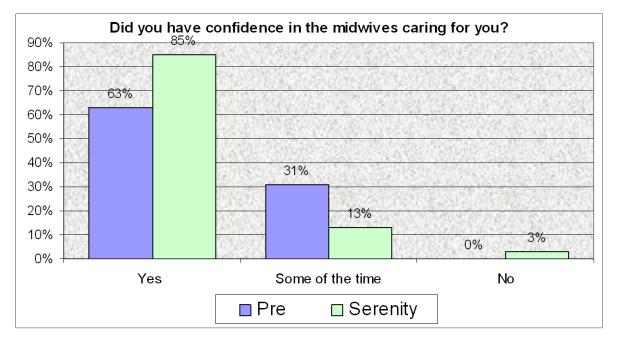
Rather more so at Serenity (94%) than before (84%), patients said they felt midwives gave them enough reassurance and support through their labour and childbirth.

The opening of Serenity appears to have resulted in shorter hospital stays: an average of 36 hours now compared with 44 hours previously.



After the baby is born (only asked in Serenity survey) the **average stay** is just under 20 hours. 37% leave less than 12 hours after giving birth, 54% stayed less than 24 hours, 46% stayed longer. Among those who stayed longer than 24 hours after giving birth, a third said that their main visitor had come with them and had been with them the whole time, and a third said their main visitor had travelled by car.

The strong majority said that they had **confidence in the midwives** caring for them – rather better among those using Serenity than before.



There are higher ratings of **quality of care** in Serenity than before the unit was opened. 78% now rate the care as being very good. Satisfaction increases with age group and is highest among first-time mothers: 85% say it is 'very good'.

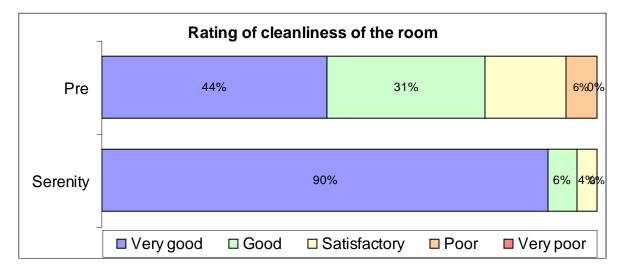


The amount of **information** received was rated by most (78% pre, 85% Serenity) as being 'the right amount'. Most were more than satisfied with the information they received, although satisfaction is rather higher among mothers in Serenity.



In terms of **access to refreshments**, nearly all (96%) of mothers in Serenity said they had access, compared with 63% before.

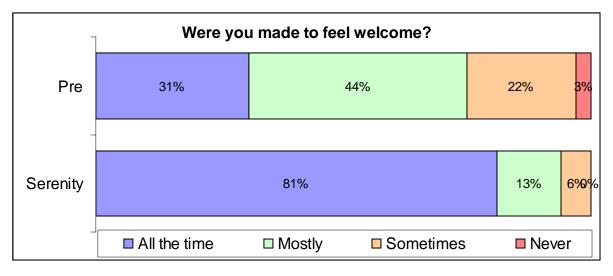
Cleanliness of the room where they had their baby is rated significantly better among mothers at Serenity: nearly all, 90%, say it was 'very good', up from 44% previously.



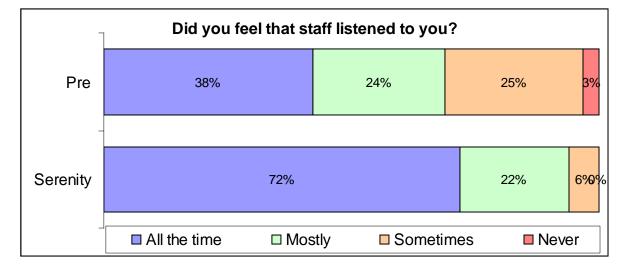
Breastfeeding is higher among mothers who went through Serenity. More so than previously, a good majority (81% in Serenity, 50% before) said they had planned to breastfeed. This is rather higher among first-time mothers, and rather lower among younger (under 25) and older (over 35) mothers. Similarly, 86% breastfed in hospital after having their baby compared with 56% before. Support from staff with breastfeeding was at the same level in the old units and in Serenity – about four in five said they had help, and a similar proportion said they found the support helpful and continues breastfeeding when they went home.

Breastfeeding:	Pre	<u>Serenity</u>
Planned to:	50%	81%
Did breastfeed in hospital	56%	86%
Had support from staff (all who breastfed)	86%	83%
Found support useful (if had support)	71%	81%
Continued breastfeeding at home	81%	83%

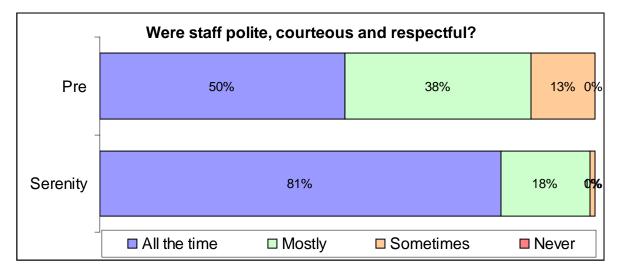
Much more at Serenity than before, patients said they felt they were made to feel **welcome**. 81% of patients who went through Serenity said they felt welcome all the time. This is particularly the case among patients aged 30 plus.



Similarly, patients at Serenity are far more likely to have felt that staff **listened** to them – and again, particularly among those aged over 30.

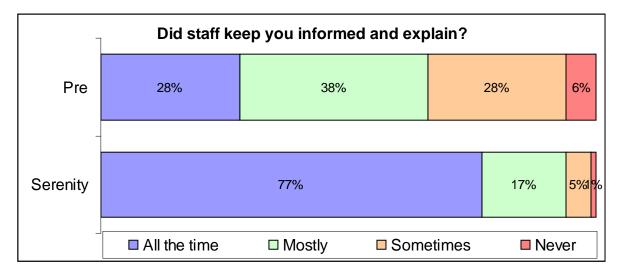


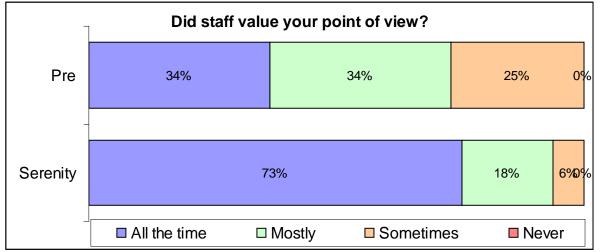
Patients who went through Serenity are much more likely to feel that staff there were **polite**, **courteous and respectful** – 81% said 'all the time'.

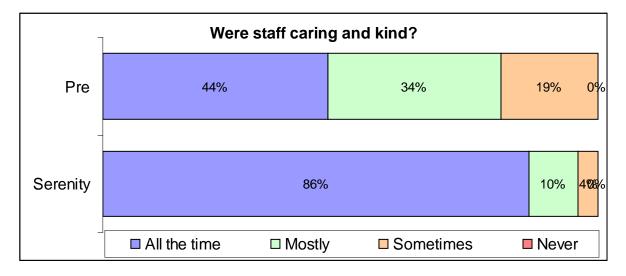


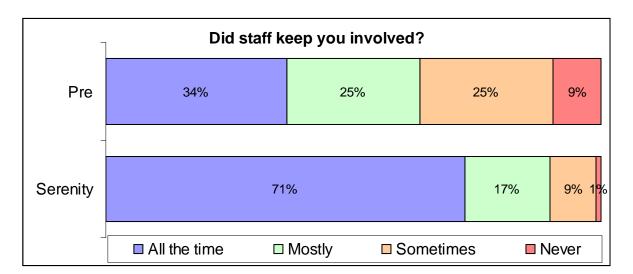
13% of patients before Serenity said staff always **apologised if they made a mistake**, rising to 27% at Serenity, although the majority, 58%, said that the staff did not make any mistakes.

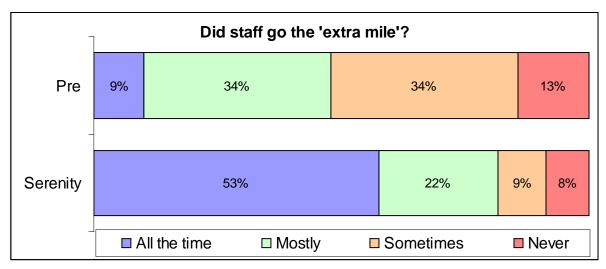
This pattern is consistent: a significantly higher level of satisfaction among patients who went through Serenity compared with before. They felt **better informed**, **more valued**, were more likely to feel the staff were caring and kind, felt more involved, and were more likely to feel staff went the 'extra mile'.







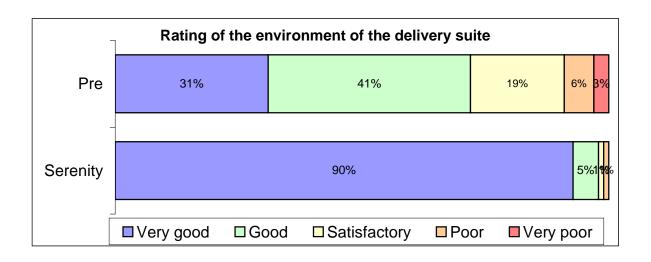


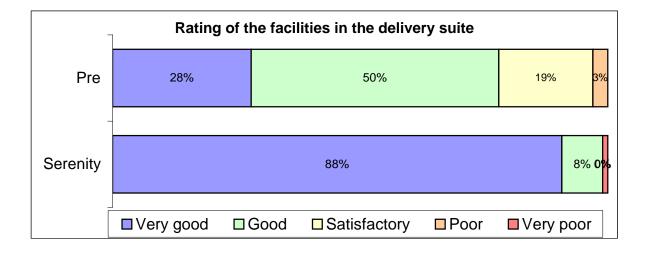


Nearly all (96% in Serenity, 88% before) patients had a **birth partner** present at the birth. Most felt that their birth partner was as involved as they wanted him or her to be, although this was higher among patients at Serenity (90%) than before (78%). Patients felt that their birth partner was made to feel welcome, although significantly more so at Serenity, where 81% said their partner was made to feel welcome 'all the time', compared with 56% previously

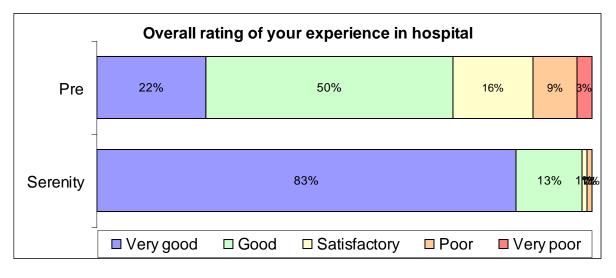
In terms of **discharge** there is no improvement on the already good level of satisfaction: 87% of Serenity patients said they received all the help and advice they needed when they were sent home, compared with 88% previously.

Patients are very happy with the **environment of the delivery suite** in Serenity, much more so than previously. Similarly, patients in Serenity are very much happier with the **delivery suite facilities**, although one thought they were 'very poor'.





Given the perceived improvements on every aspect of the patient's stay and care it is not surprising that the **overall satisfaction** rating of their experience is very much higher now than it was before Serenity was opened. 96% of Serenity patients rate their overall experience as good or very good.



88% of Serenity patients say they would want to have any subsequent baby delivered there. The main reasons given were quality of care, the better facilities, the cleanliness and infection control, and the staff. 13% say they would prefer City Hospital labour ward, whilst 3% would like to have one at home.

Comments - what was good about your experience?

59% of patients using the old maternity units, and 85% of those using Serenity, made some verbatim comment about what was *good* about their experience. The most frequently mentioned issues were:

- Staff or midwife

Everything. I had a brilliant midwife who I couldn't thank enough

The midwife and student midwife were fantastic and made me feel totally reassured

From the time I arrived the staff were very helpful and hands on. Asked for my views and what I wanted. Staff would give you 100% helping you through labour and made sure we were comfortable. Allowed me to be in control of my birth rather than being pushy and demanding.

Very good, welcoming staff. Kind and respectful. Midwife made me feel relaxed and in control.

Excellent staff, nothing was too much of a problem. All very professional.

- Comments about Serenity or calming/stress-free environment

The Serenity unit was brilliant. Welcoming, just like a hotel. I would recommend it to everyone.

I enjoyed the whole experience of the Serenity unit. Great facilities, I felt really comfortable

The centre was the best experience, really like the environment and atmosphere. Water birth is lovely, the room I stayed in was beautiful and comfortable.

Serenity was fantastic - would recommend it to anyone. A totally different experience to birth of my first in regular delivery suite.

- The room/suite

Since I arrived at the unit in the morning everyone was very helpful, calming, informative, friendly. My partner was kept involved throughout.

Everything very calm and relaxing. Listened to what my views and knew what I wanted to do and acted straight away.

A really relaxing environment and staff help you feel calm. Water pool really relaxing for me for the final stages.

Comments - what was poor about your experience?

69% of patients using the old maternity unit facilities, and 73% of those using

Serenity, made some verbatim comment about what was poor about their

experience. The most frequently mentioned issues were:

- Aftercare

The aftercare received by the community midwives. The care and information provided was awful and they were very badly organised.

No training about breastfeeding. Left hospital with awful sore nipples. Perhaps midwife assumed I should know how to breastfeed because it was my second.

Aftercare from midwives in Coventry was less good and maybe more communication is required, but all the staff at Serenity were fantastic.

When I went for breastfeeding support I didn't receive any, I did not see anyone who could advise me. I went home with a very poor attachment.

Being sent home so quickly with really no idea what to do - no demo of bathing or when to, no help with breastfeeding

- Staff

Hand-over poor and changeover. Night staff did not bother with me again or come to check if I was OK when I asked for help as my baby was not settling. They offered me a cup of tea but what happened to helping with my baby, also when reading my notes they stated that I was restless and tired. I felt that comment was unfair.

During labour the staff kept asking my if I wanted to give birth in the bath, but how would I know. I didn't know what was better/less painful/quicker. They should have decided.

I didn't appreciate the way I was spoken to by one of the doctors. Also felt there should be more toilet and bathroom facilities on the ward.

- Other

Waiting in waiting room for nearly an hour. Kept saying I was in labour. NO pain relief given Waiting room was awful to stay in. I had to ASK about Serenity - had read about it. When calling labour ward before arrival they said I should not come in until more pain or waters broke. Wanted water birth but midwives too slow to prepare bath. If I'd come in when I first called I would have had a water bath. Had to leave Serenity because no diabetic tests for baby.

Toilet blocked with toilet paper

My iron levels should have been checked more regularly

Being checked in triage in the main delivery ward at City hospital.

Made me walk back to ward straight after delivery - very painful.

Sandwell and West Birmingham Hospitals

NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Changes to the Trust's Establishment Order
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	31 March 2011

SUMMARY OF KEY POINTS:

In view of the plans for the transfer of adult and children community services from Sandwell PCT on 1 April 2011, amendments to the Trust's Establishment Order have been requested to reflect the new scope of the Trust.

A change is proposed specifically to Section 3.2 of the Order to add 'community health services' into the Trust's function.

The opportunity to seek retrospective approval for a change to Section 4 of the Order has also been taken, to reflect that the Trust has six Executive Directors, not five, following the appointment of the Director of Strategy and Organisational Development in the summer of 2010.

The changes requested have been submitted to the Department of Health via the Strategic Health Authority. It is likely that the approval of the amendments will not be received until after 1 April, however confirmation has been received from the Department of Health that it is happy that the Trust continues the provision of the community services prior to receipt of the amended establishment order, subject of course, to the Trust exercising its functions appropriately in the meantime.

A version of the Establishment Order, with changes tracked is attached.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Board is recommended to NOTE the proposed amendments to the Establishment Order.

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	х	
Equality and Diversity		
Patient Experience	х	
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

The plans for Transforming Community Services (TCS) have been discussed and agreed at previous meetings of the Trust Board.

2002 No. 1364

NATIONAL HEALTH SERVICE, ENGLAND

The Sandwell and West Birmingham Hospitals National Health Service Trust (Establishment) and the City Hospital National Health Service Trust and Sandwell Healthcare National Health Service Trust (Dissolution) Order 2002

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Made Coming into force 26th March 2002 1st April 2002

The Secretary of State for Health, in exercise of the powers conferred upon him by section 126(3) of the National Health Service Act 1977^1 and by section 5(1) of, and paragraphs 1, 3 and 29(1) of Schedule 2 to, the National Health Service and Community Care Act 1990^2 and of all other powers enabling him in that behalf, considering it appropriate in the interests of the health service to dissolve the City Hospital National Health Service Trust and the Sandwell Healthcare National Health Service Trust³, and having completed the consultation prescribed under section 5(2) of and paragraph 29(3) of Schedule 2 to that Act⁴, makes the following Order:

Notes

and by paragraph 27 of Schedule 2 to the National Health Service (Primary Care) Act 1997 (c.46).

2 Section 5 was amended by the Health Authorities Act 1995 (c. 17), Schedule 1, paragraph 69(d) and by the Health Act 1999 (c.8) section 13; paragraph 1 of Schedule 2 is cited for the definition of "an order"; paragraph 3 of Schedule 2 to the 1990 Act was amended by the Health Act 1999, section 13(7).
3 See paragraph 29(2) of Schedule 2 to the 1990 Act.
4 See S.I. 1996/653.

Amendments Pending

Preamble: repealed by Health and Social Care (Community Health and Standards) Act 2003 c. 43 Pt 1 s. 7(2) (date to be appointed)

Extent Preamble: England

¹ Section 126(3) was amended by section 65(2) of the National Health Service and Community Care Act 1990 (c.19) ("the 1990 Act"), by paragraph 57 of Schedule 1 to the Health Authorities Act 1995 (c. 17) ("the 1995 Act")

1.— Citation, commencement and interpretation

(1) This Order may be cited as the Sandwell and West Birmingham Hospitals National Health Service Trust (Establishment) and the City Hospital National Health Service Trust and the Sandwell Healthcare National Health Service Trust (Dissolution) Order 2002 and shall come into force on 1st April 2002.

(2) In this Order, unless the context otherwise requires—

"the Act" means the National Health Service and Community Care Act 1990; "community health services" means any services which the Secretary of State may provide under section 3(1)(d) or (e) of, or Schedule 1 to, the National Health Service Act 1977 and any service which he has a duty to provide under section 5(1) or (1A) of that Act¹;

"operational date" has the meaning assigned to it in paragraph 3(1)(e) of Schedule 2 to the Act;

"the trust" means the Sandwell and West Birmingham Hospitals National Health Service Trust established by article 2 of this Order.

Notes

1 1977 c.49; section 5(1) was amended by, and section 5(1A) was inserted by the Health and Medicines Act 1988 (c.49), section 10(1); Schedule 1 was amended by the Education Reform Act 1988 (c.40), paragraph 21 of Schedule 12, the Health and Medicines Act 1988, Schedule 2, paragraph 7 and the Education Act 1996 (c.56), Schedule 37, paragraph 46.

