Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Anne Gibson Boardroom, City Hospital **Date** 24 November 2011; 1530h - 1730h

Members			**In Attendance**	
Mrs S Davis	(SD)	[Chair]	Mr G Seager	(GS)
Mr R Trotman	(RT)		Miss K Dhami	(KD)
Dr S Sahota	(SS)		Mrs J Kinghorn	(JK)
Mrs G Hunjan	(GH)		Mrs C Rickards	(CR)
Prof D Alderson	(DA)		Mrs C Powney	(CP) [Sandwell LINks]
Mrs O Dutton	(OD)			
Mr P Gayle	(PG)		**Guest**	
Mr J Adler	(JA)		Dr J Middleton	(JM) [Sandwell PCT]
Mr D O'Donoghue	(DO'D)			
Mr R White	(RW)		**Secretariat**	
Miss R Barlow	(RB)		Mr S Grainger-Payne	(SGP) [Secretariat]
Miss R Overfield	(RO)			
Mr M Sharon	(MS)			

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	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 27 October 2011 as true and accurate records of discussions*	**SWBTB (10/11) 224**	**Chair**
4	**Update on actions arising from previous meetings**	**SWBTB (10/11) 224 (a)**	**Chair**
5	**Questions from members of the public**	**Verbal**	**Public**
	PRESENTATION		
6	**Public Health Matters – Sandwell PCT**	**Presentation**	**JM**

FOR APPROVAL			
7	**Trauma Unit action plan**	**SWBTB (11/11) 232** **SWBTB (11/11) 232 (a)**	**MS**
MATTERS FOR INFORMATION/NOTING			
8	**Safety, Quality and Governance**		
8.1	Progress with Care Quality Commission (CQC) report action plans	SWBTB (11/11) 233 SWBTB (11/11) 233 (a) SWBTB (11/11) 233 (b) SWBTB (11/11) 233 (c)	RO
8.2	Infection Control quarterly report	SWBTB (11/11) 238 SWBTB (11/11) 238 (a)	RO
8.3	Cleanliness and PEAT report	SWBTB (11/11) 234 SWBTB (11/11) 234 (a) SWBTB (11/11) 234 (b)	RO
8.4	Update on complaints handling	Hard copy paper	KD
8.5	Integrated risk report – Quarters 1 and 2	SWBTB (11/11) 237 SWBTB (11/11) 237 (a)	KD
8.6	Letter from Black Country Partnership NHS Foundation Trust re position of stakeholder governor	Verbal	SD
8.7	Minutes of the Quality and Safety Committee – 22 September 2011 and update from the Quality and Safety Committee held on 17 November 2011	SWBQS (9/11) 043	DA
9	**Performance Management**		
9.1	Monthly finance report	SWBTB (11/11) 229 SWBTB (11/11) 229 (a)	RW
9.2	Draft minutes from the Finance and Performance Management Committee meeting held on 17 November 2011	To follow	RT
9.3	Monthly performance monitoring report	SWBTB (11/11) 228 SWBTB (11/11) 228 (a)	RW
9.4	NHS Performance Framework/FT Compliance monitoring report	SWBTB (11/11) 227 SWBTB (11/11) 227 (a)	RW
10	**Strategy and Development**		
10.1	'Right Care, Right Here' programme: progress report including update on decommissioning	SWBTB (11/11) 231 SWBTB (11/11) 231 (a)	MS
10.2	Foundation Trust application programme		
▶	Programme Director's report	SWBTB (11/11) 235 SWBTB (11/11) 235 (a)	MS
▶	Minutes of the FT Programme Board held on 27 October 2011	SWBFT (10/11) 068	MS

10.3	Midland Metropolitan Hospital project: Programme Director's report	Verbal	GS
11	**Draft minutes from the meeting of the Audit Committee held on 8 September 2011**	**SWBAC (9/11) 053**	**GH**
12	**Draft minutes from the meeting of the Charitable Funds Committee held on 8 September 2011**	**SWBCF (9/11) 018**	**SS**
13	**Any other business**	**Verbal**	**All**
14	**Chair's closing comments**	**Verbal**	**SD**
15	**Details of next meeting** *The next public Trust Board will be held on 15 December 2011 at 1530h in the Boardroom, Sandwell Hospital*		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.2

Venue Boardroom, Sandwell Hospital **Date** 27 October 2011

Present

Mrs Sue Davis CBE (Chair)
Mr Roger Trotman
Mrs Gianjeet Hunjan
Dr Sarindar Sahota OBE
Mrs Olwen Dutton
Mr Phil Gayle
Mr John Adler
Mr Robert White
Mr Donal O'Donoghue
Miss Rachel Barlow
Miss Rachel Overfield
Mr Mike Sharon

In Attendance

Miss Kam Dhami
Mr Graham Seager
Mrs Jessamy Kinghorn
Mrs Carol Powney [Sandwell LINks]

Secretariat

Mr Simon Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Professor Derek Alderson.	
2 Declaration of Interests	**Verbal**
There were no declarations of interest raised.	
3 Chair's Opening Comments	**Verbal**
The Chair took the opportunity to welcome Mr Phil Gayle, a new Non Executive Director, who she advised had previously undertaken a similar role at Sandwell PCT. The Board was also advised that the Chair had recently attended the opening of two new facilities for the Trust, the Halcyon Standalone Birth Centre and the Henderson Reablement Unit at Rowley Regis Hospital. All were encouraged to take a tour of the new Birth Centre if possible.	

4 Minutes of the previous meeting	**SWBTB (9/11) 203**
The minutes of the previous meeting were presented for approval and were accepted as a true and accurate reflection of discussions held on 29 September 2011.	
AGREEMENT: The Trust Board approved the minutes of the last meeting	
5 Update on actions arising from previous meetings	**SWBTB (9/11) 203 (a)**
The updated actions list was reviewed and it was noted that there were no outstanding actions requiring discussion or escalation.	
6 Questions from members of the public	**Verbal**
No questions were raised by members of the public present.	
Items for Approval	
7 Application for the use of the Trust Seal – Lease and supply agreements for the Krypton generator service	**SWBTB (10/11) 217** **SWBTB (10/11) 217 (a)**
Miss Barlow presented an application for the use of the Trust Seal on the lease renewal and supply agreements for the Krypton generator service. The Trust Board approved the application.	
AGREEMENT: The Trust Board unanimously approved the application for the use of the Trust Seal on the lease renewal and supply agreements for the Krypton generator service	
8 Safety, Quality and Governance	
8.1 Care Quality Commission (CQC) reports and action plans	**SWBTB (10/11) 223** **SWBTB (10/11) 223 (a) - SWBTB (10/11) 223 (e)**
Miss Overfield presented the CQC report into the findings from its recent national dignity and nutrition inspections and the report on the second unannounced visit to Sandwell Hospital in August 2011. Both of these reports were published on 13 October 2011. The Board was asked to receive and note the covering report which outlined the key findings and actions taken to address the recommendations in the reports. In terms of the findings related to the visit to Sandwell Hospital, Miss Overfield reported that the concerns on nutrition had been downgraded from major to minor as a consequence of the second visit by the CQC. Since the visit, the Board	

was informed that ward Newton 4 had been split into two separate wards to ensure that the acute and rehabilitation stroke pathway were more efficiently managed. As a result, the patient experience and overall feel of the ward had improved.

Regarding the action plans to address the reports' recommendations, Miss Overfield reported that updated versions needed to be submitted to the CQC within two weeks. It was noted that there were some areas where further work was required, however work was underway to address these issues.

In addition to the action plan, the Board was informed that an emergency Executive Team meeting had been convened and the actions arising were drawn to the Board's attention, as summarised in Miss Overfield's covering report. The actions were highlighted to include development of more robust controls over winter bed capacity planning and introduction of mock CQC inspections that would be undertaken by the Trust's managers, Non Executive Directors and the Executive Team. The key findings and actions planned were reported to have been communicated to staff through a series of special 'Hot Topics' briefings and had been the subject of a recent payslip attachment. Every doctor and nurse had also personally received a letter outlining the expectations in terms of behaviours and key actions from the Chief Nurse and Medical Director. The Executive Team was also reported to have agreed funding for a range of measures, including purchase of pyjamas and the provision of snacks for patients.

In terms of leadership, Miss Overfield reported that effort would be directed into ensuring that ward managers were robustly equipped and capable to lead their areas and manage patient flows. The WRVS was reported to be taking on the management of the volunteer service which would be anticipated to deliver an improved level of support to the wards. The nursing dashboard was highlighted to be under development which would form part of the corporate performance reports.

Mrs Dutton remarked that it was pleasing to see the improvements that had been delivered and recommended that the updated action plans be reviewed by the Board on a monthly basis for the foreseeable future. This suggestion was supported by the Board.

Mrs Dutton asked whether there were any lessons learned from the visits that had been communicated throughout the Trust. Miss Overfield advised that there were and a key lesson had been that there was a need to look at a means of ensuring accountability at an individual level. It was also reported that there was a need to consider outcomes as opposed to solely evidence of compliance with the CQC standards. In order to prepare staff for the inspection regime, the Board was informed that a self-assessment tool had been sourced which would be customised and used to assess individuals against the various outcomes.

Mr Gayle noted that a particular area of importance related to leadership and suggested that there was a need to differentiate between management

responsibilities and day to day operational matters. Miss Overfield agreed and advised that consideration was being given to the means by which ward managers could be provided with more time to undertake management responsibilities, however there were cost implications to these plans. The Board was advised that the ward managers in the Medicine & Emergency Care division had recently been reconfigured and specific objectives had been set around management and leadership. A review of the role of the matron was also reported to be being considered. The Chair remarked that a culture of accountability needed to be developed, including the responsibility to challenge situations where a shortfall in standards or performance was identified. She added that hospital operations varied according to the time of day, week and year and asked whether any inspections had been set for out of hours situations. Miss Overfield advised that internal out of hours inspections had been undertaken since March 2011 which had not revealed any particular issues. Mr Adler reported that the attendance at the three extraordinary 'Hot Topics' briefings had been pleasing, with unprecedented numbers present. Miss Overfield reported that Sandwell PCT was planning to undertake a further series of unannounced visits and that a peer review had been requested. The Chair suggested that an update on the progress with the delivery of the CQC action plan should continue to be considered by the Board as the first substantive agenda item at future meetings. She also suggested that there may be a need to consider increasing the number of Trust Board walkabouts and to making better use of the time on Board days to allow members to visit operational areas. Mrs Kinghorn suggested that the content of the Trust Board walkabouts questionnaires should be reviewed to make it more focussed on the matters that would be assessed by the CQC. Miss Overfield agreed and suggested that the CQC visit template could be adapted for this purpose. Mrs Dutton proposed that a qualitative assessment should be built into the questionnaires. Miss Overfield agreed to revise the schedule of Trust Board walkabouts to focus the visits at Sandwell Hospital and amend the current proforma to reflect the suggestions received and align more closely with privacy and dignity outcome measures. Mr Trotman advised that in a recent walkabout he has observed some examples of excellent nursing care on the three wards visits and suggested that this perspective needed to be borne in mind.	
ACTION: **Miss Overfield to revise the schedule of Trust Board walkabouts and amend the questionnaire used to reflect the suggestions received at the meeting** **ACTION:** **Mr Grainger-Payne to ensure that consideration of progress with the CQC action plan is added as the first substantive item to future agenda of the public Trust Board meetings**	

8.2 Safeguarding update	**SWBTB (10/11) 219** **SWBTB (10/11) 219 a)**
Miss Overfield presented the routine quarterly update on safeguarding matters. She advised that consideration was currently being given to agreeing the scope and frequency of CRB checking in the Trust, given that some staff had not been checked as they had taken up post prior to the requirement to undergo a routine CRB check as part of the appointment process. The Board was advised that the Community Services staff that had transferred from Sandwell PCT had a comprehensive programme of checks on a three-year cycle and this would be maintained. It was highlighted that there was an issue concerning compliance with the CQC standards around Mental Health care, therefore an alliance would be made with the local Mental Health trust to provide the necessary requirements. The Board was informed that a number of inspections on Safeguarding were underway or planned, including a review by the West Midlands Quality Review Service. Mr Gayle noted that it appeared that some staff would not be certain how to handle a Vulnerable Adult patient and asked what plans were in place for training staff in this respect. Miss Overfield advised that there was difficulty with training all nurses in Level 2 Safeguarding, therefore this had been delivered to a set of staff on a prioritised basis, meaning that 40% of nurses had been trained to date. All nursing staff were reported to have received Level 1 training in safeguarding however. It was reported that at least one individual trained in Level 2 safeguarding would be in place on each ward in the Trust. Mr Gayle acknowledged that there were cost implications to undertaking CRB checks and suggested that there should be a programme developed to cover those staff who had not been CRB checked and to manage those revealed to have a conviction. Miss Overfield agreed and advised that the focus of the CRB check programme had been focussed initially in the Women and Child Health Division. Dr Sahota agreed that there was a need to target those areas where there was a clear necessity initially and asked what training had been provided to lone workers to date. Miss Overfield advised that all staff working in the community had received Safeguarding Level 2 training. Mr Gayle added that a lone worker policy was also in place to which community services staff worked. In terms of Safeguarding referrals from Maternity, Mrs Kinghorn asked whether these cases were given adequate support. Miss Overfield confirmed that a lead 'Women in Need' midwife was in place and if social issues were detected then a referral would be made. The Board was informed that a similarly robust process was in place for managing patients experiencing domestic violence.	
8.3 Update on complaints handling	**Tabled report**

Miss Dhami reported that the total number of active complaints was 286, a significant reduction from the previous month. In terms of the backlog, the Board was asked to note that there had been a pleasing decline, with 33 complaints now requiring to be addressed. It was reported that effort was being directed to prevent further complaints maturing into the backlog. During the 21 day period, Miss Dhami advised that 66 complaints had been received. Mr Gayle advised that dissatisfaction about the current situation with complaints handling had been expressed at a recent Board meeting of Sandwell PCT. He cited a specific case that had caused concern, for which a meeting between the complainant and the Chief Executive was awaited. Mr Adler noted that the drop in the backlog was encouraging and suggested that the failsafe timescales should be gradually reduced to ensure that all complaints were responded to in a timely manner. Miss Dhami confirmed that this was planned and highlighted that in the cases where a breach of the failsafe was expected, an explanation would be given to the Board. Mrs Dutton asked whether the issue of redress had been considered recently. Miss Dhami advised that the Health Service Ombudsman had requested redress in some cases recently, outside of the usual litigation and claims process. Mrs Dutton remarked that a financial settlement may not be desired in all cases, however an acknowledgement that something had gone wrong may be sought. Mr Adler advised that an apology was given in all cases where it is appropriate to do so. Mr Sharon asked whether sufficient capacity was available in the Complaints Team to handle the routine cases once the backlog had been addressed. Miss Dhami reported that temporary staffing were in place at present, however the substantive element of the team had been increased. The Board was informed that in future, a review of the current centralised approach would be undertaken, which might prompt an altered staffing model in the Complaints Team. Miss Overfield advised that the issuing of timely complaints responses was dependent on local investigations and information and highlighted that there were delays with providing this in some cases. The Chair expressed her congratulations for the good progress made to address the backlog during the month.	
ACTION: Miss Dhami to present proposals to reduce the failsafe targets for complaints, once the current backlog is cleared	
8.4 Board Assurance Framework – Quarters 1 and 2	**SWBTB (10/11) 218** **SWBTB (10/11) 218 (a)**
Mr Grainger-Payne presented the Board Assurance Framework (BAF) which had	

been updated with progress with measures to address the gaps in control and assurance for the management of the risks to the delivery of the Trust's annual priorities. The Board was asked to note that the BAF template had been amended and the process to populate the document had been more closely tied into the risk assessment process. Mr Trotman suggested that post mitigation score should be reflected in the BAF. Mr Grainger-Payne advised however, that this was not necessary to include as this detail was already provided within the Trust Risk Register. Mrs Hunjan asked whether the BAF would be presented to the Audit Committee at its next meeting. Mr Grainger-Payne confirmed that the Audit Committee was asked to receive and note the BAF twice yearly and that it would next be presented in December 2011. Mr Gayle asked for an explanation as to the scores assigned to the pre-mitigation risk. Mr Grainger-Payne offered to send Mr Gayle a copy of the risk severity matrix which provided an explanation.	
ACTION: Mr Grainger-Payne to send the risk severity matrix to Mr Gayle	
8.5 Annual Audit Letter	**SWBTB (10/11) 207** **SWBTB (10/11) 207 (a)**
The Board was asked to receive and note the Annual Audit Letter from the Trust's external auditors, KPMG LLP. The letter was noted to confirm that an Unqualified Opinion had been provided on the Trust's annual accounts for 2010/11. Mrs Hunjan advised that the Annual Audit Letter had been presented to the Audit Committee at its last meeting.	
9 Performance Management	
9.1 Monthly finance report	**SWBTB (10/11) 210** **SWBTB (10/11) 210 (a)**
Mr White reported that following the previously reported dip in results, the overall position had improved, which was mainly attributable to a better than planned income position. In month, the Board was informed that a surplus of £144k had been generated against an expected level of £85k. Year to date, Mr White reported that a surplus of £249k had been generated, which was highlighted to be £46k poorer than the planned position. In terms of pay, the Board was asked to note the improving trend in agency usage and the lower than planned Whole Time Equivalent (WTE) position. The Trust's cash balance was reported to remain strong, however the budgetary flexibility to handle unplanned demands was noted to be limited.	
9.2 Draft minutes from the meeting of the Finance and Performance Management Committee held on 20 October 2011	**Hard copy paper**

Mr Trotman asked the Trust Board to receive and note the draft minutes from the meeting of the Finance and Performance Management Committee held on 20 October 2011.

The Board was advised that representatives from the IM & T directorate had presented an update on performance at the meeting and that it was pleasing to see that Mr O'Donoghue, as the responsible Executive Director, had attended and had provided the majority of the commentary. The main issue that had been discussed was reported to have been the current deficit of £47k and the shortfall against the directorate's CIP by £86k. It was noted that this situation was linked to a delay with the scheme to implement electronic transfer of letters to GPs. The Board was advised that actions had been taken to generate a projected surplus on payroll by the year end of £85k, which should be sufficient to prevent a worse case scenario of £20k deficit at the year end. It was highlighted that some IM & T developments were to be delivered over a lengthy timespan; Atos consultants had been engaged to assist in the development of more robust plans.

The Board was informed that the six month financial performance had been presented by Mr White and it had been encouraging to note that majority of divisions were now breaking even or performing better, including the Medicine & Emergency Care and Surgery, Anaesthetics & Critical Care divisions. Other key points noted by the Committee were reported to have concerned the current Whole Time Equivalents position, a reduction in expenditure on waiting list initiatives and a decline in expenditure on agency staff.

The Board was informed that the financial recovery plan had been discussed at some length and that it had been noted that the majority of actions were on track to be delivered as planned. Initial interviews were reported to have taken place for the Divisional General Manager for the Medicine & Emergency Care division, with further interviews planned shortly. The recovery plan for the Medicine & Emergency Care division was noted to have incorporated new ward establishments, which addressed identified areas of pressure. Priorities for the Surgery, Anaesthetics & Critical Care division were reported to have been set.

Mr Trotman advised that Miss Barlow had presented a report on the performance of the Women and Child Health division. She was reported to have advised that there was an anticipation that the assumptions on activity levels for the area had been set too high and that a further update would be provided at the next meeting.

The Board was advised that the Committee had been provided with an update on consultancy support and the plans to establish a Transformation Plan. Assurance was also given that the financial budgets incorporated some flexibility for the financing of the Transformation Support Office.

Mr Trotman concluded by reporting that a proposal for an exceptions report had been considered which would be developed further, with the aim of reducing the complexity and summarising the detail in the current performance monitoring

report.	
9.3 Monthly performance monitoring report	**SWBTB (10/11) 221** **SWBTB (10/11) 221 (a)**
Mr White reported that there had been a slight increase in the level of cancelled operations to 0.8%. Delayed Transfers of Care were reported to have reduced to 5.4%, which was highlighted to be a significant improvement from the previous month. Performance against the stay on stroke unit target was reported to 86.1%, with performance against the TIA target noted to have also improved slightly. In terms of performance against the Accident and Emergency Care targets, year to date the percentage of patients seen within four hours of arrival was reported to 95% during the month and 95.5% year to date. The Board was advised that no MRSA bacteraemia had been reported during the month and there had been no breaches to the Single Sex Accommodation rules. The level of PDRs was noted to be increasing. The standardised mortality rate was reported to be 95, although the Board was advised that a rebasing exercise was planned which would affect this. It was noted that the mortality rate was higher than the national average and this might be contributed to by health economy influences, including the lack of hospice provision in the area. It was suggested that a full briefing on the different mortality definitions and the Trust's position be provided at a future meeting. Mr O'Donoghue agreed to incorporate this within the update on mortality due to be presented to the Board in November 2011.	
ACTION: Mr O'Donoghue to incorporate the definitions and sources of mortality information within an update to the Trust Board on mortality due for November 2011	
9.4 NHS Performance Framework/FT Compliance monitoring report	**SWBTB (10/11) 220** **SWBTB (10/11) 220 (a)**
Mr White presented the NHS Performance Framework update for receiving and noting.	
9.5 Corporate Objectives progress report – Quarter 2	**SWBTB (10/11) 209** **SWBTB (10/11) 209 (a)**
Mr Sharon presented an update on progress with the delivery of the Trust's corporate objectives. He asked the Board to note that progress was rated as green for 14 of the 33 objectives. A red status was noted to have been assigned to the progress with the objectives concerning procurement of the new hospital and decommissioning. Mr Adler advised that the current round of PDRs for the Executive Team would	

further inform progress.	
10 Strategy and Development	
10.1 'Right Care, Right Here' programme: progress report including an update on decommissioning	**SWBTB (10/11) 213** **SWBTB (10/11) 213 (a)**
Mr Sharon asked the Board to note the summary activity trends which had been produced by the 'Right Care, Right here' Programme Team. Overall, the Board was advised that there was a downward trend in activity. A review of the care pathways was reported to be in progress, albeit with some delay. The decommissioning programme was reported to be continuing. The programme management structure of the 'Right Care, Right Here' Programme was reported to be being reviewed at present. Mrs Kinghorn asked whether the community facilities elements of the programme were on track. Mr Sharon advised that the Sandwell side of the programme was progressing well.	
10.2 Foundation Trust application: progress update	
Programme Director's report	**SWBTB (10/11) 212** **SWBTB (10/11) 212 (a)**
Mr Sharon presented the Foundation Trust Programme Director's report for receiving and noting. The minutes of the FT programme Board from 27 October 2011 were received and noted.	
10.3 Midland Metropolitan Hospital project: progress report	**Verbal**
Mr Seager reported that work was continuing to answer enquiries concerning the Outline Business Case (OBC) for the new hospital from the Department of Health. It was highlighted that the impact of the delay in the approval of the OBC on the Trust's Foundation Trust application was being assessed.	
11 Operational Matters	
11.1 Sustainability update	**SWBTB (10/11) 208** **SWBTB (10/11) 208 (a)**
Mr Seager reported that a sustainability event had been held in October 2011, at which new sustainability champions had been recruited. Mr Gayle asked what savings were attached to the Trust's sustainability plans. Mr	

Seager advised that the Trust had an obligation to achieve a 15% reduction in the use of carbon by 2015 and that there was much work to do on building sustainability considerations into procurement processes which would generate significant savings. Mrs Dutton asked for an indication of the take up of the Trust cycle scheme. She was advised that this was a salary sacrifice mechanism to purchase a new bicycle, but data on uptake was not available at the meeting. The Board was advised however that a cycling club had been established which had proved to be very popular with staff.	
11.2 TCS benefits realisation	**SWBTB (10/11) 208** **SWBTB (10/11) 208 (a)**
Miss Barlow reminded the Board that community staff had transferred from Sandwell PCT in April 2011 and that the initial integration had gone well. The Board was advised that some enhanced practice had been gained from the transfer, such as the robustness of the CRB checking process. The Board was informed that a number of staff ambassadors had been identified in the Community Services areas as part of the 'Owning the Future' pilot. . It was highlighted that the 'Owning the Future' concept had been embraced well by the Community Services staff and it had been used to good effect to resolve some issues. In terms of IM & T systems, Miss Barlow reported that many processes remained paper-based. The integration of the community services was reported to be one of the key cross cutting themes of the Transformation Plan, which would provide an opportunity to look at rehabilitation facilities and a number of care pathways. Mrs Hunjan noted that in terms of finance policies, such as that relating to vacancy factors, there was further work to do to harmonise approaches. Mr White reported that this work would form part of the budget setting process for 2012/13.	
12 Any other business	**Verbal**
There was none.	
13 Details of the next meeting	**Verbal**
The next public session of the Trust Board meeting was noted to be scheduled to start at 1530h on 24 November 2011 and would be held in the Anne Gibson Boardroom at City Hospital.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 24 November 2011, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

27 October 2011, Boardroom @ Sandwell Hospital

Members present: Mrs S Davis (SD), Mr R Trotman (RT), Dr S Sahota (SS), Mrs G Hunjan (GH), Mr P Gayle (PG), Mrs O Dutton (OD), Mr J Adler (JA), Mr R White (RW), Mr Donal O'Donoghue (DO'D), Miss R Barlow (RB), Mr M Sharon (MS), Miss R Overfield (RO)

In Attendance: Mr G Seager (GS), Miss K Dhami (KD), Mrs J Kinghorn (JK), Mrs C Powney (CP) [Sandwell LINks]

Apologies: Prof D Alderson (DA)

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 28 November 2011

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.195	Update on complaints handling	Hard copy papers	28-Apr-11	Consider the suggestion made to organise a 'walk through' a complainant's experience and the complaints process	KD	~~31/07/2011~~ ~~22/09/2011~~ 15/12/2011	Process flow of complaints process being developed at as part of the revised Complaints Handling strategy which will be shared at the Trust Board meeting in December 2011. **ACTION NOT YET DUE**	G
SWBTBACT.214	Equality and Diversity update	SWBTB (9/11) 196 SWBTB (9/11) 196 (a)	29-Sep-11	Ensure that the Transformation Plan project templates include a requirement to assess the proposals for Equality and Diversity implications	RB	30/11/11	Will be built into templates, such as Equality Impact Assessments on discussion with Atos. **ACTION NOT YET DUE**	G
SWBTBACT.217	Update on complaints handling	Tabled report	27-Oct-11	Present proposals to reduce the failsafe targets for complaints, once the current backlog is cleared	KD	31-Jan-12	**ACTION NOT YET DUE**	G
SWBTBACT.208	Sustainability update and Sustainability & Environment policy	SWBTB (7/11) 149 SWBTB (7/11) 149 (a) - SWBTB (7/11) 149 (c)	28-Jul-11	Arrange for the anticipated position in respect of the Trust's carbon credit allocation to be presented at a future meeting of the Finance and Performance Management Committee	GS	~~20/10/2011~~ 31/11/2011	Presented at the Finance and Performance Management Committee meeting held on 17/11/11	B
SWBTBACT.215	CQC reports and action plans	SWBTB (10/11) 223 SWBTB (10/11) 223 (a) - SWBTB (10/11) 223 (e)	27-Oct-11	Revise the schedule of Trust Board walkabouts and amend the questionnaire used to reflect the suggestions received at the meeting	RO	31-Dec-11	Walkabouts focussed on Sandwell site at present. Schedule of mick CQC inspections arranged, the questionnaires for which are clearly tailored to the questions that the CQC would be likely to ask	B
SWBTBACT.216	CQC reports and action plans	SWBTB (10/11) 223 SWBTB (10/11) 223 (a) - SWBTB (10/11) 223 (e)	27-Oct-11	Ensure that consideration of progress with the CQC action plan is added as the first substantive item to the future agenda of the public Trust Board meetings	SG-P	24-Nov-11	Added to the agenda of the meeting scheduled for 24/11/11 and for all other Trust Board meetings thereafter	B
SWBTBACT.218	Board Assurance Framework - Quarters 1 & 2	SWBTB (10/11) 218 SWBTB (10/11) 218 (a)	27-Oct-11	Send the risk severity matrix to Mr Gayle	SG-P	24-Nov-11	Sent as requested	B
SWBTBACT.219	Draft minutes of the F & PMC - 20-10-11	Hard copy paper	27-Oct-11	Incorporate the definitions and sources of mortality information within an update to the Trust Board on mortality planned for November 2011	DO'D	24-Nov-11	Incorporated as requested	B

KEY:

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

Next Meeting: 24 November 2011, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

27 October 2011, Boardroom @ Sandwell Hospital

Members present: Mrs S Davis (SD), Mr R Trotman (RT), Dr S Sahota (SS), Mrs G Hunjan (GH), Mr P Gayle (PG), Mrs O Dutton (OD), Mr J Adler (JA), Mr R White (RW), Mr Donal O'Donoghue (DO'D), Miss R Barlow (RB), Mr M Sharon (MS), Miss R Overfield (RO)

In Attendance: Mr G Seager (GS), Miss K Dhami (KD), Mrs J Kinghorn (JK), Mrs C Powney (CP) [Sandwell LINks]

Apologies: Prof D Alderson (DA)

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 28 November 2011

Reference No	Item	Paper Ref	Date	Agreement
SWBTBAGR.249	Minutes of the previous meeting	SWBTB (9/11) 203	27/10/2011	The Trust Board approved the minutes of the previous meetings as a true and accurate records of discussions held
SWBTBAGR.250	Application for the use of the Trust Seal - lease and supply agreements for the Krypton generator service	SWBTB (10/11) 217 SWBTB (10/11) 217 (a)	27/10/2011	The Trust Board approved the application for the use of the Trust Seal on the lease renewal and supply agreements for the Krypton generator service

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	The Trust's Submission To Be Designated A Trauma Unit - Progress Report
SPONSORING DIRECTOR:	Mike Sharon, Director of Organisational Development and Strategy
AUTHOR:	Jayne Dunn, Redesign Director – RCRH
DATE OF MEETING:	24 November, 2011

SUMMARY OF KEY POINTS:

The West Midlands Specialised Commissioning Team on behalf of NHS West Midlands has undertaken a review and option appraisal for the reconfiguration of major trauma services in the West Midlands. This work has identified options for a West Midlands Trauma Care System including a number of Trauma Networks each with a single Major Trauma Centre, ambulance triage of major trauma and a number of Trauma Units. A Business Case has now been produced setting out the case for change and an option appraisal. Under all of these options the Trust would sit within the Trauma Network that has the Major Trauma Centre at the University of Birmingham Hospitals Foundation NHS Trust. The Trust would want to be a designated Trauma Unit at both City and Sandwell Hospitals.

In August 2011 we submitted a self assessment and portfolio of evidence against the West Midlands Trauma Unit standards and were formally notified in September 2011 that the Trauma Unit Selection Panel had considered the Trust eligible for Trauma Unit status with designation being formally awarded following demonstration of full compliance with Trauma Unit standards which we indicated would be by June 2012.

We are now required to submit an action plan by the end of November for the standards where we were assessed as partially compliant or not yet compliant, along with confirmation that we can deliver the Trauma Unit standards within current tariff reimbursement, will participate in the West Midlands Quality Review Service Trauma Peer Review in 2013 and attend and be an active member of the Trauma Network.

This report presents the Trauma Unit Action Plan along with a high level assessment of the resource implications. The activity and financial analysis can only be undertaken at a high level given the lack of robust data around levels of major trauma and because a number of the standards are not yet sufficiently clear and are unlikely to become clearer until the Trauma Networks are established. There are two broad categories of resource implications relating to the loss of income and the cost of meeting TU standards.

The high level analysis suggests once the Trauma Networks are established we will see an associated net loss of income of £1,959,054. We believe the fixed costs associated with this activity are higher than estimated in the Business case and can not be easily released given the standards that need to be met and our initial analysis that there are some additional costs of circa £70 000 associated with meeting the standards. A further more detailed activity and financial analysis will be required as evidence of activity becomes available and as greater clarity about the standards evolves once the Trauma Network is established.

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is recommended to:

1. APPROVE the Action Plan to deliver the Trust's full compliance with the Trauma Unit standards.
2. NOTE the initial work undertaken around resource implications and that in order to finalise this further, clarity is required around both major trauma activity and detail of the Trauma Unit standards.
3. NOTE the Trust intends to seek consideration of the impact of the assumed loss of income from major trauma with commissioners as part of contracting discussions. In particular the Trust will dispute the assumption that only 20% of costs associated with major trauma are fixed.
4. CONFIRM that the Trust is able to deliver the Trauma Unit standards within current tariff reimbursement subject to finalising the above work around resource implications.
5. CONFIRM the Trust is willing to participate in the West Midlands Quality Review Service Trauma Peer Review in 2013.
6. CONFIRM the Trust is committed to attend and be an active members of the Trauma Network.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High Quality Care
Annual priorities	Make improvements in A & E services and Make improvements in Trauma and Orthopaedic services.
NHSLA standards	
CQC Essential Standards of Quality and Safety	
Auditors' Local Evaluation	

PREVIOUS CONSIDERATION:

At its meeting in August 2011 the Trust Board supported the Trust's submission to be designated a Trauma Unit at both City and Sandwell Hospital sites and the supporting self assessment.

Following the above submission the Trust was formally notified at the end of September 2011 that the Trauma Unit Selection Panel had considered the Trust eligible for Trauma Unit status with designation being formally awarded following demonstration of full compliance with Trauma Unit standards which the Trust has indicated would be by June 2012.

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

Financial	**X**	The loss of income to the Trust from transfer of Major Trauma to a MTC is estimated as £2 million. Further analysis is required regarding the level of associated costs that can be released. It should also be noted that there ahs been a change in the trauma tariff in 2011/12 resulting in a higher tariff for more complex cases and a lower tariff for other trauma cases. In addition it is estimated that in order to achieve full compliance with Trauma Unit standards there is an additional cost of circa £70, 000.
Business and market share		
Clinical	**X**	Need to ensure clinical practice shows compliance with the West Midlands Trauma Unit Standards
Workforce	**X**	Need to assess competencies, develop training plans and audit programmes to ensure compliance with the West Midlands Trauma Unit Standards
Environmental		
Legal & Policy		
Equality and Diversity	**X**	The West Midlands Specialised Commissioning Team has undertaken an impact assessment as part of its option appraisal and development of the Business case for Change.
Patient Experience		
Communications & Media	**X**	The West Midlands Specialised Commissioning Team on behalf of NHS West Midlands has undertaken a review and option appraisal for the reconfiguration of major trauma services in the West Midlands. A Preferred Option has been identified and this will be subject to Formal Consultation between November 2011 and February 2012.
Risks		The Trauma Unit Action Plan identifies risk to non compliance or delayed delivery of actions against specific actions. In addition the covering report highlights a number of overarching risks.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

THE TRUST'S SUBMISISON TO BE DESIGNATED A TRAUMA UNIT
PROGRESS REPORT: NOVEMBER 2011

1. INTRODUCTION

In the summer of 2010 the West Midlands PCTs requested the West Midlands Specialised Commissioning Team to undertake a review and a financial option appraisal of options for the reconfiguration of major trauma services in the West Midlands including the establishment of Major Trauma Centres as recommended by the NHS West Midlands Strategic Health Authority Investing for Health group on major trauma. This work was subsequently established as a formal and expanded project and has developed options for a West Midlands Trauma Care System including a number of Trauma Networks each centred around a Major Trauma Centre with ambulance triage of major trauma and a number of Trauma Units. A Business Case has now been produced setting out the case for change and an option appraisal.

The Trust Board will recall that in August 2011 it supported our submission to be designated a Trauma Unit at both City and Sandwell Hospital sites and the supporting self assessment. The Trust Board will also recollect following the submission we were formally notified in September 2011 that the submission and self assessment had been considered by the Trauma Unit Selection Panel and that the Trust had been considered eligible for Trauma Unit status with designation being formally awarded following demonstration of full compliance with Trauma Unit standards which we had indicated would be by June 2012.

Following this work has been undertaken to develop an action plan for the standards where we were assessed as partially compliant or not yet compliant and in the format requested by the West Midlands Specialised Commissioning Team. This action plan has to be submitted to the Black Country Cluster Chief Executive by the end of November. In addition the Trust Board is required to confirm in writing that the Trust will:

- Deliver the Trauma Unit standards within current tariff reimbursement.
- Participate in the West Midlands Quality Review Service Trauma Peer Review in 2013.
- Attend and be active members of the Trauma Network.

The purpose of this paper is therefore to present the Trust Board with our Trauma Unit Action Plan and a high level analysis of resource implications for approval of the action plan and commitment to the above requirements.

2. BACKGROUND

The Business Case (*Business Case and Options Appraisal for a West Midlands Trauma Care System: September 2011)* developed by the West Midlands Strategic Commissioning Group sets out in detail the drivers for establishing a West Midlands Trauma Care System, the benefits being sought, options considered along with option appraisal and a preferred option.

The Case for Change:
In summary available evidence (from the London Trauma Network and similar systems in other countries) demonstrates that trauma care based on a network model incorporating a range of specialist units including a Major Trauma Centre (MTC), a number of Trauma Units (TU), pre-hospital care (including triage) and a range of rehabilitation providers is seen to:

- Reduce mortality (e.g. evidence in the United States suggests a 25% reduction) and disability for the most complex trauma cases (i.e. major trauma);
- Improve communication;
- Improve equality of access; and
- Provide more effective educational programmes for clinicians and staff.

A Trauma Care System:
A Trauma Care System therefore consists of one or more networks which each have:

- A single major acute emergency hospital (MTC) containing all of the required specialist departments on site.
- Other acute emergency hospitals that meet a range of defined standards will be designated Trauma Units. These will be supported by the MTC hospital to optimise some patients and support patients in their ongoing acute care following initial treatment at the MTC.
- Some hospitals that are not designated as a Trauma Unit may still have Emergency Departments but will have a very limited role to play in the management of trauma care.

The network comes together to deliver a safe, high quality and accessible trauma system to maximise outcomes for patients.

Options for the West Midlands Trauma Care System:
Within the proposed Trauma Care System for the West Midlands the eligible MTCs have been identified as :

- University Hospitals Birmingham NHS Foundation Trust (UHB)
- University Hospital of North Staffordshire NHS Trust (UHNS)
- University Hospitals Coventry and Warwickshire NHS Trust (UHCW) and
- (Paediatric MTC) Birmingham Childrens Hospital NHSFT (BCH).

All of the options identified for the West Midlands Trauma Care System include the Paediatric MTC at Birmingham Children's NHS Foundation Trust.

In relation to the Adult MTCs the options are:
Option 1: 3 Trauma Networks with MTCs at all of the above eligible adult MTCs
Option 2: 2 Trauma Networks with MTCs at University Hospitals Birmingham NHS Foundation Trust (UHB) and University Hospital of North Staffordshire NHS Trust (UHNS)
Option 3: 2 Trauma Networks with MTCs at University Hospitals Birmingham NHS Foundation Trust (UHB) and University Hospitals Coventry and Warwickshire NHS Trust (UHCW)
Option 4: 1 Trauma Network with MTC at University Hospitals Birmingham NHS Foundation Trust (UHB)

Following an option appraisal process the West Midlands Strategic Commissioning Group has identified Option 1 as the Preferred Option on the basis of it providing improved access, ease of deliverability and fewer capacity constraints whilst requiring an additional investment which is only marginally higher than the next best option.

In all options we will form part of a Trauma Network with University Hospitals Birmingham NHS Foundation Trust (UHB) as the MTC.

Key Project Timescales:

- Consultation November 2011 – February 2012
- Implementation October 2011– March 2015
- Monitoring and Evaluation April 2012 – ongoing.

3. TRAUMA UNIT ACTION PLAN

We submitted a self assessment against the West Midlands Trauma Unit Standards and a portfolio of evidence in August 2010. This showed only partial or non-compliance with some standards and we estimated we would be able to demonstrate full compliance by June 2012. This self assessment was accepted and formed the basis of the decision by the Trauma Unit Selection Panel that the Trust had been considered eligible for Trauma Unit status with designation being formally awarded following demonstration of full compliance with Trauma Unit standards i.e. by June 2012.

Trauma Unit

In summary a Trauma Unit (TU) is:

- A hospital that will have a role to optimise a patient if they are too unstable to be transported direct to a MTC or if a patient is longer than 45 minutes away from an MTC. The TU will have systems in place to rapidly move the most severely injured patients who are treated by them initially on to MTCs that can manage their injuries.
- The TU will continue to receive general trauma cases that are not brought in by ambulance and who self-present.
- TU services should be overseen by speciality teams with a designated responsible consultant for each patient: including general surgery, orthopaedics and a specific level of vascular network support.
- The TU may also provide some specialist services for patients who do not have major trauma (e.g. complex orthopaedic reconstruction).
- Other TUs may have only limited facilities, being able to stabilise and transfer serious cases but only to admit and manage less severe injuries.
- TUs will also still receive major trauma cases that are under triaged (i.e. they do not trigger the triage tool when they should).

Action Plan

Our TU Action Plan is attached as Appendix 1. It should be noted that there are a number of standards where developing action plans and compliance is not possible until the Trauma Networks are established. The most significant of these are:

- Protocols for the transfer of major trauma case from the TU to the MTC
- A robust process for accepting patients ready for repatriation from the Major Trauma Centre within 48 hours, including a clear point of contact, a process for rapid identification of a speciality team to accept patient and escalation process if no speciality team can be identified.
- Regular input from a Consultant in Rehabilitation Medicine based at the MTC to assess and treat patients and determine the rehabilitation prescription and plan.
- An identified Rehabilitation Coordinator within the Trauma Centre to act as point of contact throughout the episode of care and to oversee the provision of rehabilitation.

The TU standards are divided into a number of headings and the sections below highlight the key actions required to achieve full compliance (with the exception of standards where the establishment of the Trauma Network is required first).

Institutional Commitment:

- Establish a Trauma Steering Group and produce regular progress reports to the Trust Management Board
- Consider the need for a Clinical Lead/Director for Trauma with designated time
- Set up cold scenario teaching for the management of trauma cases requiring the call out of the Trauma Team
- Commitment to fund time for a Consultant in Rehabilitation based at the MTC to provide regular assessment and treatment on site
- Commitment to identify and/or fund a Rehabilitation Coordinator

Service and Process:

- Standard Operating Procedure for Trauma Team including a log, debrief process, review and audit process
- Skills and competency review, subsequent development of training plans for consultants and middle grade doctors in non training posts who are involved in the management of Trauma and evidence of trauma CPD– applies across a number of specialities
- Skills and competency review and subsequent development of training plans for nurses in ED who support the Trauma Team
- Need to clarify if 24/7 on site juniors are required in Imaging given consultants can access images on line from home 24/7
- Develop a protocol for CT requests from ED (in addition to stroke and head injury) including maximum time to CT from request of 30mins for urgent patients in ED

Estimates of the cost implications of the TU Action Plan have been included in the section below.

4. RESOURCE IMPLICATIONS

The Trauma Care System Business Case (*September 2011)* developed by the West Midlands Strategic Commissioning Group (WMSCG) recognises that whilst major trauma represents a small number of patients there is a lack of consistent data on the incidence of major trauma in England and so it uses a 'best estimate' based on analysis of different methods of estimation to model the volume of true major trauma cases. It also recognises from experience in the London Trauma Network and NHS East of England that within a Trauma Care System there will be an over triaging of cases taken to the MTCs (i.e. cases initially triaged as a major trauma case but subsequently assessed/found not to be) and to a lesser extent under triage of cases taken to TUs. The Business Case therefore uses these estimates in its activity and financial analysis along with estimates from the MTCs of additional costs required to fully meet the MTC standards. The Business Case does not include activity and financial analysis for TUs but assumes that the costs associated with delivery of TU standards will be covered within tariff and no additional investment will be required from Commissioners. WMSCG have also commissioned an Integrated Impact Assessment (IIA) report from an independent third party – Mott MacDonald. Part of this impact assessment deals with the economic consequences of the change and this has been used to inform the Activity and Income Analysis below.

Activity and Income Analysis
In summary the modelling suggests there are 729 true major trauma cases and a further 1,917 (72%) over-triaged cases per annum in the West Midlands.

The baseline activity analysis from the IIA (appendix A) suggests that currently 229 of these cases are treated by us. In the future the majority of these will be transferred to the MTC at UHBFT although some will return to us for rehabilitation.

The tariff for trauma has changed in 2011/12 with a shift in financial resource to the more complex cases (higher coded VA chapters) and this is included with the consequence of activity changes in the income calculations below.

The Income Changes forecast for us are as follows:

Income Type	£
Loss of Adult Major Trauma	-1,249,387
Offset Rehabilitation Income	34,342
Loss of NCRS Income	-632,713
Loss of Paediatric Major Trauma	-111,295
Total	***-1,959,054***

The IIA makes the assumption that the cost related to this income is 20 % fixed in the short term and can all be removed over time.

We would argue that a much higher percentage is fixed as much of the infrastructure supporting major trauma will still be needed to comply with the standards required of a Trauma Unit. Further work is needed to more accurately identify the net deficit.

In addition there will be some costs associated with meeting the standards required of a Trauma Unit. Based on our TU Action Plan these are:

Costs Associated with TU compliance	£
Trauma CD -2 PAs	20,000
Training Costs	50,000
Total	***70,000***

We now participate in submitting data to the Trauma Audit and Research Network (TARN) but have only consistently done so since September 2011 and so are unable to use this as a source for estimating trauma workload. An analysis of trauma activity presenting to our Emergency Departments undertaken in 2010 suggested that circa 200 major trauma cases are seen a year based on initial presentation. This is broadly in line with the suggested activity of 229 in the IIA.

5. RISKS

The Trauma Unit Action Plan identifies risks to non compliance or delayed delivery of actions. There are however also a number of overarching risks that need to be highlighted and are summarised in the following table:

Risk	***Mitigation***
Unable to reduce costs to the same level as reduction in income from the loss of major trauma activity to the MTC whilst at the same time reaching full compliance with TU standards.	Further analysis of cost implications as standards become clearer. Identify savings in other elements of the emergency and trauma service to cover the gap.
Further reduction in income as a result of loss of greater levels of major trauma activity than modelled.	Identify savings in other elements of the emergency and trauma service to cover the gap.
Inability or delay in meeting full compliance with TU standards resulting in the Trust not becoming a designated Trauma Unit with subsequent loss of significant elements of trauma activity and income and a negative impact on the sustainability of our Emergency Departments.	Trauma Steering Group to actively manage the TU Action Plan.
The income associated with repatriated patients from the MTC is insufficient to cover the costs of providing the service.	Continue to analyse the implications of the activity associated with this element of care once a clearer model is available from the Trauma Care Service Project.

6. CONCLUSION

We have developed an action plan to deliver full compliance with the Trauma Unit standards in order to be designated a Trauma Unit by June 2012.

There are a number of standards where full compliance will not be possible until the Trauma Networks are established.

For the remaining standards a key issue in relation to delivering compliance will be clinical ownership, commitment and time to deliver and embed the required changes. To oversee this, the Trust's Trauma Steering Group needs to be formally established and to report progress on a regular basis to the Trust Management Board. Whilst the Trust's Medical Director is the nominated Trauma Lead, in order to ensure sufficient profile is given to implementing and maintaining the standards and liaising with the Trauma Network it is suggested that there should be consideration given to establishing a formal Clinical Lead/Director for Trauma with designated time.

Activity and financial analysis has been difficult because of the lack of robust data around levels of major trauma and because a number of the TU standards are not yet sufficiently clear and are unlikely to become clearer until the Trauma Networks are established. There are two broad categories of resource implications relating to the loss of income and the cost of meeting TU standards.

The high level analysis suggests once the Trauma Networks are established we will loose approximately 229 major trauma case to the MTC with an associated net loss of income of £1,959,054. The analysis undertaken by the WMSCG suggests that only 80% of associated costs can be released when the activity is lost as only 20% of associated costs are fixed and even these can be released over time. We would argue the fixed costs are higher and can not be easily released given the TU standards that need to be met. Indeed an initial analysis suggests there are some additional costs associated with meeting the TU standards. A further more detailed activity and financial analysis will be required as evidence of activity becomes available from TARN and TU standards awaiting establishment of the Trauma Networks become clearer.

7. RECOMMENDATIONS

The Trust Board is recommended to:

1. APPROVE the Action Plan to deliver the Trust's full compliance with the Trauma Unit standards.
2. NOTE the initial work undertaken around resource implications and that in order to finalise this further, clarity is required around both major trauma activity and detail of the Trauma Unit standards.
3. NOTE the Trust intends to seek consideration of the impact of the assumed loss of income from major trauma with commissioners as part of contracting discussions. In particular the Trust will dispute the assumption that only 20% of costs associated with major trauma are fixed.
4. CONFIRM that the Trust is able to deliver the Trauma Unit standards within current tariff reimbursement subject to finalising the above work around resource implications.
5. CONFIRM the Trust is willing to participate in the West Midlands Quality Review Service Trauma Peer Review in 2013.
6. CONFIRM the Trust is committed to attend and be an active member of the Trauma Network.

Jayne Dunn
Redesign Director Right Care Right Here
17th November 2011

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	CQC action plans
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Rachel Overfield, Chief Nurse
DATE OF MEETING:	24 November 2011

SUMMARY OF KEY POINTS:

The Trust Board are asked to note the contents of the revised action plans for Outcomes 1 and 5 and the corporate action plan.

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	**x**	
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Action plans submitted to the Trust Board on 27th October 2011.

Sandwell and West Birmingham Hospitals NHS Trust

Corporate actions in response to CQC unannounced visits (Sandwell 28.03.11, City 04.05.11 and repeat visit to Sandwell on 03.08.11) v3

Key

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

Executive and Operational Lead	RO

Status Key:

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

Board Approved:

Governance Board – 08.07.11
Trust Board – approved 28.07.11, 27.10.11
Exec Team – approved 8.11.11

Ref	Action	Progress	By Whom	Timeframe	Status
1.1	Share CQC reports with Trust Board and wider organisation. Share CQC reports with OSC, PCT, MPs and Patient reps. Second report also shared with same partner organisations.	Complete. Going to Public Trust Board July 28th. Complete 27.10.11.	**RO**	**June for 1st report** **October for 2nd report**	
1.2	Cross reference CQC findings with internal intelligence and PCT ward visits and share findings with TB/PCT/SHA.	Complete – reviewed again following second report.	**RO**	**June** **October**	
1.3	Review patient survey results and cross reference to CQC findings.	Complete – some correlation noted. Review again post second report.	**RO**	**June** **October**	
1.4	Ensure staff on relevant wards are briefed on CQC findings and appropriately supported. Staff briefings held week commencing 17th October 2011.	Complete.	**RO/JA**	**May** **October**	
1.5	Advise Unions of CQC visit and plans for N4. Unions briefed on on-going CQC actions at every JCNC meeting.	Complete.	**RO**	**June (and monthly thereafter)**	
1.6	Prepare press handling strategy for when reports published. Repeated for publication of second report.	Complete.	**JKi**	**June** **October**	
1.7	Produce appropriate Communication Strategy for publishing CQC findings.	In place.	**JKi**	**June** **October**	
1.8	Brief Matrons/Ward Managers/medical staff re CQC findings.	Complete.	**RO**	**May/June and at every Senior Nurse Forum since**	
2.1	Develop a means of collating all sources of patient views in one place.	Progressing.	**JKi**	**January 2012**	
2.2	Continue with TB safety visits that include observation of mealtime, dignity etc and use Mock CQC template.	In place since February and process revised post second visit.	**RO**	**Ongoing**	
2.3	Establish a 'Patient User Group'.	Progressing.	**DT**	**December**	

3.1	Commence weekly Matron 'rounds'/audit across the Trust.	Complete.	**HJ/HS**	**June**	
3.2	Commence weekly Head of Nursing 'rounds'	Complete.	**HJ/HS**	**June**	
3.3	Invite LINKS/PCT to do unannounced visits over meal times.	Complete.	**RO**		
3.4	Ensure 'worry wards' are on the Trust Risk Register.	Complete.	**HS/HJ**	**May**	
3.5	Commence unannounced visit of other elderly care/rehab/stroke areas to ensure similar issues not there.	Complete.	**ADN's**	**June**	
3.6	Review ward level documentation and audits to produce streamlined and less resource intensive processes.	Work commenced. Plan in place.	**RO/DT**	**January 2012**	
3.7	Establish 'coaching' support for challenged wards via ADN's and L&D.	In place.	**RO**	**June**	
4.1	Exec Team to agree immediate ceasing of bed 'flexing' other than where there is an established winter plan. Establish weekly monitoring of bed flexing via Exec Team.	Complete.	**Exec Team**	**October**	
4.2	N4 to be separated into its component parts, ie Acute Stroke and Stroke Rehab on two separate wards to enable staff skills to be developed accordingly and appropriate environment for patients.	Complete.	**RO**	**October**	
4.3	N4 and N1 to remain in Special measures until standards are consistently satisfactory.	Complete.	**HJ**	**Ongoing**	
4.4	TB/Exec Team alerted to planned changes for N4 and progress reports against special measures action plan.	Complete.	**RO**	**Ongoing**	
4.5	Special measures turnaround meetings established.	Complete.	**RO**	**May**	
4.6	N4 staff meeting to advise on planned and ongoing changes fully established.	Complete.	**RO**	**May**	
5.1	Exec Team to agree bed capacity plan to avoid unstaffed bed risk in future.	Agreed at PMB July 2011	**Exec Team**	**July**	
5.2	Staff:bed ratio to be discussed monthly at Exec Team, TMB and Trust Board.	System in place since April.	**RO**	**April**	
5.3	Develop a bed escalation policy to avoid the indiscriminate opening of additional beds.	In place.	**MD**	**July**	
5.4	Mock CQC inspections to commence to compliment work underway by senior nurses.	Schedule in place.	**RO**	**October**	

5.5	Reports from mock CQC inspections to be shared with Ward Manager/Matron, head of Nursing and themes with Exec Team and Trust Board.	In place.	**RO**	**October**	
5.6	Bed Boards to be replaced behind every bed space with clear prompts for fluid, diet, preferred name etc.	Ordered	**RO**	**December**	
5.7	Appreciative enquiry/peer review requested by RO to the PCT/Cluster. Appreciative enquiry for Stroke pathway scheduled 16th December.	Planned.	**RO**	**December**	
5.8	Payroll attachment for all staff stating requirements around nutrition, privacy and dignity to be issued.	Done.	**RO**	**October**	
5.9	Personal Letter to all nursing and medical staff stating requirements around privacy, dignity and nutrition to be issued.	Done.	**RO**	**October**	
6.0	Self assessment tool for nursing practice to be issued and completed by all nursing staff and incorporated into ward performance review process.	Tool to be issued WC 14th November.	**RO**	**November**	
6.1	Nursing performance electronic dashboard to be developed to replace existing paper based system to enable real time monitoring of standards.	Meeting with IT. Priority action. Work progressing with aim to have in place by January.	**RO**	**January 2012**	
6.2	Consider new ward management structure to release ward managers for leadership role 100% of the time. Paper to go to Exec Team.	Paper presented to Exec Team. Principle agreed but requires further work and funding agreement.	**RO**	**January 2012**	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Sandwell & West Birmingham Hospitals NHS Trust
CQC Essential Standards for Quality and Safety
Outcome Measure 1 – Respecting and Involving People Who Use Services
Improvement Plan v12

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

Key

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

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

NB – Completed actions are moved to the back of the action plan but numbering is not changed to maintain audit trail.
Status Key:

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

Board Approved:
Governance Board – 08.07.11
Trust Board –approved 28.07.11, 27.10.11

Ref	Action	By Who	When	Evidence	Comments	Status
1	***1A - People understand the care, treatment and support choices available to them.***					
1.2	Ensure information is available to patients in all settings regarding treatment choices.	JKi	Sept 2011 Completed	Visits Space utilisation Patient surveys	Information is generally available but further work required to ensure information is actually given to patients.	
1.3	Ensure information is accessible to patients, ie language format etc.	JKi	Sept 2011 TBC	Visits Space utilisation Patient surveys	Some information is available in alternative languages/formats but further work required.	
1.4	Ensure appropriate areas exist to enable private conversations with patients.	~~MD/~~GS	Sept 2011 Completed	Visits Space utilisation Patient surveys	Given the age of the estate as much opportunity as possible has been taken to develop quiet spaces.	
1.5	Remove unnecessary staff offices etc from ward /clinical areas to provide quiet rooms	~~MD~~ GS	Dec 2012	Visits	Significant progress made on reallocating non clinical functions away from wards but not yet complete.	
1.6	Ensure Trust is compliant with Equality Act. Action reviewed due to new elements to the Act,	LP	In place. Review Mar 2012	Action Plan. Minutes of E&D Steering Group. Visits	Gap analysis complete. Action plans in place. Board reporting occurring. Included in staff training although not all staff will have received this yet.	
1.13	Wards/departments record in the patients/nursing notes any information given to patients regarding their planned care/treatment.	WMs/ Matrons	September 2011 Revised due to Clinical Documentation Project Jan 2012	Notes audit. Ward reviews.	Staff have been reminded to do this and audits suggest improvement. This is part of the new clinical record due out in January.	
1.14	All wards/departments understand how to access services to promote communication for service users that are: - Deaf - Visually impaired- determine access to audio equipment and insert into communication folder - Cannot speak English as first language	LP	~~August 2011~~ Oct 2011	Ward info leaflet. Pre-admission info. Disabled Go website. Communication Aides Folders Access to Interpreting Policy	Staff have been reminded of how to access various services but mock inspections still suggest further improvement required re staff awareness.	