Amendments Pending

art. 1: repealed by Health and Social Care (Community Health and Standards) Act 2003 c. 43 Pt 1 s.7(2) (date to be appointed)

Commencement

art. 1(1)-(2) definition of "the trust": April 1, 2002

Extent

art. 1(1)-(2) definition of "the trust": England

2. Establishment and name of trust

There is established an NHS trust which shall be called the Sandwell and West Birmingham Hospitals National Health Service Trust.

Amendments Pending

art. 2: repealed by Health and Social Care (Community Health and Standards) Act 2003 c. 43 Pt 1 s. 7(2) (date to be appointed)

Commencement art. 2: April 1, 2002

Extent art. 2: England

3.— Nature and functions of the trust

(1) The trust is established for the purposes specified in section 5(1) of the Act.

(2) The trust's functions shall be to provide goods and services, namely hospital accommodation and services and community health services, for the purposes of the health service at or from Sandwell General Hospital, Lyndon, West Bromwich, West Midlands, B71 4HJ and City Hospital, Dudley Road, Birmingham, B18 7QH and at or from any associated hospitals, establishments and facilities.

[(3) The trust is to be regarded as having a significant teaching commitment within the meaning of paragraph 3(1)(d) of Schedule 2 to the Act.]¹

Notes

1 Added by Sandwell and West Birmingham Hospitals National Health Service Trust (Establishment) Amendment Order 2003/2345 art.2 (September 29, 2003)

Amendments Pending

art. 3: repealed by Health and Social Care (Community Health and Standards) Act 2003 c. 43 Pt 1 s. 7(2) (date to be appointed)

Commencement

art. 3(1)-(2): April 1, 2002

Extent art. 3(1)-(3): England

[4.—

(1) The trust shall have, in addition to the chairman, 6 non-executive directors and $\frac{56}{56}$ executive directors.

(2) One of the non-executive directors shall be appointed from the University of Birmingham.]¹

Notes

1 Substituted by Sandwell and West Birmingham Hospitals National Health Service Trust (Establishment) Amendment Order 2003/2345 art.3 (September 29, 2003)

Amendments Pending

art. 4: repealed by Health and Social Care (Community Health and Standards) Act 2003 c. 43 Pt 1 s. 7(2) (date to be appointed)

Commencement

art. 4: April 1, 2002

Extent art. 4(1)-(2): England

5.— Operational date and accounting date of the trust

(1) The operational date shall be 1st April 2002.

(2) The accounting date of the trust shall be 31st March.

Amendments Pending

art. 5: repealed by Health and Social Care (Community Health and Standards) Act 2003 c. 43 Pt 1 s. 7(2) (date to be appointed)

Commencement art. 5(1)-(2): April 1, 2002 **Extent** art. 5(1)-(2): England

6.— Dissolution of NHS trust

(1) The City Hospital National Health Service Trust established by the City Hospital National Health Service Trust (Establishment) Order 1993 is hereby dissolved, and accordingly that Order is revoked.

(2) The Sandwell Healthcare National Health Service Trust established by the Sandwell Healthcare National Health Service Trust (Establishment) Order 1994₁ is hereby dissolved, and accordingly that Order is revoked.

Notes

1 As amended by S.I. 1999/62.

Amendments Pending

art. 6: repealed by Health and Social Care (Community Health and Standards) Act 2003 c. 43 Pt 1 s. 7(2) (date to be appointed)

Commencement art. 6(1)-(2): April 1, 2002

Extent art. 6(1)-(2): England

Signed by authority of the Secretary of State for Health

Yvette Cooper Parliamentary Under Secretary of State, Department of Health

26th March 2002

Amendments Pending

Signatures: repealed by Health and Social Care (Community Health and Standards) Act 2003 c. 43 Pt 1 s. 7(2) (date to be appointed)

EXPLANATORY NOTE

(This note is not part of the Order)

This Order establishes the Sandwell and West Birmingham Hospitals National Health Service Trust as an NHS trust, provided for in section 5 of the National Health Service and Community Care Act 1990. This Order also dissolves on 1st April 2002;

the City Hospital National Health Service Trust; and the Sandwell Healthcare National Health Service Trust.

The new trust will provide certain services previously provided by the City Hospital National Health Service Trust and the Sandwell Healthcare National Health Service Trust which are dissolved by this Order.

The Order provides for the functions of the trust (article 3) and the number of executive and non-executive directors (article 4). It specifies the operational date (the date on which the trust assumes all its functions), and the accounting date of the trust (article 5).

This Order does not impose a charge on businesses.

Sandwell and West Birmingham Hospitals

NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Tripartite Formal Agreement
SPONSORING DIRECTOR:	Mike Sharon, Director of Strategy and Organisational Development
AUTHOR:	Mike Sharon, Director of Strategy and Organisational Development
DATE OF MEETING:	31 March 2011

SUMMARY OF KEY POINTS:

This sets out our formal agreement with the Strategic Health Authority (SHA) and Department of Health to deliver a Foundation Trust Application.

The Chair and Chief Executive have approved the document to send to the SHA to meet the deadline required by the SHA

This represents a challenging timescale to achieve FT status, in particular a first draft Integrated Business Plan and Long Term Financial Model by end of July 2011.

The timetable assumes approval as an FT by Quarter three of 2012

The Board is asked to **approve** the TFA

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

Approval	Receipt and Noting	Discussion
X		Х

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to **approve** the draft Tripartite Formal Agreement.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Becoming an effective organisation
Annual priorities	Achieve FT status
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		
Legal & Policy	x	
Equality and Diversity		
Patient Experience	x	
Communications & Media	x	
Risks		Failure to comply with national requirement of the development of a TFA for all aspirant FT's

PREVIOUS CONSIDERATION:

FT Programme Board on 24 March 2011

TFA document





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 – Chief Executive Officer SHA – 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

SWBTB (3/11) 069 (a)

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



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	Signature
NHS Trust	Date:

Name, Job Title (CEO of SHA)	Signature
	Date:

Name, Job Title (Ian Dalton)	Signature
	Date:

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.

Name, Job Title (CEO of Lead commissioner)	Signature
	Date:

Part 3 – NHS Trust summary

Short summary of services provided, geographical/demographical information, main commissioners and organisation history.

Required information

Current CQC registration (and any conditions):

Unconditional

Financial data (figures for 2010/11 should to be based on latest forecast)

2009/10	2010/11
£000	£000
384,774	383,816
30,876	23,480
(28,646)	(3,237)
7,260	2,038
15,075	20,840
13,564	20,797 [#]
1,511	43
	£000 384,774 30,876 (28,646) 7,260 15,075 13,564

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	2010/11
	£000	£000
Sandwell PCT	157,658	162,574
Of which 'Right Care Right Here'		9,000
Programme Transitional Framework		
Funding (via Sandwell PCT)		
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 £350m 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.

Profile of the Trust

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 will provide 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 1000 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			
Financial			
Current financial Position			
Level of efficiencies			
PFI plans and affordability			
Other Capital Plans and Estate issues Loan Debt			
Working Capital and Liquidity			
Quality and Performance			
Quality and clinical governance issues			
Service performance issues			
Governance and Leadership			
Board capacity and capability, and non-			
executive support			
Please provide any further relevant local info	ormation in relation to the key issues to		
be addressed by the NHS Trust:			
Contracting Arrangements			
The health economy has agreed a medium t	erm Transitional Funding programme as		
part of the implementation of the Right Care			
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.			
PEL plans			
PFI plans			
OBC approval by DH and HM Treasury is currently awaited. The draft IBP cannot be submitted until final approval of the OBC has been received as it is central to the			
Trust's strategy.			
Successful procurement of a PFI partner als	o requires a Deed of Safeguard (DoS) or		
equivalent guarantee.			
In order to achieve compliance with Monitor Financial Risk Ratings, the Trust will			
require the same dispensation relating to the			
previously granted to existing FTs with large			
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			
Financial Current financial position			
CIPs			
Other capital and estate Plans	\boxtimes		
Quality and Performance Local / regional QIPP			
Service Performance			
Quality and clinical governance	\boxtimes		
Governance and Leadership Board Development			
Other key actions to be taken (please provide detail below)	\boxtimes		
Describe what actions the Board is taking the maintaining and improving quality of care f			
 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 Governance and Risk Management Committee of the Board provides support for the Board to examine issues in greater depth. The Board has considered a new Quality and Safety Strategy and is expected to approve the Strategy in April 2011. This includes a fully integrated approach addressing Monitor's Quality Governance Framework. 			
 Capital and estate Plans Complete land acquisition via voluntary and compulsory purchase by August 2011 (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 Quality and Clinical Governance Conversion of a ward into two same sex wards by June 2011(Director of Estates) 			
 Other Actions 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)		
Contracting arrangements		
Transforming Community Services		
Financial CIPs\efficiency		
Quality and Performance Regional and local QIPP		
Quality and clinical governance		
Service Performance		
Governance and Leadership Board development activities		
Other key actions to be taken (please provide detail below)		
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.		
 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		
Financial NHS Trusts with debt		
Short/medium term liquidity issues		
Current/future PFI schemes	\boxtimes	
National QIPP workstreams		
Governance and Leadership Board development activities		
Other key actions to be taken (please provide detail below		
 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: Approval of OBC by DH and Treasury (asap) Dead of Safaguard or equivalent solution confirmed (July 2014) 		
 Deed of Safeguard or equivalent solution confirmed (July 2011) Resolution of issues relating to Prudential Borrowing Code compliance (July 2011) 		

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	April 2011
purchase	
3. Ensure compliance with same sex	June 2011
accommodation standards	
4. Deed of Safeguard confirmed	July 2011
5. Resolution of PBC issues	July 2011
6. Draft IBP and LTFM submitted	End of July
7. Assess and challenge IBP/LTFM	August 2011
8. Complete land acquisition	August 2011
9. SHA Consultation Sign Off	Early Sept 2011
10. Consultation Commences	September 2011
11. Historical Due Diligence Stage 1 begins	September 2011
12. Complete updated estates strategy to	October 2011
reflect RCRH community hospital programme	
13. Historical Due Diligence Stage 1 ends	October 2011
14. Consultation Ends	December 2011
15. Finalise IBP <FM	February 2012
16. SHA Approval Review	February/March
	2012
17. FT Quality and Safety Assessment	February 2011
18. Historical Due Diligence Stage 2 begins	March 2012
19. Historical Due Diligence Stage 2 ends	April 2012
20. NTDA recommend to Exec Board (2 nd	May 2012
B2B)	1 st June 2012
21. Submission of papers to DH	

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.

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)

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)

Part 9 – Key risks to delivery

TFA - Guidance notes





Guidance to support completion of Tripartite Formal Agreements

Introduction

- 1. This guidance is provided in support of the completion of the Tripartite Formal Agreements (TFAs) being established to support the delivery of the NHS Foundation Trust (FT) pipeline by April 2014.
- 2. The main purpose of each TFA is to confirm an agreed date by which the NHS Trust will submit their FT application to the Department of Health (DH).
- 3. Alongside this, the TFA will provide information about the issues to be addressed by the NHS Trust to enable them to submit their application, to the agreed date, and ultimately achieve NHS Foundation Trust (FT) status by April 2014. The TFA should align with the local QIPP agenda.
- 4. The three parties signing up to each agreement are:
 - NHS Trust Chief Executive Officer
 - SHA Chief Executive Officer
 - Department of Health Ian Dalton, Managing Director of Provider Development, DH

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

5. SHAs will lead the process for completing and agreeing the TFA locally. For each of the signatories the actions they are agreeing to undertake to support the issues being addressed by the NHS Trust will be included in the document. The milestones towards submitting an application to DH should be provided. Associated risks may be identified in Part 9.

- 6. This guidance is by section as organised in the TFA. Each NHS Trust and SHA is asked to keep to the guidance provided when completing the TFAs to enable an efficient and effective process to finalise them.
- 7. A TFA needs to be completed for **all remaining NHS Trusts**. This includes those NHS Trusts who have already submitted an application to DH and are either still to be considered for Secretary of State support or have received this and are currently being assessed by Monitor. For these organisations, it is expected there will be little detail in their TFA but it is still required to ensure we have clear and consistent information about all the remaining NHS Trusts.
- 8. Correspondence to the DH on all TFAs should be addressed to the DH Foundation Trust Team mailbox <u>ftapplication@dh.gsi.gov.uk</u>

TFA step-by-step guidance

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

- This is the date agreed by the NHS Trust, SHA and DH when the NHS Trust will submit it's "FT ready" application to DH seeking Secretary of State support approval before commencing assessment with Monitor.
- The latest date this can be for any NHS Trust is April 2013
- For those organisations that have already submitted an application to DH and are either still being considered for Secretary of State support or are with Monitor, this box should be marked 'Application submitted'

Part 2a - Signatories to agreements

- This section requires the name, job title and signatures of each NHS Trust CEO, the SHA CEO and Ian Dalton, Managing Director of Provider Development, DH.
 - It is requested that electronic signatures are provided for the agreement for all signatories. Where this is not possible, a formal audit needs to be provided confirming the signatory's sign-up to the agreement.

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.

Part 3 – NHS Trust summary

- This section requests a short summary of services provided, geographical/demographical information, CQC registration, main commissioners and organisation history. Standard financial information is also required. Latest management information should be used to forecast 2010/11 position.
- It is requested that this summary be no more than half a page of A4.

Part 4 – Key issues to be addressed by NHS trust

- The agreed issues to be addressed by each NHS trust need to be marked on the check-boxes provided. These issues were determined following analysis of the November 2010 returns so should cover most issues faced by NHS Trusts.
 - These can be marked by right-clicking on the box, selecting properties and then changing the default value to 'checked'
- The free text box in part 4 needs to be used to provide any further information about the key issues that the NHS Trust needs to address.
 - Every attempt should be made to keep this further information brief and high-level and it is suggested that no more than half a page of A4 is used for this. Where necessary extra space can be used.

Part 5 – NHS Trust actions required

- The agreed actions to be taken by each NHS trust need to be marked on the check-boxes.
 - These can be marked by right-clicking on the box, selecting properties and then changing the default value to 'checked'
- Describe what actions the Board is taking to assure themselves that they are maintaining and improving quality of care for patients.
- The free text box in part 5 also needs to be used to provide a summary of other actions being taken by the NHS Trust to address the issues agreed in part 4.
 - Every attempt should be made to keep this further information brief and high-level. Where necessary extra space can be used.

Part 6 – SHA actions required

- The agreed actions to be taken by each SHA need to be marked on the check-boxes.
 - These can be marked by right-clicking on the box, selecting properties and then changing the default value to 'checked'
- The free text box in part 6 needs to be used to provide a summary of other actions being taken by the SHA to address the issues agreed in part 4.

 Every attempt should be made to keep this further information brief and high-level. Where necessary extra space can be used.

Part 7 – Supporting actions led by DH

- The agreed actions DH is supporting to deliver the application date need to be marked on the check-boxes. In the first instance, SHAs should identify the issues for DH to consider.
 - These can be marked by right-clicking on the box, selecting properties and then changing the default value to 'checked'
- The free text box in part 7 needs to be used to provide a summary of other actions being taken by DH to address the issues agreed in part 4.
 - Every attempt should be made to keep this further information brief and high-level. Where necessary extra space can be used.

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

- Milestones will be reviewed quarterly. Dates and key milestones need to be provided in the table, ideally timed to the quarter ends but not if that is going to cause new problems.
- Milestones to be determined as appropriate for each individual case.
 General rule for a milestone is that if it were not achieved it would put delivery of the date agreed in part 1 at risk.
- Detail should be provided on what the milestone will achieve, for example, underlying financial problem resolved.
- Describe what actions\sanctions the SHA will take where a milestone is likely to be, or has been missed.
- For NHS Trusts who have already submitted their applications to DH, no milestones are required in this section, as the date agreed has already passed.
- Free text box allows short description of actions to take if a milestone is missed.

Part 9 – Key risks to delivery

- Key high level risks and mitigations to be provided at this table
- Risks to be determined as appropriate for each individual case but requested to be not more than five risks.

SWBTB (3/11) 063

Sandwell and West Birmingham Hospitals

NHS Trust

TRUST BOARD		
DOCUMENT TITLE:	'Right Care, Right Here' Progress Report	
SPONSORING DIRECTOR:	Mike Sharon, Director of Organisational Development and Strategy	
AUTHOR:	Jayne Dunn, Redesign Director – RCRH	
DATE OF MEETING:	31 March 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 February 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	х	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	х	The Right Care Right Here Programme sets the context for future clinical service models.
Workforce	х	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	х	The service redesign elements of the Right Care Right Here Programme will require equality impact assessments.
Patient Experience		
Communications & Media	х	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 MARCH 2011

INTRODUCTION

The Right Care Right Here Programme is the partnership of SWBH NHS Trust, 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 February 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 to the end of December 2010, overall the levels of community activity continue to be in excess of levels reported for the same period last year, with the exception of community outpatient activity in ENT (-25%), Gynaecology (-48%), Dermatology (-9%) and Ophthalmology (-12%) which is below last year's level for the same reasons as reported in previous months. For ENT, Ophthalmology and Gynaecology this position is expected to show an improvement from January 2011 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 also continues for the current service redesign work streams within the RCRH Programme.

- <u>Emergency and Urgent Care</u> Emergency Department (ED) and Urgent Care activity for the first 9 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, by 7%. This includes SWBH ED attendances being 11% 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 76% higher than for the same period last year.
- <u>Outpatient Work</u> Comparison between 09/10 outpatient activity and this year shows that for the first 9 months of this year the level of activity in the community has increased (37% 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 by 5% (compared to 7% in the previous month) as a result of increases in outpatient referrals and follow ups.

CARE PATHWAY REVIEWS

Care Pathway reviews continue with the following progress:

- <u>Osteoarthritis</u> reviewed and approved by RCRH Clinical Group. Divisional teams within SWBH are now assessing the impact and implications of the new pathway on services provided by the Trust.
- <u>Smoking Cessation</u> reviewed and approved by RCRH Clinical Group. Divisional teams within SWBH are now assessing the impact and implications of the new pathway on services provided by the Trust.
- <u>Cardiology</u> approved by RCRH Clinical Group. SWBH resource impact statement produced. PCTs now producing their resource impact statement.
- <u>ENT</u> Dizziness and Allergic Seasonal Rhinitis pathways have been redesigned and will be presented to the RCRH Clinical Group in March.
- Ongoing work continues for the next set of pathway reviews in ENT (Tinnitus), Gynaecology (Menstrual Cycle Irregularities and Post Menopausal Bleeding, Endometriosis and Emergency Contraception), Musculoskeletal (Spinal, Carpel Tunnel, Hip Fracture, Pain Management).

The approach for approving, publishing and implementing reviewed care pathways has been reviewed and was presented to the RCRH Partnership Board at the end of February.

LINK TO CONTRACTING

The latest contracting round has agreed a high level service change programme. The detail of this programme is yet to be worked out but it is expected that some of it will be driven by the pathway review work of the programme.

ACUTE CAPACITY REVIEWS

The Birmingham and Black Country acute capacity reviews continue. The Birmingham review is working to develop an agreed System Plan for Birmingham for the next three years and to agree the approach for developing this by mid March. This Plan will include outline work on how the Birmingham and Solihull Cluster will address the need to reduce overall expenditure over the next three years.

The approach in the Black Country Acute Capacity Review remains concentrated on specific areas including Paediatrics, Vascular Surgery and Trauma Networks.