	- Require Easy Read/translated information					
1.15	All wards to have copies of bedside directory.	JKi/	In place.	Matrons round. Observation of Care Team	Audits have shown that some directories have gone missing, therefore an order placed for more.	
1.16	All wards to have information re complaints process and advocacy services.	KD		See complaints action plan.		
1.17	All wards have patient information to support DSSA and privacy and dignity.	DT/LP	Sept 2011	Evidence in bedside directory.		
1.18	~~All wards to document patient choice re:~~ Patients will be involved in planning their care: - Choice to get dressed - Choice of meals - Choice to self-medicate - Choices re discharge	Matrons/ WMs/JK	Sept 2011 Revised date to allow disseminatio n of folders- Nov 2011	In house unannounced visits. Notes/Care Plans audits signature of patient/carer. Ward Reviews. Nutrition audits. Patient Assessment Documentation Patient Folder	Audits suggest this is generally improving. New patient bedside folder prompts specific care plans and patient involvement. These folders are currently being rolled out to all areas.	
1.21	Continue to develop Trust privacy and dignity website.	DT/ET/EB	~~Sept 2011 Delay – revised date end Oct 2011~~ January 2012	Website. Patient views.		
2	***1B*** ***People who use services have their care, treatment and support needs met.***					
2.1	The process for assessing and planning care is clearly described.	DT/RO	~~Sept 2011 Dec 2011~~ January 2012	Notes audits. Ward reviews	Patient assessment record under review as part of clinical records review. Will include 'intentional rounding' philosophy. Currently being trialled. Intend to roll out January.	
2.2	All patients have plans of care relevant to their assessment needs.	DT	Sept 2011 Revised date due to Clinical Documentati on project	Notes audits. Ward reviews Care Plans	Audits show significant improvements but requires new approach to clinical records keeping to fully resolve.	

			Jan 2012			
2.3	All patients have completed documentation.	Matrons/ WMs	Sept 2011 Revised timescale Dec 2011	Notes audits. Ward reviews	Audits show improving picture but mock inspections designed to remind staff of importance.	
2.4	Records are concise, legible and signed/dated.	Matrons/ WMs	Sept 2011 completed	Notes audits. Ward reviews		
2.5	Patient views are sought regarding their care.	Matrons/ WMs Completed	Sept 2011	Notes audits. Ward reviews Satisfaction Surveys	Patient satisfaction surveys are undertaken on an on-going basis with monthly feedback to wards.	
2.7	Tools such as the SAP are used to ensure specific care needs are passed on and understood.	DT	In place. Dec 2011	Patient Assessment Record (PAR/SAP) Safety Briefing -77% compliance on use of safety briefing across wards	See above re documentation project.	
3	***1C – People who use services receive care, treatment and support where clear procedures are followed in practice, monitored and reviewed.***					
3.1	All Clinicians adhere to the Consent Policy.	DO'D	Via consent NHSLA Action Plan.			
3.2	The following Acts/requirements are understood by staff and discussions and plans of care/treatment documented - Deprivation of Liberty - Mental Capacity - Safeguarding - Decisions relating to religious beliefs Action revisited and added to live action plan as target for training implementation not fully met.	DT	In place. Mar 2012	Programme – Safeguarding training NHSLA assessment. Care plans WMQRS peer group- review 13th July	Training is in place for Band 7s and Senior Clinicians and is currently being rolled out to shift co-ordinators and middle grade Doctors as per the Trust's agreed Training Plan which is spread over 3 years. (currently in year 2).	
3.6	All wards/departments involve patients in decision making about care/treatment.	DT	Sept 2011 Completed	Audit data – not yet available. Patient Satisfaction Surveys		
3.7	Discharge arrangements ensure involvement of patients in planning and choices.	HJ	October 2011	Discharge records. Readmissions. LINK audit. Patient surveys.	Evidence of good practice in some areas need further work to ensure consistent approach across the Trust. Working with local links to achieve this.	

4	***1E*** ***People who use services are supported to make informed choice about their care, treatment and support.***					
4.1	All wards/departments have relevant up to date condition specific information.	JKi	Sept 2011	Patient surveys. Observation of Care Team.		
4.2	All clinical teams ensure patients have the opportunity to discuss care and treatment.	Matrons/ WMs		Patient Satisfaction Surveys		
4.3	All wards/departments have access to quiet areas for private conversations.	MD	See action 1.4	See action 1.4		
5	***1F*** ***People who use services receive care, treatment and support that is provided in a way that ensures independence.***					
5.1	Wards/departments ensure patients are involved in care planning and treatment choices.	Matrons/ WMs	Part of action 2.1			
5.2	Self-care is encouraged wherever possible.	DT/ET	Sept 2011	PAR Quality Audits		
5.3	All nursing staff encourage the following as the norm: - Use of bathrooms/toilets - Use of dayrooms - Occupational activities - Protected mealtimes - Self-administration of drugs	Matrons/ WMs/ET/RO	Sept 2011 Revised date Nov 2011	Dayroom use. Protected meal times audits. Medicines management audits. Patient surveys. Volunteer strategy. Observations of Care Ward Manager Objectives Patient Folder	Evidence that day rooms etc. are being more actively used but remains inconsistent – more work to do.	
5.3b	Consider need for and funding for 'Activity Co-ordinators' to meet 1F, National Dementia Strategy support volunteers on rehabilitation wards.	RO	Mar 2012	Visits Activities Schedule	Discussed with Exec Team – pursuing options through WRVS.	
5.4	Environments are managed to promote 'normality', eg: - Reduced noise at night - Access to TV/radio - Relaxed visiting where possible - Protected mealtimes - Own clothes - Choice of food - Access to food/snacks/drinks 'round the	Matrons/ WMs/RO	Sept 2011 Revised awaiting outcome re TVs to Nov 2011	Dayroom use. Protected meal times audits. Medicines management audits. Patient surveys. Volunteer strategy.	See above – being actively encouraged but not yet consistent.	

	clock'.					
6	***1G*** ***People who use services receive care, treatment and support that is provided in a way that ensures human rights and diversity are respected.***					
6.1	The interpreting services will be accessible and clearly understood by staff.	LP	In place.	All actions in place via E&D Steering Group and Action Plan. Interpreter policy Mailshots Internal Measures Boards Laminates /stickers	Interpreter services are accessible but further work required with staff to ensure services are actually being accessed.	
6.2	Telephone and staff interpreting will be clearly defined and accessible.	LP	In place. Requires audit dec 2011	All actions in place via E&D Steering Group and Action Plan. Interpreting Policy Laminates	As above.	
6.3	Written information where appropriate will be available in other languages/formats.	JKi	In place.	All actions in place via E&D Steering Group and Action Plan.	Some information is available in alternative languages/formats on request. Audits suggest that staff require further information on how to access for patients – work is progressing.	
6.4	Devices to assist deaf/blind patients will be available.	LP	In place for out patients. Audit of in-patients planned to be complete Dec 2011	All actions in place via E&D Steering Group and Action Plan.		
6.6	E&D training will be part of MT.	JP	In place. But needs review Jan 2012	All actions in place via E&D Steering Group and Action Plan.	Is part of MT but is so integrated into other subject matter staff sometimes fail to recognise that they have received training. Review under way and will deliver in different format in future.	

7	***1H*** ***People who use services are provided with information.***					
7.1	All wards/departments/services will have information on the service.	JKi	See previous action notes.	See previous action notes.		
7.2	All wards/departments will have a meet and greet pack that describes the service, care, treatment and staff.	HoN/JK	Sept 2011 Revised and extended – delay due to capacity required to print and laminate Nov 2011	Patient surveys. Ward reviews.	In place in many areas but will be fully resolved with the introduction of patient bedside folders.	
7.4	All other departments will 'publish' key quality/performance measures.	RO/MD	Oct 2011	Audits. Measures Boards		
7.5	All wards/departments will have information about how to raise a concern/complaints.	KD	See complaints action plan.			
7.6	All wards/departments will have information about advocacy services.	DT				
8	***1I*** ***People who use services are given encouragement, support and opportunity to describe their needs and raise concerns.***					
8.1	All wards/departments have clear assessment/admission processes in place.		See action 2.1			
8.2	All wards/departments have information about Complaints/PALS in place.		See above re complaints action plan.			
8.3	Provide suggestion Boxes near all wards and review /report themes.		Complete.			
9	***1J*** ***People who use services can influence how the service is run.***					
9.3	Establish a user group/forums.	DT/JKi	Oct 2011 revised date due to extension of	User group minutes.		

			remit of action- Dec 2012			
9.4	Develop productive relationships with LINKS and other local networks.	JKi/DT	Sept 2011 completed			
9.5	E&D roadshows to local community groups.	LP	In place.	Reports to E&D Steering Group.		
9.7	All wards to have a 'dignity' champion – clearly identifiable to patients/visitors and responsible for local dignity initiatives.	RO/ET/SH/JK	August 2011 Revised date due to audit – SH- Sept 2011 Completed	Displayed on ward.	Dignity champion has been identified for every ward – mock inspections are testing staff awareness of the role. Suggests largely understood.	
10	***All staff treating patients, carers and families do so with respect.***					
10.1	Staff do not use inappropriate 'terms of endearment'. Staff will ensure tone and volume of voice is respectful.	Matrons/ WMs/JK	~~August 2011~~ Oct 2011	Observations of care quarterly	Being assessed via mock CQC inspections and audits.	
10.2	Wards to document preferred name the person would like to be called.	Matrons/ WMs/ET/JK	~~July 2011~~ Oct 2011 Revised date due to P&D Campaign in Nov 2011	PAR/SAP- need to audit as part of quality audits or matron checklist Bed boards – matron audit	See Above.	
10.4	Wards/departments to have appropriate patient nightwear available including footwear and provision for bariatric patients.	Matrons/ WMs	Oct 2011	Matron rounds. Patient surveys.	See Above. In-house laundry and bespoke pyjamas available from January.	
10.5	Ward staff to provide timely assistance to meet comfort needs, eg toileting, pain relief.	Matrons/ WMs/DT	~~August 2011~~ Dec 2011	Patient surveys. Matron rounds.		
10.6	~~Permission should be sought and documented before every intervention by staff.~~ Staff are observed explaining and seeking permission before interventions.	Matrons/ WMs/JK	August 2011 Completed Action reviewed Oct	Patient surveys. Observations of care.	Audits required to assess progress on this standard to be included in next observation of care audit due December.	

			2011 – due to inclusion of word 'every'. New date – Jan 2012 (post Q3 audits and P&D campaign)			
10.11	Laundry development to be completed.	SC	Oct 2011			
10.12	Purchase of new Trust nightwear.	SC/ward managers/JK/ RO	~~Oct 2011~~ Dec 2011			
10.13	P & D campaign to: increase awareness illustrate role of Champions monitor P&D on wards . departments, during transfer	ET/ Ward managers	Nov 2011	P & D Campaign plan Evaluation Spot checks	Campaign planned for late November.	

COMPLETED ACTIONS

Ref	Action	By Who	When	Evidence	Progress	Status
1	***1A*** ***People understand the care, treatment and support choices available to them.***					
1.1	Ensure Consent Policy is up to date and robustly in place.	DO'D	In place.	NHSLA evidence.		
1.5	Ensure training/awareness raising re privacy, dignity and respect available and delivered.	DT	August 2011 ?completed	Training programme and lesson plan.	Training Programme in place (MOT) but will take 12 months to train every member of staff.	
1.7	Ensure SES up to date and captures actions required to ensure patients human rights are respected.	LP	In place.	SES. Action Plan.		
1.8	Provide MT training on E&D.	JP	June 2011	MT records.		
1.9	Ensure patients confidentiality is protected.	DO'D/ Matrons/ WMs	Oct 2011	Policy. Audits. Data Protection.	Last observation of care audits showed 94 – 98% compliance. Staff have been reminded re confidentiality of handover.	
1.11	Observe care to ensure privacy, dignity and respect are maintained.	DT	In place.	Observation of care results. Patient surveys. Unannounced visits.		
1.12	Ensure staff aware of and use independent advocacy services Action revised – staff know how to use/ access independent advocacy services or access Safeguarding team to do so.	DT	July 2011	Poster. Referral to MCA.	Staff who have received relevant training know how to do this and there should always be access to advice for staff who have not yet received the training via Matron, Safeguarding team etc.	
1.19	Trust to be fully compliant with SSA guidance.	MD	In place.	Fully compliant.		
1.20	Patient experience Ward → Board reports to continue monthly.	RO	In place.	Trust Board papers.		
2	***1B*** ***People who use services have their care, treatment and support needs met.***					
2.6	Patients have access to a variety of support sources including:	RO/DT/LP	In place.	PALS posters. WMQRS assessment July	Services are available but staff need to promote them further.	

	- Chaplaincy - Advocacy - Interpreter Services			2011		
2.8	~~Staff demonstrate respect and kindness at all times.~~ On observation staff demonstrate respect and kindness	Matrons/ WMs	Ongoing. Action re-worded due to use of phrase 'at all times' .	Patient survey results.	Survey results suggest compliance but mock CQC inspections testing further.	
3	***1C*** ***People who use services receive care, treatment and support where clear procedures are followed in practice, monitored and reviewed.***					
3.3	Access to advocacy services is in place and understood by staff.	DT	In place.	Programme – Safeguarding training NHSLA assessment. Care plans WMQRS peer group- review 13th July	As previous.	
3.4	Access to Chaplaincy and spiritual care is available and understood by staff.	RO/LP	In place.	Patient Surveys.	As previous.	
3.5	The Trust is DDA compliant.	LP	In place.	The Trust is compliant within the limitations of old estate.		
6	***1G*** ***People who use services receive care, treatment and support that is provided in a way that ensures human rights and diversity are respected.***					
6.5	Chaplaincy/spiritual care will be sufficiently diverse to meet the needs of patients.	RO	In place.	All actions in place via E&D Steering Group and Action Plan.		
8	***1I*** ***People who use services are given encouragement, support and opportunity to describe their needs and raise concerns.***					
8.1	All wards/departments have clear assessment/admission processes in place.		See action 2.1			
8.2	All wards/departments have information about Complaints/PALS in place.		See above re complaints action plan.			
8.3	All in patients have the opportunity to complete a patient survey.	DT	In place.	Survey statistics.		

9	***1J*** ***People who use services can influence how the service is run.***					
9.1	Regular FT member forums are in place.	JKi	In place.	Evidence of forums/timetables/ minutes.		
9.2	Patient views are sought via patient surveys.	DT	In place.	Surveys		
9.6	Engagement plan in place.	JKi	In place.			
10	***All staff treating patients, carers and families do so with respect.***					
10.3	Call bells should always be in easy reach and are answered responsively. Revised action; every patient has access to a call button excluding critical care services	Matrons/ WMs	Ongoing.	Audit. Patient surveys. Matron rounds. Patient surveys.	Generally this standard is achieved but on-going audits and mock CQC inspections continue to test our compliance.	
10.7	All wards to use Privacy signs.	Matrons/ WMs	In place.	Quality Audits		
10.8	All ward rounds/handovers to be carried out without breaching patient confidentiality.	Matrons/ WMs	In place.		Generally this standard is compliant but staff have been reminded again to be aware of sensitive information during walkaround handover.	
10.9	DSSA toilet signage to be in place.	Estates	In place.			
10.10	Patients confidentiality to be maintained when answering the phone/IT.	DT	In place but requires regular audits.	Quality Audits	Generally this standard is compliant but staff have been reminded to be vigilant regarding sensitive information when talking on the phone.	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Sandwell & West Birmingham Hospitals NHS Trust
CQC Essential Standards for Quality and Safety
Outcome Measure 5 – Keeping Nourished and Hydrated
Improvement Plan v 11

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

Key

Rachel Overfield	**RO**	**Linda Pascall**	**LP**
Luke Banfield	**LB**	**Helen Shoker**	**HS**
Steve Clarke	**SC**	**Fiona Shorney**	**FS**
Helen Jenkinson	**HJ**	**Ward Managers**	**WMs**
Graham Seager	**GS**	**Mike Beveridge**	**MB**
Executive Lead		RO	
Implementation Leads		Outcome 5 – FS	
Divisional Leads		HS and HJ	

NB – Completed actions are moved to the back of the action plan but numbering is not changed to maintain audit trail.

Status Key:

	Complete.
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Board Approved:
Governance Board – 08.07.11
Trust Board – 28.07.11 and 27.10.11

Ref	Action	By Who	When	Evidence	Comments	Status
1	5A and 5B Where the service provides food and drink, people who use services have their care, treatment and support needs met.					
1.1	Patients will be assessed on admission for nutritional risk using the MUST tool within 12 hours of admission to base ward.	Matrons/ Ward Managers	~~October 2011~~ Revised Nov 2011	In nursing records. Monthly nutrition audits. Red @ Risk patients included in handover report	Audits improving month on month but not yet fully compliant.	
1.2	At risk inpatients will be reassessed for risk every 7 days as a minimum	Matrons/ Ward Managers	~~October 2011~~ Revised Nov 2011	In nursing records. Monthly nutrition audits.	As above.	
1.3	Bed plans will reflect those patients identified as being at nutritional risk ie. MUST score of 1 or 2	Matrons/Ward Managers	~~October 2011~~ Revised Nov 2011	Adherence to MUST guidance documented in nursing records. Monthly nutrition audits.	Monthly improvement noted but not at pace expected. Mock CQC inspections expected to raise importance further.	
1.4	Meal diaries will be kept for those patients identified as being at risk ie MUST score of 1 or 2	Matrons/Ward Managers	~~October 2011~~ Revised Nov 2011	Adherence to MUST guidance in nursing records. Monthly nutrition audits	As above.	
1.5	Inpatients will have Fluid Balance Chart unless identified as an exception via risk assessment and documented accordingly	Matrons/Ward Managers	~~October 2011~~ Revised Nov 2011	In nursing documentation. Monthly nutrition audits	Improvement slow thought to be in part due to confusion over bedside charts. Further clarification issued but full resolution expected with launch of improved clinical documentation in January.	
1.6	Implement escalation process where compliance is not achieved with no sign of sustained improvement and where there is persistent failure to do as expected	LP FS Matrons	November 2011	Monthly nutrition audits. Nursing documentation		
1.7	Weight will be monitored and recorded via the MUST process.	Matrons/ Ward Managers	~~October 2011~~ Revised Dec 2011	In nursing records. Monthly audits. Included in handover report	Audits improving but not yet fully compliant.	
1.8	Monthly audits of every ward for compliance.	FS	August 2011	PEPAG minutes. Audit results.		
1.9	All wards will have access to SLT for swallow	FS	August 2011	Patient records.		

	assessments via referrals.					
1.10	Matron/Ward Manager weekly checks introduced.	HoN	~~October 2011~~ Revised Nov 2011	Records of checks undertaken.		
1.11	Those patients assessed as being at risk will have an appropriate Nutritional care plan.	Matrons/ Ward Managers	~~October 2011~~ Revised Nov 2011	Patient records. Monthly audits.	Improving within audits but not fully embedded, expect further improvements with introduction of new clinical records.	
1.12	Nutritional needs will be discussed with patients/relatives/carers	Matrons/ Ward Managers	~~October 2011~~ Revised Dec 2011	Patient records. Patient surveys.	Patient survey suggests improvement in this area but not yet fully consistent.	
1.13	Nursing staff in In patient areas will be trained in the use of MUST tool.	FS LB	~~October 2011~~ Revised Nov 2011	Training records. Attendance records at ward based training sessions		
1.14	Continue to monitor fluid balance on food diary charts and fluid balance chart on existing until launch of new documentation in the new year	FS	~~October 2011~~ Revised Nov 2011	Monthly audits		
1.15	Wards will have appropriate weighing/measuring equipment.	FS	~~October 2011~~ Revised Nov 2011	Audit required. Attendance records at ward based training sessions		
1.16	Nutrition Policy to be produced and implemented to clearly identify what is expected.	FS	September 2011	Policy approved at September Governance Board.	Policy is available on the Intranet and included in staff training. A Nutrition Resource Folder will be shortly available on every ward.	
1.17	Cultural and a la carte menus to be combined	SC	October 2011	Audits. Patient surveys.		
1.18	Review diversity of additional cultural menus, eg Chinese and Thai.	SC	Jan 2012			
1.19	Ensure patients can gain access to special diets	SC	August 2011	Audits. Patient surveys.		
1.20	Ensure all ward staff know how to access hot/cold food out of hours.	SC Matrons/Ward Managers	August 2011	Audits. MOT study day Attendance records at ward based training sessions. Matrons rounds		

				Spot checks to ensure staff knowledge.		
1.21	Pre meal time routines established on wards to ensure patients are positioned appropriately, offered hand wash and toileting, The immediate bed area will be cleared if unnecessary clutter	Matrons Ward Managers	~~October 2011~~ Revised Nov 2011	Monthly audit reports to PEPAG Patient surveys Weekly matron rounds Regular spot checks	Audits demonstrate month on month improvements but not yet fully embedded.	
1.21	Protected meal times will be enforced on all wards. Meal service co-ordinators must be identified at every meal.	Matrons/ Ward Managers	~~October 2011~~ Revised Nov 2011	PMT monthly audit, results to PEPAG. Patient surveys. Matrons spot checks.	There has been significant improvement in all areas but the standards are not fully embedded at every meal time. On-going audits and mock CQC inspections will further drive this.	
1.22	Appropriate cutlery and food aids will be provided to assist independence.	Matrons/ Ward Managers	October 2011	Observation. Patient views. Liaison with ward OT	New stock of cutlery has been received and distributed to relevant areas.	
1.23	Volunteer Staff will be trained in how to feed patients and flexible workforce will be identified for wards with highly dependent patients.	LP	~~October 2011~~ Revised Nov 2011	Training records. MOT		
1.24	Relatives/carers will be encouraged to come in at mealtimes to assist with feeding where appropriate.	Matrons/ Ward Managers	~~Sept 2011~~ Revised Nov 2011	Patient surveys. Visual evidence/ observations. Measures boards. Visitors policy.		
1.25	Members of MDT working with patients during Protected Meal Times as part of their therapy will be identified by silver aprons.	FS	August 2011	Observations.		
1.26	Red trays, mugs and glasses will be used to identify patients those at risk and those who need assistance.	Matrons/ Ward Managers	July 2011	Monthly audits. Observation of care.	Mostly compliant but will be further tested via audits and mock CQC inspections.	
1.27	At meal time a meal co-ordinator to be identified. Meal times will be supervised by an identified member of staff.	Matrons/ Ward Managers	~~October 2011~~ November 2011	Monthly PMT audits. Observation of care.	This is mostly in place but requires further effort to ensure full compliance.	
1.28	Provision of bottled water to all wards.	SC	November 2011	Supplies orders.		
1.29	Re-launch the Nutrition champions and develop a Nutrition resource folder for each area	LB	~~October 2011~~ November	Staff aware of their ward champion.		

			2011	Monthly PMT audits Nutrition folder on each ward.		
2	***5C*** ***Where the service provides food and drink people who use services can make decisions about their food and drink.***					
2.1	Menu cards are available equitably for all patients	SC	August 2011	Patient Survey		
2.2	Menus include cultural meals, special diets and soft/pureed options	SC	July 2011	Patient Survey. Mealtime audits. Patient groups.		
2.3	Range of snacks (cake, yoghurts, cheese & biscuits etc) will be available at all times to most vulnerable patients, biscuits to all patients	SC	October 2011	Patient Survey. Mealtime audits. Patient groups. Matrons rounds		
2.4	Information regarding diet/nutrition will be provided to patients.	Matrons/ Ward Managers	~~October 2011~~ November 2011	Patient Survey. Mealtime audits. Patient groups.		
3	***5D*** ***People who use services benefit from clear procedures that are followed in practice, monitored and reviewed.***					
3.1	Nutritional Steering Group to review existing Fasting Policy and ensure it reflects Enhanced Recovery recommendations.	HS/MB	~~October 2011~~ Revised Nov 2011	Nutritional Steering Group minutes		
3.2	Monitor adherence to policy when reviewed by Nutritional Steering Group	HS/MB	~~October 2011~~ Revised Dec 2011	Audit reports.		
4	***5E*** ***People who use services have access to facilities for infant feeding including facilities to support breastfeeding.***					
4.1	Predominantly for outpatients or visitors in an unplanned situation.	GS	~~October 2011~~ Revised Nov 2011	Identified area @ City and possible location @ Sandwell.		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Infection Control Quarterly Report (July - Sept 2011)
SPONSORING DIRECTOR:	Rachel Overfield – Chief Nurse & Director of Infection Prevention and Control
AUTHOR:	Rebecca Evans – Head of Infection Control Nursing Services Richard Anderson – Informatics Officer Dr Natasha Ratnaraja – Consultant Microbiologist/Infection Control Doctor
DATE OF MEETING:	24 November 2011

SUMMARY OF KEY POINTS:

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

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

Continued surveillance on a range of other healthcare associated infections to include MSSA and E. Coli bacteraemia's are now mandatory.

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

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

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

Approval	Receipt and Noting	Discussion
	X	

To advise the Trust Board of the work undertaken by the Infection Control Service at Sandwell & West Birmingham Hospitals NHS Trust for the period July – Sept 2011

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to receive and note the Quarterly Report for the period July – Sept 2011.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	▪ Compliance with Health Code and National Targets for MRSA and ▪ Ensure systems are in place for the prevention and control of healthcare associated infections. ▪ *C.difficile*. MRSA National Targets.
Annual priorities	
NHS LA standards	NHS LA Risk Assessment - 2.4.9 – Infection Control
CQC Essential Standards of Quality and Safety	Core Standards - C1- & C9
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Routine quarterly report to the Trust Board.

Quarterly Infection Prevention and Control Report July - Sept 2011

1. Executive Summary

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

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

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

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

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

2. Management and Organisation

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

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

3. Surveillance

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

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

3.1 MRSA

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

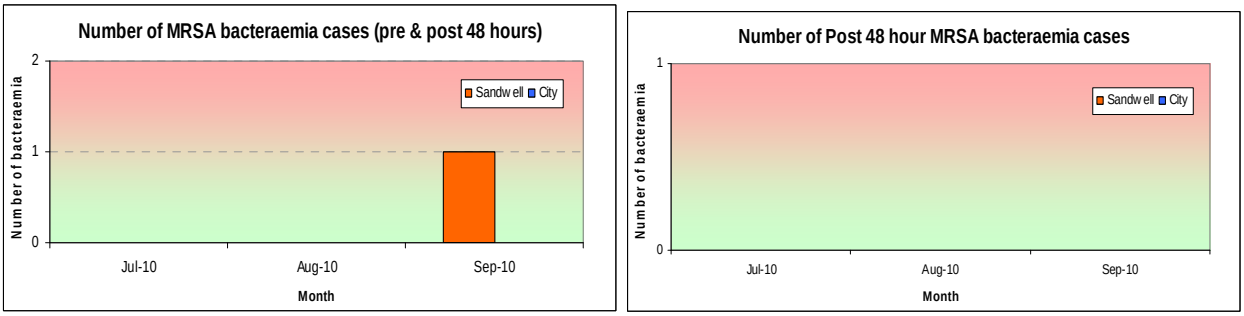


Figure 1: Number of MRSA bacteraemia cases

3.1.2 Percentage of possibly contaminated blood cultures.

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

Signature on blood culture form legible

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

Signature on blood culture form not legible.