JOINT OVERVIEW AND SCRUTINY COMMITTEE MEETING

The RCRH Programme attended a Joint Overview and Scrutiny Committee meeting in February to provide an update on progress with the New Hospital, the impact of GP Consortia and the RCRH Programme Risk Register. A very positive discussion was held at the meeting and the Committee was very supportive of maintaining progress with the RCRH Programme. The Committee agreed to issue a public statement of support to the Programme and the New Hospital.

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 March 2011



Sandwell and West Birmingham Hospitals

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

1. Compulsory Purchase Order (CPO)

Preparation for the activation of the compulsory purchase order is now well underway. This will allow the acquisition of the remaining land at Grove Lane ready for when we start the procurement process.

2. Outline Business Case (OBC)

The team has completed the valuation of project benefits to strengthen the economic appraisal. This is a new requirement for major capital investments and will be considered by the Department of Health (DH) before the OBC Update can be approved.

The DH economists have given positive feedback so far, commenting that we are leading the way with our approach, which emphasises the benefits to patient health and local regeneration as well as the usual financial benefit measures.

When the DH is content with this work the approval process will move forward. The Treasury still needs to approve the OBC Update before the procurement process can start.

3. Commercial Documents

The Project Agreement and associated schedules are now being finalised. Many of these important documents have now been signed off by the Private Finance Unit of the DH. Our advisors are supporting this work to ensure that all legal, financial and technical issues are resolved before we start the procurement.

The operational policies and specifications for the clinical departments are being signed off by Clinical Directors and Divisional Managers ensuring that they are ready to form the brief for the procurement. These documents will inform the development of departmental designs in the Midland Metropolitan Hospital.

The team is also working on the scoring methodology, weighting structure and approach to evaluation. Meetings will be set up in April to brief the evaluation groups and agree the evaluation process.







4. Preparing for OJEU

The procurement will be initiated by the release of a notice in the Official Journal of the European Union (OJEU). This is an electronic process that will make potential bidders aware of the scheme and invite application using a pre-qualification questionnaire.

A Memorandum of Information will be used to inform potential bidders about the scheme and emphasise the benefits of bidding for our project.

An open day will be arranged within 4 weeks of the placement of the OJEU notice. This event will showcase the scheme and provide opportunities for bidders to meet Trust leaders and project staff.

Sandwell and West Birmingham Hospitals

NHS Trust

TRUST BOARD		
DOCUMENT TITLE:	Midland Metropolitan Hospital Development: 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:	31 March 2011	

SUMMARY OF KEY POINTS:

The Project Director's report gives an update on:

- The Compulsory Purchase Order (CPO)
- The Outline Business Case (OBC)
- Commercial Documents
- Preparation for OJEU

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

Approval	Receipt and Noting	Discussion
	Х	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is requested to receive and note the report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	21st Century Facilities
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Usual monthly update.

Sandwell and West Birmingham Hospitals

NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – February 2011
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Robert White/Tony Wharram
DATE OF MEETING:	31 March 2011

SUMMARY OF KEY POINTS:

The report provides an update on the financial performance of the Trust for the period April 2010 – February 2011.

For the period 1st April 2010 to 28th February 2011, the Trust achieved a "bottom line" surplus of £1,748,000 which is £167,000 better than the planned position (as measured against the DoH performance target).

Capital expenditure for the year to date is £12,124,000 and the cash balance at 28th February was £8.6m above the revised plan.

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

Approval	Receipt and Noting	Discussion
	Х	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

NOTE the contents of the report; and ENDORSE any actions taken to ensure that the Trust remains on target to achieve its planned financial position.

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	х	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:

Financial Management Board and Trust Management Board on 22 March 2011 and Finance and Performance Management Committee on 24 March 2011.

Sandwell and West Birmingham Hospitals

NHS Trust

Financial Performance Report – February 2011

EXECUTIVE SUMMARY

• For the period 1st April 2010 to 28th February 2011, the Trust achieved a "bottom line" surplus of £1,748,000 which is £167,000 better than the planned position (as measured against the DoH performance target).

• For February, a surplus of £222,000 was delivered which is £17,000 ahead of the plan for the month.

•At month end, WTE's (whole time equivalents), excluding the impact of agency staff, were approximately 146 below plan compared with 87 below plan in January. After taking into account the impact of agency staff, actual wte numbers are broadly in line with plan. Total pay expenditure for the month, inclusive of agency costs, was £46,000 or 0.2% above plan which brings the year to date position to £291,000 or 0.1% above plan.

• The month-end cash balance is approximately £8.6m above the revised plan, an increase of almost £3m compared with January.

• Capital expenditure is below plan for February but remains marginally above plan for the year to date, the result of the purchase of Grove Lane land.

	Current	Year to						
Measure	Period	Date	Thresholds					
			Green	Amber	Red			
l&E Surplus Actual v Plan £000	17	167	>= Plan	> = 99% of plan	< 99% of plan			
EBITDA Actual v Plan £000	(166)	311	>= Plan	> = 99% of plan	< 99% of plan			
Pay Actual v Plan £000	(46)	(291)	<=Plan	< 1% above plan	> 1% above plan			
Non Pay Actual v Plan £000	(517)	(2,198)	<= Plan	< 1% above plan	> 1% above plan			
WTEs Actual v Plan	(0)	(1)	<= Plan	< 1% above plan	> 1% above plan			
Cash (incl Investments) Actual v Plan £000	8,571	8,571	>= Plan	> = 95% of plan	< 95% of plan			
]					

	Year to	Date
Target	Plan £000	Actual £000
Income and Expenditure	1,581	1,74
Capital Resource Limit	11,665	12,12
External Financing Limit		8,57
Return on Assets Employed	3.50%	3.49%

Performance Against Key Financial Targets

	Annual	CP	CP	СР	YTD	YTD	YTD	Forecast
2010/2011 Summary Income & Expenditure	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Outturn
Performance at February 2011	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Income from Activities	342,375	28,591	28,992	401	313,749	315,376	I,627	343,647
Other Income	39,953	3,127	3,123	(4)	35,113	36,286	1,173	40,948
Operating Expenses	(358,594)	(29,705)	(30,268)	(563)	(327,476)	(329,965)	(2,489)	(360,659)
EBITDA	23,734	2,013	1,847	(166)	21,386	21,697	311	23,936
Interest Receivable	25	2	9	7	23	78	55	85
Depreciation & Amortisation	(18,724)	(1,090)	(979)	111	(14,409)	(14,673)	(264)	(19,057)
PDC Dividend	(5,855)	(488)	(423)	65	(5,367)	(5,302)	65	(5,784)
Interest Payable	(2,417)	(201)	(201)	0	(2,215)	(2,215)	0	(2,417)
Net Surplus/(Deficit)	(3,237)	236	253	17	(582)	(415)	167	(3,237)
IFRS/Impairment Related Adjustments	5,275	(31)	(31)	0	2,163	2,163	0	5,275
SURPLUS/(DEFICIT) FOR DOH TARGET	2,038	205	222	17	1,581	1,748	167	2,038

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

Sandwell and West Birmingham Hospitals

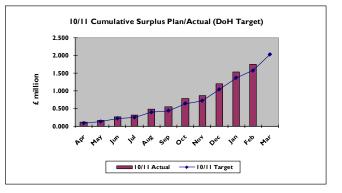
NHS Trust

SWBTB (3/11) 052 (a)

Financial Performance Report – February 2011

Overall Performance Against Plan

• The overall performance of the Trust against the DoH planned position is shown in the adjacent graph with current performance remaining slightly ahead of plan.

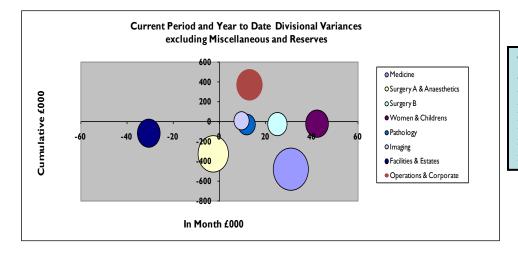


Divisional Performance

• With the exception of Miscellaneous and Reserves, performance in month has been broadly in line with plan.

- Of the operational divisions, only Facilities and Estates and Surgery A, Anaesthetics and Critical Care posted in month deficits and these were small at $\pm 31,000 (0.08\%)$ and $\pm 3,000 (0.01\%)$ respectively.
- For the year to date, Medicine & Emergency Care and Surgery A, Anaesthetics & Critical Care remain as the two divisions with significant recognised deficits against plan at £478,000 and £322,000 respectively.
- Adverse performance in Miscellaneous and Reserves is a reflection of a prudent approach being taken on a number of issues which contain an element of uncertainty rather than fundamental or ongoing adverse performance.

•This level of performance needs to be maintained for the remainder of the financial year to ensure that the Trust meets its statutory targets at 31st March.

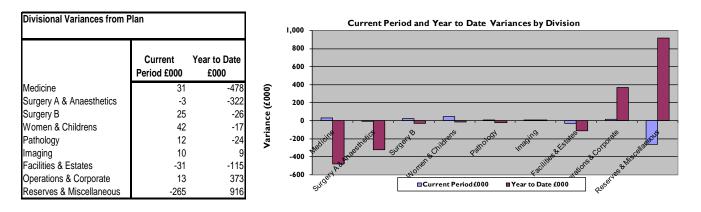


The tables adjacent and overleaf shows that, with the exception of Miscellaneous and Reserves, performance in month has been broadly in line with plan.

Sandwell and West Birmingham Hospitals

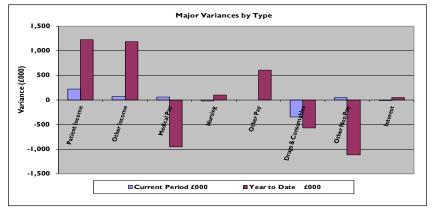
NHS Trust

Financial Performance Report – February 2011



For the year to date, the table and graph below illustrate that overall, income continues to perform better than planned but this is offset by higher levels of expenditure required to maintain additional capacity and deliver higher activity levels.

Variance From Plan by Ex	penditure Type	
	Current Period £000	Year to Date £000
Patient Income	401	1,627
Other Income	-4	1,173
Medical Pay	-37	-1,021
Nursing	-267	-134
Other Pay	258	864
Drugs & Consumables	-48	-616
Other Non Pay	-469	-1,582
Interest & Dividends	72	120

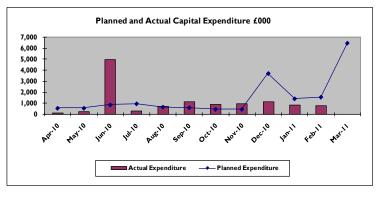


Capital Expenditure

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

•Lower than planned expenditure was again incurred in month, with actual expenditure in month mainly being in respect of ultrasound replacement, statutory standards and medical equipment.

•The car parking barrier scheme requires additional resources (10%) owing to unforeseen cabling renewal and this has been adjusted for.



Sandwell and West Birmingham Hospitals

NHS Trust

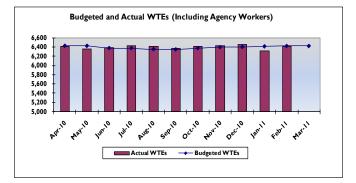
Financial Performance Report – February 2011

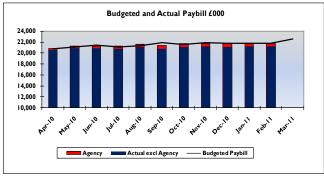
Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are approximately in line with plan for February. Excluding the impact of agency staff, wte numbers are around 146 below plan. The increase in actual wtes of 96 compared with January is predominantly accounted for by changes in bank usage rather than any significant shifts in numbers of substantive staff.

• Total pay costs (including agency workers) are £46,000 above budgeted levels for the month and £291,000 above for the year to date. The main areas where expenditure remains in excess of plan continue to be medical staffing and healthcare assistants offset to some degree by lower than planned expenditure among other pay groups.

• Expenditure for agency staff in February was £598,000 compared with £583,000 for January. The biggest single group accounting for agency expenditure remains medical staffing.





Pay Variance by Pay Group

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

Analysis of Total Pay Costs by Staff Group												
		Year to Date to February										
		Actual										
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000						
Medical Staffing	69,182	67,492		2.711	70,203	(1,021)						
Management	12,607			, 0	11,832	775						
Administration & Estates	26,995		438	941	26,868	127						
Healthcare Assistants & Support Staff	25,219	23,126	1,822	930	25,878	(659)						
Nursing and Midwifery	69,268	65,313	3,212	877	69,402	(134)						
Scientific, Therapeutic & Technical	32,932	31,921		486	32,407	525						
Other Pay	96	0			0	96						
Total Pay Costs	236,299	225,172	5,473	5,945	236,590	(291)						

NOTE: Minor variations may occur as a result of roundings

Sandwell and West Birmingham Hospitals

NHS Trust

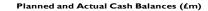
Financial Performance Report – February 2011

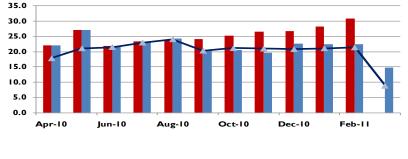
Balance Sheet

• The opening Statement of Financial Position (balance sheet) for the year at 1st April reflects the statutory accounts for the year ended 31st March 2010.

• Cash balances at 28th February are approximately £8.6m higher than the revised plan, an improvement of approximately £3m compared with January, primarily the result of the receipt of a number of unplanned one off items in month as well as the clearance of a number of outstanding invoices by HoB and BEN PCTs.

	Sandwell & West Birmingham Hospita STATEMENT OF FINANCIAL PO			
		<u>Opening</u> <u>Balance as at</u> <u>March 2010</u> <u>£000</u>	Balance as at February 2011 £000	Forecast at March 2011 <u>£000</u>
Non Current Assets	Intangible Assets	426	350	375
	Tangible Assets	220,296	217,872	219,475
	Investments	0	0	(
	Receivables	1,158	1,275	1,350
Current Assets	Inventories Receivables and Accrued Income Investments Cash	3,439 19,289 0 15,867	3,493 17,310 0 30,967	3,450 19,250 (18,779
Current Liabilities	Payables and Accrued Expenditure	(31,962)	(46,508)	(40,269
	Loans	0	0	(
	Borrowings	(1,698)	(1,660)	(1,690
	Provisions	(5,338)	(2,906)	(5,000
Non Current Liabilities	Payables and Accrued Expenditure	0	0	(
	Loans	0	0	(
	Borrowings	(32,476)	(31,203)	(30,786
	Provisions	(2,175)	(2,250)	(2,150
Financed By		186,826	186,741	182,784
Taxpayers Equity	Public Dividend Capital	160,231	160,231	160,23'
	Revaluation Reserve	36,545	37,110	36,25(
	Donated Asset Reserve	2,148	1,940	1,69(
	Government Grant Reserve	1,103	1,076	1,042
	Other Reserves	9,058	9,058	9,058
	Income and Expenditure Reserve	(22,259)	(22,674)	(25,496





Actual Revised Plan

——— Original Plan

Sandwell and West Birmingham Hospitals

NHS Trust

Financial Performance Report – February 2011

Cash Flow

• The table below shows cash receipts and payments for February 2011 and a forecast of expected flows for the following 12 months.

Sandwell & West Birmingham Hospitals NHS Trust CASH FLOW													
				12 MONTH R	OLLING FOR	ECAST AT F	ebruary 2011						
ACTUAL/FORECAST	Feb-11 £000s	Mar-11 £000s	Apr-11 £000s	May-11 £000s	Jun-11 £000s	Jul-11 £000s	Aug-11 £000s	Sep-11 £000s	Oct-11 £000s	Nov-11 £000s	Dec-11 £000s	Jan-12 £000s	Feb-12 £000s
Receipts													
SLAs: Sandwell PCT	13,460	13,460	13,236	13,236	13,236	13,236	13,236	13,236	13,236	13,236	13,236	13,236	13,236
HoB PCT	7,933	7,183	7,022	7,022	7,022	7,022	7,022	7,022	7,022	7,022	7,022	7,022	7,022
Associated PCTs	5,126	5,075	4,765	4,765	4,765	4,765	4,765	4,765	4,765	4,765	4,765	4,765	4,765
Pan Birmingham LSCG	1,410	1,375	1,371	1,371	1,371	1,371	1,371	1,371	1,371	1,371	1,371	1,371	1,371
Other SLAs	544	540	820	820	820	820	820	820	820	820	820	820	820
Over Performance Payments	0	0	0	750	750	750	750	750	750	750	750	750	750
Education & Training	1,272	1,250	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500
Loans	0	0				0	0	0	0	0	0	0	C
Interest	7	6	6	6	6	6	6	6	6	6	6	6	6
Other Receipts	4,172	2,750	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
Total Receipts	33,924	31,639	30,719	31,469	31,469	31,469	31,469	31,469	31,469	31,469	31,469	31,469	31,469
Payments													
Payroll	12,467	12,546	12,450	12,450	12,450	12,450	12,450	12,450	12,450	12,450	12,450	12,450	12,450
Tax, NI and Pensions	8,577	14,150	8,900	8,900	8,900	8,900	8,900	8,900	8,900	8,900	8,900	8,900	8,900
Non Pay - NHS	1,436	2,366	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
Non Pay - Trade	7,378	8,418	6,500	6,500	6,500	6,500	6,500	6,500	6,500	6,500	6,200	6,200	6,200
Non Pay - Capital	709	2,982	750	750	750	750	750	750	750	750	750	750	750
PDC Dividend		2,746						2,750					
Repayment of PDC													
Repayment of Loans													
Interest													
BTC Unitary Charge	381	370	379	379	379	379	379	379	379	379	379	379	379
Other Payments	225	250	250	250	250	250	250	250	250	250	250	250	251
Total Payments	31,173	43,827	31,229	31,229	31,229	31,229	31,229	33,979	31,229	31,229	30,929	30,929	30,930
Cash Brought Forward	28,216	30,967	18,779	18,269	18,509	18,749	18,989	19,229	16,720	16,960	17,200	17,740	18,280
Net Receipts/(Payments)	2,751	(12,188)	(510)	240	240	240	240	(2,510)	240	240	540	540	539
Cash Carried Forward	30.967	18,779	18,269	18.509	18,749	18,989	19,229	16,720	16.960	17.200	17,740	18,280	18,819

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

Measure	Description	Value	Score
EBITDA Margin	Excess of income over operational costs	6.6%	:
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	101.5%	:
Return on Assets	Surplus before dividends over average assets employed	1.6%	:
I&E Surplus Margin	I&E Surplus as % of total income	-0.1%	1
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	1.8	
Overall Rating			2.3

Risk Ratings

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

•In addition to the normal low score in respect of liquidity (because as a non Foundation Trust, SWBH does not have access to an uncommitted overdraft facility), other measures have also deteriorated as a result of the inclusion of impairment charges which are scored against Monitor targets but which are offset when measuring performance against DoH objectives and in a normalised Monitor assessment.

Sandwell and West Birmingham Hospitals

NHS Trust

Financial Performance Report – February 2011

External Focus

There has been little change in the reported or forecast position of local PCTs either against overall performance targets or in respect of the performance of contracts with secondary care providers. Expectations remain that performance will be in line with plans at the year end.