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

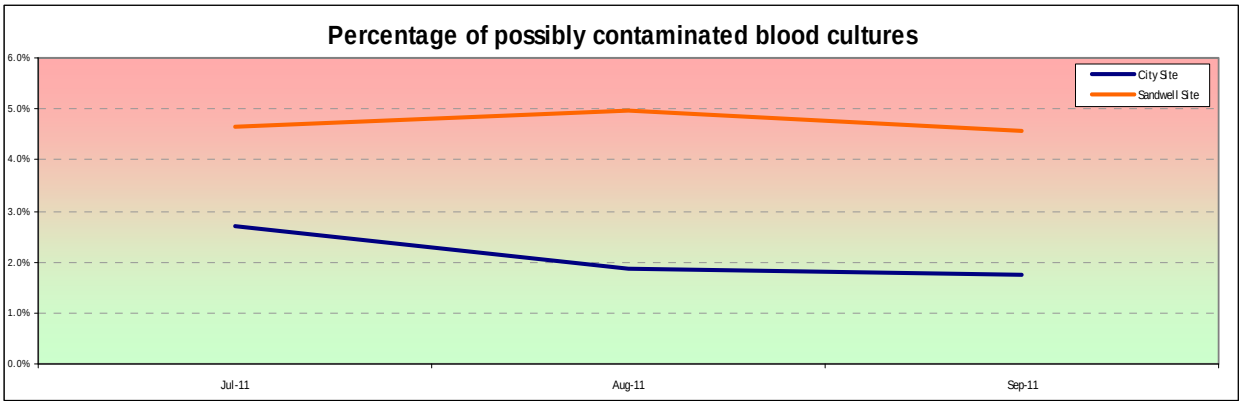


Figure 2: Percentage of possibly contaminated blood cultures

3.1.3 Number of MRSA Screening undertaken

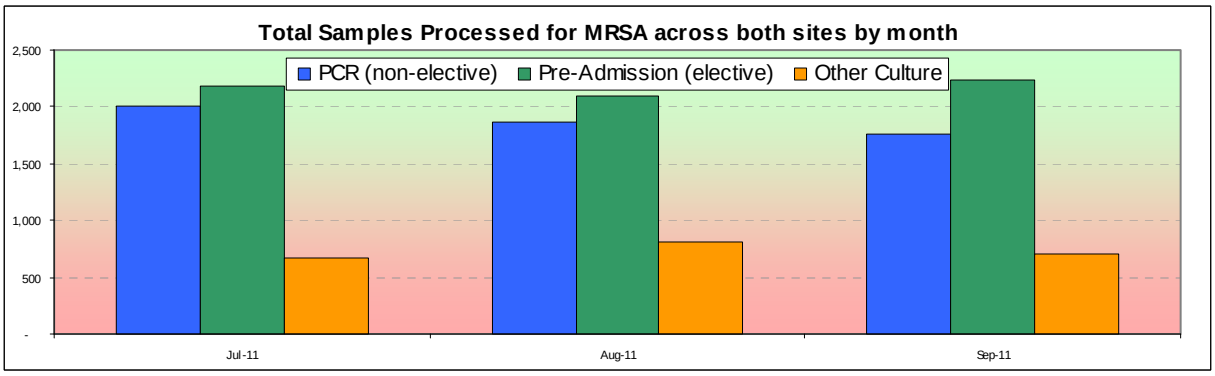


Figure 3: MRSA screening numbers

3.1.4 Graph to identify the percentage positively rate by month

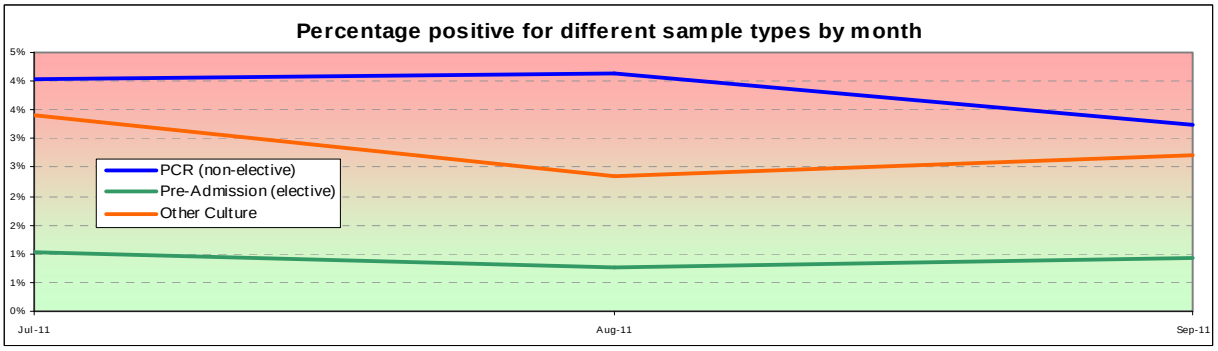


Figure 4: MRSA screening positivity rates

3.2 Clostridium difficile infections (CDI)

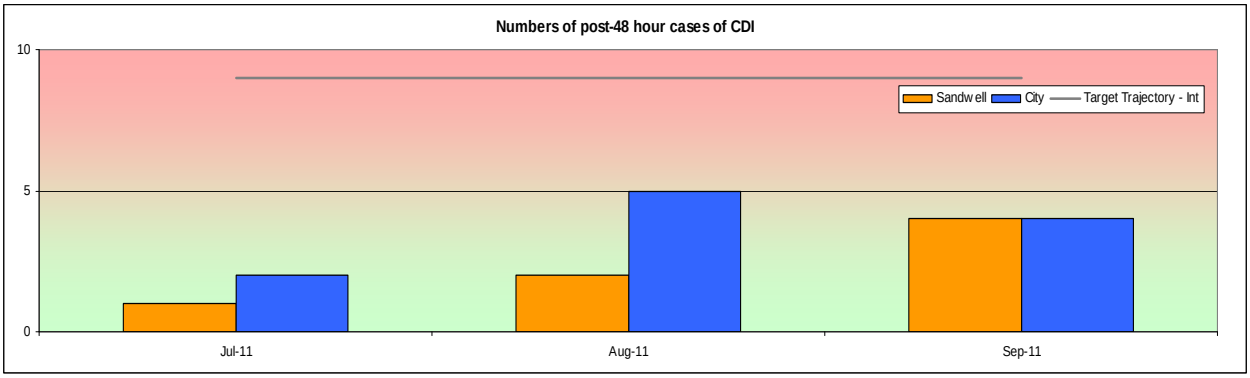


Figure 5: Numbers of post-48 hour cases of CDI

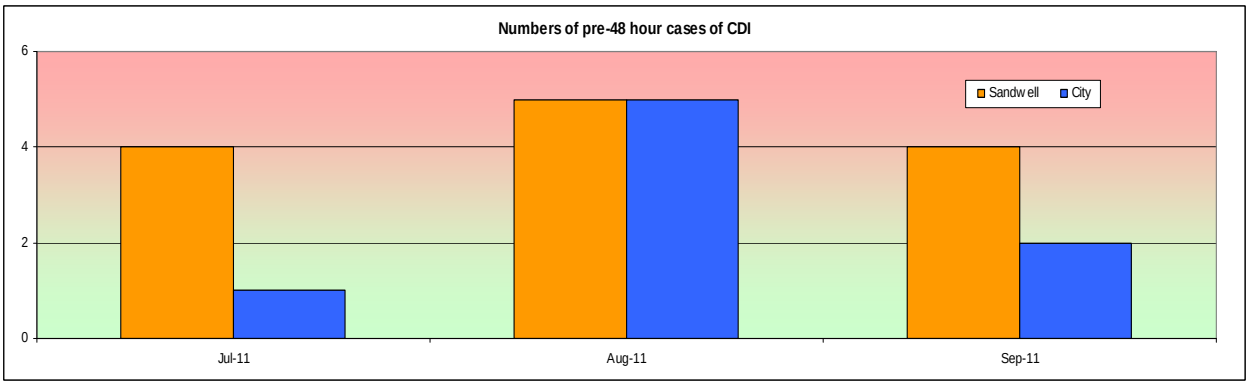


Figure 6: Numbers of pre-48 hour cases of CDI

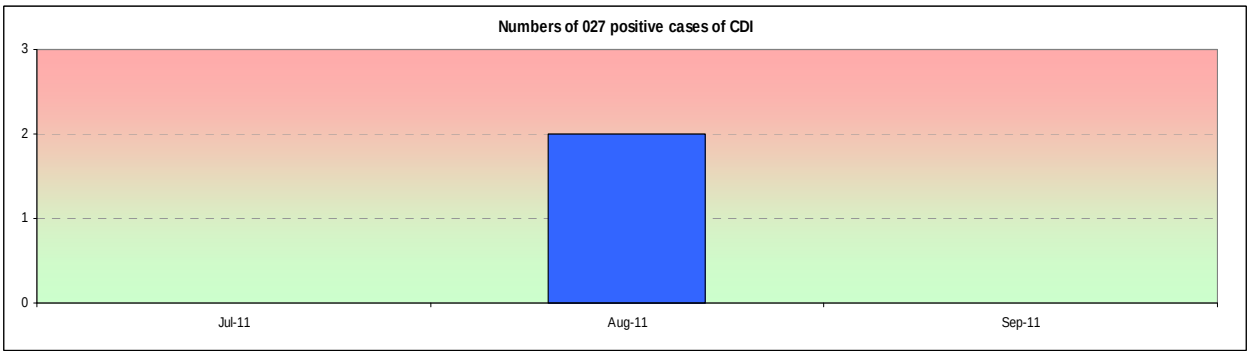


Figure 7: Number of 027 ribotype cases of CDI

3.3 Number of MSSA bacteraemia's

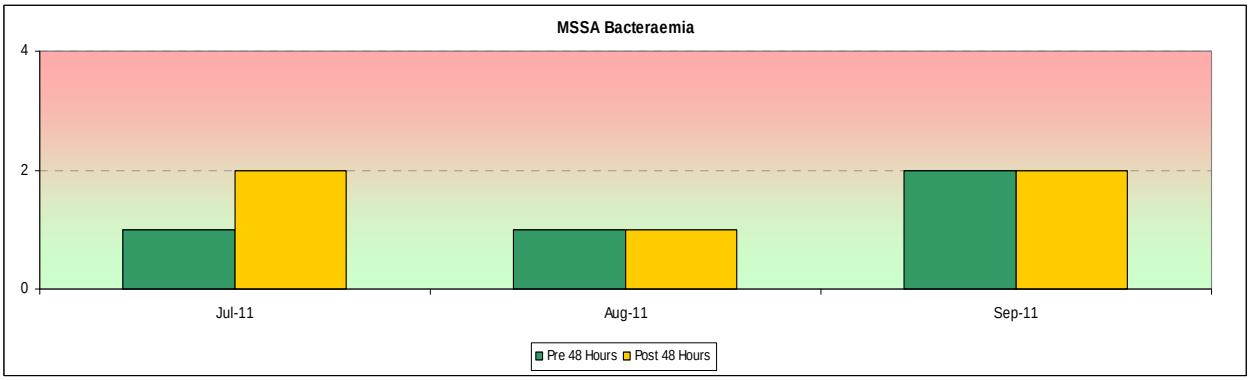


Figure 8: Numbers of MSSA bloodstream infections

3.4 Number of E.coli bacteraemia's

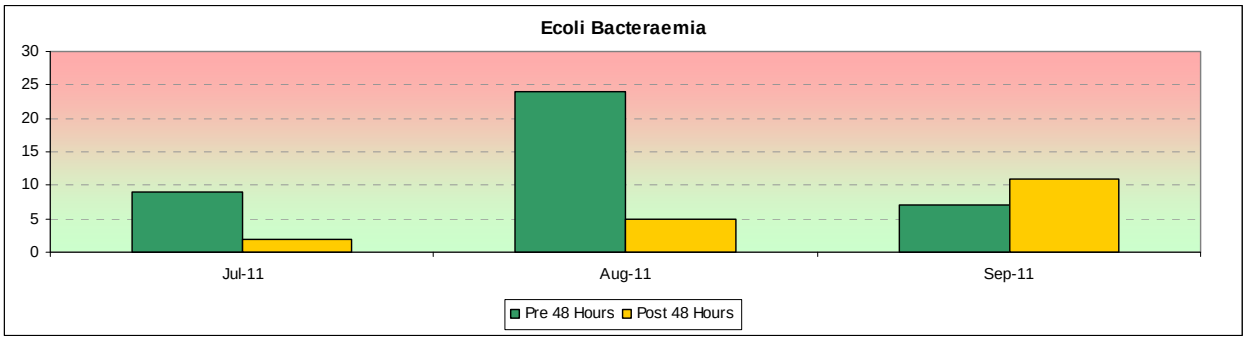


Figure 9: Numbers of E coli bloodstream infections

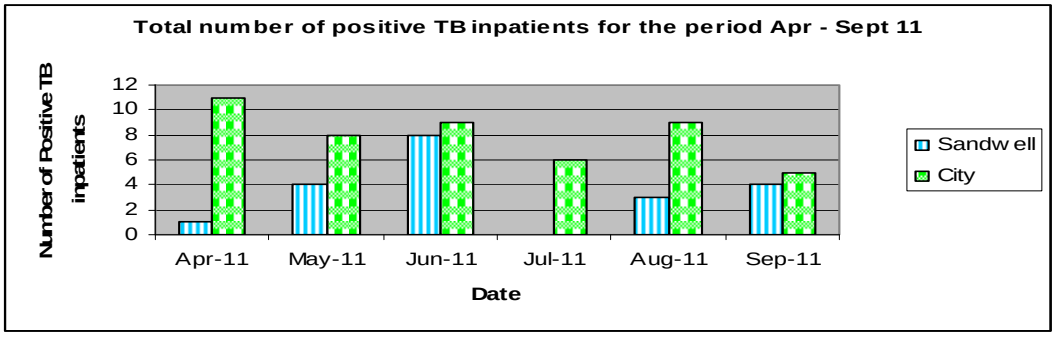
3.5 Tuberculosis

The West Midlands has the 2nd highest incidence of Tuberculosis (TB) in the United Kingdom (11%). SWBH is responsible for the care and management of a large proportion of those patients known to or suspected of having Tuberculosis (TB). In addition to drug sensitive TB, SWBH also sees a proportion of patients identified as Multi drug resistant tuberculosis (MDR-TB).

Patients with TB are identified to the ICS from either clinical specimen received in laboratory or by clinical diagnosis at ward/departmental level (i.e. imaging) or via the community chest clinics/GP's. All patients with TB are nursed in line with respiratory and infection control guidance. All patients suspected or known to have open TB should be nursed in isolation. The trust has in place a risk assessment tool to enable staff to determine risk and isolate appropriately.

There were a total of 27 inpatients diagnosed with TB for the period July – Sept 2011, compared to 17 for the previous quarter. Of those 27, 22 were diagnosed with pulmonary TB from positive laboratory isolates (e.g. Sputum specimens, bronchial washings).

3.5.1 Chart to identify the total number of positive TB inpatients for the period Apr – Sept 2011



Outlined below are a series of tables identifying: - the number of specimens processed in the laboratory for TB, the number of positive isolates and the total number of patients diagnosed with TB as inpatients. The tables below do not identify the additional number of patients admitted with suspected TB, these may include patients for which results are subsequently negative or still under investigation at time of report. The number of specimens processed for TB can be used as a marker to identify the number of patients suspected of having TB.

During the period July – Sept 2011, there were no newly identified inpatients diagnosed with MDRTB.

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

SPECIMEN TYPE	TOTAL PROCESSED	
	Apr – Jun 11	July- Sept 11
Fluids	76	73
Pus	17	18
Respiratory	756	347
Tissue	42	38
Urine	147	77
Total	1038	553

3.5.3 Total number of TB positive isolates

SPECIMEN TYPE	POSITIVE PATIENTS	
	Apr – Jun 11	July- Sept 11
Fluids	8	7
Pus	7	7
Respiratory	37	30
Tissue	4	4
Urine	4	2
Total	60	50

3.5.4 Total number of Positive TB inpatients.

All TB	July 2011	Aug 2011	Sept 2011	Total
Sandwell	-	3	4	7
City	6	9	5	20
Total	6	12	9	27

3.5.5 Total number of patients identified with drug sensitive pulmonary TB from positive laboratory isolates

PTB & MDR TB*	July 2011	Aug 2011	Sept 2011	Total
Sandwell	0	3	4	7
City	5	7	3	15
Total	5	10	7	22

3.5.6 Number of confirmed cases of drug Sensitive PTB as inpatients

PTB	July 2011	Aug 2011	Sept 2011	Total
Sandwell		3	4	7
City	5	7	3	15
Total	5	10	7	22

3.5.7 Number of confirmed cases of MDRTB as inpatients.

MDR TB*	July 2011	Aug 2011	Sept 2011	Total
Sandwell	0	0	0	0
City	0	0	0	0
Total	0	0	0	0

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

NonPTB	July 2011	Aug 2011	Sept 2011	Total
Sandwell	0	0	0	0
City	1	2	2	5
Total	1	2	2	5

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

The management and investigations of outbreaks, periods of increased incidence (PII) and investigation of other potential breeches in infection control practices is an intrinsic part of the Infection Control Service's. The severity of an outbreak or investigation is dependent on the type of infective organism its virulence and potential to cause harm. Small outbreaks occur frequently requiring immediate investigation and control measures. On the other hand, large or protracted outbreaks to include investigation of incidence requiring look back exercises and contact tracing can be extremely time consuming, expensive and

offsetting to the hospital. All outbreaks/investigations present an increased cost to healthcare settings and thus require quick action and a structured management approach to control their impact.

	Outbreak	Summary
4.1	Diarrhoea and/or vomiting	▪ During the period July - Sept 2011 there were a total of 3 occasions where ward closures were required attributed to D&V. Of those 3 occasions, closures by site equated to City 1 and Sandwell 2. The outbreaks involved a total of 26 patients and 11 staff. Wards were closed for a total period of 20 days with a range of between 4 and 12 days. Norovirus was confirmed from specimens taken from one ward.

5. Decontamination

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

Progress against the Decontamination program 2011/12 continues to be made during the third reporting period July 2011 to September 2011; local reprocessing of Transoesophageal Echocardiography (TOE) probes and Nasendoscopes has been removed. High level disinfection is now achieved via the Endoscopy suites. This delivers an improvement in quality of patient care as the decontamination process is validated and equipment can be tracked and traced in-between and to whom it was used upon.

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Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Cleanliness/PEAT Report
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Steve Clarke, Deputy Director - Facilities
DATE OF MEETING:	24 November 2011

SUMMARY OF KEY POINTS:

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

The report provides an overview of the:

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

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

To receive and note the report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Routine monthly update.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

TRUST BOARD REPORT

CLEANLINESS & PEAT

24TH NOVEMBER 2011

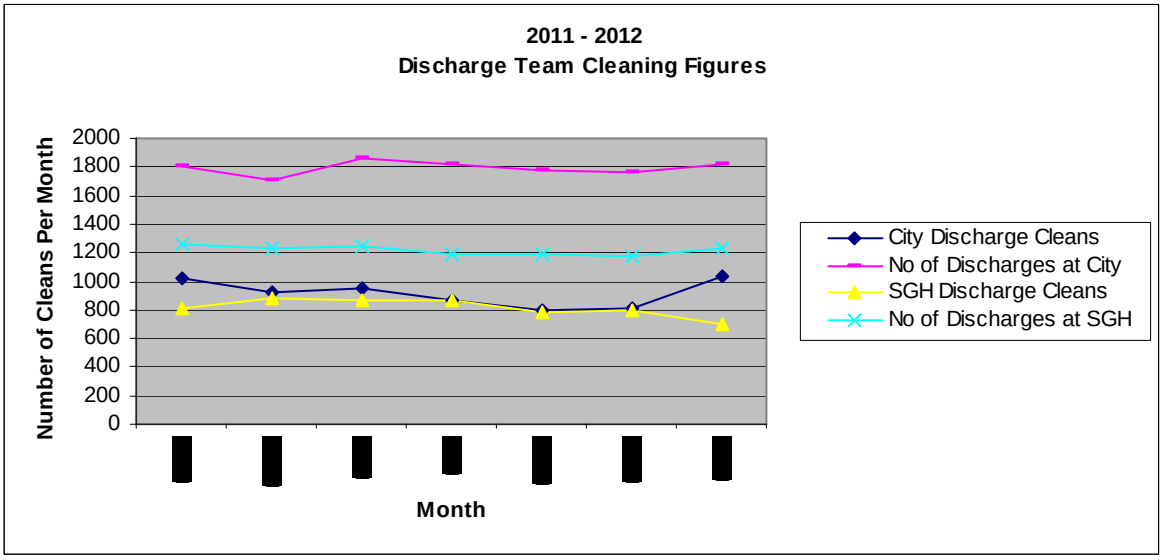
The report provides an update regarding the results from the National Standards of Cleanliness, PEAT audits and inspections and summary for the year to date April – September 2011.

NATIONAL STANDARDS OF CLEANLINESS AUDITS

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

	April 11		May 11		Jun-11		Jul-11		Aug-11		Sep-11	
	V High %	High %	V High %	High %	V High %	High %	V High %	High %	V High %	High %	V High %	High %
City	96	95	96	96	96	95	95	94	96	93	96	94
Sandwell	96	97	97	96	97	95	97	97	96	97	97	97
Rowley	N/A	99	N/A	99	N/A	99	N/A	99	N/A	99	N/A	99
BTC	97	98	97	96	97	97	97	96	98	97	98	97
Target	98	95	98	95	98	95	98	95	98	95	98	95
Overall Average	**96**	**97**	**97**	**97**	**97**	**97**	**96**	**97**	**97**	**97**	**97**	**97**

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



- % of cleans undertaken at City against the number of discharges 51%.
- % of cleans undertaken at Sandwell against the number of discharges 67%.

A review of the discharge cleaning teams work schedules is being undertaken in conjunction with bed management to increase the number of cleans, this is following changes to the weekend programme, the introduction of protected mealtimes etc.

which have all affected performance. The revised roster was introduced in Mid September and the ratio of cleans has increased from October at City Hospital.

PEAT

- **External PEAT Audits**
  The 2012 Patient Environment Action Team (PEAT) national programme will commence on the 3rd January 2012. Responsibility for all aspects of the delivery of the PEAT programme has now transferred to the NHS Information Centre, other than this change, those involved in the programme should not notice any other changes to the management arrangements.

  Following a review of the 2011 PEAT assessment round a number of changes have been made to the detail of the assessment form for 2012.

  The sections of the assessment form are now:

  - Cleanliness (excluding bathrooms/toilets);
  - Condition/Appearance (excluding bathrooms/toilets);
  - Cleanliness – Toilets/Bathrooms;
  - Condition/Appearance – Toilets/Bathrooms;
  - Additional Services;
  - Access, Wayfinding and Information;
  - Social Spaces and Facilities;
  - Infection Prevention and Control (parts 1 and 2)
  - Privacy and Dignity;
  - Food/Nutrition/Hydration (parts 1 and 2)

  The review sought the views and comments of a range of interested parties including all NHS PEAT contacts, the Department of Health and the Care Quality Commission. The changes made to the assessment reflect the views and comments of all respondents to the review wherever desirable/possible.

- **PEAT Audits (Internal)**
  The audits are ongoing; there have been a number of initiatives. Listed are some of the major schemes to date 2011/12:

  - Purchase and installation of dishwashers (all wards at Sandwell)
  - Refurbishment of the Outpatient Rooms (Sandwell)
  - Installation of wheelchair corrals (City)
  - Purchase of new wheelchairs (City & Sandwell)
  - Refurbishment of ward storage areas (City & Sandwell)

- **PEAT Expenditure 2011/12**
  Overall summary of the PEAT expenditure to date is detailed below.

EXPENDITURE TO DATE	PEAT £000's	BED REPLACEMENT £000's	WARD EQUIPMENT £000's	TOTAL EXPENDITURE £000's
Budget	626	150	145	**921**
Expenditure	475	58	71	**603**

HOSPITAL SERVICES INITIATIVES

- **Bottled Water**
  The bottled water has now been introduced at both Sandwell and City, the feedback from patients and staff is very positive in terms of quality and accessibility. Attached are the survey results from the patients and staff audit at Sandwell.

  The change of service provision has also created additional time for the Ward Service Officers (WSO's), this capacity has been reinvested in the wards with extra drink rounds and an additional toilet clean has been included in the WSO's daily work schedule, all ward toilets are now cleaned 3 times each day.

- **Laundry Project Update**
  The On Premises Laundry (OPL) has experienced a number of problems with the design and installation of the equipment. However, the final configuration has now been agreed with the contractors and manufacturers and the work should be complete by the end of November.

  The design of the nightwear for the Trust has been agreed by all the relevant parties, an order has been placed with the successful company for the purchase of bespoke nightwear; the first consignment should be available for delivery early December.

- **Decontamination Equipment**
  The current equipment used for decontaminating areas as part of the deep clean process needs to be replaced (Sterinis Robots). The Trust is currently evaluating a number of new models that have come on to the market.

- **Decontamination/Bed Store Areas**
  - City
    Possible area for development is Theatre 4

  - Sandwell
    Work part complete, the delay is because there are a number of schemes and to move forward is dependent on the completion of the laundry, therefore the bed store will be complete mid December 2011.

STEVE CLARKE
DEPUTY DIRECTOR - FACILITIES

SANDWELL HOSPITAL
BOTTLED WATER SURVEY - PATIENT FEEDBACK

Summary of Results:

Patient Feedback:

1. Majority of wards have sufficient space in the patient fridge to store bottled water.
2. Majority of patients would ask for assistance to have bottles of water opened
3. Four fifths of patients found the bottles of water easy to open. N3 , L3 & P4, half the patients considered the bottles not easy to open.
4. 99% of patients considered that they had been supplied with sufficient bottles of water during their stay.
5. 93% of patients prefer bottled water to jugs of water.
6. Four fifths of patients found the water temperature to be acceptable.

Staff Feedback:

1. Nurses often get asked to open bottles of water.
2. Majority of nurses find it easier to record patient's water intake using bottled water.

		PATIENT FEEDBACK																STAFF FEEDBACK			
Date & Month	Ward	Sufficient space available to store 2-3 bottles in fridge		Patient nutritionally at risk		Bottle of water on bed table opened at the time of survey		If bottle unopened would patient ask for assistance		Is the bottle of water easy to open		Have you been supplied with sufficient bottles of water during the day		Do you prefer water supplied in a bottle to a jug of water		Suitability of temperature		Do you often get asked to open the bottles of water		Do you find it easy to record patients water intake	
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
13.07.11	L3	√	0	1	18	19	0	19	0	16	3	18	1	18	1	17	2	3	1	2	2
20.07.11	N3	0	√	0	22	22	1	22	0	15	7	22	0	20	2	13	9	5	1	2	3
26.07.11	L3	0	√	1	18	9	1	7	1	0	8	8	0	7	0	4	2	0	0	0	0
12.08.11	P2	√	0	0	12	12	0	12	0	7	0	12	0	8	2	10	2	3	0	3	0
12.08.11	N3	0	√	0	17	17	0	17	0	16	1	17	0	12	5	8	9	1	3	4	0
18.08.11	L2	0	√	0	18	17	1	18	0	15	3	18	0	16	2	10	8	4	0	4	0
18.08.11	N2	√	0	0	10	10	0	10	0	10	0	10	0	10	0	10	0	3	0	3	0
22.08.11	P5	√	0	0	10	10	0	10	0	10	0	10	0	10	0	10	0	4	0	4	0
25.08.11	CCU	√	0	0	8	8	0	8	0	8	0	8	0	8	0	8	0	3	1	4	0
25.08.11	EAU	√	0	0	13	0	0	12	1	11	2	13	0	13	0	13	0	4	2	6	0
13.09.11	P4	√	0	0	16	16	0	16	0	11	5	16	0	16	0	16	0	4	0	4	0
15.09.11	L4	√	0	0	15	15	0	15	0	13	2	15	0	15	0	15	0	6	0	6	0
27.09.11	N5	√	0	0	3	3	0	1	0	1	2	2	0	3	0	1	1	3	0	2	0
27.09.11	N4	√	0	0	2	3	0	2	2	3	2	5	0	4	0	4	0	3	1	4	0
Total		10	4	2	182	161	3	169	4	136	35	174	1	160	12	139	33	46	9	48	5
%				**1%**	**99%**	**98%**	**2%**	**98%**	**2%**	**80%**	**20%**	**99%**	**1%**	**93%**	**7%**	**81%**	**19%**	**85%**	**15%**	**91%**	**9%**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Risk Management Report – Q1&2 2011/12
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Allison Binns, Head of Risk Management Hillary Mottishaw, Head of Complaints, Litigation & PALS Dally Masaun, Head of Health and Safety
DATE OF MEETING:	24 November 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 4834 reported incidents during Q1 and Q2 (4937 in Q1+Q2 2010/11)
- Reported clinical incidents decreased to 3337 during Q1 and Q2 (3339 in Q1+Q2 2010/11)
- Reported health & safety incidents fell from 1598 in first two quarters in 2010/11 to 1498 in Q1+Q2 2011/12
- There were 150 incident forms received relating to red incidents during Q1+Q2 (3% of the total), compared with 198 in Q1+Q2 2010/11 (4% of the total),

Key complaints statistics:

- During the reporting period the complaints team dealt with 252 (Q1) and 233 (Q2)

Key claims statistics:

- At present the Trust has 326 Clinical claims and 109 personal injury claims at various stages of the legal process.

Key PALS statistics:

- Total enquiries to PALS team : Q1/2 (2011/2012) is:2113 compared to 2392 in the previous quarter Q1/2 (2010/2011)

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	**x**	
Workforce		
Environmental		
Legal & Policy	**x**	
Equality and Diversity		
Patient Experience	**x**	
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Routine quarterly update. Considered by the Governance Board at its meeting on 4 November 2011 and Quality and Safety Committee on 17 November 2011.