LDP negotiations with PCTs, primarily with Sandwell PCT as lead commissioner, for 2011/12 have now largely been concluded and the outcome of these negotiations will form a key element of the Trust's financial plan for next year. This is further considered in other papers presented to the Finance & Performance Management Committee and the Trust Board.

The theme of efficiency requirements and delivery of a QIPP programme in 2011/12 (and beyond), not surprisingly, continues to be actively pursued and promoted by the Department of Health and the Strategic Health Authority. Submission of activity, financial and workforce plans via the FIMS and LTSM processes will take place during March and the Trust will then be judged on the deliverability of those plans and performance monitored in year against them.

Conclusions

• The Trust's performance against its Department of Health control total (i.e. the bottom line budget position it must meet) shows a surplus of £1,748,000 for the eleven months to 28th February. Performance against the statutory accounts position (which includes one-off charges for changes in asset values) shows a deficit of £415,000 as this includes non cash adjustments for revised asset values (Grove Lane land).

• The corresponding results for the month of February show a DH control total surplus of £222,000 and a statutory accounts surplus of £253,000.

• Capital expenditure in February was £980,000, primarily related to ultrasound replacement, statutory standards and medical equipment.

•At 28th February, cash balances are approximately £8.6m higher than the revised cash plan.

•For February, the performance of the majority of divisions has been broadly in line with plan. The only significant in month adverse performance relates to Reserves and Miscellaneous which is a reflection of a prudent view of a number of uncertain events rather than a fundamental or ongoing worsening of performance.

• Current performance needs to continue for the remainder of the financial year to ensure that the Trust meets its statutory financial duties.

SWBTB (3/11) 052 (a)

Sandwell and West Birmingham Hospitals

NHS Trust

Financial Performance Report – February 2011

Recommendations

The Trust Board is asked to:

- i. NOTE the contents of the report; and
- ii. ENDORSE any actions taken to ensure that the Trust remains on target to achieve its planned financial position.

Robert White

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals

NHS 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:	31 March 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 2010 – February 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	х	
Business and market share	х	
Clinical	х	
Workforce	х	
Environmental	х	
Legal & Policy	х	
Equality and Diversity		
Patient Experience	х	
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Financial Management Board and Trust Management Board on 22 March 2011 and Finance and Performance Management Committee on 24 March 2011.

SANDWELL AND WEST BIRMINGHAM HOSPITALS PERFORMANCE MONITORING REPORT - FEBRUARY 2011

EXECUTIVE SUMMARY

Note	Comments										
	tional column has been addec iority and CQUIN targets. The	•			-	•	•		he various National &		
	SHA Winter Targets - 3 per Each indicator, A/E 4-hour w generates additional income	vaits, Delayed T	ransfers of (Care and Amb	ulance Turn	around Time	have specific				
					Feb	ruary		Year to Da	ate (since October)		
	Area			Target	Actual	Available £s	Achieved £s	Available £s	Achieved £s		
	A/E 4-hour waits		%	=>96.00	97.80	50485	50485	252425	201940		
	Delayed Transfers of Care		%	<4.00	5.00	50485	0	252425	0		
	Ambulance Turnaround (<30	mins)	%	=>82.00	75.90	67314	0	336570	0		
	Total					168284	50485	841420	201940		
а	The overall percentage of C half (12) of the cancellations (lowest) since monitoring ag	were in Ophtha	almology. Th	ne proportion c	of Late Starts	s in theatre (1	9%) for the m	nonth of Febru	ary was the best		
b	Delayed Transfers of Care 4.5%	- the number a	nd percenta	ge (5.0%) of d	elays remair	ned high durir	ng February.	Performance f	or the year to date is		
С	Stroke Care - provisional da on a Stroke Unit impoved to within 24 hours of registratio	80.0% (nationa	l target 60%	b). TIA outpatie	ent performa	ince (the perc	entage of Hig	gh Risk patient	s who were treated		
d	Accident & Emergency 4-h performance 97.17%.	iour waits - per	formance di	uring the mont	h of Februar	y further imp	oved to 97.8	0%, increasing	year to date		
е	GU Medicine - the percenta patients offered appointmentinclusive.	•				•		•			
f	The overall number of cases Bacteraemia reported durin Internal trajectories for the p which is also 5.	g the month. Th	e total num	ber of C Diff c	ases for the	year to date r	emains withii	n both the Exte	ernal (DoH) and		
g	Overall Referral to Treatme meet the 90% admitted care	•		•	•		•		astic Surgery failed to		
h	Sickness Absence - the overall sickness absence				•				-		
	CQUIN:										
	Overall scheme financial val	ues are include	d within the	main body of	the report.						

VTE (Venous Thromboembolism) Risk Assessment - Performance for January and February combined is 90.06%. Maintaining this performance during March will ensure the 90% target for Quarter 4 is achieved.

Breast Feeding - Breastfeeding status at time of Guthrie Test (usually day 6 or 7) (*or discharge from midwifery care*). Q1 Baseline data 62.3%, was used to set the target of 72.3% (baseline plus 10%). Final assessment is an audit of Q4 performance. Performance during November fell to 63.0%.

Tissue Viability (Pressure Ulcers) - Comprises 3 components; Assessment on admission, Decrease in number of acute hospital acquired grade 2, 3 and 4 ulcerations and Table Top Reviews on all ulcerations of grade 3 or 4.

• The Q3 audit indicated 92% of patients were assessed on admission (target 75%).

The number of Hospital Acquired Pressure Sores (Grades 2, 3 and 4) for the first 10 months is 40.0% less than the baseline (target 10% less).
 Performance during the month of January was 43.7% less.

• Table Top Reviews for Grade 3 and 4 Pressure Sores are all up to date.

i

Note					Co	omments			SWB	TB (3/11) 049 (a)						
	-	npatient Falls - the target comprises 3 components. An assessment of risk for in-patients, with a target of 75%, a 10% reduction in the number of inpatient falls and Table Top Reviews on all falls with fracture.														
	Most recent perfet	ormance for I	November in	dicated 93.6%	6 of patients	were assess	ed (target 75	%).								
		• The number of inpatient falls reported for the first 9 months of the year is 16.7% less than the baseline (target 10% less). Performance during the month of December was 46.7% less.														
	Table Top Reviews on falls with fracture are all up to date.															
	Brain Imaging for Emergency Stroke Admissions (within 24 hours admission) - provisional data for February indicates performance of 90.9%.															
	Hip Fracture Operations within 24-hours of admission - the percentage of patients receiving an operation with 24 hours of admission during February was 57.1%. Of Note - All patients assessed as clinically suitable have received an operation within 24 hours during the months of January and February.															
	Smoking (Brief Intervention in Outpatients) - a total of 162 referrals are recorded for February. This increases the total for the period to date to 1874 compared with a trajectory for the period of 1833.															
i cont'd)	Safer Prescribing of Warfarin - Number of patients prescribed warfarin with INR (International Normalised Ratio) within the target range															
	Patient Experience - Composite of response to 5 inpatient survey questions. Goal to improve responsiveness to personal needs of patien Survey to be conducted between October and January, for patients who had an inpatient episode between July and August. Target is an improvement (increase) of 2 percentage points on 2009 / 10 baseline.															
Think Glucose - target relates to Inpatients with a secondary diagnosis of Diabetes. Final indicator value is evidence of particip Institute Think Glucose Programme.																
	Parent's Consultation with Senior Clinician - parents able to discuss care of their baby with senior clinician within 24 hours of admission onto neonatal unit. A target of 81% has been set by the Specialised Commissioners. Q4 CQUIN payments for the Neonatal schemes will be based upon Q3 and Q4 performance combined, which for the period October to February inclusive is 78.3%.															
	Neonates Offered Breast Milk - to maximise the number of babies admitted to the neonatal unit who will be offered some breast milk (from nother) during the inpatient episode. A target of 79% has been set by the Specialised Commissioners. Q4 CQUIN payments for the Neonatal schemes will be based upon Q3 and Q4 performance combined, which for the period October - February inclusive is 92.3%.															
	Herceptin Home aim for 50%. This	-			•				m 90%, with Tru	st's now required to						
j	Detailed analysis	of Financial	Performance	e is contained	l within a sep	arate paper t	to this meetin	ıg.								
k	Following the decl 2011. Although thi referrals was more	s still represe	ents a reduct	ion when com	pared with o					638 during January al reduction in GP						
	Activity (trust-wid	e) to date is o	compared wit	h the contrac	ted activity p	lan for 2010 /	/ 2011 - Mon	th and Year	to Date.							
			Мо	nth					Year to Date							
		Actual	Plan	Variance	%		Actual	Plan	Variance	%						
			1024	-80	-7.8	4	10652	11617	-965	-8.3						
	IP Elective	944			16.0	4	48961	42041	6920	16.5						
	Day case	4298	3706	592			E0640	53658								
	Day case IPE plus DC	4298 5242	4730	512	10.8	-	59613		5955	11.1						
	Day case IPE plus DC IP Non-Elective	4298 5242 4487	4730 5039	512 -552	10.8 -11.0		54056	57299	-3243	-5.7						
	Day case IPE plus DC IP Non-Elective OP New	4298 5242 4487 12290	4730 5039 12619	512 -552 -329	10.8 -11.0 -2.6		54056 148597	57299 143173	-3243 5424	-5.7 3.8						
	Day case IPE plus DC IP Non-Elective OP New OP Review	4298 5242 4487 12290 34437	4730 5039 12619 32174	512 -552 -329 2263	10.8 -11.0 -2.6 7.0		54056 148597 401061	57299 143173 365039	-3243 5424 36022	-5.7 3.8 9.9						
	Day case IPE plus DC IP Non-Elective OP New OP Review OP Review:New	4298 5242 4487 12290 34437 2.80	4730 5039 12619 32174 2.55	512 -552 -329 2263 0.25	10.8 -11.0 -2.6 7.0 9.8		54056 148597 401061 2.70	57299 143173 365039 2.55	-3243 5424 36022 0.15	-5.7 3.8 9.9 5.9						
	Day case IPE plus DC IP Non-Elective OP New OP Review	4298 5242 4487 12290 34437	4730 5039 12619 32174	512 -552 -329 2263	10.8 -11.0 -2.6 7.0		54056 148597 401061	57299 143173 365039	-3243 5424 36022	-5.7 3.8 9.9						

	2009 / 10	2010 / 11	Variance	%
IP Elective	12474	10652	-1822	-14.6
Day case	47608	48961	1353	2.8
IPE plus DC	60082	59613	-469	-0.8
IP Non-Elective	58734	54056	-4678	-8.0
OP New	150304	148597	-1707	-1.1
OP Review	382803	401061	18258	4.8
OP Review:New	2.54	2.70	0.16	6.3
AE Type I	174336	165918	-8418	-4.8
AE Type II	31774	33478	1704	5.4

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Overall Elective activity for the month and period to date continues to exceed the plan for the respective periods by a similar level (c.11%). Year to date Non-Elective activity is 5.7% less than plan, although variable by specialty. The Follow Up to New Outpatient activity ratio for the month has increased (adversely) to 2.80.

Please Note: The impact of the in-year revision to the recording of HRG N12 activity within maternity is reflected below. Essentially the annual activity plan for Non-Elective activity is reduced by 4000, with a corresponding increase in the Outpatient Review plan for the year. Actual activity remains unaltered.

		Мо	nth			Ň	Year to Date	
	Actual	Plan	Variance	%	Actual	Plan	Variance	%
IP Non-Elective	4487	4715	-228	-4.8	54056	53615	441	0.8
OP Review	34437	32498	1939	6.0	401061	368723	32338	8.8

Cervical Cytology Turnaround Time - on going monitoring indicates that no samples were waiting to be reported in excess of 9 days throughout the period November 2010 to February 2011. The actual turnaround time on the census date was 5 days. The Trust's performance of 100% of samples being turned around within 14 days compares favourably with West Midlands performance of 95.8% and national performance of 94.7% (for the month of February).

N West Midlands Ambulance Service data indicates further improvement (reduction) in the proportion of ambulances with a turnaround time in excess of 30 minutes (24.1%). During the same period the number of delays in excess of 60 minutes also reduced from 78 to 29.

					SANDWELL AI	ND WEST BIRMINGHAM HOSPITALS C	CORPORATE QUALI	TY AND PERFORMANCE MONITO	ORING REPORT - F	FEBRUA	RY 2011						
Exec			October	November	December	January		Februar	ry		To Date (*=most	TARGET	Exec Summary	THRESHOLDS	S 10/11	Forward	
Lead	ATIONAL AND LOCAL PRIORITY INDICATORS		Trust	Trust	Trust	S'well City	Trust	S'well City	Tru	st	recent month)	YTD 10/11	Note			ection 08/09 Outt	urn 09/10 Outturn
RW Net Income & Expendi	ture (Surplus / Deficit (-))	£000s	223 🔻	91 🔻	341	\rightarrow	332 🔻	\rightarrow	222		1748	1581 2038		0% 0 - 1%	>1%	• 2535	2279
	2 weeks	%	94.9	93.8 🔻	95.0 🔺	\rightarrow	94.6 🔻	\rightarrow			94.3	=>93 =>93		No variation	Any variation	98.6	93.9
BK Concor	2 weeks (Breast Symptomatic)	%	95.7 🔺	97.7 🔺	95.7 🔻	\rightarrow	95.1 🔻	\rightarrow			94.7	=>93 =>93		No variation	Any variation	n/a	93.6 (Q4 only)
RK Cancer	31 Days	%	98.8 🔻	99.4	99.4	\rightarrow	100 🔺	\rightarrow			99.7	=>96 =>96		No variation	Any variation	• 100	99.7
	62 Days	%	83.2	92.4	93.3	→	87.6 🔻	\rightarrow			88.1	=>85 =>85		No variation	Any variation	98.6	89.1
	Elective Admissions Cancelled at last minute for nor clinical reasons	٦- %	0.7	0.7	1.0	1.8 🔻 0.6 🝙	1.1	0.2 0.8	0.6		0.8	<0.8 <0.8	-	<0.8 0.8 - 1.0	>1.0	• 1.0	0.8
Cancelled Operations	28 day breaches	No.	0 🔳	0	0 🗖	\rightarrow	0	→	0		1	0 0	a	3 or less 4 - 6	>6	• 0	0
Delayed Transfers of C	Care Total	%	4.1	5.0 🔻	4.5	2.7 6.8 🔻	4.7 🔻	4.0 6.0	5 .0	▼	4.5	<3.0 <3.0	b	<3.0 3.0 - 4.0	>4.0	3.1	3.0
	Primary Angioplasty (<150 mins)		100	91 🔻	80 🔻						90.4	=>80 =>80		=>80 75-79	<75	83.6	86.2
Cardiology	Rapid Access Chest Pain	%	100	100	100						100	=>98 =>98		>99 98 - 99	<98	• 100.0	99.7
	Thrombolysis (60 minutes)	%	no pts	no pts	0	\rightarrow		\rightarrow			0	80 80		>80 75-80	<75	0	no pts
	>90% stay - EXTERNAL (DH) TARGET	%	68.3 🔻	73.1	77.8	\rightarrow	70.8 🔻	\rightarrow	80.0		72.0	60 60		=>60 31-59	=<30	36.5	62.0
DO'D Stroke Care	>90% stay - INTERNAL TARGET	%	68.3	73.1	77.8	\rightarrow	70.8	\rightarrow	80.0		80.0*	80 80	с	No 0 - 2% Variation Variation	>2% Variation	36.5	62.0
	TIA High Risk Pts. Treatment <24 hours	%	0.0	15.8	20.0	\rightarrow	58.3	\rightarrow	66.7		66.7*	59 60		No 0 - 2%	>2% Variation	•	
A/E 4 Hour Waits		%	96.3 🔻	97.2	93.3	97.4 97.0	97.1	98.7 🛕 97.2	97.8		97.17	98 98	d	=>96 95 - 96	<95	98.16	98.55
RK	Patients seen within 48 hours	%	88.6	86.0 🔻	84.4 🔻	\rightarrow	86.1 🔺	\rightarrow	77.7		85.2	=>90 =>90		=>90 80-89	<80	81.0	86.8
GUM 48 Hours	Patients offered app't within 48 hrs	%	100	100	100	→	100	→	100		100	=>98 =>98	е	=>98 95-98	<95	98.3	99.8
	C. Diff - EXTERNAL (DH) TARGET	No.	9 🔻	6	7 🔻	1 🔺 2 🔺	3	3 🔻 1	▲ 4	•	116	223 243		No variation	Any variation	163	158
R0 Infection Control	C. Diff - INTERNAL TARGET	No.	9 🔻	6	7 🔻	1 🔺 2 🔺	3	3 🔻 1	4	•	116	144 158	f	No	Any variation	163	158
	MRSA - EXTERNAL (DH) TARGET	No.	1 🔳	0	0	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$		0 🔺 0	• 0		5	5 6		No	Any variation	15	14
	Valid Coding for Ethnic Category (FCEs)	%	95	95	94 🔻	\rightarrow	95 🔺	\rightarrow	95		94.5*	90 90		>/=90 89.0-89.9	<89	87.0	95.5
RK Data Quality	Maternity HES	%	5.3	5.5 🔻	5.5	\rightarrow	5.3	\rightarrow	5.7	•	5.70*	<15 <15		=<15 16-30	>30	n/a	5.8
	Maternal Smoking Status Data Complete	%	→	→	99.8	\rightarrow	→	\rightarrow	→	•	99.58	=>98.0 =>98.0		=>98 95-98	<95	99.9	99.3
Infont Health 8	Breast Feeding Status Data Complete	%	→	→	100.0	\rightarrow	→	\rightarrow	→	•	99.98	=>98.0 =>98.0		=>98 95-98	<95	97.8	99.3
RO Infant Health & Inequalities	Maternal Smoking Rates	%	\rightarrow	→	12.6	\rightarrow	→	\rightarrow	→	•	12.44	<11.5 <11.5		<11.5 11.5 - 12.5	>12.5	12.6	11.6
	Breast Feeding Initiation Rates	%	→	→	64.6	\rightarrow	→	\rightarrow	→	•	63.34	>63.0 >63.0		>63.0 61-63	<61.0	54.2	63.1
	Admitted Care (RTT <18 weeks)	%	92.0 🔻	92.6	92.4 🔻	\rightarrow	91.5 🔻	\rightarrow	91.0	•	91.0*	=>90.0 =>90.0		=>90.0 85-90	<85.0	98.6	93.4
	Admitted Care RTT -Specialties <90%	No.	3 🔻	4	2	\rightarrow	2	\rightarrow	2	•	2*	0 0		0	>0	•	
	Admitted Care RTT -Backlog	No.	611	691	736	\rightarrow	844	\rightarrow	548		548*	No. Only No. Only					
RK RTT Milestones	Non-Admitted Care (RTT <18 weeks)	%	97.2 🔻	97.8	97.9	\rightarrow	97.5 🔻	\rightarrow	97.9		97.9*	=>95.0 =>95.0	g	=>95.0 90 - 95	=<90.0	98.8	97.6
	Non-Admitted Care RTT -Specialties <95%	No.	0	0	0	\rightarrow	1	\rightarrow	0		0*	0 0		0	>0		
	Non-Admitted Care RTT -Backlog	No.	142	146	176	→	120	→	117		117*	No. Only No. Only					
	Audiology Direct Access Waits (<18 wks)	%	100	100	100	\rightarrow	100	→	100		100*	=>95 =>95		=>95.0 90 - 95	=<90.0	99.0	100.0
	Hospital Standardised Mortality Rate	HSMR	88.2	82.1	95.3	→	100.8	\rightarrow	99.5	-	94.3				>Upper	105.1	93.0
DO'D Mortality in Hospital	Peer (SHA) HSMR	HSMR	Jul'10 92.6		91.9 Sep '10	→	94.7 Oct '10	\rightarrow		Nov '10	96.7	< Lower Confidence Limit		Confidenc C	Confidenc e Limit	103.9	93.5
	Readmission to any specialty	%	8.5	8.7	9.3	9.2 9.0	9.1				9.1	No. Only No. Only]	11.6	11.4
Readmission Rates w 28 days of discharg		%	3.6	4.0	4.1	4.4 3.5	3.9				4.1	No. Only No. Only				4.6	5.7
RK Desidering Determine	ithin Readmission to any specialty	%	6.3	6.6	6.9	7.0 7.0	7.0				6.9	No. Only No. Only				7.3	8.8
Readmission Rates w 14 days of discharg	ge Readmission to same specialty	%	2.7	3.2	3.2	3.3 2.9	3.1					No. Only No. Only				3.4	4.6
	Long Term	%	3.32	3.27	3.95	→ →	3.57	\rightarrow	3.24		3.41 (Q4	<2.80 <2.80		<2.80 2.80-	>3.10		3.10
Sickness Absence	Short Term	0/_	1.19	1.18	1.44	\rightarrow	1.16	→ ×	0.99		to date) 1.08 (Q4	<1.20 <1.20	h	<u> </u>	>1.35	1.22	1.31
		/0					-				to date) 4.49			<1.20 1.35 4.00-			
RO		<u>%</u>	4.51	4.45	5.39	\rightarrow	4.73	\rightarrow	4.23	-	(Q4 to date)	<4.00 <4.00		<4.00 4.45 0-15% 15 - 25%		4.38	4.41
Learning & Developme		No.	377	358 🔻	245	\rightarrow	337	\rightarrow	267		4353	4896 5341		variation variation v	variation	4518	4748
	Mandatory Training Compliance	%	81.9	84.3	84.4	\rightarrow	84.9	\rightarrow	87.7		87.7	100 100		=>80 50 - 79	<50	• 4044 (No	.) 71.1
																	Page 1 of 6

Exco					Octo	ober	Nove	ember	Dece	mber	January			February			To Date (*=most		Exec Summary	THRESHOLDS		10 / 11 Forward					
Exec Lead	NATIONAL AND LOC	CAL PRIORITY INDICATORS (Cont'd)	Value £000s		Tru	ust	Тг	rust	Tr	ust	S'well	City	Trus	t	S'well	City	Tru	st	recent month)	YTD	10/11	Note			Projection	08/09 Outturn	09/10 Outturn
0'D	VTE F	Risk Assessment (Adult IP)	454	%	54.9		71.7		82.0			, →	88.5		→	-	91.8		90.06	90	90		=>90	<90		n/a	n/a
20	Breas	st Feeding (At D'charge from M'wife)	420	%	74.0	-	63.0					` →			→				(Q4 to date) 63.0*	72.3	72.3		No variation	Any variation	•••	n/a	n/a
20	Tissue	e Viability - assessment <12hrs	210	%		>	-	→	92.0			→			→				92.0 (Q3)	75	75		=>75	<75		n/a	n/a
RO	Tissue	e Viability - Hosp Acq'd Grade 2/3/4	84	%	-57.0		-66.0		-61.0	•		→	-43.7	•	→				-40.0	Base - 10%	Base - 10%		=>-10.0%	<-10.0%	,	n/a	n/a
RO	Tissue	e Viability - TTR of Grade 3/4	126	%	100		100		100			→	100		→				100	1078	1078		100	<100		n/a	n/a
RO	Inpatie	ent Falls Assessment		%		>	93.6					→			→				93.6*	75	75		=>75	<75		n/a	n/a
20	Inpatie	ent Falls reduction	420	%	-15.9		-33.6		-46.7			→			→				-16.7	Base - 10%	Base - 10%		=>-10.0%	<-10.0%	,	n/a	n/a
20	CQUIN Inpatie	ent Falls - TTR of all Fractures		%	100.0		100.0		100.0			→			→				100	10%	1078		100	<100		n/a	n/a
ם'כ	Brain	Imaging for Em. Stroke Admissions	420	%	85.7		88.2		86.5			→	94.3		→		90.9	•	93.0 (Q4 to date)	90.0	90.0	i		- 2% >2% riation Variation		72.0	81.8
RK	Hip Fr	racture Op's <24 hours of admission	420	%	60.0		64.3		73.7				60.0				57.1	•	58.6* (Q4 to date)	70.0	70.0		No 0	- 2% >2% riation Variation	•••	n/a	55.0
סיס	Smok	king - Brief Intervention in OP	420	No.	215		172	•	164			→	146		→		162		1874	1833	2000		->167	per <167		7	1164
ĸ		Prescribing of Warfarin	420	%		- >	.	→ →	69.4			→	→		→		→	-	69.4(M9)	65.0			=>65	onth <107 <65		n/a	n/a
b		nt Experience	454	%		•	.	, →			Composite of 5 Qs -	Survey October	· · · ·		Composite of 5 Qs - Surv	ey October	I				09/10				-	n/a	n/a
D'D		Glucose	420				-	\rightarrow				k Glucose Programme	9		Participation in Think G						+2%				1	n/a	n/a
		nt's consultation with senior clinician	51	%	69		73		85			→ →	81	•	· · · · · · · · · · · · · · · · · · ·	-	83		78.3	81	81		No	Any		n/a	n/a
		ates Offered Breast Milk	51	%	71	-	100		100			, →	90		, >		94	_	(since Oct) 92.3 (since Oct)	79	79		variation No	variation Any		n/a	n/a
	Commissioners)	eptin Home Delivery	85	%	58		52		55			→	58	·	· · · · · · · · · · · · · · · · · · ·		58	_	(since Oct) 58*	50.0	50.0		variation =>50	variation <50		n/a	n/a
															•												
	CLINICAL QUALITY Savings Lives Compliance			%	100	-	100	-	100	-		→	99	•	→		100		100*	>95	>95		< YTD	> YTD]	99.0	99.0
20	Infection Control	MRSA Screening (Elective)		No.	2878	-	3121		2529	-	Numerator = 3116	Denominator =	3116	·		Denominator =	2857	-	30126				target 0-15% 16	5-30% >30%	-	6495	24710
		htrol MRSA Screening (Elective) MRSA Screening (Non-Elective)		No.	1758		1611		1228		Numerator = 1635	Denominator =	1635			2430 Denominator =	1569	· •	21737	27630				5-30% >30%	-	n/a	18571
		Post Partum Haemorrhage (>2000 m	1)	No.	0		1	 	0		0	2430	1	• •	→	2430	0	,	7	44	48			3 - 4 >4	-		10
		Admissions to Neonatal ICU	,	%				•	3.2		-	<u> </u>		•	, >			_	3.2*	=<10	=<10		=<10 10.		-		5.5
D'D	Obstetrics	Adjusted Perinatal Mortality Rate		/1000	7.7	•	9.9	_	8.8	-					→				8.8*	<8.0	<8.0			- 10.0 >10	-		10.9
		Caesarean Section Rate		%	22.8		24.0		25.4		20.0	21.5	21.1	-	→		22.6	•	23.6	<25.0	<25.0			5-28 >28.0	-	27.0	23.3
	FIN	NANCE & FINANCIAL EFFICIENCY		70		_		•		-				•				•		42010	12010						
C	Gross Margin			£000s	2317		1917	•	2168			→	2168	•	→		1847		21697	21386	26711		0% 0	- 1% >1%]	26436	30436
w	-			£000s			1700		2148			→	1771	·	· · · · · · · · · · · · · · · · · · ·		1766	-	19030		20840		0 - 2.5% 2.5	- 7.5% >7.5%	-	11084	15075
	n Year Monthly Run Rat	ite		%	8.78	•	13.75		6.90	•		→	0.91	•	→		8.29		10.56	0	0		NO or a + 0 variation va		-	1.4	0.44
	ncome / WTE			£s	5061		5018		5017	•		→	5109		→		5119		5093	5127	5127			- 5% >5%	1	5014	5058
ŀ	ncome / Open Bed			£s	33952	▼	33975		33270	•		→	34087		>		34983		34548	32697	32697			- 5% >5%	1	30498	32697
		Total Income		£s	3011		2990	▼	3280			→	3043	•	>		3301		3094	2908	2908		No 0	- 4% >4% riation Variation	1	2701	2908
	ncome per Spell	Clinical Income		£s	2661	▼	2692		2932			→	2774	▼	\rightarrow		2980		2775	2580	2580		No 0	- 4% >4% riation Variation	1	2400	2580
		Non-Clinical Income		£s	350		298		348			→	269		→		321	•	319	328	328	j	No 0	- 4% >4% riation Variation	1	301	328
~		Total Cost		£s	3218		2978		3242			→	3008		\rightarrow		3275		3097	2891	2891		├ ─── ├ ──	- 4% >4%]	2682	2891
		Total Pay Cost		£s	2064	▼	2060		2217	▼		→	2096		\rightarrow		2240	▼	2081	1909	1909		No 0 Variation Va	- 4% >4% riation Variation]	1785	1909
	Cost per Spell	Medical Pay Cost		£s	600		583		631	▼		\rightarrow	587		\rightarrow		628	▼	594	555	555		No 0 Variation Va	- 4% >4% riation Variation		532	555
((* Excludes the cost of drugs which are recharge	ged Nursing Pay Cost (including Bank)		£s	614	▼	627	▼	666			→	620		\rightarrow		679		623	660	660			- 4% >4% riation Variation		625	660
C	directly to PCTs)	Non-Pay Cost		£s	1153		918		1025			→	912		\rightarrow		1035		1016	982	982			- 4% >4% riation Variation		897	982
		Mean Drug Cost* / IP Spell		£s	126		147		156	▼		\rightarrow	142		\rightarrow		150	▼	138	124	124		Variation Va	- 4% >4% riation Variation		120	124
		Mean Drug Cost* / Occupied Bed Da	у	£s	50		57		55		.	>	52	-	\rightarrow		58		54	49	49		No 0 Variation Va	- 4% >4% riation Variation		47	49

Exec				Octol	ber	Nover	mber	Decei	mber	January			February		To Date (*=most	TAR	GET	Exec Summary	тн	IRESHOLDS
Lead		PATIENT EXPERIENCE		Trus	st	Tru	ist	Tru	ust	S'well City	Tru	ust	S'well City	Trust	recent month)	YTD	10/11	Note		
	Same Sex Accommodation	Number of Breaches	No.	1270	V	812		1198	▼	→	715		\rightarrow	622	10082	5500	6000		<500 pcm	501 -800 pcm >800 pcm
RK	Breaches	Percentage of overall admissions	%	10.10	V	7.22		11.4	▼	\rightarrow	6.4		\rightarrow	6.0	8.30	<3%	<3%		<3%	3 - 6% >6%
	Operation	Number Received	No.	→	•	→	>			\rightarrow			\rightarrow		398	No. Only	No. Only		LI	
KD	Complaints	Response within initial negotiated date	%	\rightarrow	•	÷	>			\rightarrow			\rightarrow		n/a	85	85		80%+	70 - 79% <70%
	Thank You Letters		No.	\rightarrow	•	→	>			\rightarrow			\rightarrow		n/a	No. Only	No. Only			
		Number of Calls Received	No.	1134	46	113	28	110)39	\rightarrow	110)52	\rightarrow	9806	126997	No. Only	No. Only			
	Elective Access Contact Centre	Average Length of Queue	mins	1.43		0.41		1.09		\rightarrow	0.37		\rightarrow	0.45 🔻	0.45*	<1.0	<1.0		<1.0	1.0-2.0 >2.0
		Maximum Length of Queue	mins	18.4		13.5		26.4		\rightarrow	15.1		\rightarrow	33.2 🔻	33.2*	<6.0	<6.0		<6.0	6.0-12.0 >12.0
		Number of Calls Received	No.	7670	08	762	56	796	61	\rightarrow	775	520	\rightarrow	69366	830909	No. Only	No. Only			
RK		Calls Answered	%	90.8		91.7		88.6		\rightarrow	89.6		\rightarrow	92.0	90.5	No. Only	No. Only			
	Telephone Exchange	Answered within 15 seconds	%	53.1		54.4		48.2		\rightarrow	49.9		\rightarrow	59.1	52.2	No. Only	No. Only			
		Answered within 30 seconds	%	68.8		71.0		63.9		\rightarrow	65.6		\rightarrow	75.3	68.2	No. Only	No. Only			
		Average Ring Time	Secs	24.2		21.8		26.8		\rightarrow	25.6		\rightarrow	18.5	18.5*	No. Only	No. Only			
		Longest Ring Time	Secs	412		594		653		\rightarrow	591		\rightarrow	699	699*	No. Only	No. Only			
	1	STRATEGY	-					1		1			T							
		Total	No.	15055		15448		11742		→	13638		\rightarrow		152139	160017	192945		No Variation	0 - 2% >2% Variation Variation
		Total GP Referrals	No.	10076		10592		7762		→	9438		\rightarrow		103279	105326	127001		No Variation	0 - 2% >2% Variation Variation
		Total Other Referrals	No.	4979		4856		3980		→	4200		\rightarrow		48860	54691	65944		No Variation	0 - 2% >2% Variation Variation
RK	Referrals	By PCT - Heart of B'ham	No.	3956		4195		3046		→	3702		\rightarrow		41171	43628	52604	k	No Variation	0 - 2% >2% Variation Variation
		By PCT - Sandwell	No.	7581		7884		6102		\rightarrow	7082		\rightarrow		77031	80198	96699		No Variation	0 - 2% >2% Variation
		By PCT - Other	No.	3518		3369		2594		\rightarrow	2854		\rightarrow		33937	36196	43642		No Variation	0 - 2% >2% Variation Variation
		Conversion (all referrals) to New OP Att'd	%	91.2		94.2		96.1		\rightarrow	98.5		\rightarrow		89.6	No. Only	No. Only			
		OP Source of Referral Information	%	1.27	•	1.38	•	1.58	•	\rightarrow	1.47		\rightarrow	1.33 🔺	1.21	=<5.0	=<5.0		No variation	Any variation
		ΑCTIVITY	_											1						
		Elective IP	No.	1022		973		884		\rightarrow	913		\rightarrow	944 🔻	10652	11617	12641		No Variation	0 - 2% >2% Variation Variation
		Elective DC	No.	4486	▼	4711		3828	▼	\rightarrow	4554		\rightarrow	4298 🔻	48961	42041	45747		No Variation	0 - 2% >2% Variation Variation
		Total Elective	No.	5508	▼	5684		4712	▼	\rightarrow	5467		\rightarrow	5242	59613	53659	58338		No Variation	0 - 2% >2% Variation Variation
	Spells	Non-Elective - Short Stay	No.	1243	V	1207		1125	▼	→	1190		\rightarrow	1143 🔻	15162	14471	15712		No Variation	0 - 2% >2% Variation Variation
		Non-Elective - Other	No.	3779	V	3665		3951		\rightarrow	3716	V	\rightarrow	3344	38894	42828	46502		No Variation	0 - 2% >2% Variation Variation
RK		Total Non-Elective	No.	5022		4872	_	5076		→	4906		→	4487 🔻	54056	57299		I	No	0 - 2% >2%
		New	No.	13723	•	14549		11284		→	13414		→	12290	148597		155792		Variation No	VariationVariation0 - 2%>2%
	Outpatients	Review	No.	35815		38301		30768		→ ×	35272		→	34437	401061		397213		Variation No	VariationVariation0 - 2%>2%
	A/E Attandances				_							-							Variation No	Variation Variation 0 - 2% >2%
	A/E Attendances	Type I (Sandwell & City Main Units)	No.	14997	• 	14444		14721		6504 8 028	14532		5976 7 317	13293	165918		191845		Variation No	Variation Variation 0 - 2% >2%
	A/E Attendances	Type II (BMEC)	No.	3238	•	3132		2426	-	→ 2889	2889		→ 2800 ▲	2800	33478	32463	35133			Variation Variation

08/09 Outturn	09/10 Outturn
n/a	3711 (Nov - Mar)
n/a	6.47 (Nov - Mar)
789	875
81.1	70.6
2912	2286
190434	
0.44	incomplete data
17.4	
1559688	1100521
82.3	83.6
39.1	43.8
55.5	58.8
28.8	36.0
695	646