SWBTB (11/11) 237 (a)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Risk Management Report

Quarter 1&2 - 2011-2012

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

Where EVERYONE Matters

Integrated Risk, Complaints and Claims Report: Quarter 1&2 2011/12

1. Overview

This report highlights key risk activity including:

- Summary incident data
- Summary complaints data
- Summary PALS data

2. Introduction

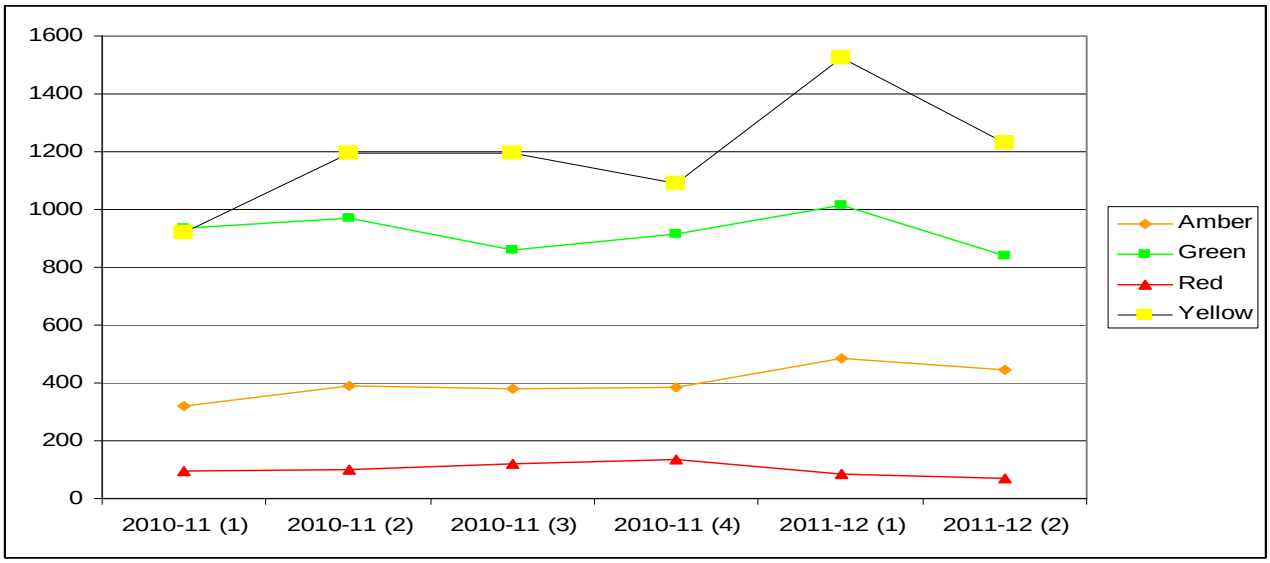
This report combines previous quarterly reports on incident/risk and complaints to implement the Policy for the Investigation, Analysis and Learning of Lessons from Adverse Events and meet NHS Litigation Authority assessment requirements. Where possible, comparisons across these areas of activity will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

3. Key Issues

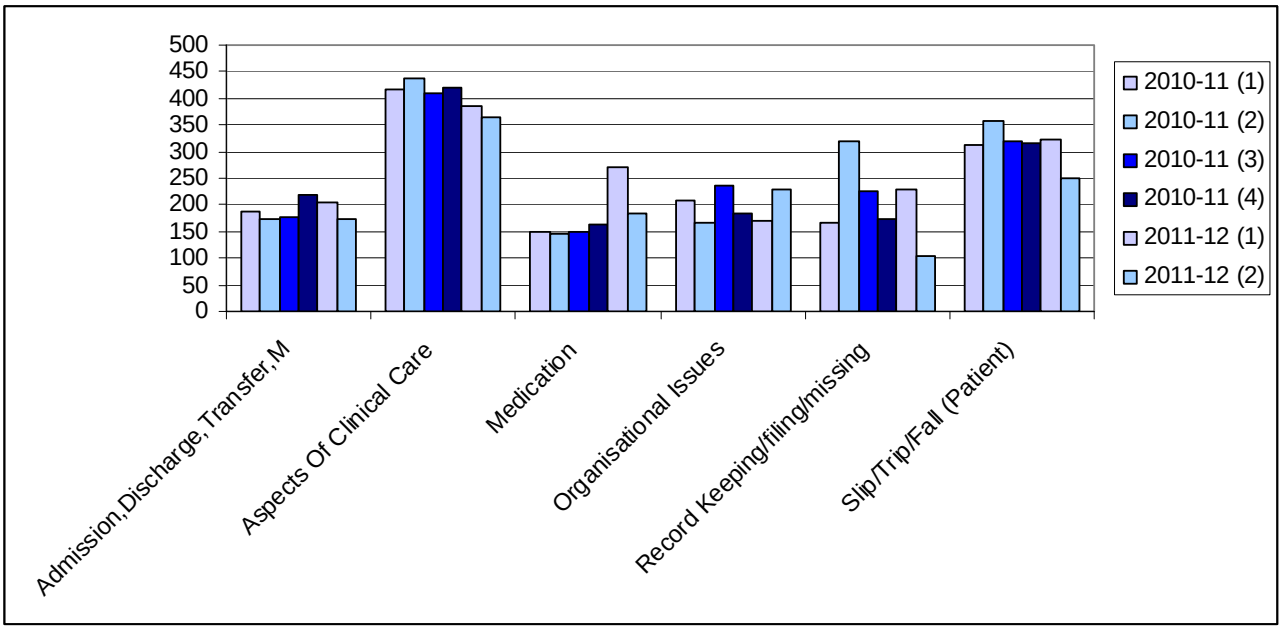
3.1 Review of Quarters 1 & 2 2011/12 Incident Data

- There were 4834 reported incidents during Q1 and Q2 (4937 in Q1+Q2 2010/11)
- Reported clinical incidents decreased to 3337 during Q1 and Q2 (3339 in Q1+Q2 2010/11)
- Reported health & safety incidents fell from 1598 in Q1 + Q2 2010/11 to 1498 in Q1+Q2 2011/12
- There were 150 incident forms received relating to red incidents during Q1+Q2 (3% of the total), compared with 198 in Q1+Q2 2010/11 (4% of the total),

Graph 3.1a - **Incident Trends** by risk score Q1 2010/11 – Q2 2011/12

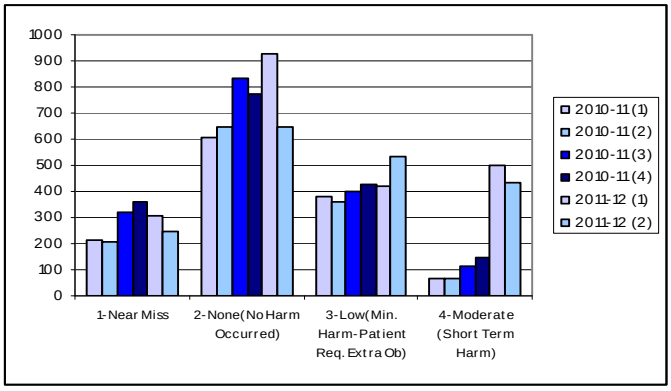


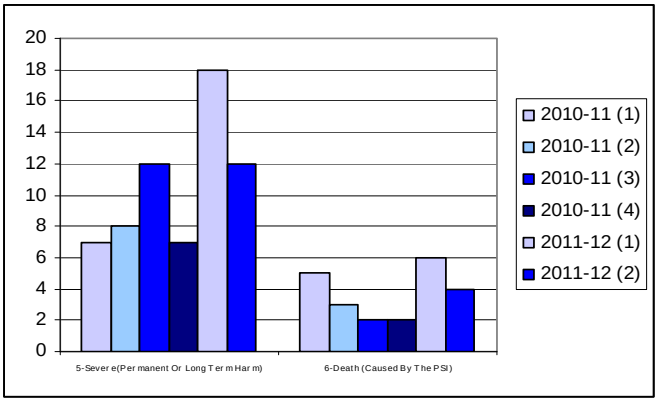
Graph 3.1b – Top 6 reported **clinical incidents** by quarter (Q1 2010/11 – Q2 2011/12)



The top 6 most frequently reported categories remains consistent.

Graph 3.1c & d **Patient Safety incidents**
by reported impact by quarter (Q1 2010/11 – Q2 2011/12)





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

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

Table 3.1 **Patient Safety incidents** by reported impact by division within Q1/2 2011/12

	Near Miss	None(No Harm Occurred)	Low(Min. Harm- Patient Req. Extra Ob)	Moderate (Short Term Harm)	Severe(Perm Or Long Term Harm)	Death (Caused By The PSI)
Medicine	186	661	356	167	21	8
Women & Child Health	136	343	196	126	5	
Surgery A	113	309	181	36	4	
Pathology	19	18	6	6		
Imaging	13	15	25	12	1	
Operations	18	36	14			
Surgery B	30	51	37	10	3	
Facilities/Nurs & Therapy	4	14	11	2		
Development/Cancer	2	3	5	1		
Adult Community health	34	132	Not defined on Datix using the same terminology			2

3.2 Complaints

During the reporting period the complaints team dealt with 252 (Q1) and 233 (Q2) new complaint contacts. By means of comparison, 256 contacts were received in Q4 2010/11.

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

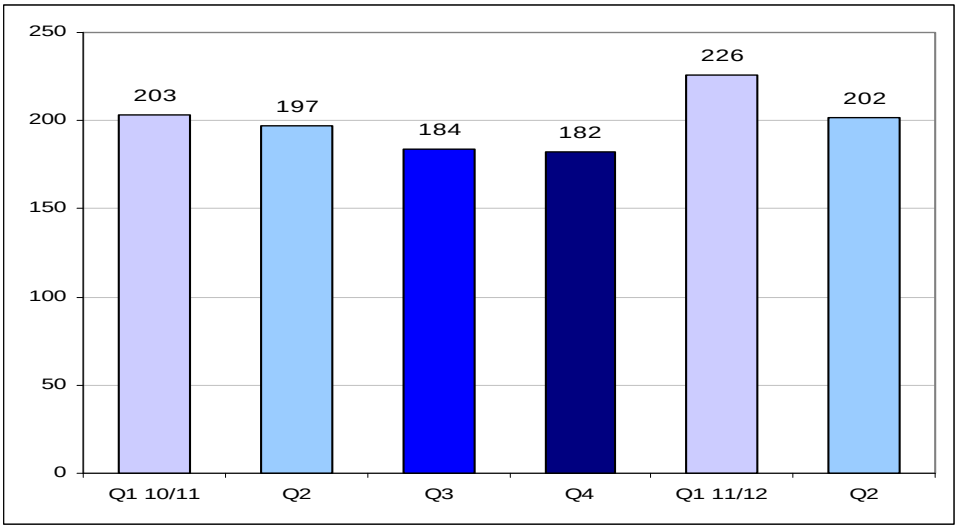
Table 3.2a Types of **Contact** during Q1 and Q2 (2011-12)

Types of Contact	Q1	Q2	Notes
Formal Complaints	226	202	Formal complaints with negotiated timescales
Can't Accept	0	0	Concerns not addressed (due to time elapsed since incident etc)
General Query/Feedback	7	13	Not dealt with formally (concerns/query addressed via letter)
GP/intra NHS Concerns	0	1	Concerns raised by GPs or other NHS organisations/staff members
Dealt with informally	1	5	Not dealt with formally (concerns/query addressed via phone or meeting)
Under Review	0	0	Pathway not finalised (e.g. reviewing records to establish whether a complaint can still be reviewed given time elapsed)
Withdrawn	18	12	Complaints are typically withdrawn if a relative has made the complaint, but patient consent cannot be obtained. Occasionally complaints are withdrawn as the complainant changes their mind about taking their concerns forward.

The following link complaint contacts were received:

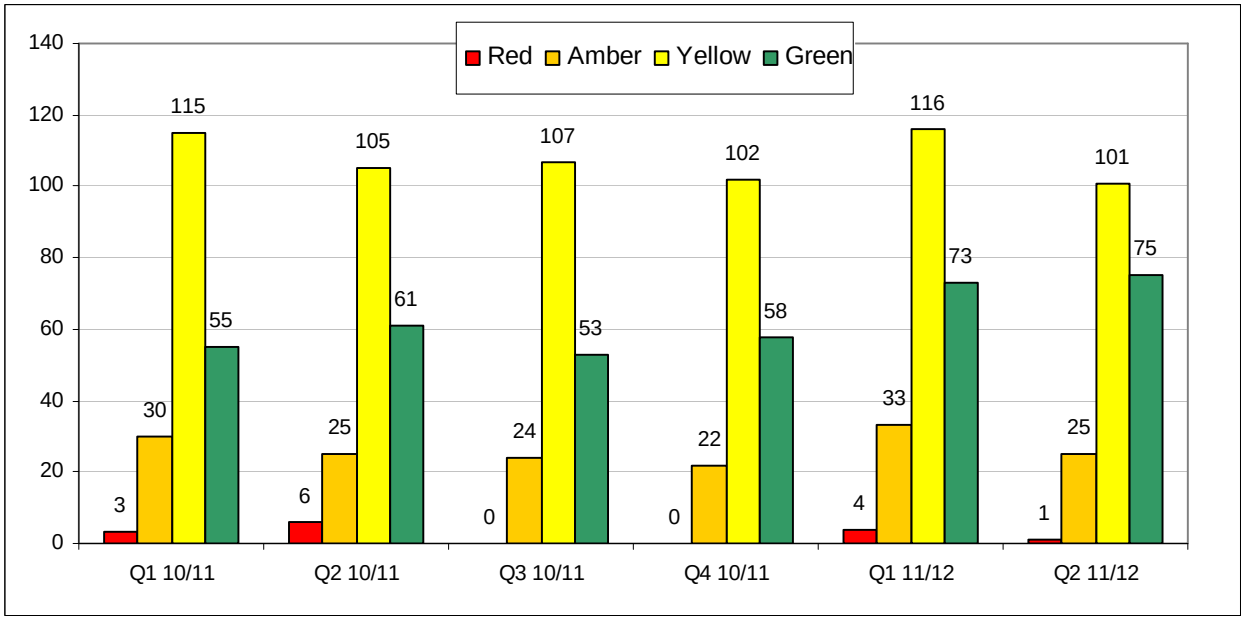
Types of Contact	Q1	Q2	Notes
Link Complaints	34	39	The complainant has received the substantive response to their complaint but has returned as they remain dissatisfied/or require additional clarification.

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



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

Graph 3.2b **Grading** of formal complaints (Q1 2010/11 – Q2 2011/12)

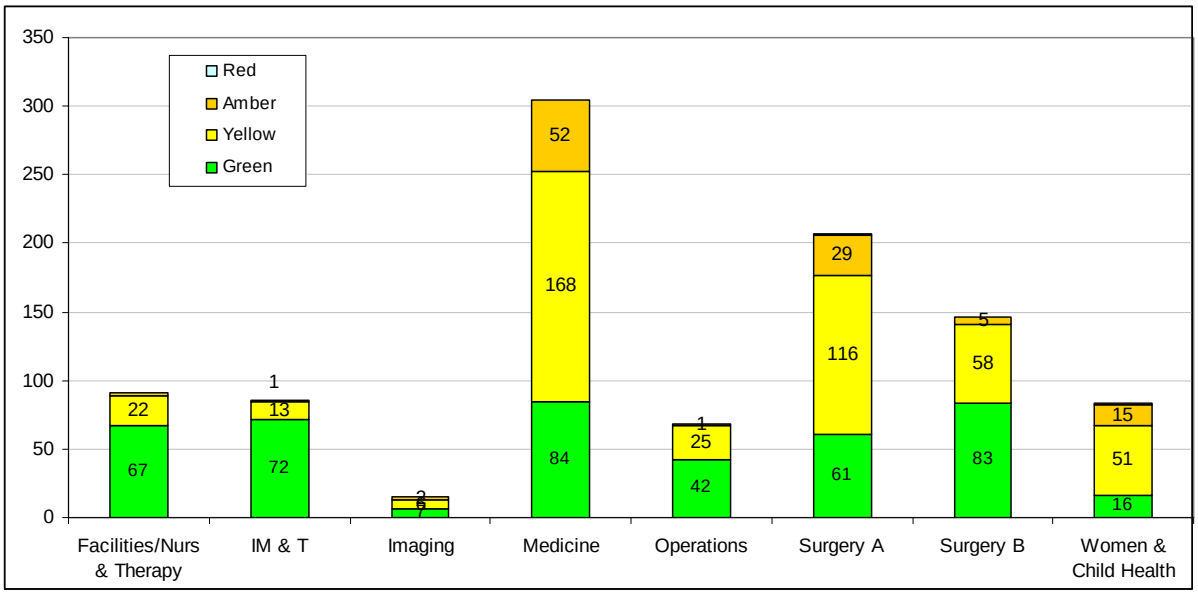


Action Plan Completion

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

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

Graph 3.2c Number of **action plans outstanding**
by divisional lead (responses to end of Q2 2011/12)



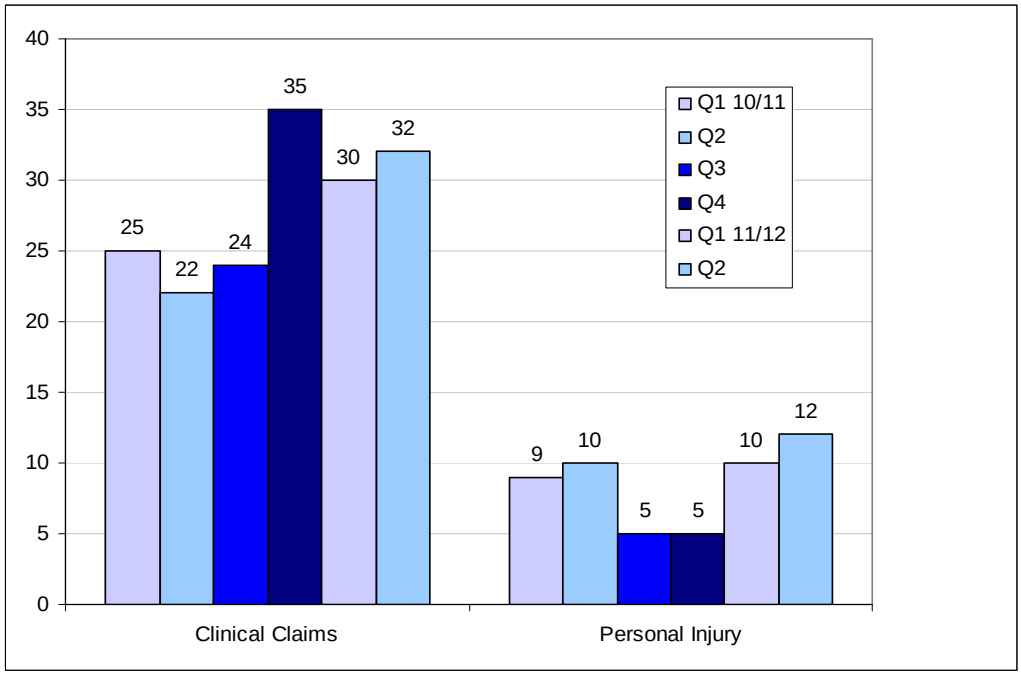
The results show further increases in action plans outstanding when compared to previous reporting periods. This may be reflective of the current monitoring processes and communication with the divisions. Work will therefore be undertaken with the divisions to ensure that (i) action plans are completed in a timely manner and (ii) where action plans are completed in a timely, this is appropriate logged on the Complaints Department database.

Referral of Complaints to the Health Service Ombudsman

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

3.3 Claims
The claims received are as follows:

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



Of the 62 clinical claims received in Q1 and Q2, there were 6 that had a reported clinical incident related to the case. 18 claimants had already raised their concerns via the complaints procedure.

Of the 22 personal injury claims received, 1 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 and staff are not able to raise their concerns via the NHS complaints procedure.

Table 3.3a **Categories** of claims

Allegation Category	Clinical Claims Q1	Clinical Claims Q2	Personal Injury Q1	Personal Injury Q2
Burns/scalds/reactions	1	-	1	-
Delay in Treatment	-	-	-	-
Dissatisfied With Treatment	13	9	-	-
Drug Error	-	1	-	-

Allegation Category	Clinical Claims Q1	Clinical Claims Q2	Personal Injury Q1	Personal Injury Q2
Failure Or Delay In Diagnosis	6	11	-	-
Failure to Recognise Complications	-	-	-	-
Fall/slip	-	-	2	6
Lacerations/Sores	-	-	-	-
Late Diagnosis And Treatment	1	2	-	-
Lifting/moving/handling	-	-	4	2
Moving/falling Objects	-	-	1	2
Needlestick	-	-	2	1
Not Known	1	3	-	-
Operation Carried Out Negligently	2	4	-	-
Toxic Fumes	-	-	-	1
Treatment Carried Out Negligently	6	2	-	-
Violence and Aggression	-	-	-	-

At present the Trust has 326 Clinical claims and 109 personal injury claims at various stages of the legal process.

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

Status Type	Clinical Claims	Personal Injury Claims
Defence Served	2	-
Disclosure Of Records*	232	4
Early Stages	4	2
Letter Of Claim	22	75
Letter Of Response	3	-
Liability Admitted	5	13
Liability Being Assessed	9	5
Liability Denied	5	-
Negotiate Settlement	12	3
Part 36 Offer	8	1
Proceedings Issued/served	5	1
Settlement Made	19	5

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

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

Division	Clinical Claims	Personal Injury Claims
Estates	-	21
Facilities	-	28
Finance	-	1
Imaging	1	3
IM&T	-	1
Medicine	26	23
Not Known	4	-
Pathology	1	1
SCAH	-	1
Surgery A	28	10
Surgery B	9	5
Women & Child Health	26	5

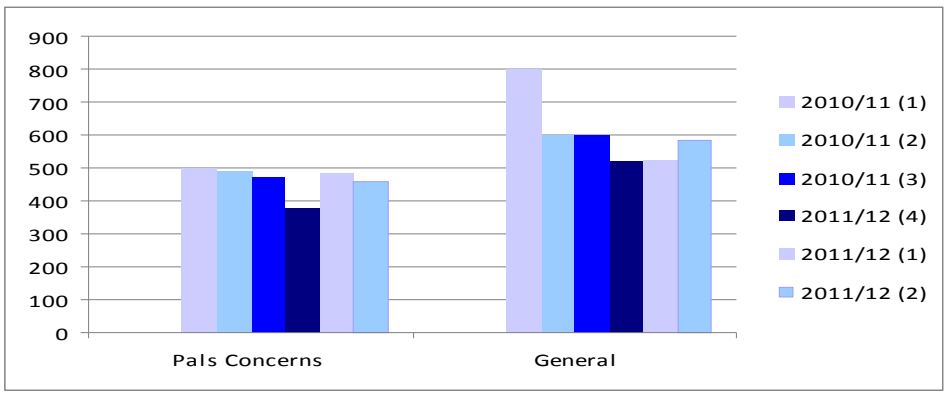
3.3 Aggregated analysis

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 (April - September 2011)



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

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

Table 4.1a **Top 10 categories** of issues raised with PALS Q1/Q2 2011-12

Category breakdown	Number of Contacts Q1	Number of Contacts Q2
APPOINTMENTS		
Appointment Cancellation	23	21
Appointment Delay	15	21
Appointment Notification	13	15
Appointment time	28	16
Appointment Booking (Choose and Book)	0	0
Appointment (other)	1	1
ATTITUDE OF STAFF		
Admin	4	4
AHP	1	1
Ancillary	2	0
Doctor/Consultant	4	3
Nurse	17	8
CLINICAL TREATMENT		
Clinical Care	13	13
Clinical Treatment	11	13
Delay in Investigations	1	2
Delay in Results	7	10
Delay in Surgery	5	2
Delay in Treatment	6	3
Delay in Xray/Scan	3	7
Information – Condition	9	14
Medicines	7	5
Waiting time	0	0
COMMUNICATION		
Written	11	12
Verbal	14	11
ADMISSION/DISCHARGE/TRANSFER		
Admission Arrangements	0	3
Discharge Arrangements	9	9
Transfer arrangements	5	1
FORMAL COMPLAINTS		
Complaint advice	44	8

Category breakdown		Number of Contacts Q1	Number of Contacts Q2
	Complaint process	27	77
	Complaint referral	15	15
	Complaint Handling	14	17
	Complaint response time	2	1
TRANSPORT			
	Patient Transport Service	12	7
	Car Park Charges	2	5
ESSENCE OF CARE			
	Continence	4	4
	Hygiene	2	2
	Nutrition	0	5
	Privacy and Dignity	0	1
	Safety	2	0
	Safety of patient with MH	1	0
	Mouthcare	0	1
PERSONAL RECORDS			
	Access	3	7
	Content	4	1
	Mislaid	0	0
GENERAL ENQUIRY			
	General Advice	57	45
	Information	34	14
	Referral	9	2
	Support Other ie benefits	4	1

5. Recommendations

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality and Safety Committee – Version 0.1

Venue Executive Meeting Room, City Hospital **Date** 22 September 2011; 0900h – 1100h

Members Present

Prof D Alderson [Chair]
Mrs S Davis
Dr S Sahota
Mrs O Dutton
Mr J Adler
Mr R White
Mr D O'Donoghue
Miss R Overfield
Miss K Dhami

In Attendance

Miss A Binns
Mr S Parker

Secretariat

Mr S Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received apologies for absence from Rachel Barlow and Hillary Mottishaw.	
2 Minutes of the previous meeting	**SWBGR (7/11) 027**
The minutes of the Quality and Safety Committee meeting held on 21 July 2011 were approved as a true and accurate reflection of discussions held.	
AGREEMENT: The minutes of the previous meeting were approved	
3 Matters arising from the previous meeting	**SWBGR (7/11) 027 (a)**
The updated actions list was noted by the Committee. In connection with action SWBGRACT.065, Mr Parker reported that it was the responsibility of the Thrombosis Committee to develop the action plans against the NICE Quality Standards regarding VTE, however at present the appointment of a new Chair following the departure of Dr Langford remained to be arranged. It was	

agreed that a further briefing was required at the next meeting.	
ACTION: **Mr Parker to update the Committee on progress with developing the action plans to meet the NICE Quality Standards for VTE at the next meeting**	
4 Complaints	
4.1 Complaints referred for independent review	**SWBQS (9/11) 035** **SWBQS (9/11) 035 (a)**
Miss Dhami presented the list of complaints that had been referred for independent review by the Public and Health Service Ombudsman (PHSO) as at 14 September 2011. The Committee was advised that there were currently 16 active live cases that had been referred to the Ombudsman for review, a position that was highlighted to have remained static since the previous meeting. It was reported that the majority of cases were awaiting a decision from the Ombudsman in terms of the next steps required. The scope for further action by the Trust was reported to have been assessed in each case and in many determined that there was limited possibility for further action. In some cases, it was reported that the complaints had been referred to the Ombudsman prematurely, which had prevented any attempt at local resolution before escalation. The position regarding the number of cases referred for independent review compared with that of other trusts in the region was reported to have been reviewed, which had suggested that the Trust had one of the higher levels of cases. Regionally, the Trust was noted to be ranked seventh in terms of the overall number of complaints handled. Mr Adler asked the Committee to note that despite the relatively high number of complaints, the proportion of those referred to the Ombudsman was low. Miss Dhami reported that a liaison visit with the PHSO had been held in July 2011 and she offered to circulate the outcome of the visit and the complaints analysis. Dr Sahota remarked that it appeared to take a long time between receiving a letter of complaint and meeting with the patients on the occasions when it was regarded as appropriate to hold a meeting. Miss Dhami acknowledged that there was a delay on occasion however it was important to ensure that the most appropriate members of staff and managers are available to the meet with the complaints. Prof Alderson noted that due to the complexity of some of the complaints, he would expect the resource requirements to handle them to be high.	
ACTION: **Miss Dhami to circulate the outcome of the July PHSO liaison visit**	
4.2 Action plan to the CQC regarding registration: Outcome 17	**SWBQS (9/11) 034** **SWBQS (9/11) 034 (a)**