192945
127001
65944
52604
96699
43642
85.3
1.4

13106	13722
50873	52729
63979	66451
12770	18769
56226	47072
68996	65841
152923	164358
374867	425850
191141	190254
30800	34836
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	iting Times	PATIENT ACCESS & EFFICIENCY Diagnostic Waits greater than 6 weeks		Trus											-									Exec Summary	-	
	-	Diagnostic Waits greater than 6 weeks		i i us	st	Trus	st	Tru	st	S'we	ell	Cit	ty	Tru	st	S'well	С	ity	Tru	ıst	To Date (*=most recent month)	YTD	10/11	Note		
Len			No.	4		22	▼	45	▼		_	>		32			→		24		24*	0	0		0	>
Len		Average Length of Stay	Days	3.9		4.6	•	4.5		5.0	▼	4.0		4.4							4.3	5.0	5.0		No Variation	0 - 5% >5 Variation Varia
Len		All Patients with LOS > 14 days	No.	320		320		342		180		147		327		201	149		350		350	No. Only	No. Only			
	gth of Stay	All Patients with LOS > 28 days	No.	180		178		182		97		90		187		106	81		187		187	No. Only	No. Only			
		Min. Stay Rate (Electives (IP/DC) <2 days)	%	92.2	▼	93.4		92.9	▼	96.0		92.3		93.8		95.2 🔻	90.6	▼	92.5	▼	93.1	92.0	92.0		No Variation	0 - 5% >5 Variation Varia
		Day of Surgery (IP Elective Surgery)	%	90.1		91.0		90.2	▼	90.8	▼	90.5		90.6		91.3 🔺	89.4	▼	90.0	▼	88.5	82.0	82.0		No Variation	0 - 5% >5 Variation Varia
Г. I.		Day of Surgery (IP Non-Elective Surgery)	%	72.2		75.0		77.5		68.6		74.5		72.4		71.2	77.1		75.8		73.4	No. Only	No. Only			
Aam	nissions	With no Procedure (Elective Surgery)	%	8.8		9.1		8.5		8.9		7.3		7.9							8.2	No. Only	No. Only			
		Per Bed (Elective)	No.	5.61		5.52	•	5.43	▼	4.54		6.34	▼	5.43		4.73	6.46		5.60		5.69	5.90	5.90		No Variation	0 - 5% >5 Variation Varia
Die		Pt's Social Care Delay	No.	27		32	▼	20		9		19		28	-	14	8		22		22*	<18	<18	•	No Variation	0 - 10% >10 Variation Varia
Disc	charges	Pt.'s NHS & NHS plus S.C. Delay	No.	15		13		8		3		12		15		7	12		19	▼	19*	<10	<10	D	No Variation	0 - 10% >10 Variation Varia
		Occupied Bed Days	No.	26616		26747	▼	27602	▼	14156	▼	14126	▼	28252	▼	11863	13023		24886		292396	305209	331946		No Variation	0 - 5% >5 Variation Varia
Bed	ls	Occupancy Rate	%	86.6	•	87.2	•	84.9		88.3		85.6		87.0	-	90.0	83.5		86.7		86.5	86.5- 89.5	86.5- 89.5		86.5 - 89.5	85.5-86.4 <8 or o
DK		Open at month end (exc Obstetrics)	No.	934		929	•	965		452		474		926		455	463		918		918*	960	920		No Variation	0 - 2% >2 Variation Varia
RK		All Procedures	%	80.1	▼	81.9		80.6	▼	85.2		79.8		82.0		85.6	78.1	▼	81.2	▼	81.5	80.0	80.0		No Variation	0 - 5% >5 Variation Varia
Day	v Case Rates	BMEC Procedures	%	84.3		82.3	•	83.4		\rightarrow	•	86.4		86.4		\rightarrow	80.9	▼	80.9	▼	82.3	80.0	80.0		No Variation	0 - 5% >5 Variation Varia
		New : Review Rate	Ratio	2.61		2.63	▼	2.71	▼	2.70		2.60		2.63		2.99 🔻	2.72	▼	2.80	▼	2.70	2.30	2.30		No Variation	0 - 5% >5 Variation Varia
		DNA Rate - New Referrals	%	13.8	▼	13.1		15.0	▼	12.9		14.1		13.7		11.1	12.2		11.8		13.2	<8.0	<8.0		<8%	8 - 12% >12
		DNA Rate - Reviews	%	12.3		11.6	-	13.2		13.6	▼	13.1	▼	13.3	▼	9.8	10.4		10.2		11.9	<8.0	<8.0		<8%	8 - 12% >12
New		OP Cancs / Rescheduled - Trust Initiated	No.	8808		9464		11650			_	>		15247			\rightarrow		10749		121948	No. Only	No. Only			•
Non	Non-Admitted Care	OP Cancs / Rescheduled - Patient Initiated	No.	7450		8438		9148			_	>		8520			\rightarrow		7454		85002	No. Only	No. Only			
		OP Cancs (<14 days) - Trust & Patient	No.	8997		9935		10732			_	>		10988			\rightarrow		8818		101449	No. Only	No. Only			
		OP Cancs (>2 since last app't) - Trust & Pt	No.	2214		2300		2382			_	>		3417			\rightarrow		2659		24535	No. Only	No. Only			
		OP App'ts Booked (>14 days notice)	%	58.9		60.6		60.6			_	>		63.3			\rightarrow		57.8		60.1	No. Only	No. Only			
	gnostic Report naround	Cervical Cytology Turnaround	Days			<9 days	•	<9 days			_	>		<9 days			\rightarrow		<9 days		<9 days*	<9 days	<9 days	m	<9 days	9-12 days >12
		In Excess of 30 minutes	%	26.5	▼	25.1		30.5	▼	30.2		24.7		27.2		24.7	23.6		24.1		24.1*	<10.0	<10.0		<10	10 - 12.5 >12
Amł	bulance Turnaround	(West Midlands average)	%	33.7		32.7		36.9			_	>		32.1			\rightarrow		30.2		30.2*	No. Only	No. Only	n		
		In Excess of 60 minutes	No.	33	▼	32		134	▼	51		27		78		19 🔺	10		29		29*	0	0		0	1 - 5 >
		THEATRE UTILISATION															-						•			
		General Surgery	No.	6		1	•	5	▼	4		1		5		0	1		1		58	55	60		0-5% variation	5 - 15% >15 variation varia
		Urology	No.	5		2	•	10		22		0		22	▼	1	1		2		85	44	48		0-5% variation	5 - 15% >15 variation varia
		Vascular Surgery	No.	0	•	0	•	0		0		0		0		0	1		1		8	3	3		0-5% variation	5 - 15% >15 variation varia
		Trauma & Orthopaedics	No.	3	•	6	•	5		2		0		2		0	0		0		49	66	72		0-5% variation	5 - 15% >15 variation varia
		ENT	No.	0	•	2	•	2		0		1		1	-	0	2		2	-	17	11	12		0-5% variation	5 - 15% >15 variation varia
	•	Ophthalmology	No.	8	•	20		10		5		9		14	-	0	12		12	-	131	99	108		0-5% variation	5 - 15% >15 variation varia
	ncellations by ecialty	Oral Surgery	No.	0	•	2		3	▼	0		1		1	-	0	1		1		10	7	8	а	0-5% variation	5 - 15% >15 variation varia
		Cardiology	No.	1	•	2	•	0		1		0		1	▼	0	0		0		14	19	21		0-5% variation	5 - 15% >15 variation varia
		Gynaecology / Gynae-Oncology	No.	6		2	•	11		3		1		4		2	4		6		58	50	54		0-5% variation	5 - 15% >15 variation varia
		Plastic Surgery	No.	0		2		1		0		0		0		0	0		0		8	11	12		0-5% variation	5 - 15% >15 variation varia
		Dermatology	No.	6		0	•	0		0		0		0		0	0		0		13	22	24		0-5%	5 - 15% >15 variation varia
		TOTAL	No.	35	•	39	•	47		37		13		50	•	3	22		25		451	387	422		0-5%	5 - 15% >15 variation varia

08/09 Outturn	09/10 Outturn
26	3
5.0	4.4
312	356
152	195
91.6	92.3
79.4	85.5
70.2	69.7
10.6	9.7
5.33	5.49

342793	331946
90.3	86.0
975	989
79.0	79.4
79.7	79.7
2.45	2.59
12.0	13.5
13.5	12.3

19.0	23.9
21.0	25.5
	46

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Exec				Octo	ober	Nover	mber	Decer	nber	January			February			To Date (*=most	TARGET	Exec Summary	THRESHOLDS			
Lead		WORKFORCE		Tru	ust	Tru	ıst	Tru	Ist	S'well City	Tru	st	S'well City	Tru	ust	recent month)	YTD 10/11	Note		08/0	09 Outturn	09/10 Outturn
		Total	No.	6266	▼	6289	•	6306	•	\rightarrow	6178		→	6274	▼	6274*	6420 6107		No 0 - 1% >1% Variation Variation		6042	6539
		Medical and Dental	No.	750		752	•	752		\rightarrow	746		\rightarrow	752	▼	752*	786 790		No 0 - 1% >1% Variation Variation		755	825
		M'ment, Admin. & HCAs	No.	2489		2518	•	2533	•	\rightarrow	2512		\rightarrow	2522	▼	2522*	2751 2492		No 0 - 1% >1% Variation Variation		1852	2046
rk V	VTE in Post	Nursing & Midwifery (excluding Bank)	No.	1774	▼	1770		1764		\rightarrow	1744		\rightarrow	1761	▼	1761*	1832 1822		No 0 - 1% >1% Variation Variation		2259	2385
		Scientific and Technical	No.	988	▼	980		985	▼	\rightarrow	984		\rightarrow	981		981*	1052 1003		No 0 - 1% >1% Variation Variation		913	1002
		Bank Staff	No.	264		269		303		\rightarrow	192		\rightarrow	258		258*	No. Only No. Only				260	281
		Gross Salary Bill	£000s	21736		21749	•	21697	▼	\rightarrow	21737	•	\rightarrow	21796		236590	236299 250319		No0 - 1%>1%VariationVariationVariation	:	238674	252557
		Nurse Bank Fill Rate	%	85.2		87.2		77.2		\rightarrow	82.0		\rightarrow	86.9		86.2	No. Only No. Only				81.8	85.1
		Nurse Bank Shifts covered	No.	4791	▼	4750		4325		\rightarrow	4569	•	\rightarrow	4408		49482	56486 61621		0 - 2.5% 2.5 - >5.0% Variation 5.0% Variation		69675	61621
RK		Nurse Agency Shifts covered	No.	451		449		538	•	\rightarrow	590	▼	\rightarrow	305		4143	4368 4765		0 - 5% 5 - 10% >10% Variation Variation		4765	5388
ĸĸ		Nurse Bank AND Agency Shifts covered	No.	5242	▼	5049		4863		\rightarrow	5159	•	\rightarrow	4713	▼	53625	60854 66386		0 - 2.5% 2.5 - >5.0% Variation 5.0% Variation		74440	67009
		Nurse Bank Costs	£000s	508	▼	474		534	▼	\rightarrow	331		\rightarrow	489	▼	5013	5870 6404		0 - 2.5% 2.5 - >5.0% Variation 5.0% Variation		6844	6263
E	Bank & Agency	Nurse Agency Costs	£000s	93		127		96		\rightarrow	110	▼	\rightarrow	116	▼	873	909 992		0 - 5% 5 - 10% >10% Variation Variation		832	1268
L		Medical Agency Costs	£000s	282	▼	228		253	▼	\rightarrow	269	▼	\rightarrow	294	▼	2709	1093 1192		0 - 5% 5 - 10% >10% Variation Variation		2026	2384
KD		Medical Locum Costs	£000s	179		161		223		\rightarrow	231	▼	\rightarrow	194		2609	2062 2250		0 - 2.5% 2.5 - >5.0% Variation 5.0% Variation		2747	2896
ND		Med Ag./Loc Costs as % Total Med Costs	%	7.0		6.1		7.4		\rightarrow	7.9		\rightarrow	7.6		7.6	No. Only No. Only				6.6	7.0
		Med Staff Exp variance from Budget	%	4.5	▼	3.7		4.1	▼	\rightarrow	4.4	▼	\rightarrow	4.8	▼	4.02	0 0		No 0 - 1% >1% Variation Variation		2.86	3.24
RK		Other Agency Costs	£000s	230		242	▼	214		\rightarrow	204		\rightarrow	188		2362	1292 1410		0 - 5% 5 - 10% >10% Variation Variation		3759	2600
RK/KD		Agency Spend cf. Total Pay Spend	%	2.78		2.74		2.59		\rightarrow	2.49		\rightarrow	2.74	▼	2.51	<2.00 <2.00		<2 2 - 2.5 >2.5		2.77	2.47
RO		Permission to Recruit	wte	75		30		57		\rightarrow	62		\rightarrow	40		674	No. Only No. Only				1124	813
	Recruitment & Retention	New Starters	wte	83		79		61		\rightarrow	47		\rightarrow	81		903	No. Only No. Only				1066	1017
		Leavers	wte	75		47		52		\rightarrow	48		\rightarrow	73		891	No. Only No. Only				999	928
		Corporate Inductions	%	80		90		78		\rightarrow	90	•	\rightarrow			88	100 100		=>80 50 - 79 <50		896	805
КЕҮ ТО Р	ERFORMANCE ASSESSI	MENT SYMBOLS																KEY TO FORWAR	D PROJECTION ASSESSMENT			
F	Fully Met - Performance co	ontinues to improve																•	Maintain (at least), existing perfo	prmance to meet target		
F	Fully Met - Performance Ma	aintained																•	Improvement in performance re	equired to meet target		
V N	Net, but performance has d	deteriorated																••	Moderate Improvement in perfe	ormance required to meet	t target	
	Not quite met - performance	e has improved																•••	Significant Improvement in pe	rformance required to me	eet target	
	Not quite met																					
V	Not quite met - performance	e has deteriorated																				
	Not met - performance has	improved																				
	Not met - performance show	wing no sign of improvement																				
	lot mot - porformanco sho	ws further deterioration																				

Please note: Although actual performance within the period may have improved, this may not always be reflected by a symbol which reflects this, if the distance from trajectory has worsened



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LATE STARTS (%)			20	09 / 2010			2010 / 2011												
Theatre Location	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Мау	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb		
City (Main Spine)	28	26	24	31	23	21	22	29	26	20	25	25	23	21	21	20	12		
City (BTC)	31	32	25	36	30	31	29	28	33	37	48	35	40	31	23	30	21		
City (BMEC)	42	43	30	19	22	23	27	23	26	24	26	9	20	20	36	30	14		
Sandwell (Main Theatres)	29	43	32	38	30	36	39	32	37	33	41	34	37	38	53	40	25		
Sandwell (SDU)	23	34	22	30	25	23	21	12	23	24	19	27	21	27	41	34	28		
TRUST	32	36	27	31	26	26	27	25	29	28	31	25	28	28	34	30	19		
	•	KE	Y: GREEN	\ = <5.1%	deviation from	n target,	AMBER =	5.1 - 15.0	9% deviati	on, <mark>RED</mark> =	= >15.0% c	leviation	•	•	•	•			

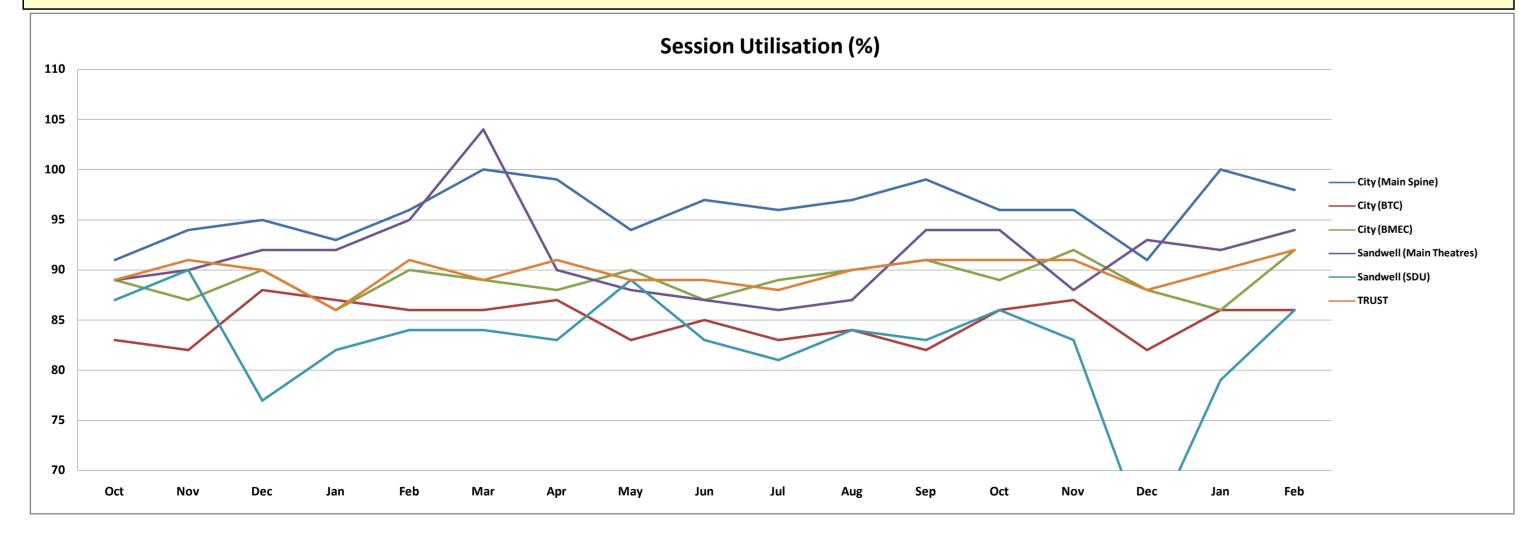
Late Starts (%) 50 45 40 35 30 25 15



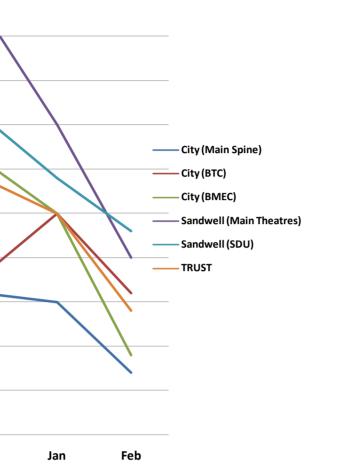
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		20	09 / 2010			2010 / 2011												
Oct	Nov	Dec	Jan	Feb	Mar	Apr	Мау	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb		
91	94	95	<mark>9</mark> 3	96	100	99	94	97	96	97	99	96	96	91	100	98		
83	82	88	87	86	86	87	83	85	83	84	82	86	87	82	86	86		
89	87	90	86	90	89	88	90	87	89	90	91	89	92	88	86	92		
89	90	92	92	95	104	90	88	87	86	87	94	94	88	93	92	94		
87	90	77	<mark>82</mark>	84	84	83	89	83	81	84	83	86	83	63	79	86		
89	91	90	86	91	89	91	89 8	89	88	90	91	91	91	<mark>88</mark>	90	92		
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KEY: GREEN = <5.1% deviation from target, AMBER = 5.1 - 15.0% deviation, RED = >15.0% deviation

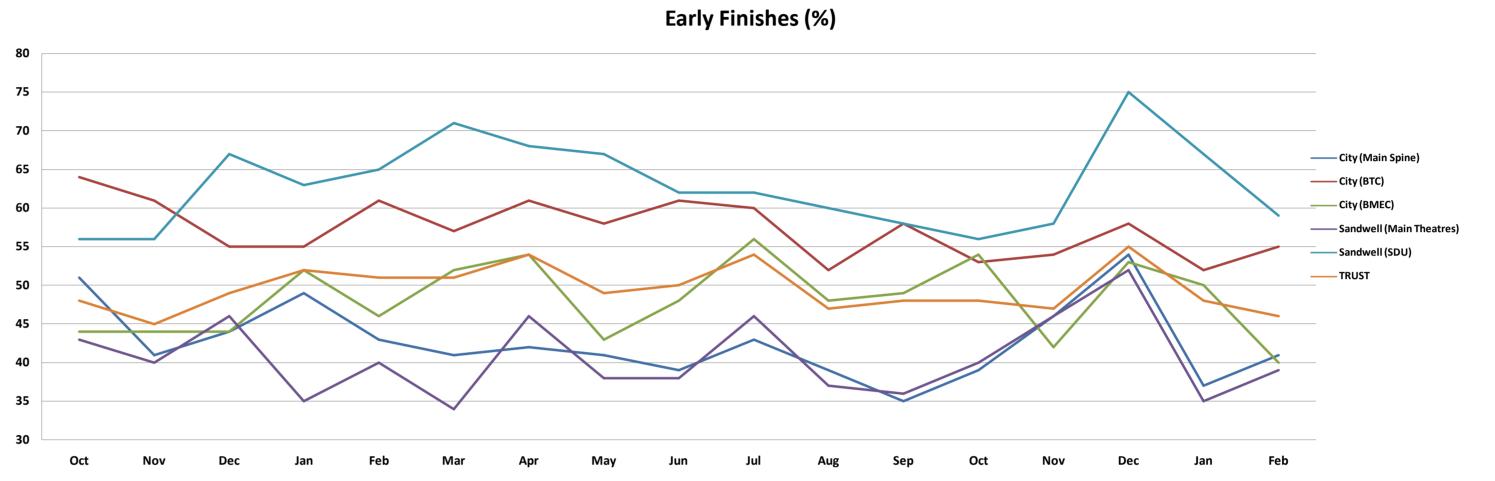


SUPPLEMENTARY DATA THEATRE UTILISATION



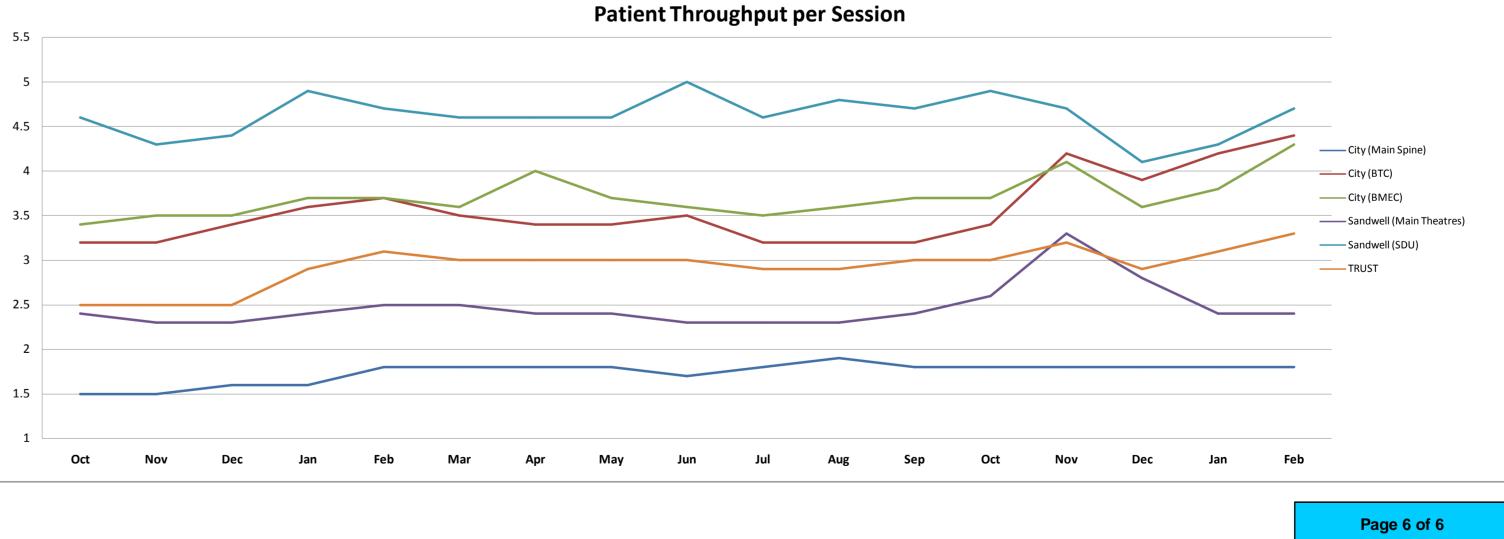
EARLY FINISHES (%)			2009	2010			2010 / 2011													
Theatre Location	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Мау	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb			
City (Main Spine)	51	41	44	49	43	41	42	41	39	43	39	35	39	46	54	37	41			
City (BTC)	64	<u>61</u>	55	55	61	57	61	58	61	60	52	58	53	54	58	52	55			
City (BMEC)	44	44	44	52	46	52	54	43	48	56	48	49	54	42	53	50	40			
Sandwell (Main Theatres)	43	40	46	35	40	34	46	38	38	46	37	36	40	46	52	35	39			
Sandwell (SDU)	56	56	67	63	65	71	68	67	62	62	60	58	56	58	75	67	59			
TRUST	48	45	49	52	51	51	54	49	50	54	47	48	48	47	55	48	46			

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



THROUGHPUT / SESSION			2009 /	2010			2010 / 2011												
Theatre Location	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Мау	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb		
City (Main Spine)	1.5	1.5	1.6	1.6	1.8	1.8	1.8	1.8	1.7	1.8	1.9	1.8	1.8	1.8	1.8	1.8	1.8		
City (BTC)	3.2	3.2	3.4	3.6	3.7	3.5	3.4	3.4	3.5	3.2	3.2	3.2	3.4	4.2	3.9	4.2	4.4		
City (BMEC)	3.4	3.5	3.5	3.7	3.7	3.6	4.0	3.7	3.6	3.5	3.6	3.7	3.7	4.1	3.6	3.8	4.3		
Sandwell (Main Theatres)	2.4	2.3	2.3	2.4	2.5	2.5	2.4	2.4	2.3	2.3	2.3	2.4	2.6	3.3	2.8	2.4	2.4		
Sandwell (SDU)	4.6	4.3	4.4	4.9	4.7	4.6	4.6	4.6	5.0	4.6	4.8	4.7	4.9	4.7	4.1	4.3	4.7		
TRUST	2.5	2.5	2.5	2.9	3.1	3.0	3.0	3.0	3.0	2.9	2.9	3.0	3.0	3.2	2.9	3.1	3.3		
				1º/ dovia	tion from	torgot A		. 1 . 1 5 . 00/	doviatio	DED -	15.0% da	viation	:		,,				

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



Sandwell and West Birmingham Hospitals

NHS Trust

TRUST BOARDDOCUMENT 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 MgtAUTHOR:Mike Harding, Head of planning & Performance Management
and Tony Wharram, Deputy Director of FinanceDATE OF MEETING:31 March 2011

SUMMARY OF KEY POINTS:

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

Service Performance:

- There is 1 area of underperformance during the month of February; Delayed Transfers of Care.
- The overall weighted score for the month of February is calculated as 2.80 with the Trust classified as Performing.

Financial Performance:

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

Foundation Trust Compliance (Summary) Report:

- There were no areas of underperformance reported within the framework during the month of February. Performance in areas where no data are currently available for the month are expected to meet operational standards.
- The projected overall score for the month of February 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:

Finance and Performance Management Committee on 24 March 2011.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2010/11

Operational Standards and Targets

	Г	Thre		
Indicator	Weight	Performing	Underperforming	Q3 2
		05.00	04.00	
A/E Waits less than 4-hours	1.00	95.00	94.00	95.
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	2
18-weeks RTT Admitted Median Wait (weeks)	0.50	11.1	>11.1	
18-weeks RTT Admitted 95 Percentile(weeks)	0.50	27.7	>27.7	
18-weeks RTT Non Admitted Median Wait (weeks)	0.50	6.6	>6.6	
18-weeks RTT Non Admitted 95 Percentile(weeks)	0.50	18.3	>18.3	
18-weeks RTT Incomplete Pathway Median (weeks)	0.50	7.2	>7.2	
18-weeks RTT Incomplete Pathway 95 percentile (weeks)	0.50	36.1	>36.1	
Cancer - 2 week GP Referral to 1st OP Appointment	0.50	93.0%	88.0%	94
Cancer - 2 week GP Referral to 1st OP Appointment - breast symptoms	0.50	93.0%	88.0%	94
Cancer - 31 day second or subsequent treatment (surgery)	0.33	94.0%	89.0%	98
Cancer - 31 day second or subsequent treatment (drug)	0.33	98.0%	93.0%	100
Cancer - 31 day diagnosis to treatment for all cancers	0.33	96.0%	91.0%	99
Cancer - 62 day referral to treatment from screening	0.33	90.0%	85.0%	100
Cancer - 62 day referral to treatment from hospital specialist	0.33	85.0%	80.0%	91
Cancer - 62 day urgent referral to treatment for all cancers	0.33	85.0%	80.0%	89
Reperfusion - Primary Angioplasty (within 150 minutes of call)	1.00	75.00%	60.00%	90.
2-week Rapid Access Chest Pain	1.00	98.0%	95.0%	100
48-hours GU Medicine Access	1.00	98.0%	95.0%	100
Delayed Transfers of Care	1.00	3.5%	5.0%	3.50 -
Stroke (Stay on Stroke Unit)	1.00	60.0%	30.0%	73.

2.4

Sum Average Score

Performing if greater than

Scoring: Underperforming 0 Performance Under Review 2 Performing Assessment Thresholds Underperforming if less than 2.1 Performance Under Review if between 2.1 and 2.4

15.00

Q3 2010-11	Score	Weight x Score	January 2011	Score	Weight x Score	February 2011	Score	Weight x Score
95.62%	3	3.00	97.10%	3	3.00	97.80%	3	3.00
0%	3	3.00	0%	3	3.00	0%	3	3.00
1	3	3.00	1	3	3.00	0	3	3.00
22	3	3.00	3	3	3.00	4	3	3.00
5	3	1.50	7	3	1.50	6	3	1.50
20	3	1.50	22	3	1.50	22	3	1.50
4	3	1.50	6	3	1.50	4	3	1.50
15	3	1.50	16	3	1.50	15	3	1.50
5	3	1.50	4	3	1.50	4	3	1.50
17	3	1.50	18	3	1.50	17	3	1.50
94.5%	3	1.50	94.6%	3	1.50	>93.0%*	3	1.50
94.6%	3	1.50	95.1%	3	1.50	>93.0%*	3	1.50
98.5%	3	0.99	100.0%	3	0.99	>94.0%*	3	0.99
100.0%	3	0.99	100.0%	3	0.99	>98.0%*	3	0.99
99.2%	3	0.99	100.0%	3	0.99	>96.0%*	3	0.99
100.0%	3	0.99	91.7%	3	0.99	>90.0%*	3	0.99
91.1%	3	0.99	94.1%	3	0.99	>85.0%*	3	0.99
89.9%	3	0.99	87.6%	3	0.99	>85.0%*	3	0.99
90.50%	3	1.50	>75.0%*	3	3.00	>75.0%*	3	3.00
100.00%	3	3.00	>98.00%*	3	3.00	>98.00%*	3	3.00
100.00%	3	3.00	100.00%	3	3.00	100.00%	3	3.00
3.50 - 5.00%	2	2.00	4.70%	2	2.00	5.00%	0	0.00
73.80%	3	3.00	70.80%	3	3.00	80.00%	3	3.00

42.44 2.83

*projected

43.94 2.93

*projected

41.94 2.80

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2010/11

Financial	Indicators		1		SCORING						2011 / 2012			
Criteria	Metric	Weight	(%)	3	2	1	December	Score	Weight x Score	January	Score	Weight x Score	February	Score
Initial Planning	Planned Outturn as a proportion or turnover	^{of} 5	5	surplus that is either equal to or at	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	0.00%	3	0.15	0.00%	3	0.15	0.00%	3
Year to Date	YTD Operating Performance	25	20	that is aither agual to an at variance to	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of forecast income.	Operating deficit more than or equal to 2% of forecast income	0.04%	3	0.6	0.04%	3	0.6	0.04%	3
	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.	6.15%	3	0.15	6.22%	3	0.15	6.17%	3
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.		Operating deficit more than or equal to 2% of income	0.00	3	0.6	0.00	3	0.6	0.00	3
	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.	6.30%	3	0.15	6.31%	3	0.15	6.22%	3
	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 of greater than 2% of forecast income.	0.00%	3	0.45	0.00%	3	0.45	0.00%	3
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	0.53%	3	0.15	0.53%	3	0.15	0.53%	3
	EBITDA Margin (%)		5		Underlying EBITDA equal to or greater than 5% but less than 1% of underlying income		6.30%	3	0.15	6.31%	3	0.15	6.22%	3
	Better Payment Practice Code Value (%)		2.5	95% or more of the value of NHS and Non NHS bills are paid within 30days			83.00%	2	0.05	57.00%	1	0.025	65.00%	2
	Better Payment Practice Code Volume (%)		2.5		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	82.00%	2	0.05	59.00%	1	0.025	68.00%	2
Finance Processes & Balance Sheet Efficiency	Current Ratio	20	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	1.02	3	0.15	1.01	3
	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	19.33	3	0.15	19.98	3	0.15	17.64	3
	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	48.57	2	0.1	47.16	2	0.1	47.07	2

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

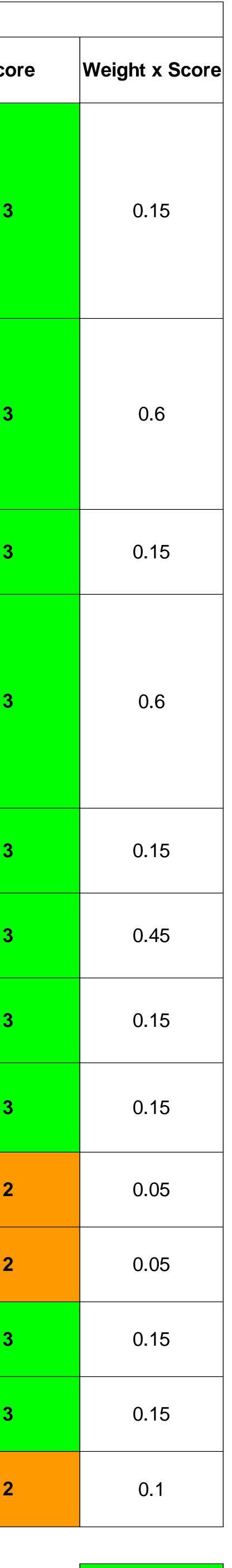
Assessment Thresholds					
> 2.40					
2.10 - 2.40					
< 2.10					

Weighted Overall Score

2.85

2.85

SWBTB (3/11) 048 (a)



2.90

Sandwell and West Birmingham Hospitals

NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Same-Sex Accommodation Progress Report
SPONSORING DIRECTOR:	Richard Kirby, Chief Operating Officer
AUTHOR:	Richard Kirby, Chief Operating Officer
Date of meeting:	31 March 2011

SUMMARY OF KEY POINTS:

The attached paper notes the progress that has been made in delivering same-sex accommodation especially at City Hospital but recommends a declaration of non-compliance with the national standards as at 1st April 2011 in light of the delays to converting D26 into a pair (D26 / D28) of same-sex elective orthopaedic wards.

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

Approval	Receipt and Noting	Discussion
Х		

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 February 2011;
- 2. APPROVE the declaration of non-compliance with the national standards in light of the delays to changes to ward D26 at City Hospital;
- 3. REQUEST a further update including confirmation that the changes to D26 have been delivered for Board meeting in June 2011.

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	х	£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	х	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.

Sandwell and West Birmingham Hospitals

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

INTRODUCTION

At its meeting in October 2010, the Trust Board agreed a plan to ensure full compliance with national same-sex accommodation standards by the end of March 2011. This plan included a change in the configuration of wards at City Hospital from single-speciality / mixed-sex to same-sex / mixed-specialty. The board noted a number of significant risks associated with this plan. This paper provides a progress report on delivery of this plan and includes the annual declaration of compliance or non-compliance with the national standards required from all Trusts.

PROGRESS

The Trust has made significant progress with ensuring full compliance with national standards for same-sex accommodation. The following arrangements are now in place across our hospitals:

- a. Wards at Sandwell General Hospital, Rowley Regis Hospital and the Sheldon Block at City Hospital. These wards are configured in 6 bed samesex bays with separate male and female toilet and washing facilities on the wards.
- **b.** Wards at City Hospital. In line with the plan agreed in October 2010 these wards will be same-sex wards caring for patients from a pair of specialties by 1st April arranged as follows:
 - D7 (F) / D41 (M): short stay medicine (inc. poisons and sickle-cell patients)
 - D16 (F) / D18 (M): general medicine / care of the elderly (inc. renal patients)
 - D17 (F) / D15 (M): respiratory and gastroenterology
 - D24 (F) / D21 (M): vascular and ENT
 - D30 (M): general surgery / urology
 - D25 (F): general surgery / breast / plastics
 - D27 (F): gynaecology / gynae-oncology
 - D24 / D29: vacant wards for use as decant and/or flexible winter capacity.

One pair of wards (D26 / D28 orthopaedics) will not be same-sex by the 1st April. More information is provided on this ward below.

- c. Assessment Units (EAU at Sandwell, MAU and SAU at City). Operate same-sex bays with separate male and female washing and toilet facilities.
- **d.** Clinically Specialist Areas. There are a number of clinically specialist areas where it is necessary for men and women to be cared for within the same unit. These are:
 - the critical care units at Sandwell and City Hospitals;
 - the acute stroke and brain injury unit at City Hospital (D11);
 - the coronary care units at City (D5) and Sandwell Hospitals (CCU);
 - the monitored bays in MAU at City and EAU at Sandwell;
 - post-operative recovery facilities in theatres.

All of these areas have agreed approaches to maintaining high standards of privacy and dignity (e.g. operation of same-sex bays / sleeping areas whenever capacity permits). The Trust's capital programme for 2011/12 includes provision for further improvements in privacy and dignity in the Acute Stroke and Brain Injury Unit at City.

- e. Children's Wards. The children's wards at Sandwell and the Paediatric Assessment Unit at City aim to accommodate the preferences of children and their parents / guardians for age-specific and/or same-sex accommodation.
- **f. Other Areas**. Other areas within the Trust (e.g. Planned Admissions Unit at City, endoscopy units at the BTC, City and Sandwell) have been reviewed and approaches agreed to ensuring compliance with the national standards.

As noted above there is one ward at City Hospital that will not be compliant with the national same-sex accommodation standards at the 1^{st} April 2011. D26 is currently the elective orthopaedic ward for the Trust with some orthopaedic rehabilitation provided on D47 in the Sheldon Block. The plan is to change to two wards - D26 (F) and D28 (M) – each combining elective orthopaedics and orthopaedic rehabilitation. It has not been possible to deliver this change by 1^{st} April because:

- the move required investment in additional staffing (see below) which could not be confirmed until the trust had concluded the financial plan for 2010/11;
- efforts to recruit sufficient additional nurses to deliver the change safely within the time available once the LDP was agreed have not been successful;
- a range of alternatives have been explored (e.g. temporary move of activity to Sandwell, temporary move to same-sex operating lists, use of temporary

staffing) but all of these present significant quality and safety risks to the Trust.

This change will now take place as soon as possible and by June 2011 at the latest. The impact of this change not being delivered by April is that:

- a. the Trust will have to declare non-compliance with national standards until the change is completed (see below);
- b. the Trust may risk fines from commissioners. It has been proposed to commissioners that fines should only be levied if men are admitted to the female area of the ward or vice versa which would significantly reduce the risk to the Trust.

An update on ongoing discussions with the SHA and commissioners will be provided at the Trust Board meeting on 31st March 2011.

RESOURCES

The resource impact of the plan to ensure full compliance with the same-sex accommodation standards remains consistent with the estimates presented to the Board in October and included in our financial plan for 2011/12. It is set out in the table below.

Туре		£,000s
Revenue	D21 / D24 additional staffing (16.8 WTE)	571
(from	D26 / D28 additional staffing (20.8 WTE)	741
2011/12)	Physiotherapy for D26 / D28 (3.0 WTE)	80
	Total	1,392

Capital (in	MAU refurbishment	2,000
2010/11)	Sandwell surgical day unit refurbishment	450
	City CCU (D5) refurbishment	400
	SAU partition into bays	60
	Planned admissions unit partitions	40
	Medical day case unit (D7B / D8 separate sexes)	35
	Total	2,985

The capital show in this table has been spent as part of this year's capital programme. The revenue has been included in the Trust's financial plan for 2011/12.

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 is shown in the table below.