Miss Dhami presented the updated action plan that had been developed in response to the responsive review of complaints undertaken by the Care Quality Commission (CQC). It was noted that the majority of actions had been completed or were on track to be delivered as planned. It was highlighted that actions arising from the Ombudsman's visit had been added into the action plan. The Committee was advised that the CQC had been kept informed of progress with the action plan and there was continued confidence that the backlog of complaints could be handled according to the agreed trajectory. Prof Alderson asked whether the staffing levels in the Complaints Team had been increased to handle the level of complaints received. Miss Dhami advised that a Band 7 Deputy Complaints Manager had been successfully appointed and cover for maternity leave had been arranged. It was reported that the temporary staff in the department have changed during the past few months, however overall the level of resource in the department was sufficient.	
4.3 Complaints trend analysis	**SWBQS (9/11) 040** **SWBQS (9/11) 040 (a)**
Miss Dhami presented a report showing the various categories to which the complaints had been assigned. It was highlighted that there were no obvious trends in the reasons for the complaints, although the majority were noted to be related to matters in the Medicine & Emergency Care and Surgery, Anaesthetics & Critical Care divisions. Mrs Dutton asked if a record was maintained of whether a complaint was made by a patient or someone of behalf of the patient. Miss Dhami advised that this was the case. It was suggested that the category of complaints related to medical/surgical teams was not clear. Miss Dhami offered to review the categories of complaint with a view to clarifying the position. Miss Overfield was asked whether she was aware of any issues in EAU and Lyndon 4, given that there appeared to be a cluster of complaints reported in these areas. Miss Overfield advised that there was no apparent issues, however she offered to review the position further. Professor Alderson asked whether staff were aware of the need to provide information to inform complaints responses in a timely manner. Mr O'Donoghue advised that staff were now much better at responding. Miss Overfield advised that on some wards where leadership was strong, few complaints were received. Miss Dhami reported that a centralised approach to complaints handling was being implemented whereby a basic statement would be provided for simple complaints,	

rather than a full investigation report. It was highlighted that this approach would be applied to green and yellow complaints. Mrs Dutton suggested that a question on complaints should be included within the Board walkabouts template, which was agreed.	
ACTION: **Miss Dhami to review the department/area categories of complaints, to provide clarity on the 'Medical/Surgical Team' category** **ACTION:** **Miss Overfield to review the complaints reported in association with EAU and Lyndon 4 to determine the reason for the clusters in these areas** **ACTION:** **Miss Overfield to update the Board Walkabouts questionnaire to include a question about complaints**	
5 CQC Privacy, Dignity & Respect and Nutrition & Hydration reports and action plans	**SWBQS (9/11) 041** **SWBQS (9/11) 041 (a) - SWBQS (9/11) 041 (c)**
Miss Overfield presented the updated action plans to address the recommendations arising from the CQC Privacy, Dignity & Respect and Nutrition & Hydration reports. The Committee was advised that the key actions as a whole were progressing well. In particular actions related to improving discharge arrangements were highlighted to be being addressed. Arranging dissemination of patient information was reported to require further consideration and was noted to be difficult to audit. In terms of patient laundry, the Committee was advised that sourcing pyjamas had been difficult, although a provider had been identified, with nightwear anticipated to be delivered within six weeks. The Committee was informed that this was an important step, given that a significant number of patients treated by the Trust lacked any bed wear. Regarding the Nutrition and Hydration action plan, the Committee's attention was drawn to the areas where amber status had been reported. It was highlighted however, that patients were now routinely assessed for nutritional needs on admission, apart from on two wards. Completion of bed plans, meal diaries and fluid balance charts was reported to be variable. The Committee was informed that adherence to the Protected Mealtimes policy was good, apart from in small areas of the Trust where compliance needed to be reinforced. It was noted that a degree of flexibility with adoption of the Protected Mealtimes policy was required. Professor Alderson asked whether there were plans to ensure that delivery of the actions reported to be at amber status were on track. Miss Overfield advised that the progress with delivery of these actions could be confirmed by audits currently	

underway, however there was an expectation that these would be addressed. It was highlighted that better use of the discipline and capability procedures would be used to encourage compliance with the strengthened systems that were being put into place. Miss Overfield reported that the provision of snacks on wards had been arranged. Mrs Davis asked whether wards were sufficiently equipped for Ramadan and whether mealtimes were adequately flexible during this period to accommodate patients wishing to fast. Miss Overfield confirmed that this was the case, with hot and cold meals available throughout the day and night. In terms of educating staff about the requirements in Ramandan, the Committee was advised that communications had been issued, although these needed to be further reinforced through the nursing communications structures. The Committee was informed that the provision of services on Newton 4 was improving and a matron had been put into place to manage the ward specifically. Work was reported to be underway to close Newton 4 and create two separate acute stroke units, both of which would remain in 'special measures' for the near future until consistent standards were achieved. Dr Sahota asked whether comments could be made on menu cards that were collected from patients daily. Miss Overfield advised that although this was not in place, patients were given the opportunity to see a catering manager if they wished. Miss Overfield reported that the draft report following the CQC's visit in August had been received recently, which suggested that the level of concern around nutrition was to be downgraded from major to minor.	
6 Tuberculosis death review and action plan	**SWBQS (9/11) 042** **SWBQS (9/11) 042 (a) - SWBQS (9/11) 042 (c)**
Mr O'Donoghue presented a report outlining the case of a child that had been under the care of the Trust three months before her death from Tuberculosis. The Committee was advised that an independent review of the case had been undertaken, which had revealed that clinicians had acted appropriately and that the care delivered was of a high standard, with decisions made having been well documented. An independent review panel was reported to have made a number of recommendations, which the Trust had accepted. It was highlighted that there was little treatment that could have been given to prevent the death of the child. Professor Alderson remarked that there was no set of tests that would provide an infallible diagnosis. Mrs Davis suggested that the single electronic patient record would assist with cases where treatment by more than one health provider was	

involved. Mr Adler summarised that the process had been tested robustly and had been found to be sound. Miss Overfield reported that it was likely that a Safeguarding Review would be initiated for this case. Mr Adler advised that a complaint allied to the case had been received and was to be addressed as a matter of urgency.	
7 Review of Haematology service and action plan	**SWBQS (9/11) 033** **SWBQS (9/11) 033 (a) -** **SWBQS (9/11) 033 (c)**
Mr O'Donoghue reported that following concerns over the provision of Haematology services by the Trust an external review had been commissioned. The outcome of the review was reported to have highlighted difficulties in the working interactions in the department and the functioning of the Multi Disciplinary Team approach. The Committee was asked to note the action plan that had been developed in response to the recommendations proposed by the review. Prof Alderson noted that although there were no apparent patient safety issues suggested, the situation was not encouraging. He asked whether the plans would deliver an improved service with better outcomes for patients. Mr O'Donoghue advised that this would be achieved through better working relationships in the team and as such this was to be given significant focus. It was agreed that a further update on the delivery of the Haematology action plan should be scheduled for the January 2012 meeting of the Quality and Safety Committee.	
ACTION: Mr Grainger-Payne to schedule a further update on the delivery of the Haematology service action plan for the January 2012 meeting	
8 Breast screening service review	**SWBQS (9/11) 031** **SWBQS (9/11) 031 (a)** **SWBQS (9/11) 031 (b)**
Mr O'Donoghue presented the outcome of a review of the joint breast screening service that the Trust operated with Walsall Heathcare NHS Trust. The Committee was asked to note that a number of the recommendations needed to be addressed by Walsall Heathcare NHS Trust. It was emphasised that the issues with the service reported did not suggest that patient safety was being compromised, however a number of operational issues needed to be addressed. Prof Alderson advised that breast screening services had historically received good oversight by peer review.	

9 PROMs update	SWBQS (9/11) 030 SWBQS (9/11) 030 (a)
Mr Parker presented the latest available set of PROMs data, covering the period April 2010 – March 2011. The Committee was reminded that it had been previously been made aware that the Trust was an outlier in hip and knee replacement PROMs scores. The diagrams presented were noted to indicate that the Trust remained a significant outlier in terms of average heath gain scores for knee replacements in particular, however the scores for varicose vein procedures also represented a concern. The Committee was informed that a number of media enquiries about these scores had been received. Mr Parker reported that the data had been presented to directorates and they had been asked to consider what actions were planned to improve the scores. A report of these measures was reported to be planned for presentation to the Governance Board at a later date. It was highlighted that although the data suggested that there should be concern over the Trust's position, further information to inform the overall position was needed, including patient and consultant specific intelligence. It was also suggested that the low number of returned questionnaires might be influencing the position. Mr O'Donoghue confirmed that the information was concerning in general terms and had been discussed in detail with the Clinical Director for Trauma and Orthopaedics. Prof Alderson suggested that it might be beneficial to organise for an audit structure to be implemented internally to capture a related set of information. It was noted that post-operative scores were already collected routinely, however a single process for collecting the information was needed. Mrs Dutton suggested that patients should be made aware pre-operatively that information would be canvassed following treatment. In terms of the action plan to improve the Trust's position, it was noted that this would be informed by the measures being put into place to improve the Trauma and Orthopaedics area's position particularly. Mr O'Donoghue advised that this was to form part of the wider plan to improve Trauma and Orthopaedics services. It was agreed that a further briefing on PROMs should be presented at the January 2012 meeting of the Quality and Safety Committee.	
ACTION: **Mr Grainger-Payne to schedule a briefing on PROMs to be presented at the January 2012 meeting**	

10 Review of CIP Quality and Safety risks	**SWBQS (9/11) 038** **SWBQS (9/11) 038 (a)** **SWBQS (9/11) 038 (b)**
Miss Binns presented an updated version of the risk log that had been prepared detailing the Quality and Safety related risks associated with the delivery of the Cost Improvement Plans for 2011/12. It was reported that Ophthalmology had proposed a new scheme against which an assessment had been undertaken. The Committee was disappointed to note that updates had not been received from some areas. Prof Alderson asked that the next report be amended to show the current score and the change from the previous version. Mr Adler suggested that the updated version of the CIP Quality and Safety risk register be presented at the November meeting of the Quality and Safety Committee, in view of the current scrutiny of the delivery of the Medicine & Emergency Care and the Surgery, Anaesthetics & Critical Care division's Cost Improvement Plans.	
ACTION: Miss Binns to amend the CIP Quality and Safety risk register to reflect the current score and changes made from the previous meeting **ACTION: Mr Grainger-Payne to schedule presentation of the CIP Quality and Safety risk register at the November 2011 meeting of the Quality and Safety Committee**	
11 Never Events update	**SWBQS (9/11) 039** **SWBQS (9/11) 039 (a)**
Miss Binns reported that since June 2009, six Never Events had been reported. A briefing paper on Never Events, was presented, which the Committee was advised had been considered by the Adverse Events Committee previously. Miss Binns highlighted that the number of incident types that could be categorised as Never Events had been increased since the initial introduction of the Never Events concept. The Committee was advised that one of the Never Events concerning wrong site surgery had recently been reviewed with the PCT and agreed that this did not in reality, represent a Never Event given the circumstances and therefore an application would be made to the Strategic Health Authority to declassify this incident from as a Never Event.	

The Committee was asked to note that an action plan had been developed to raise the profile of Never Events with divisions. Mrs Davis agreed that major attention should be given to Never Events, given the seriousness of these incidents and she expressed concern over the recent number of Never Events reported in the Trust, particularly in recent months. Mrs Davis asked whether the new categories of Never Events had been applied to incident data retrospectively to determine whether a further number of Never Events would have been reported had the classifications been in place earlier. It was agreed that this measure should be considered. Mr O'Donoghue acknowledged the gravity of Never Events and agreed that the profile of these needed to be raised with senior clinicians. Mr Adler further agreed that more work needed to be done to agree a more robust process for responding to these incidents, given the seriousness of their nature. It was agreed that Miss Dhami should develop a proposal as to how the current process might be strengthened. Miss Dhami agreed and reminded the Committee that the Trust Board had recently requested that Table Top Reviews of Never Events should occur within four weeks of the incident being reported.	
ACTION: **Miss Dhami to develop a proposal as to how the current process for responding to Never Events might be strengthened**	
12 NPSA safety alerts update	**SWBQS (9/11) 032** **SWBQS (9/11) 032 (a)**
Miss Binns presented the latest progress on actions to address the NPSA safety alerts, which the Committee received and noted. She advised that the radiological imaging alert would be addressed by the Back Office project that was currently being delivered, with electronic acknowledgement of results to be trialled shortly. It was reported that the implementation plan to address the safety net issue would not be signed off by September 2011 as planned, therefore an extension for completion of the alert action plan to January 2012 had been requested and agreed by the Clinical Quality Review Group. Mr O'Donoghue advised that there was a need to improve the mechanisms by which diagnostic tests were ordered, however at present, there remained a number of issues to address. The Committee was advised that it would receive a routine update of progress with addressing the NPSA safety alerts at its meeting planned for November 2011 and January 2012. Mr Adler asked whether the alert concerning essential care after a fall was on track to be addressed as planned. Miss Binns advised that this was the case, as the delay concerned a training issue which would be resolved shortly.	

13 Quality Account review and action plan	**SWBQS (9/11) 029** **SWBQS (9/11) 029 (a)** **SWBQS (9/11) 029 (b)**
Mr O'Donoghue presented the outcome of a 'dry run' of the External Audit review of the Trust's Quality Account. The Committee was informed that two specific areas of data had been tested, which had revealed areas needing to be addressed as a priority. It was highlighted that improving the quality of data informing the various indicators was a challenge. The Committee was advised that a draft action plan had been developed, an update of which would be presented at the January 2012 meeting of the Committee. Mrs Davis asked whether there was any indication of how the Trust performed on its Quality Account review compared to other trusts. Mr O'Donoghue advised that the Trust was not seen to be an outlier generally, although attention needed to be given to the 62-day cancer wait performance.	
ACTION: Mr Grainger-Payne to schedule an update on the Quality Account action plan for the January 2012 meeting of the Quality and Safety Committee	
14.1 – 14.2 Minutes from Governance Board	**SWBGB (7/11) 118** **SWBGB (7/11) 118 (a)**
The Quality and Safety Committee received and noted the minutes from the Governance Board meeting held on 8 July 2011. The Committee also noted the actions list that was discussed at the meeting held on 2 September 2011.	
15.1 Minutes from Clinical Quality Review Group	**SWBQS (9/11) 036** **SWBQS (9/11) 037**
The Quality and Safety Committee received and noted the minutes from the Clinical Quality Review Group meeting held on 4 May 2011 and 6 July 2011.	
16 Any other business	**Verbal**
There was none.	
17 Details of the next meeting	**Verbal**
The date of the next meeting of the Quality and Safety Committee was reported to be 17 November 2011 at 0900h in the Executive Meeting Room, City Hospital.	

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – October 2011
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Robert White/Tony Wharram
DATE OF MEETING:	24 November 2011

SUMMARY OF KEY POINTS:

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

For October, the Trust generated a "bottom line" surplus of £175,000 which is £18,000 higher than the planned position (as measured against the DoH performance target).

For the year to date, the Trust has a surplus of £429,000 which is £23,000 worse than the planned position

Capital expenditure for the year to date is £2,443,000 and the cash balance at 31st October was £38.8m.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Performance Management Board and Trust Management Board on 15 November 2011 and Finance and Performance Management Committee on 17 November 2011.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – October 2011

EXECUTIVE SUMMARY

• For the month of October 2011, the Trust delivered a "bottom line" surplus of £175,000 compared to a planned surplus of £157,000 (as measured against the DoH performance target).

• For the year to date, the Trust has a surplus of £429,000 compared with a planned surplus of £452,000 so generating an adverse variance from plan of (£23,000).

•At month end, WTE's (whole time equivalents), excluding the impact of agency staff, were approximately 182 below plan. After taking into account the impact of agency staff, actual wte numbers are 99 below planned levels. This compares with a position last month of 77 below plan. Total pay expenditure for the month, inclusive of agency costs, is £420,000 below the planned level.

• The month-end cash balance was approximately £22.7m above the planned level.

Financial Performance Indicators - Variances

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	18	(23)	>= Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	(212)	(290)	>= Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	420	150	<=Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	(411)	(1,069)	<= Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	99	34	<= Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	22,696	22,696	>= Plan	> = 95% of plan	< 95% of plan

Note: positive variances are favourable, negative variances unfavourable

Performance Against Key Financial Targets

Target	Year to Date Plan £000	Year to Date Actual £000
Income and Expenditure	452	429
Capital Resource Limit	19,910	0
External Financing Limit	---	22,696
Return on Assets Employed	3.50%	3.50%

2011/2012 Summary Income & Expenditure Performance at October 2011	Annual Plan £000's	CP Plan £000's	CP Actual £000's	CP Variance £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's	Forecast Outturn £000's
Income from Activities	374,857	31,577	31,231	(346)	218,698	218,706	8	374,857
Other Income	39,875	3,292	3,417	125	22,903	23,524	621	40,675
Operating Expenses	(391,163)	(32,898)	(32,889)	9	(228,457)	(229,376)	(919)	(392,288)
EBITDA	23,569	1,971	1,759	(212)	13,144	12,854	(290)	23,244
Interest Receivable	25	2	10	8	15	61	46	100
Depreciation & Amortisation	(13,269)	(1,106)	(884)	222	(7,740)	(7,519)	221	(13,019)
PDC Dividend	(5,803)	(484)	(484)	0	(3,385)	(3,385)	0	(5,803)
Interest Payable	(2,156)	(180)	(180)	0	(1,258)	(1,258)	0	(2,156)
Net Surplus/(Deficit)	**2,366**	**203**	**221**	**18**	**776**	**753**	**(23)**	**2,366**
IFRS/Impairment Related Adjustments	(557)	(46)	(46)	0	(324)	(324)	0	(557)
SURPLUS/(DEFICIT) FOR DOH TARGET	**1,809**	**157**	**175**	**18**	**452**	**429**	**(23)**	**1,809**

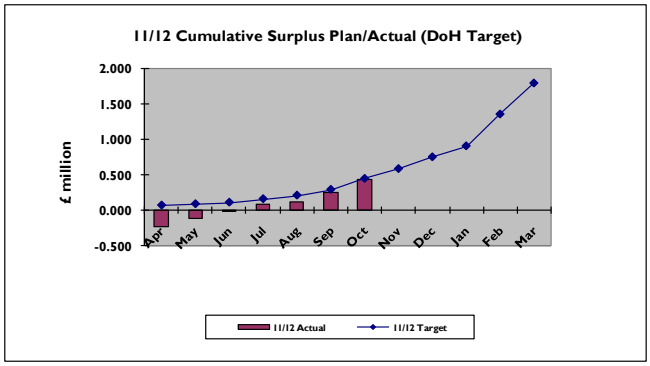
The Trust's financial performance is monitored against the DoH target shown in the bottom line of the above table. IFRS and impairment adjustments are technical, non cash related items which are discounted when assessing performance against this target.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – October 2011

Overall Performance Against Plan

• The overall performance of the Trust against the DoH planned position is shown in the adjacent graph. Overall bottom-line performance delivered an actual surplus of £175,000 in October against a plan of £157,000. The resultant £18,000 positive variance moves the year to date position to £23,000 below targeted levels.



Divisional Performance

• For October, adverse variances exist for several divisions, notably Surgery A, Anaesthetics & Critical Care, Womens & Child Health and Facilities.

• There has been a significant worsening in performance against SLA income targets in September (the latest month for which fully costed data is available) . For the month, actual performance is £567,000 lower than plan.

• Major divisional adverse variances are primarily driven by income shortfalls. Performance for key divisions is as follows:

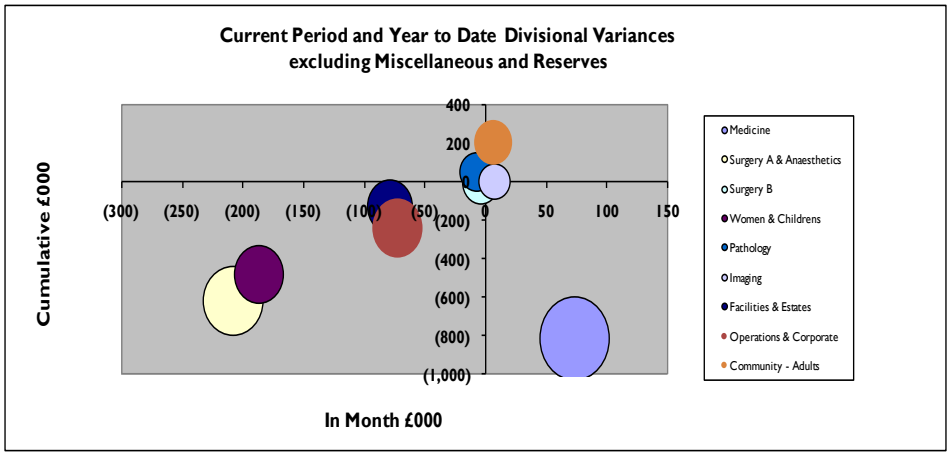
Division	Overall Variance (£000)	Income Variance £000
Surgery A, Anaesthetics & Critical Care	(208)	(194)
Womens & Child Health	(187)	(202)
Facilities	(101)	(60)

• There are some continuing signs of improvement in performance against expenditure budgets, particularly the better than planned performance for pay and wtes as well as a further decrease in agency expenditure in month. The in-month pay performance brings the year to date position on pay to a small overall under spend.

• Although overall performance is broadly in line with the planned position, this is only delivered as a result of better than planned performance for ICR income (reflecting improvements in data processing and capture from the NHS Injury Cost Recovery Unit for the first half of the year) and depreciation (a reflection of the effects of downward revaluations at the end of 2010/11 and a slow start to capital expenditure in 2011/12). However, these are largely one off benefits and it is unlikely that any sizeable contributions will be made from these sources for the remainder of the year.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

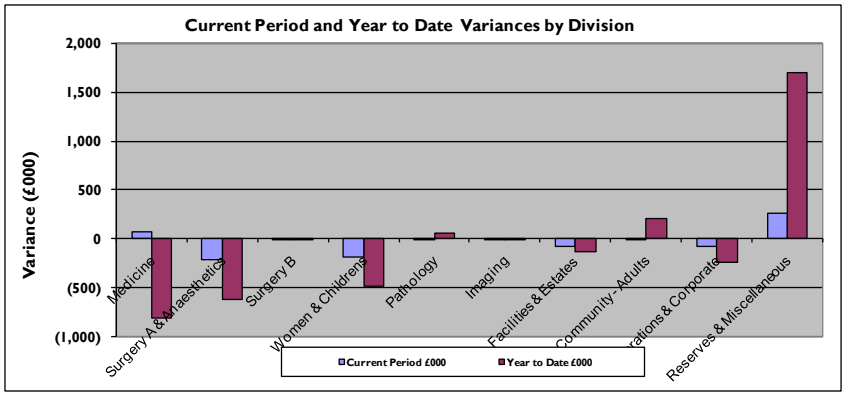
Financial Performance Report – October 2011



The tables adjacent and below show both in month and year to date adverse performance for Surgery A, Womens & Child Health, Facilities and Corporate Services and a remaining year to date deficit for Medicine and Emergency Care.

Divisional Variances from Plan

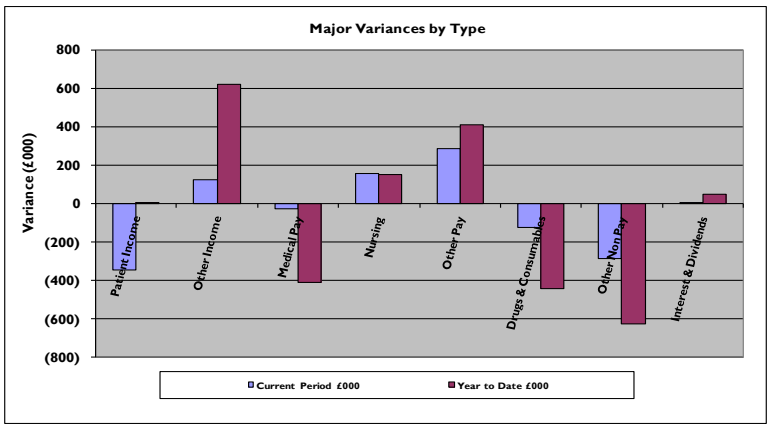
	Current Period £000	Year to Date £000
Medicine	74	(814)
Surgery A & Anaesthetics	(208)	(617)
Surgery B	(4)	4
Women & Childrens	(187)	(479)
Pathology	(7)	55
Imaging	7	5
Facilities & Estates	(79)	(125)
Community - Adults	6	212
Operations & Corporate	(73)	(236)
Reserves & Miscellaneous	258	1,705



For October, patient income shows a significant adverse variance along with non pay but a positive position against plan for pay.

Variance From Plan by Expenditure Type

	Current Period £000	Year to Date £000
Patient Income	(346)	8
Other Income	125	621
Medical Pay	(26)	(412)
Nursing	157	151
Other Pay	289	411
Drugs & Consumables	(124)	(443)
Other Non Pay	(287)	(626)
Interest & Dividends	8	46



Sandwell and West Birmingham Hospitals NHS
NHS Trust

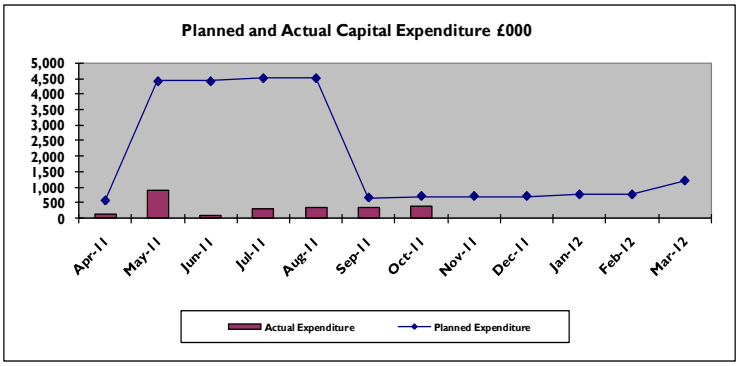
Financial Performance Report – October 2011

Capital Expenditure

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

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

• October expenditure was, similar to previous periods, at very low levels, even after taking into account the delay in land purchases.

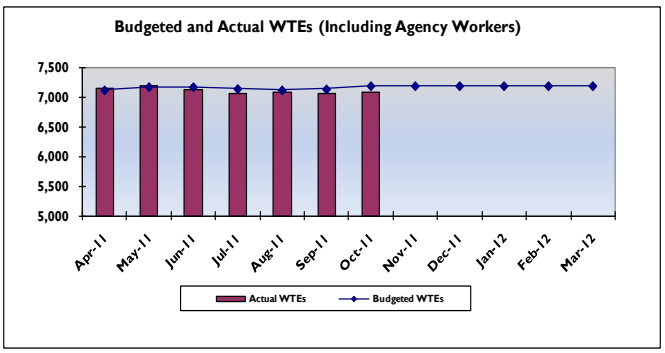


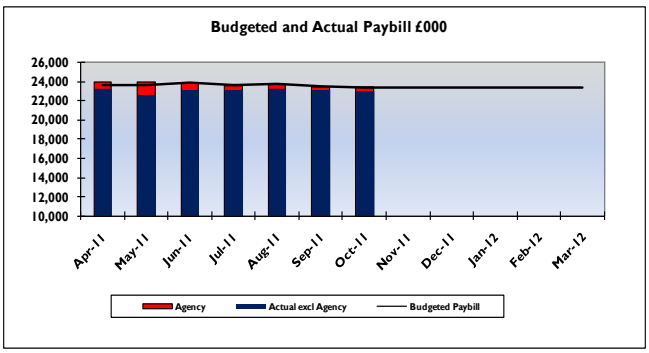
Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are approximately 99 below plan for October compared with 77 below plan in September. Excluding the impact of agency staff, wte numbers are around 168 below plan. Actual wtes have risen by approximately 31 compared with September although there have been larger increases in budgeted numbers, primarily reflecting the changes which have taken place as a result of the review of Medicine ward establishments.

• Total pay costs (including agency workers) are £420,000 lower than budgeted levels for the month , particularly on nursing and scientific & therapeutic staff groups.

• Expenditure for agency staff in October was £425,000 compared with £459,000 in September, an average of £598,000 for the year to date and an October 2010 spend of £605,000. The biggest single group accounting for agency expenditure remains medical staffing.





Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – October 2011

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 October					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	44,298	42,389		2,321	44,710	(412)
Management	8,998	8,713		0	8,713	285
Administration & Estates	18,611	17,359	710	574	18,643	(32)
Healthcare Assistants & Support Staff	17,582	16,463	1,289	153	17,905	(323)
Nursing and Midwifery	50,868	48,132	1,866	719	50,717	151
Scientific, Therapeutic & Technical	25,695	24,812		419	25,231	464
Other Pay	30	13			13	17
Total Pay Costs	166,082	157,881	3,865	4,186	165,932	150

NOTE: Minor variations may occur as a result of roundings

Balance Sheet

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

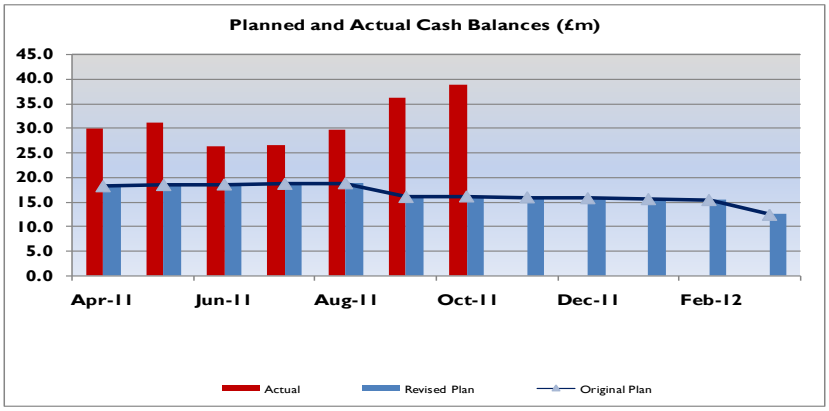
• Cash balances at 31st October are approximately £38.8m which is around £2.7m higher than at 30th September.

Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION

		Opening Balance as at 1st April 2011 £000	Balance at 31st October 2011 £000
Non Current Assets	Intangible Assets	1,077	1,027
	Tangible Assets	216,199	211,173
	Investments	0	0
	Receivables	649	650
Current Assets	Inventories	3,531	3,860
	Receivables and Accrued Income	12,652	12,767
	Investments	0	0
	Cash	20,666	38,847
Current Liabilities	Payables and Accrued Expenditure	(33,513)	(40,127)
	Loans	0	(2,000)
	Borrowings	(1,262)	(1,250)
	Provisions	(4,943)	(3,687)
Non Current Liabilities	Payables and Accrued Expenditure	0	0
	Loans	0	(6,000)
	Borrowings	(31,271)	(30,772)
	Provisions	(2,237)	(2,237)
		181,548	182,251
Financed By			
Taxpayers Equity	Public Dividend Capital	160,231	160,231
	Revaluation Reserve	36,573	37,073
	Donated Asset Reserve	2,099	0
	Government Grant Reserve	1,662	0
	Other Reserves	9,058	9,058
	Income and Expenditure Reserve	(28,075)	(24,111)
		181,548	182,251

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – October 2011



Cash Forecast

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

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW

12 MONTH ROLLING FORECAST AT October 2011

ACTUAL/FORECAST	Oct-11 £000s	Nov-11 £000s	Dec-11 £000s	Jan-12 £000s	Feb-12 £000s	Mar-12 £000s	Apr-12 £000s	May-12 £000s	Jun-12 £000s	Jul-12 £000s	Aug-12 £000s	Sep-12 £000s	Oct-12 £000s
Receipts													
SLAs: Sandwell PCT	**15,420**	15,399	15,399	15,399	15,399	15,399	15,091	15,091	15,091	15,091	15,091	15,091	15,091
HoB PCT	**7,642**	7,410	7,410	7,410	7,410	7,410	7,262	7,262	7,262	7,262	7,262	7,262	7,262
Associated PCTs	**5,792**	5,691	5,691	5,691	5,691	5,691	5,577	5,577	5,577	5,577	5,577	5,577	5,577
Pan Birmingham LSCG	**1,377**	1,377	1,377	1,377	1,377	1,377	1,349	1,349	1,349	1,349	1,349	1,349	1,349
Other SLAs	**462**	462	462	462	462	462	453	453	453	453	453	453	453
Over Performance Payments							0	0	0	0	0	0	0
Education & Training	**1,427**	1,457	1,457	1,457	1,457	1,457	1,255	1,255	1,255	1,255	1,255	1,255	1,255
Loans													
Other Receipts	**4,957**	2,976	2,976	2,976	2,976	2,976	2,500	2,500	2,500	2,500	2,500	2,500	2,500
Total Receipts	**37,077**	34,772	34,772	34,772	34,772	34,772	33,488	33,488	33,488	33,488	33,488	33,488	33,488
Payments													
Payroll	**13,735**	13,911	13,911	13,911	14,911	16,411	13,633	13,633	13,633	13,633	13,633	13,633	13,633
Tax, NI and Pensions	**9,167**	9,463	9,463	9,463	9,963	10,963	9,274	9,274	9,274	9,274	9,274	9,274	9,274
Non Pay - NHS	**2,408**	2,500	2,500	2,500	2,500	2,500	2,450	2,450	2,450	2,450	2,450	2,450	2,450
Non Pay - Trade	**7,896**	7,496	4,997	8,328	7,496	7,363	7,215	6,215	6,215	6,465	6,465	6,465	6,465
Non Pay - Capital	**535**	1,083	4,331	4,331	2,166	5,414	500	500	500	500	500	500	500
PDC Dividend						2,928						2,900	
Repayment of Loans						1,000						1,000	
Interest						34						30	30
BTC Unitary Charge	**396**	396	396	396	396	396	415	415	415	415	415	415	415
Other Payments	**179**	250	250	250	250	250	200	200	200	200	200	200	200
Total Payments	**34,316**	35,098	35,848	39,179	37,681	47,259	33,687	32,687	32,687	32,937	32,937	36,867	32,967
Cash Brought Forward	**36,086**	38,847	38,521	37,446	33,038	30,130	17,644	17,445	18,246	19,047	19,598	20,149	16,770
Net Receipts/(Payments)	**2,761**	(326)	(1,076)	(4,407)	(2,909)	(12,486)	(199)	801	801	551	551	(3,379)	521
Cash Carried Forward	**38,847**	38,521	37,446	33,038	30,130	17,644	17,445	18,246	19,047	19,598	20,149	16,770	17,291

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – October 2011

Risk Ratings			
Measure	**Description**	**Value**	**Score**
EBITDA Margin	Excess of income over operational costs	5.6%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	97.4%	4
Return on Assets	Surplus before dividends over average assets employed	1.7%	2
I&E Surplus Margin	I&E Surplus as % of total income	0.3%	2
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	34.0	4
Overall Rating			**2.8**

Risk Ratings

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

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

• Return on Assets and I&E Surplus Margin are lower than would normally be expected due to relatively low levels of surplus being delivered.

External Focus

• Birmingham and Solihull Cluster is reporting a difficult financial position and an overall year to date deficit position. In order to manage this position, uncommitted resources are being switched from Heart of Birmingham and South Birmingham PCTs to support adverse performance elsewhere. Within the cluster, Heart of Birmingham PCT (which is by a significant margin the biggest commissioner within the cluster for SWBH services) continues to report a surplus position although it has identified a degree of year to date over spending on acute services reflecting higher than planned activity levels.

• The Black Country Cluster is reporting a strong financial position, particularly for Wolverhampton PCT although all PCTs within the Cluster are reporting a year to date surplus and continuing to forecast a year end surplus. Over performance against plans has been recognised at Royal Wolverhampton, Dudley Group and Walsall Hospitals.

• Although there have been no further specific publications of financial performance information at either a national or regional level, indications continue to emerge of both current and expected difficulties across a number of NHS organisations, both NHS Trusts and PCTs/Clusters, in maintaining acceptable financial performance. Further information is likely to become available when a full analysis of Q2 data has been completed.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – October 2011

Conclusions

• Measured against the DoH target, the Trust generated an actual surplus of £175,000 during October bringing its financial performance for the first six months of the year to an overall surplus of £429,000.

•The Trust's year to date performance against both its Department of Health control total (i.e. the bottom line budget position it must meet) and the statutory accounts target shows a deficit of (£23,000) against the planned position.

• The £175,000 surplus in October is £18,000 better than planned for the month.

• Significant non recurrent benefits have been realised in month from additional ICR income and savings against depreciation budgets.

• Year to date capital expenditure was £2,443,000 which remains significantly lower than plan although the bulk of the shortfall relates to the actual phasing of acquisition compared to the original plan for the Grove Lane site. However, expenditure on other capital items also remains relatively slow.

•At 31st October, cash balances are approximately £22.7m higher than the cash plan which is around £2.7m greater than the position at 30th September. This in part reflects receipt of the proceeds to ensure resources are in place associated with the Grove Lane acquisition plan.

• The monthly performance across several key divisions is generally worse than plan. This is primarily driven by adverse performance against patient related income targets.

• Monitoring and review of the measures implemented in Medicine & Emergency Care, Surgery A, Anaesthetics & Critical Care and Women and Child Health Divisions continues on an ongoing basis. The current situation in these and all other divisions is being actively monitored and managed as any failure to deliver key financial targets will present a significant risk to the Trust's overall financial position including its agreed yearend surplus target.

Recommendations

The Trust Board is asked to:

i. NOTE the contents of the report; and

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

Robert White

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Monthly Performance Monitoring Report
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of planning & Performance Management
DATE OF MEETING:	24 November 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 – October 2011.

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

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Performance Management Board and Trust Management Board on 15 November 2011 and Finance and Performance Management Committee on 17 November 2011.

SANDWELL AND WEST BIRMINGHAM HOSPITALS CORPORATE QUALITY AND PERFORMANCE MONITORING REPORT - OCTOBER 2011 - EXCEPTION REPORT

AREA	PERFORMANCE				COMMENTS
	National Indicator(s)		Local Indicator(s)		
	Current	Year to date	Current	Year to date	
Cancer	🟢	🟢			The Trust has met, in month (September) and year to date performance thresholds for each of the 9 (national) headline, 2-week, 31-day and 62-day cancer indicators.
Cancelled Operations	🟢	🟢	🟢	🟢	For the year to date there have been no breaches of the national 28-day cancelled operations target. The percentage of overall cancelled operations during the month reduced to 0.5% (0.6% year to date).
Delayed Transfers of Care	🟡	🔴			Delayed Transfers of Care reduced overall to 4.3% during the month, influenced exclusively by a significant reduction of delays on the Sandwell site to 2.3%. Year to date Delayed Transfers of Care (5.9%) remain in excess of the 3.5% performance threshold.
Stroke Care	🔴	🔴	🟡	🟡	Provisional data for the month of October indicates that the percentage of patients who spent at least 90% of their hospital stay on a Stroke Unit reduced to 79.2%. TIA outpatient performance (the percentage of High Risk patients who were treated within 24 hours from initial presentation to the medical profession) also reduced to 44.4% during the month. Locally, 100% of stroke patients received a CT Scan within 24 hours of arrival /admission. Other local targets include admission to an Acute Stroke Unit within 4 hours of arrival (target 60%, actual 44.4% during the month) and CT Scan within 1 hour of arrival (target 50%, actual 33.3% during the month).
Accident & Emergency	🔴	🟢			A/E 4-hour waits - performance for the month of October is 94.10% and for the year to date 95.18%.
	🔴	🔴			Accident & Emergency Clinical Quality Indicators - for the purpose of performance monitoring the indicators are grouped into two groups, timeliness and patient impact. Organisations will be regarded as achieving the required minimum level of performance where robust data shows they have achieved the thresholds for at least one indicator in each of the two groups. During October only 1 of the 5 indicators was met; 'Time to treatment Year to date (median)'. Year to date performance is aggregated from the months of August, September and October which is to be used by the Department of Health as a proxy for Quarter 3. During this period the Trust met 1 of the 5 A&E Clinical Quality Indicators.
Infection Control	🔴	🟢			There were 11 cases of C Diff reported across the Trust during the month of October, 8 at Sandwell and 4 at City. The number of C Diff cases reported during the month was outside of the trajectory (9) for the month, but overall numbers (55) remain within the trajectory (64) for the year to date.There remain no cases of MRSA Bacteraemia reported for the year to date.
Referral to Treatment	🟢	🟢	🔴	🔴	All 5 National and 3 Local high level RTT Performance Indicators were met in month (September) and year to date. The only exception by specialty was Trauma & Orthopaedics, where 77.82% of admitted patients commened treatment within 18 weeks of referral (target 90%).
Cervical Cytology			🟢	🟢	The Turnaround Time of Cervical Cytology requests has been less than 9 days for each month for the year to date.
Same Sex Accommodation	🟢	🔴			There were 0 Breaches of Same Sex Accommodation reported during the month of October. No breaches have been reported since August.
Mortality			🟢	🟢	The Trust's HSMR for the month of July is 90.7 (Peer SHA 94.5) and for the period April -July inclusive is 96.5 (Peer SHA 100.6). Both values for the Trust are within statistical confidence limits.
Sickness Absence			🔴	🔴	Sickness Absence for the month of October increased to 4.19%. This is less than the absence rate of 4.51% for the corresponding month last year.
Learning & Development			🟡	🟡	Approximately 3700 staff have received a PDR for the period to date, this is equivalent to a rate of 78%. Overall Mandatory Training compliance at the end of October decreased slightly to 79.4%.
CQUIN	🟡	🟡			Acute Schemes - all schemes for which data is available contunue to be met in month and year to date with the exception of Medicines Management (July data) and Mortality Review (September data). With regards to the latter the percentage of mortlaity reviews carried out reduced in month to 33.8% (target 40%).
	🟡	🟡			Community Schemes - performance trajectories for all schemes were met during September and for the year to date with the exception of 'Falls Prevention' were performance of 42.9% is marginally less than the target for the period of 45%.
	🟡	🟡			Specialised Commissioners Schemes - all schemes are met in month and year to date with the exception of Access to Chemotherapy Out of Hospital which is aimed at increasing the volume of chemotherapy / anti-cancer drug deliveries made either at the patient's home or in a community setting closer to the patient's home. To date 87 home deliveries have been made, compared with a trajectory for the period of 123.
Referrals			🔴	🔴	For the period April - September inclusive overall referrals are approximately 7900 (8.2%) fewer and GP Referrals are approximately 5200 (8.0%) fewer than the corresponding period last year. Overall Referrals from Sandwell, HOB and Other (non-Sandwell / HOB) PCTs are approximately 3700 (7.7%), 1250 (4.8%) and 3000 (13.6%) less respectively for the 6 months year to date than for the same period last year.
Activity			🟡	🟢	Overall Elective activity for the month was 1.5% less than plan, although remains in excess of plan for the year to date by 8.1%.
			🔴	🔴	Non Elective activity is 13.7% less than plan for the month and 10.4% less than plan for the first 7 months of the year.
			🔴	🟡	Outpatient New and Review activity continues to exceed the plan for the year to date by 7.2% and 8.7% respectively, although both were less than plan for the month by 3.5% and 1.2% respectively. The Follow Up to New Outpatient Ratio for the year to date is 2.64, compared with a ratio derived from plan of 2.61.
			🟡	🔴	A/E Type I activity during the month of October was 0.2% less than plan, and is 2.6% less than plan for the year to date. Type II activity is 0.4% less than plan for the month, but remains in excess of plan for the year to date by 4.7%.
Ambulance Turnaround			🔴	🔴	During the month (September) there were an Increased proportion of ambulances waiting in excess of 30 minutes and an increase in the number of ambulances delayed by 60 minutes or more.

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

Operational Standards and Targets

Indicator		Weight	Thresholds Performing	Thresholds Underperforming	July 2011	Score	Weight x Score	August 2011	Score	Weight x Score	September 2011	Score	Weight x Score	Quarter 2 2011	Score	Weight x Score	October 2011	Score	Weight x Score
A/E Waits less than 4-hours		1.00	95.00%	94.00%	96.80%	3	3.00	94.40%	2	2.00	95.00%	3	3.00	95.02%	3	3.00	94.10%	2	2.00
A/E Unplanned re-attendance rate	{Patient Impact Group}	2.00	=<5.00%	>5.00%	9.52%	3	6.00	9.05%	3	6.00	7.25%	2	4.00	8.62%	3	6.00	8.36%	2	4.00
A/E Left Department without being seen rate	{Patient Impact Group}		=<5.00%	>5.00%	4.54%			4.48%			5.08%			4.70%			5.52%		
A/E Time to Initial Assessment - 95th centile	{Timeliness Group}		=<15mins	>15mins	23.00			25.00			22.00			23.00			23.00		
A/E Time to treatment in department (median)	{Timeliness Group}		=<60mins	>60mins	60.00			55.00			54.00			56.00			55.00		
Cancelled Operations - 28 day breaches		1.00	5.0%	15.0%	0%	3	3.00	0%	3	3.00	0%	3	3.00	0%	3	3.00	0%	3	3.00
MRSA Bacteraemia		1.00	0	>1.0SD	0	3	3.00	0	3	3.00	0	3	3.00	0	3	3.00	0	3	3.00
Clostridium Difficile		1.00	0	>1.0SD	4	3	3.00	7	3	3.00	8	3	3.00	19	3	3.00	12	0	0.00
18-weeks RTT Admitted 95 Percentile(weeks)		0.50	<=23.0	>27.7	18	3	1.50	19	3	1.50	19	3	1.50	<=23.0	3	1.50	<=23.0*	3	1.50
18-weeks RTT Non Admitted 95 Percentile(weeks)		0.50	<=18.3	>18.3	13	3	1.50	14	3	1.50	14	3	1.50	<=18.3	3	1.50	<=18.3*	3	1.50
18-weeks RTT Incomplete Pathway 95 percentile (weeks)		0.50	<=28.0	>36.0	16	3	1.50	16	3	1.50	15	3	1.50	<=28.0	3	1.50	<=28.0*	3	1.50
18-weeks RTT 90% Admitted		0.75	=>90.0%	85.0%	95.1%	3	2.25	94.6%	3	2.25	94.8	3	2.25	=>90.0%	3	2.25	=>90.0%*	3	2.25
18-weeks RTT 95% Non -Admitted		0.75	=>95.0%	90.0%	98.9%	3	2.25	97.5%	3	2.25	99.1	3	2.25	=>95.0%	3	2.25	=>95.0%*	3	2.25
Cancer - 2 week GP Referral to 1st OP Appointment		0.50	93.0%	88.0%	93.2%	3	1.50	94.9%	3	1.50	93.6%	3	1.50	94.2%	3	1.50	>93.0%*	3	1.50
Cancer - 2 week GP Referral to 1st OP Appointment - breast symptoms		0.50	93.0%	88.0%	96.9%	3	1.50	94.9%	3	1.50	95.4%	3	1.50	95.8%	3	1.50	>93.0%*	3	1.50
Cancer - 31 day diagnosis to treatment for all cancers		0.25	96.0%	91.0%	98.8%	3	0.75	98.9%	3	0.75	100.0%	3	0.75	99.2%	3	0.75	>96.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (surgery)		0.25	94.0%	89.0%	98.0%	3	0.75	98.1%	3	0.75	100.0%	3	0.75	98.6%	3	0.75	>94.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (drug)		0.25	98.0%	93.0%	100.0%	3	0.75	100.0%	3	0.75	100.0%	3	0.75	100.0%	3	0.75	>98.0%*	3	0.75
Cancer - 31 Day second/subsequent treat (radiotherapy)		0.25	94.0%	89.0%	100.0%	3	0.75	100.0%	3	0.75	100.0%	3	0.75	100.0%	3	0.75	>94.0%*	3	0.75
Cancer - 62 day urgent referral to treatment for all cancers		0.50	85.0%	80.0%	86.5%	3	1.50	87.9%	3	1.50	85.1%	3	1.50	86.8%	3	1.50	>85.0%*	3	1.50
Cancer - 62 day referral to treatment from screening		0.50	90.0%	85.0%	100.0%	3	1.50	100.0%	3	1.50	100.0%	3	1.50	100.0%	3	1.50	>90.0%*	3	1.50
Stroke (Stay on Stroke Unit)		1.00	80.0%	60.0%	82.93%	3	3.00	90.00%	3	3.00	86.10%	3	3.00	86.30%	3	3.00	90.90%	3	3.00
Delayed Transfers of Care		1.00	3.5%	5.0%	8.30%	0	0.00	7.80%	0	0.00	5.40%	0	0.00	7.20%	0	0.00	4.30%	2	2.00
Sum		**14.00**																	
Average Score							**2.79**			**2.71**	* projected		**2.64**	* projected		**2.79**	* projected		**2.50**

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

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

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

Financial Indicators

Criteria	Metric	Weight (%)		SCORING 3	SCORING 2	SCORING 1	2011 / 2012 August	Score	Weight x Score	2011 / 2012 September	Score	Weight x Score	2011 / 2012 October	Score	Weight x Score
Initial Planning	Planned Outturn as a proportion of turnover	5	5	Planned operating breakeven or surplus that is either equal to or at variance to SHA expectations by no more than 3% of income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to SHA expectations by more than 3% of planned income.	Operating deficit more than or equal to 2% of planned income	**0.00%**	**3**	**0.15**	**0.00%**	**3**	**0.15**	**0.00%**	**3**	**0.15**
Year to Date	YTD Operating Performance	25	20	YTD operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of forecast income.	Operating deficit more than or equal to 2% of forecast income	**0.06%**	**3**	**0.6**	**0.06%**	**3**	**0.6**	**0.10%**	**3**	**0.6**
	YTD EBITDA		5	Year to date EBITDA equal to or greater than 5% of actual year to date income	Year to date EBITDA equal to or greater than 1% but less than 5% of year to date income	Year to date EBITDA less than 1% of actual year to date income.	**5.38%**	**3**	**0.15**	**5.34%**	**3**	**0.15**	**5.31%**	**3**	**0.15**
Forecast Outturn	Forecast Operating Performance	40	20	Forecast operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of income.	Operating deficit more than or equal to 2% of income	**0.00**	**3**	**0.6**	**0.00**	**3**	**0.6**	**0.00**	**3**	**0.6**
	Forecast EBITDA		5	Forecast EBITDA equal to or greater than 5% of forecast income.	Forecast EBITDA equal to or greater than 1% but less than 5% of forecast income.	Forecast EBITDA less than 1% of forecast income.	**5.70%**	**3**	**0.15**	**5.65%**	**3**	**0.15**	**5.59%**	**3**	**0.15**
	Rate of Change in Forecast Surplus or Deficit		15	Still forecasting an operating surplus with a movement equal to or less than 3% of forecast income	Forecasting an operating deficit with a movement less than 2% of forecast income OR an operating surplus movement more than 3% of income.	Forecasting an operating deficit with a movement of greater than 2% of forecast income.	**0.00%**	**3**	**0.45**	**0.00%**	**3**	**0.45**	**0.00%**	**3**	**0.45**
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	**0.44%**	**3**	**0.15**	**0.43%**	**3**	**0.15**	**0.44%**	**3**	**0.15**
	EBITDA Margin (%)		5	Underlying EBITDA equal to or greater than 5% of underlying income	Underlying EBITDA equal to or greater than 5% but less than 1% of underlying income	Underlying EBITDA less than 1% of underlying income	**5.70%**	**3**	**0.15**	**5.65%**	**3**	**0.15**	**5.59%**	**3**	**0.15**
Finance Processes & Balance Sheet Efficiency	Better Payment Practice Code Value (%)	20	2.5	95% or more of the value of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the value of NHS and Non NHS bills are paid within 30days	Less than 60% of the value of NHS and Non NHS bills are paid within 30 days	**84.00%**	**2**	**0.05**	**77.00%**	**2**	**0.05**	**89.00%**	**2**	**0.05**
	Better Payment Practice Code Volume (%)		2.5	95% or more of the volume of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the volume of NHS and Non NHS bills are paid within 30days	Less than 60% of the volume of NHS and Non NHS bills are paid within 30 days	**85.00%**	**2**	**0.05**	**83.00%**	**2**	**0.05**	**85.00%**	**2**	**0.05**
	Current Ratio		5	Current Ratio is equal to or greater than 1.	Current ratio is anything less than 1 and greater than or equal to 0.5	A current ratio of less than 0.5	**1.02**	**3**	**0.15**	**1.22**	**3**	**0.15**	**1.18**	**3**	**0.15**
	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	**14.50**	**3**	**0.15**	**12.97**	**3**	**0.15**	**11.79**	**3**	**0.15**
	Creditor Days		5	Creditor days less than or equal to 30	Creditor days greater than 30 and less than or equal to 60 days	Creditor days greater than 60	**40.55**	**2**	**0.1**	**34.25**	**2**	**0.1**	**37.29**	**2**	**0.1**
						Weighted Overall Score			**2.90**			**2.90**			**2.90**

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

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	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:	24 November 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 October 2011.

It covers:

- Progress of the RCRH Programme including activity monitoring for the period April-August 2011.
- Progress with the recommissioning schemes as agreed in the LDP.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is recommended to:

1. NOTE the progress made with the Right Care Right Here Programme.
2. NOTE progress with identifying and delivering recommissioning schemes.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Monthly progress report to Trust Board

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

RIGHT CARE RIGHT HERE PROGRAMME: PROGRESS REPORT NOVEMBER 2011

INTRODUCTION

The Right Care Right Here Programme is the partnership of SWBH, HoB tPCT, Sandwell PCT and Birmingham and Sandwell local authorities leading the development of health services within Sandwell and Western Birmingham. This brief paper provides a progress report for the Trust Board on the work of the Programme as at the end of October 2011. It summarises the Right Care Right Here Programme Director's report and the RCRH Service Redesign Report that were presented to the Right Care Right Here Partnership Board in November.

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 Trust's Right Care Right Here Implementation Board meetings.

PROJECT PERFORMANCE

The RCRH Programme activity performance reports related to service redesign are included in Appendix 1 for information. They attempt to summarise overall progress with the Programme in key areas by providing data for the first five months of 2011/12 and comparing it with actual performance in 2010/11, the trajectory in the RCRH Activity and Capacity (A&C) for 2011/12 and the targets in the A&C model for 2016/17.

In summary activity trends for April-August 2011 show:

- Inpatient Activity: Our Acute Occupied Bed Days (OBDs; in Summary A, figure 1) continue to show a downward trend and are 7.5% below 2010/11 levels but 16% above the 2011/12 trajectory. This includes a reduction in our emergency inpatient OBDs but a slight increase in our elective inpatient OBDs compared to the same period in 2010/11 (Summary A, figures 4 and 5).

- Community OBDs (in Summary B, figure 3) are 10% below 2010/11 levels and 17% below the 2011/12 trajectory.

- It is envisaged that the intermediate care/re-ablement beds opened at Rowley Regis Hospital in September will increase the Community OBDs and assist in reducing our Acute OBDs.

- Emergency Department Attendances: Our Emergency Department (ED) attendances (in Summary A, figure 2) are 1% above the 2010/11 end of year level, and 9.8% above the 2011/12 trajectory.

- The Urgent Care Centre attendances (in Summary B, figure 2) have shown a downward trend but are still 9% above 2010/11 end of year level and 82% above the 2011/12 trajectory.

- Outpatient Attendances: Our acute Outpatient Activity (in Summary A, figure 3) remains 5% below the 2010/11 end of year level and now just below (0.6%) the 2011/12 trajectory.

- Community Outpatient Activity (including our community and new Community Provider activity, in Summary B, figure 1) remains below the 2010/11 end of year level by 4.5% but is still 221% above the 2011/12 trajectory although still some way (49%) from the 2016/17 trajectory.

- Referrals to acute services have shown a further reduction and are now 10% below the 2010/11 level (in Summary B, figure 4).

At this stage it therefore appears that across all three categories, our acute activity is showing a downward trend but with further work required to ensure maintenance of this trend (acute outpatient attendances) or achievement of 2011/12 trajectories (ED attendances and acute OBDs) and ongoing

progress towards the 2016/17 position. It is anticipated that the re-commissioning work (see below) will help to achieve this.

In terms of previous projects established through specific exemplars and individual re-design initiatives performance in terms of activity is now captured within the above summaries.

CARE PATHWAY AND SPECIALITY REVIEWS

Further redesigned care pathways have been published on the three local views of Map of Medicine (Sandwell, Heart of Birmingham and Intelligent Commissioning Forum - ICoF) in October. These pathways are: -

- Emergency Contraception
- Osteoarthritis
- Allergic Rhinitis
- Hip Fracture
- Pain Management
- Spinal Pain
- Balance Disorders

A further 7 redesigned care pathways will be published to the local views in Map of Medicine in November.

The RCRH Programme is having ongoing discussions with commissioners about arrangements to commission and activate the service redesign requirements within these care pathways. Many of the published care pathways will have the impact of reducing activity to our acute services but are likely to increase activity in our diagnostic and community services. The financial impact on our acute services, for this year, of the revised care pathways with associated loss of activity and income is captured within the re-commissioning work.

TRANSFER OF ACTIVITY (RE-COMMISSIONING)

There have been ongoing discussions across the local health economy regarding implementation of the LDP agreement to transfer a range of services, activity and related income from secondary care to community and primary care during 2011/12 in line with the RCRH Programme. The Trust and GP commissioners have identified a number of specific schemes which have now been agreed and for which implementation plans are now being developed. These schemes are collectively known as the Re-commissioning Programme.

The LDP agreement set a target of re-commissioning activity worth £16.2million and to date the Trust and PCTs have identified schemes that will result in the transfer of activity worth £13.8million over a full year. Work is continues within the Trust and PCTs to identify additional schemes.

For the period April – September 2011 there has been a transfer of activity worth £1.3 million which is a slight improvement since the last report but remains below the year to date target. A number of the schemes are due to commence in the Autumn and so a further improvement in performance is expected over the next few months.

RCRH PROGRAMME MANAGEMENT STRUCTURE

The RCRH Partnership Board has agreed to continue with the existing governance arrangements and to plan to hold a half day workshop in February or March 2012 in view of the ongoing debate around GP Clinical Commissioning Group/Consortia configuration and the NHS reforms.