Area	Breaches (patients affected)		
	December	January	February
Sandwell EAU	118	51	60
City MAU	74	165	84
City SAU	116	21	7
Inpatient wards - City	18	42	23
Inpatient wards - Sandwell	6	24	4
Other units – City	0	36	36
Other units – Sandwell	0	0	0
Total	332	339	214

The majority of our nationally reportable breaches are therefore in our assessment units. The Division of Medicine & Emergency Care is working with both MAU and EAU teams to ensure that future breaches of their same-sex bay policy are kept to a minimum.

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.

In the light of the delay in converting D26 into a pair of same-sex wards, it will not be possible to declare compliance with the national standards from 1st April 2011. The proposed draft declaration of non-compliance is attached as an appendix to this paper. Once the changes to D26 have been made the Trust will be able to replace this with a formal declaration of compliance.

CONCLUSION AND RECOMMENDATIONS

This paper has provided the Trust Board with a progress on 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 or reported breaches of the standards in February 2011;
- 2. APPROVE the declaration of non-compliance with the national standards in light of the delays to changes to ward D26 at City Hospital;
- 3. REQUEST a further update including confirmation that the changes to D26 have been delivered for board meeting in June 2011.

Richard Kirby 18th March 2011

Sandwell and West Birmingham Hospitals

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 however currently unable 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.

We are unable to declare full compliance because one of our wards (D26 at City – our planned orthopaedic ward) is not yet fully compliant. Patients admitted to this ward will have separate male and female sleeping areas and separate washing and toilet facilities but will have to pass through one sleeping area to get to the other. We are working hard to correct this and will be able to declare full compliance by June 2011 at the latest.

All our other wards at City Hospital, Sandwell General Hospital and Rowley Regis Hospital 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.
- 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:

- Implementing plans to ensure that by June planned orthopaedic patients at City Hospital can also be admitted to same-sex wards
- continuing our focus on standards of privacy and dignity on all of our wards through our system to 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 samesex accommodation.

Who do I contact for more information?

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

Richard Kirby Chief Operating Officer

0121 507 4790 Richard.kirby1@nhs.net

This declaration was approved by the Trust Board on 31st March 2011. It will be formally reviewed annually.

SWBAC (2/11) 013
Sandwell and West Birmingham Hospitals

. NHS Trust

MINUTES

Audit Committee – Version 0.2

Venue Executive Meeting Rm, City Hospital

<u>Members</u>	In Attendance	
Mrs G Hunjan [Chair]	Mr R White	
Mr R Trotman	Mr P Capener	(CW Audit)
Dr S Sahota	Mr D Ferguson	(CW Audit)
Prof D Alderson	Mr M McDonagh (KMPG LLP)	
Mr G Clarke	Mr B Stone	(KMPG LLP)

<u>Secretariat</u> Mr S Grainger-Payne

3 February 2011

<u>Date</u>

Minutes	Paper Reference
1 Apologies for absence	Verbal
Apologies were received from Mrs Olwen Dutton, Mrs Rubina Chaudary, Mr Paul Westwood and Mrs Sarah-Ann Moore.	
2 Minutes of the previous meeting	SWBAC (12/10) 063
The minutes of the meeting held on 2 December 2010 were approved as a true and accurate reflection of the meeting.	
AGREEMENT: The minutes of the meeting held on 2 December 2010 were approved	
3 Matters arising	SWBAC (12/10) 063 (a)
The Committee received and noted the updated actions log.	
3.1 Comparative data on sickness absence	SWBAC (12/10) 004 SWBAC (12/10) 004 (a) SWBAC (12/10) 004 (b)
Mrs Hunjan noted that the report provided for this item did not address the issue raised in connection with sickness absence. The Committee was reminded that the original request had been to establish the Trust's position regarding the number of staff who had not taken any sickness absence leave relative to other local trusts.	

	gh offered to arrange for the annual accounts of other eviewed to establish this position.	
analysed by sickness abs Dr Sahota a the sickness White advi constrained acknowledg sickness ab possible. Mr level comp agreed, how the context level of 3.3 achievable that the targ improve the policy and c having good the number within future that that the individuals u sickness abs focus on th absence, ra Hunjan stress	asked whether the level of sickness absence could be division. He was advised that this was the case and that ence is discussed as part of the divisional review process. sked whether the level of instances where the reason for absence is recorded as 'unknown' had reduced. Mr sed that the recording of sickness absence was by the national categorisation system, however he ged that there was further work to do to ensure that sence is coded as accurately and completely as 'Clarke noted that the Trust's overall sickness absence ared favourably with the regional position. Mr White wever advised that the position remains disappointing in of the regional target to achieve a sickness absence 9% or below by March 2013. Mr Clarke asked how this target was seen to be. He was advised that it is likely get may be reached and every effort is being made to a position by robustly implementing the sickness absence considering introduction of incentives for members of staff d sickness absence records. Mrs Hunjan suggested that of return to work interviews held should be included eversions of the HR dashboard. Mr McDonagh agreed pre is a clear link between monitoring sickness absence of ising return to work interviews and an overall reduction in sence. Mr Trotman suggested that there is a need to ose members of staff with regular episodes of sickness ather than those with infrequent sickness absence. Mrs sed the importance of ensuring that all Statutory Sick Pay and asked for a note on how this was carried out nance department.	
ACTION:	Mr McDonagh to arrange for the Trust's position regarding the number of staff that had not taken any sickness absence to be determined	
ACTION:	Mr White to present an update on the process for monitoring return to work interviews at the next meeting	
ACTION:	Mr White to present a note on the current process for reclaiming Statutory Sick Pay at the next meeting	
3.2 Staff involvement in interpreting		Verbal
Mr White reported that the view of the Chief Nurse regarding the use of staff to assist with interpreting differs according to the clinical situation. Some staff do interpret in an informal way, although are discouraged from doing so where the need to seek consent is involved.		
The Commit	ttee was advised that a review of interpreting services is	

currently underway, which has highlighted the need to change the

mix of interpreters.	
On a related matter, Dr Sahota advised that on a recent visit to Ward D5, he had noted that there was difference in the published visiting times in English from those detailed in Punjabi. Mr White agreed to raise the issue with the Chief Nurse.	
ACTION: Mr White to highlight the inconsistency in visiting time information provided for ward D5 to the Chief Nurse	
3.3 Pharmacy stocks attributable to ward waste	Verbal
Mr White reported that the issue concerning the management of excess pharmacy stocks had been discussed with the Trust's Chief Pharmacist. The Committee was advised that any surplus stocks from wards are redistributed and the areas are credited using the JACS system. Spoiled stocks are not routinely monitored however. Mr Trotman asked whether there were circumstances where stocks cannot be redistributed generally due to the specific nature of the materials. Professor Alderson advised that in his experience in operating theatres, individual stocks of specialist materials are held in separate locations, although a stock of general material is held centrally.	
Mr White reported that there had been some concern raised regarding the lack of a central alarm to indicate failure of drug fridges, however this is mitigated by a robust system for checking the fridges at the beginning of each shift. Dr Sahota remarked that at a recent meeting of the Medicine and Emergency Care Division's managers that he had attended, it appeared that the Division was unclear about the process by which excess stocks may be returned to Pharmacy. He therefore recommended that further communications regarding this be issued.	
Mrs Hunjan asked whether a review of Pharmacy is included in the Internal Audit plan for 2011/12. She was advised that a follow up to the previous review is planned. Mr Capener was asked to ensure that the scope of the review includes the process for wards to handle excess Pharmacy stocks.	
3.4 KSF Internal Audit	Verbal
Mr White reported that the progress with embedding the Key Skills Framework (KSF) had been discussed with the Chief Nurse, who had advised that although appraisals are undertaken routinely within the Trust, the use of the KSF was disappointing. The Committee was advised that it is thought that one of the principal reasons for the poor uptake of KSF usage concerns the onerous nature of the document. As the issue has been raised nationally, there are plans for a streamlined version of the KSF to be issued, which will be implemented locally when available.	

at a future meeting of the Audit Committee.	
Mr Capener advised that Internal Audit was concerned that the actions raised as part of the KSF review were not being closed as promptly as desired, however he was reassured by the plans to issue the new national guidance on the KSF which would address many of the concerns.	
ACTION: Mr Grainger-Payne to arrange for an update on the progress with implementation of the new national guidance regarding the KSF to be presented at a future meeting	
4 External Audit Matters	
4.1 External Audit progress report 2010/11	SWBAC (2/11) 012 SWBAC (2/11) 012 (a) SWBAC (2/11) 012 (b)
By way of context, Mr McDonagh highlighted that the economic conditions for the NHS moving forward would be tough and that public sector issues would also be likely to impact on the Heath Service in the future. As such, there may be a need to monitor the efficiency agenda in addition to the impact of the broader public sector issues on the Trust.	
Mr Stone provided an update on the work completed by the external auditors since the last meeting, which the Committee noted included a review of the impact of the Transforming Community Services (TCS) plans.	
The Committee noted the 'Top 10 'To Dos' for Audit Committees' briefing and the overview of the key points of the UK Bribery Act 2010. Mr McDonagh remarked that the 'Top 10 'To Dos' for Audit Committees' could be used as part of the annual assessment of the effectiveness of the Committee.	
Mr Trotman asked for an update on the plans for the Audit Commission. Mr McDonagh advised that the body was initially expected to be disbanded in 2012 and that following this, organisations will be responsible for appointing their own auditors and agreeing the fees.	
Dr Sahota suggested that there may be an impact on the NHS due to an increase in the prevalence of mental health issues as a result of the depressed economy. Professor Alderson added that there is a possibility that the number of social admissions to the acute sector will increase due to the inability to manage these cases within the community setting. He highlighted that these admissions tend to lead to longer stays and are more difficult to treat. Mr Capener advised that there is likely to be an increase in the number of delayed discharges in future. Mr White added that the proposals for non- payment for readmissions are likely to impact on the financial flexibility of the acute sector.	

Mrs Hunjan suggested that in connection with the corporate hospitality reference in the briefing on the UK Bribery Act 2010, an annual report on gifts and hospitality should be considered by the Committee. Mr Grainger-Payne offered to include the consideration of the report within the annual cycle of business for the Audit Committee.	
ACTION: Mr Grainger-Payne to include the consideration of a gifts and hospitality report within the annual cycle of business for the Audit Committee	
4.2 Progress with actions arising from prior year reviews	Verbal
Mr Stone reported that informal discussions regarding asset verification plans had been held and that a further update would be provided at the May meeting of the Audit Committee.	
ACTION: External audit to present an update on progress with actions arising from prior reviews at the May meeting of the Audit Committee	
4.3 Update on Value for Money audit and Reference Costs work	Verbal
Mr Stone advised that an update on the Value for Money audit and Reference Costs work would be presented at the next meeting.	
ACTION: External audit to present an update on the Value for Money audit and Reference Costs work at the May meeting of the Audit Committee	
5 Internal Audit Matters	
5.1 Internal Audit plan 2011 - 14 for approval	SWBAC (2/11) 006 SWBAC (2/11) 006 (a)
Mr Capener presented the draft Internal Audit plan for 2011 – 14. He advised that the Executive Team was to be given the opportunity to comment on the plan, meaning that the list of 'desirable' audits in the report may change. A reduction in the number of days by 50 was highlighted.	
The individual elements of the plan were reviewed.	
Mrs Hunjan noted that some audits are repeated year on year and asked whether the focus of each was different. Mr Capener advised that there is intentional repetition of some audits, such as Payroll, although the particular aspects to be reviewed are agreed with External Audit. Mrs Hunjan asked whether Mr White was given the opportunity to provide input to this process, which she was advised was the case where needed.	
It was noted that the Transforming Community Service (TCS) plans were included in the programme.	
Mr Trotman asked why, despite an overall reduction in the number of	

days in the programme, the time dedicated to the audit of the financial ledger had not been reduced. He was advised that this was a core key control that needed to be undertaken by External Audit, if Internal Audit did not include it within its programme. The audit was highlighted to cover a large number of financially-based systems within the Trust.	
Professor Alderson remarked that there appeared to be no assurance planned regarding the new procurement services. It was agreed that this should be built into the plan, within the list of desirable options.	
Mr Trotman suggested that there may be a need to extend the time proposed for the audit of TCS plans.	
Various amendments requested since the publication of the plan were outlined by Mr Capener.	
Dr Sahota asked whether age discrimination would be covered as part of the audit into Equality and Diversity. He was advised that this was the case. Dr Sahota asked whether there was a requirement on public sector bodies concerning the need to consider procurement in the context of the sustainability agenda as part of the new Equality Bill. Mr White offered to check this point.	
Mr Capener advised that the final plan would be presented at the May meeting of the Audit Committee. It was agreed that the plan should be approved, subject to the minor amendments suggested by the Committee and the Executive Team.	
ACTION: Mr White to check whether the new Equality Bill includes a requirement on public sector bodies concerning the need to consider procurement in the context of the sustainability agenda	
AGREEMENT: The strategic Internal Audit plan for 2011-14 was approved subject to minor amendment	
5.2 Internal Audit progress report and recommendation tracking	SWBAC (2/11) 007 SWBAC (2/11) 007 (a)
Mr Capener reported that progress with the 2010/11 plan was as expected and there were no concerns with completing the programme by April 2011 as expected.	
In terms of in year changes to the Internal Audit plan, the Committee was advised that the audit of CQC registration compliance had been delayed due to a planned change to the evidential system.	
Two reports were noted to have been issued since the last meeting of the Audit Committee, one concerning agency staff payments and the other relating to the financial ledger.	
The audits in progress were outlined.	
The recommendation tracking mechanism was reported to be working well.	

5.3 Internal Audit reports for receiving and noting	
Outpatient utilisation review	Verbal
Mr Capener advised that the outcome of the outpatient utilisation review would be presented at the May meeting of the Audit Committee.	
5.4 2009/10 qualitative assessment results	SWBAC (2/11) 008 SWBAC (2/11) 008 (a)
Mr Ferguson presented the Qualitative Assessment results outcome for 2009/10, which the Committee was asked to note was previously known as the Compound Indicator assessment.	
The Committee was asked to note that the Trust had been assessed as being at Level 2, the same score as for 2008/09. Mr Capener highlighted that the scores gained by some trusts had deteriorated from the previous year.	
It was noted that the assessment had been changed to focus on outcomes.	
Mrs Hunjan noted that there appeared to be a link between the number of days in the counter fraud plan and the level awarded. It was suggested however that there needed to be an assessment of the cost effectiveness of the required investment in order to achieve a higher score. It was agreed by the Committee that there did not appear to be any justifiable need for further investment at present.	
Mr Ferguson advised that the update on progress with the actions arising from the assessment would be presented at the next meeting.	
ACTION: Mr Westwood to present an update on the progress with the actions arising from the Qualitative Assessment 2009/10 at the May meeting of the Audit Committee	
5.5 Review of Counter Fraud progress report, including an update on open cases	SWBAC (2/11) 011 SWBAC (2/11) 011 (a)
Mr Ferguson reported that the participation of Counter Fraud in corporate induction continued to be well received.	
The detail of the open cases was reviewed by the Committee.	
Dr Sahota asked why case 2008/12 was taking so long to resolve. Mr Ferguson advised that the case is particularly complex and although it had been investigated previously, it had been reopened for further review.	
It was noted that at the last meeting Mr Westwood had been asked to determine the appropriate level of detail to be provided to the Audit Committee on open cases. Mr Ferguson reported that this had been considered and determined that there is a need to ensure that sufficient detail is available without compromising the identity of the individuals involved. Mr Ferguson offered to circulate the advice	

received to the Audit Committee via Mr Grainger-Payne.	
ACTION: Mr Ferguson to circulate the advice obtained regarding the level of detail to be provided to the Audit Committee on open cases via Mr Grainger-Payne	
5.6 Consultation on the review of the NHS Counter Fraud service	SWBAC (2/11) 009
Mr Ferguson reported that the NHS Counter Fraud Service is to be restructured and it is anticipated that the number of Local Counter Fraud Specialists will be reduced from 52 to 22 for the region.	
The impact of the restructure was reported to include a reduction in the number of cases which may be handled or that the Trust will remain responsible for investigating the cases and will incur a financial liability for doing so.	
5.7 2011/12 draft Counter Fraud plan	SWBAC (2/11) 010 SWBAC (2/11) 010 (a)
The Committee reviewed the draft Counter Fraud workplan for 2011/12.	
It was highlighted that there had been a reduction in the number of days in the plan compared to the current year, although antifraud measures are to be improved during the year.	
The Audit Committee approved the 2011/12 draft Counter Fraud plan.	
AGREEMENT: The Audit Committee approved the 2011/12 draft Counter Fraud plan	
6 Update on staff overpayments	SWBAC (2/11) 005 SWBAC (2/11) 005 (a)
Mr White presented a month by month analysis of staff salary overpayments. It was highlighted that the overpayments related in some instances, to employee error where for example, an individual does not return to work after a period of maternity leave.	
The most significant area of risk relating to overpayments was noted to have concerned junior doctors pay, although the Committee was advised that systems have now been implemented to prevent undue payments.	
Mr Clarke asked what the rate of success was for recovering overpayments. Mr White advised that this varied according to the value of the payment, the length of time over which the overpayment has been accrued and the benefit of recovery.	
Mrs Hunjan recommended that an annual report on overpayments should be provided to the Committee, which should highlight the recovery rates, detail concerning the amount needing to be written off and the mechanisms to be put into place to prevent overpayment.	

ACTION: Mr Grainger-Payne to include the consideration of a report on salary overpayments within the annual cycle of business for the Audit Committee	
7 Update on the Assurance Framework 2010/11 – Quarter 2	SWBAC (2/11) 002 SWBAC (2/11) 002 (a)
The Audit Committee received and noted the updated Assurance Framework, covering Quarter 2 of the financial year.	
8 Audit Committee cycle of business for 2011/12	SWBAC (2/11) 003 SWBAC (2/11) 003 (a)
Mr Grainger-Payne presented the Audit Committee cycle of business for 2011/12 for approval. He advised that the final version would include the additional reports suggested by the Committee during the course of the meeting.	
Mr Grainger-Payne was asked to amend the reporting cycle further to remove the item concerning the Auditors' Local Assessment (ALE) improvement plan, given that ALE assessments are no longer undertaken.	
Subject to the amendments required, the Audit Committee approved its annual cycle of business for 2011/12.	
AGREEMENT: Subject to amendments suggested as part of the meeting, the Audit Committee approved its annual cycle of business for 2011/12	
9 Minutes from Trust Board Committees	
9.1 Finance and Performance Management Committee	SWBFC (12/10) 148 SWBFC (1/11) 011
The Committee noted the minutes of the Finance and Performance Management Committee meetings held on the 16 December 2010 and 20 January 2011.	
9.2 Charitable Funds Committee	SWBCF (12/10) 026
The Committee noted the minutes of the Charitable Funds Committee meeting held on 2 December 2010.	
9.3 Governance & Risk Management Committee	SWBGR (11/10) 065
The Committee noted the minutes of the Governance & Risk Management Committee held on 18 November 2010.	
10 Any Other Business	Verbal
There was none.	
11 Date and time of next meeting	Verbal

SWBAC (2/11) 013

The date and time of the next meeting will be 12 May 2011 at
10.30am in the Executive Meeting Room.

Signed

Name:....

Date:....