RECOMMENDATIONS

The Trust Board is recommended to:

1. NOTE the progress made with the Right Care Right Here Programme.
2. NOTE progress with identifying and delivering re-commissioning schemes.

Jayne Dunn
Redesign Director – Right Care Right Here
15th November 2011

APPENDIX 1 - RCRH Activity Summaries

Personal :: Summary PBR Community reports

Summary B - RCRH Programme Board Reports For Community Sector From Apr-Aug 2011

Fig 1 Summary Community Outpatients From Apr-Aug 2011 Compared to A&C Model and 10/11 Out Turn

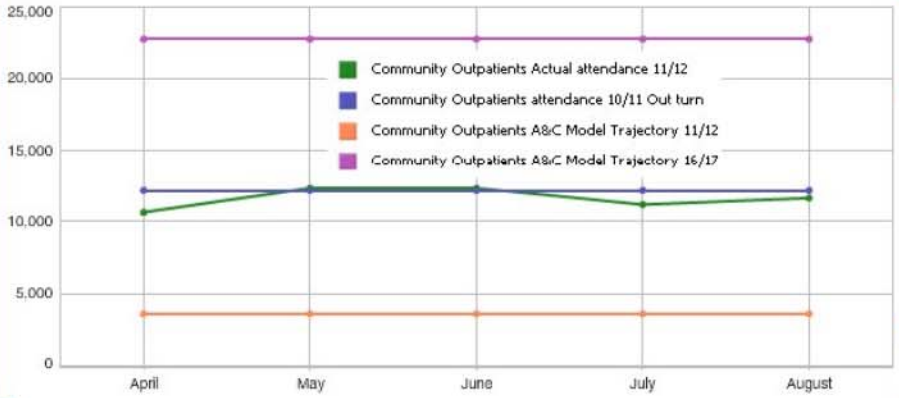


Fig 1 – At Month 5 community outpatient attendance is 4.5% less than 10/11 outturn. In comparison to the A&C model it is 221% above 2011/12 Trajectory and 49% less than 2016/17 trajectory.

Fig 2 – Urgent Care Centre attendance is 9% above 10/11 outturn. Urgent car activity appears to have a declining trend, however attendance is still above previous years out turn and modelled trajectories. We are 27% above 16/17 Trajectory and 82% above 11/12.

Fig 3 – Community OBD's are 10% below 10/11 outturn and 17% below modelled trajectory for 11/12. Please note that McCarthy ward at Rowley Regis closed in May 2011 and a new enablement ward (Henderson ward) will be opened in October 2011.

To meet 11/12 trajectory we need to introduce 16,154 new OBD's . The trajectory for 11/12 will be phased in from the point at which new beds are introduced into the system i.e October 2011. Community OBDS includes:

Leasowes IC Centre,Barthalomew Lodge Nursing Home,Waterside Nursing Home
Greenhaven Care Home,Moseley Hall,Riverside Lodge,RCRH Exemplar projects

Fig 4 – Show referral activity which includes GP as well as other types. At month 5 referrals are 10% below last years out turn.

Fig 2 Summary UCC Attendance From Apr-Aug 2011 Compared to A&C Model and 10/11 Out Turn

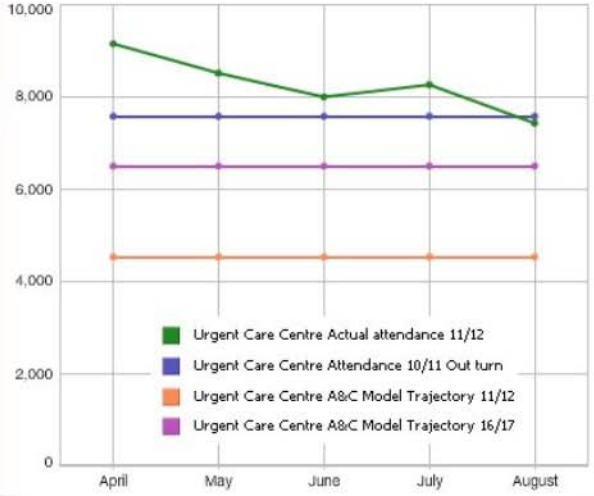


Fig 3 Summary Community OBD's From Apr-Aug 2011 Compared to A&C Model and 10/11 Out Turn

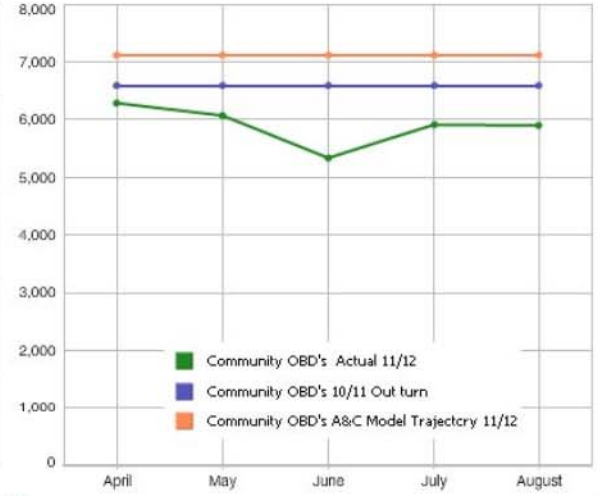
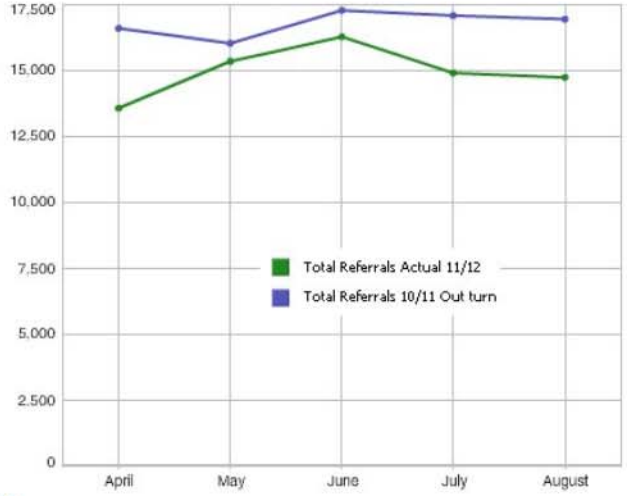


Fig 4 Summary Referrals From Apr-Aug 2011 Compared to 10/11 Out Turn



Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Foundation Trust Programme: Project Director's Report
SPONSORING DIRECTOR:	Mike Sharon, Director of Strategy & Organisational Development
AUTHOR:	Mike Sharon, Director of Strategy & Organisational Development
DATE OF MEETING:	24 November 2011

SUMMARY OF KEY POINTS:

The Project Director's report gives an update on:

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

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

FT Programme Board on 24 November 2011.

FT Programme Director Report November 2011 – Overall status - Red

Activities this period

- Board preparation session for soft mock Board to Board taken place
- Exec team members second half day workshop to review risks and downside case
- Initial legal review of Constitution received
- HDD 1 to commence at the end of November
- Majority of Board member one to one interview feedback sessions with Deloitte taken place
- Redrafted membership strategy
- Deloitte commissioned to support Quality Governance preparation and process

Activities next period

- Soft mock Board to Board on 25/11/11
- Board to consider revised risks and downside case
- Produce next draft IBP ahead of SHA B2B
- Retained Estates Strategy to be updated
- Conclusion of HDD Stage 1
- Deloitte to complete Board assessment and provide feedback on soft mock B2B
- Review of Board preparation answers
- Review bottom up modelling of ward and medical staffing

Issues for resolution and risks in next period

- Deadline of December for approval of OBC likely to be missed
- Agree revised timeline for OBC approval and FT milestones with DH/SHA
- Preparation for public and staff engagement put on hold until revised timeline agreed

MINUTES

Sandwell and West Birmingham Hospitals NHS
NHS Trust

FT Programme Board – Version 0.1

Venue Boardroom, Sandwell Hospital **Date** 27 October 2011

Present:	Mrs Sue Davis	[Chair]	Mr Mike Sharon
	Mr Roger Trotman		Miss Rachel Barlow
	Dr Sarindar Sahota		Miss Rachel Overfield
	Mrs Gianjeet Hunjan		Mr Donal O'Donoghue
	Mr Phil Gayle		Mr Graham Seager
	Mrs Olwen Dutton		Miss Kam Dhami
	Mr John Adler		Mrs Jessamy Kinghorn
	Mr Robert White		Miss Neetu Sharma

Secretariat: Mr Simon Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Professor Derek Alderson.	
2 Minutes of the previous meeting	**SWBFT (9/11) 059**
Subject to minor amendment, the minutes of the previous meeting were accepted as a true and accurate record of the discussions held on 29 September 2011.	
AGREEMENT: The minutes of the previous meeting were approved.	
3 Update on actions arising from previous meetings	**Verbal**
It was noted that there were no overdue actions or actions that required escalating for attention.	
4 FT Programme Critical Path	**SWBFT (10/11) 063** **SWBFT (10/11) 063 (a)**
The FT Programme Board received and noted the updated FT Programme Critical Path. Miss Sharma advised that the Critical Path had been updated to reflect the timetable within the new Tripartite Formal Agreement that had been submitted	

to NHS West Midlands. In terms of the key milestones, the Board was advised that the receipt of feedback on the PFI review had been indicated on the Critical Path. The Board was also asked to note that the updated estates strategy was planned for completion in November 2011. Commencement of the Historical Due Diligence exercise was noted to be planned to start in November 2011, and the Board was advised that meetings would be required between the auditors and individual Board members. The Chair asked whether this would commence in the event that approval of the Outline Business Case had not been received. Mr Sharon advised that the exercise had been planned to avoid end of year financial preparations and the negotiation of the Local Delivery Plan (LDP). It was reported that in accordance with the Tripartite Formal Agreement, a revised Long Term Financial Model (LTFM) had been submitted, which was compliant with the Prudential Borrowing Code (PBC). The Board was informed that there was an expectation that as part of its routine review, the Department of Health would seek clarity on a number of aspects of the LTFM.	
5 FT workstream high level milestone plan	**SWBFT (10/11) 064** **SWBFT (10/11) 064 (a)**
The FT Programme Board received and noted the updated FT workstream high level milestone plan. The Board was advised that the milestone plan had been refreshed to reflect that the first mock Board to Board was planned for 25 November 2011. It was highlighted that a revised version of the Integrated Business Plan (IBP) would be presented to NHS West Midlands before the following Board to Board in January 2012. The public engagement phase was also reported to be planned to commence in January 2012. Mr Sharon advised that the engagement had been timed to start in close proximity to the approval of the OBC to ensure adequate momentum was maintained. Mr Trotman enquired as to the timing of the marketing activity. Miss Sharma reported that the timing of this piece of work was yet to be agreed, principally as the business development changes anticipated would govern the strategy. It was highlighted that the Board Committee observations had been incorporated into the milestone plan.	
6 Programme Director's report	**SWBFT (10/11) 061** **SWBFT (10/11) 061 (a)**
The FT Programme Board received and noted the FT Programme Director's report. Mr Sharon presented the key activities undertaken since the previous meeting. He also distributed a set of key questions and answers that may be anticipated as part of the forthcoming Board to Board events. It was noted that answers to the	

questions concerning mortality needed to be added into the pack. Mr O'Donoghue advised that a presentation on mortality was due at the forthcoming meeting of the Trust Board. The various sources of assurance on mortality were discussed in detail, including through routine monitoring, a review of deaths and the red incident reports. Mr Sharon highlighted that the Trust's solicitors had been engaged to review the proposed constitution for the Trust following FT status. It was agreed that the version following the review should be brought the next meeting of the FT Programme Board. The Chair suggested that feedback from other trusts regarding the issues faced and best practice in terms of the content of the constitution should be sought.	
ACTION: **Miss Sharma to arrange for the Constitution to be presented at the next meeting of the FT Programme Board**	
7 Programme risk register	**SWBFT (9/11) 056** **SWBFT (9/11) 056 (a)**
The FT Programme Board received and noted the FT Programme Risk Register. Miss Sharma reported that the risk register had been refreshed. In terms of red risks, the Board was asked to note that these related to the risk of non-delivery of the new hospital project and around the ability to be able to evidence the Trust's planned Cost Improvement Programme (CIP). Mr Trotman suggested that the risk scores applied to the CIP and the Atos-related risks should be lower than proposed. Mr Adler advised that given the quantum of cost savings involved, the score remained appropriate.	
8 Communications FT action plan	**SWBFT (10/11) 066** **SWBFT (10/11) 066 (a)**
Mrs Kinghorn presented the outline plan for the communications and engagement element of the FT application process, which she advised had been developed in conjunction with engagement and communications leads. It was reported that the plan needed to be submitted as part of the FT application. Mrs Dutton noted that members could be aged 11 and upwards and asked how this group were being engaged as part of the plan. She was advised that a programme of engagement including schools, the youth parliament and Connexions was in place, which had proved to be effective. In terms of the membership, Mrs Kinghorn advised that a the Trust had a stable membership of c.7500, however a decision needed to be taken as to whether this should be increased to 8000, particularly given the impact of the TCS transfer in April 2011. Miss Sharma agreed that there was a need to ensure that the membership was representative. Dr Sahota suggested that consideration should be given to linking in with members of the arts programme.	

In terms of key messages, Mr Adler summarised that there was need for overt marketing, including a specific exercise around Maternity. Mrs Kinghorn advised that this would be added into the strategy. The FT Programme Board was asked for and gave, subject to the amendments suggested, its approval to the Communications FT action plan.	
AGREEMENT: The FT Programme Board gave, subject to amendments suggested, its approval to the Communications FT action plan	
9 Governance Rationale discussion paper	**SWBFT (10/11) 067** **SWBFT (10/11) 067 (a)**
Mrs Kinghorn summarised the key points of the proposed Governance Rationale, an appendix to the Integrated Business Plan. It was highlighted that the plans for the subdivisions of the workforce from which governors would be canvassed required review. Dr Sahota asked whether bank and agency staff could be elected as governors or apply to be members. He was advised that if these staff were not employees of the Trust already then they could apply to be a member providing that they lived within one of constituencies forming the membership catchment. It was agreed that further thought was needed as to whether these individuals could apply to be a governor. It was suggested that in terms of numbers of governors a check should be made to ensure that the numbers were representative of the number of staff in each category. It was agreed that a separate category for community staff should not be created. In terms of the role of a governor, the Chair suggested that acting as an ambassador of the Trust should be incorporated into the list of responsibilities. It was suggested that consideration needed to be given as to the plan to replace individuals when a governor stepped down in the middle of their three year term. Regarding the behaviours expected of a governor, Mrs Dutton asked whether the term 'violence' included aggressive acts. It was agreed that further work was needed to clarify the range of behaviours expected. Mr Adler cautioned that a sensible approach be taken to developing this list. The FT Programme Board was asked for and gave, subject to the amendments suggested, its approval to the Governance Rationale.	
AGREEMENT: The FT Programme Board gave, subject to the amendments suggested, its approval to the Governance Rationale	
10 Additional support for Quality Governance	**Hard copy paper**
Miss Dhami presented a proposal to seek authority to engage Deloitte in undertaking the assessment of the Trust against the Quality Governance	

Framework. It was highlighted that the work was a significant undertaking. The Board was informed that a score of four or above when assessed, would prevent the Trust being authorised as a Foundation Trust. The cost of engaging Deloitte was reported to be no greater than £40k, with the funding being met from the FT Programme budget. The FT Programme Board approved the proposal.	
AGREEMENT: The FT Programme Board gave its approval to engage Deloitte in the work to assess the Trust against the Quality Governance Framework	
11 Matters for information	
11.1 Monitor Board minutes – July 2011	**SWBFT (10/11) 065**
The FT Programme Board received and noted the minutes of Monitor's Board meeting held on 27 July 2011.	
12 Any other business	**Verbal**
There was none.	
13 Details of next meeting	**Verbal**
The next FT Programme Board meeting will be held on 24 November 2011 at 1300h in the Anne Gibson Boardroom at City Hospital.	

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Audit Committee – Version 0.2

Venue Executive Meeting Room, City Hospital **Date** 8 September 2011

Members	In Attendance		Secretariat	
Mrs G Hunjan [Chair]	Mr R White		Mr S Grainger-Payne	
Dr S Sahota	Mr T Wharram			
Mrs O Dutton	Mr P Capener	(CW Audit)	**Observers**	
	Mrs R Chaudary	(CW Audit)	Mr M Ramzan	[Deloitte LLP]
	Mr D Ferguson	(CW Audit)	Mrs L Gouldthorpe	[CW Audit]
	Mrs S-A Moore	(KPMG LLP)		

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Professor Derek Alderson, Mr Roger Trotman and Mr Andy Bostock.	
2 Minutes of the previous meeting	**SWBAC (5/11) 037** **SWBAC (6/11) 038**
Subject to minor amendment, the minutes of the meetings held on 12 May 2011 and 9 June 2011 were approved as a true and accurate reflection of the meetings.	
AGREEMENT: The minutes of the meeting held on 12 May 2011 and 9 June 2011 were approved subject to minor amendment	
3 Matters arising	**SWBAC (6/11) 037 (a)**
The Committee received and noted the updated actions log.	
3.1 Update on the implementation of the Key Skills Framework	**Verbal**

Mrs Chaudary reminded the Committee that a review of the implementation of the Key Skills Framework (KSF) had been undertaken in 2009 which had provided Limited Assurance. It was reported that a follow up to the plan had also indicated that there remained Limited Assurance. The Committee was advised that recent feedback on progress had suggested that a new working group would be set up to progress implementation of the new guidance issued in relation to the KSF. The latest information received reportedly suggested that a revised implementation date for the new guidance of March 2012. Mr Capener remarked that it had been appropriate to wait for this guidance to be issued before progressing the implementation of the KSF further.	
3.2 Benchmarking of Reference Cost information	**SWBAC (9/11) 040** **SWBAC (9/11) 040 (a)**
Mr White presented the process and latest available comparators for the Trust's performance against the Reference Cost Index (RCI). The Committee was advised that the Reference Cost information was a measure to establish how the average costs of the Trust's services compared with the national average. It was highlighted that the position did not necessarily provide an indication of the Trust's financial robustness overall. The Committee was asked to note that the information available indicated that there were some areas in the Trust requiring further scrutiny. It was noted that the Reference Cost information for the Trust's Accident and Emergency services was lower than the regional and national average due to the increasing numbers of patients attending Urgent Care Centres. Mrs Dutton pointed out that the lowest score related to Community Services. It was reported that this area had not been included in previous exercises and Mr White was asked whether there was likely to be an impact in the return for 2011/12. Mr White advised that it was likely that the Trust's position was consistent with other trusts which had been involved in a transfer of community staff from their local PCTs. Mrs Moore commented that the data quality of Community Services Reference Cost information was historically not as robust or as clearly understood as that related to Acute Services. Mrs Dutton highlighted that the Trust's average Market Forces Factor was lower than the national average and questioned whether cost savings should be made to achieve the desired level. Mr White advised that this related to a stream of income and therefore was unconnected to the Reference Cost information. It was agreed that the consideration of the Reference Cost information should be considered on an annual basis, therefore Mr Grainger-Payne was asked to build this into the Committee's reporting cycle.	
ACTION: Mr Grainger-Payne to include Reference Cost information	

into the Audit Committee's annual cycle of business	
3.3 Update on progress with improving performance against the prompt payment target	**SWBAC (9/11) 044** **SWBAC (9/11) 044 (a)**
Mr White highlighted that there had been a slight improvement in the number and value of invoices paid within the required 30 day timescale set as the Prompt Payment target. The Committee was advised that good effort was being made to eliminate the number of paper requisitions sent to the Supplies department, although it was noted that the Women & Child Health and Surgery, Anaesthetics & Critical Care division appeared to require further improvement in this respect. Mr White reported that the JACS system was now in place which assisted the performance of the Pharmacy directorate in particular. It was reported that timely receipting of goods was key to improving the position and therefore close focus would be given to this in coming months. It was highlighted that the NHS Performance Framework measured the Trust against the Prompt Payment targets, with a green status being awarded for a performance of 95% or above. It was agreed that a further update should be provided at the next meeting.	
ACTION: Mr White to provide a further update of the Trust's performance against the Prompt Payment target at the next meeting	
4 External Audit Matters	
4.1 External Audit progress report	**SWBAC (9/11) 051**
Mrs Moore reported that since the last meeting, work had been completed on finalising the financial statements for 2010/11, to allow submission to the Department of Health. A review of the Trust's Quality Account was also reported to have concluded. An audit of the Trust's Charitable Funds account was noted to be ongoing at present. The Committee was asked to note the technical updates that were provided as part of the External Audit progress report. Mrs Hunjan asked whether the debrief on the audit of the 2010/11 annual accounts had highlighted any issues. Mrs Moore advised that the debrief had suggested that the process had run well and the timetable for the 2011/12 audit had been discussed.	
4.2 Agreement of the Annual Audit Letter, including progress with	**SWBAC (9/11) 052**

actions to address the recommendation regarding clearance of suspense accounts	
Mrs Moore presented the annual audit letter, which she advised was an exception based summary of the work undertaken by the External auditors to date. It was noted that there was a requirement to make the document public, therefore Mr Grainger-Payne was asked to ensure that it was displayed on the Trust's internet. In terms of the Use of Resources assessment, Mrs Moore reported that good arrangements were in place within the Trust. Mrs Moore advised that an 'Unqualified' opinion had been given on the Annual Accounts 2010/11. In terms of the recommendations raised from the review, the Committee was asked to note the progress reported and was advised that those not due for completion would be followed up when appropriate. Mrs Hunjan asked how the Trust's timetable for the preparation of the annual report compared with that of other trusts. Mrs Moore advised that a number of other trusts worked to a similar deadline of preparing the Annual Report in time for sharing at the Annual General Meeting (AGM), however she advised that there was now a movement towards preparation earlier in line with the requirements of Monitor to coincide with the preparation of the Annual Accounts. The Trust was encouraged to expedite the publication of the Annual Report if possible. In relation to the suggestion that the report should be considered by the Audit Committee at the same time as the Annual Accounts, Mr White advised that it was likely that the final publication would not be available to this deadline. It was agreed that the report need not be the final designed and published version but needed to present the intended content of the report. Mr Capener added that the Audit Committee Handbook inferred that the Annual Report should be considered by the Audit Committee to ensure that its intended contents were in line with the Committee's understanding.	
ACTION: Mr Grainger-Payne to arrange for the Annual Audit Letter to be added to the Trust's internet **AGREEMENT: It was agreed that from 2012, the Annual Report would be produced and submitted to the Audit Committee for its consideration to the same timescale as that of the Annual Accounts**	
4.3 Review of the Quality Account 2010/11 and action plan to address recommendations	**SWBAC (9/11) 050** **SWBAC (9/11) 050 (a)** **SWBAC (9/11) 050 (b)**
Mr White presented the review of the Trust's Quality Account and the	

action plan that had been developed to address the recommendations of the review for information. It was highlighted that the report would be presented to and monitored by the Governance Board at a future meeting. Mrs Hunjan offered a selection of Quality Accounts that had been sourced from other organisations to assist with the review and discharge of the recommendations proposed. It was agreed that an update on the action plan should be presented at the December meeting of the Audit Committee.	
ACTION: **Mr Grainger-Payne to schedule an update of the action plan to address the recommendations in the Quality Account 2010/11 at the December meeting of the Audit Committee**	
5 Internal Audit Matters	
5.1 Internal Audit progress report, including recommendation tracking update	**SWBAC (9/11) 041** **SWBAC (9/11) 041 (a)**
Mr Capener advised that good progress had been made within the first quarter of the year and as such Internal Audit was ahead of the annual plan at present. In terms of changes to the audit plan, the Committee was advised that a review of the delivery of the CQuiN schemes had been abandoned, given the significant profile and monitoring of delivery already within the Trust. In its place, the Committee was informed that a review of medicines management would be undertaken. The Committee was advised that CW Audit had been engaged to undertake an occupancy review of areas within the Birmingham Treatment Centre, which as a result had incurred an additional 20 days of billed time. A summary of the audit results undertaken was considered and progress in a number of areas was noted. The Committee was asked to observe that the recommendation tracking progress showed that encouraging progress was being made with the delivery of actions. Mr Capener reported that the high risk issue relating to the physical relocation of servers as part of the Information Governance review was expected to have been completed, although to date this had not been confirmed. Referring to the Level 2 recommendations in terms of theatre utilisation, Mrs Hunjan asked whether there would be a revision to the national systems. Mrs Chaudary advised that she was seeking to confirm that the manual system in place at present was a satisfactory alternative at present. Mrs Hunjan remarked that it was pleasing to see that some audits had delivered Full Assurance.	

5.2 Staff Expenses Internal Audit review – Moderate Assurance	**SWBAC (9/11) 042** **SWBAC (9/11) 042 (a)**
Mrs Chaudary reported that the audit of the staff expenses system had reviewed the situation prior to the introduction of an electronic staff expenses system, therefore many actions would be addressed by this development. The Committee was advised that the review had raised a number of issues, including a lack of clarity around handling the various expenses in the policy. However, Mrs Chaudary advised that the expenses policy was planning to be revised to provide the additional clarity required and ensure consistency of application. Mrs Hunjan asked Mr Wharram whether he was comfortable that the policy was being consistently applied in practice at present. Mr Wharram advised that the standardised electronic system would assist the position. Mrs Hunjan asked in what timescale it was likely that the new system would be implemented. Mr Wharram advised that there was an expectation that the system would be in place by the end of December 2011. It was agreed that a check should be made at the February 2012 meeting of the Audit Committee that the recommendations had been addressed as planned. Mr White asked whether the scope of the audit had included a more efficient means of meeting travel costs. He was advised that this was not the case.	
ACTION: Mrs Chaudary to present progress with addressing the Travel Expenses review recommendations at the February 2012 meeting of the Audit Committee	
5.3 Counter Fraud annual report	**SWBAC (9/11) 046** **SWBAC (9/11) 046 (a)**
Mr Ferguson presented the Counter Fraud annual report for information. The Committee was asked to note that the Counter Fraud function had undertaken much work on induction, with presentations having been given to 572 new staff in year. Mr Ferguson also advised that a fraud survey had been conducted. The detail of the live Counter Fraud cases was presented. The Committee was asked to note that the Counter Fraud annual plan included 29 days carried over from the previous year, however overall there had been a reduction in the number of days in the plan. Mrs Hunjan suggested that there needed to be a balance between the days allocated to 'creating and maintaining a strong culture' and 'investigations, sanctions and redress'. Mr Ferguson agreed however highlighted that the current arrangements ensure that sufficient attention is given to addressing investigations while undertaking proactive work. Mrs Hunjan asked whether the Trust had a named Local Counter Fraud	

Specialist (LCFS). She was advised that this was Mr Paul Westwood, supported by Mr Ferguson who was also highlighted to be a LCFS. It was agreed that Mr Westwood should attend meetings of the Audit Committee twice yearly. Mrs Hunjan asked what advice was given to members of staff wishing to report case of suspected fraud. Mr Ferguson advised that the details of the LCFS were promoted, including the appropriate telephone number. Mrs Hunjan asked whether a log was kept of instances when staff had contacted the LCFS. She was advised that a record was kept and a case reference sheet was completed for the cases of most significance. Mrs Hunjan encouraged a comprehensive record to be kept of all cases where a member of staff contacts the LCFS. In connection with case 2010-08, relating to an instance whereby an individual was alleged to be claiming free NHS treatment to which they were not entitled, Mrs Dutton noted that there were no notices displayed in public areas of the Trust to advise that not all attending for treatment are entitled to this free of charge. Mr White agreed to check the position.	
ACTION: **Mr White to check whether notices are available to advise that not all attending for treatment are entitled to this free of charge under the NHS**	
5.4 Counter Fraud progress update, including update on open cases	**SWBAC (9/11) 047** **SWBAC (9/11) 047 (a)**
Mr Ferguson reminded the Committee that at the last meeting he had been asked to review the way in which response rates to the Counter Fraud survey could be improved. He advised therefore, that he had contacted departments that had run similar surveys which had revealed that the response rate to the Counter Fraud survey had been on a similar level to that of other surveys. The Committee was advised that some surveys that had incentivised staff to reply had received a more favourable response rate. Mr Ferguson advised that future versions of the survey would include more relevant questions and would be cascaded through line managers. Mr Ferguson reported that the participation in the National Fraud Initiative was nearing completion, with 49 cases having been prioritised although no major issues had been flagged to date. A proactive exercise to identify areas that potentially posed a fraud risk in terms of attendance was reported to be planned, with the terms of reference having been developed. The summary of cases brought forward from the previous year was reviewed and the detail discussed. Mr Ferguson was asked to report back on closure of actions related to case 2011-04 at the next meeting.	
ACTION: **Mr Ferguson to report back on progress with completing**	

actions in connection with Counter Fraud case 2011-04 at the next meeting	
5.5 Outcome of the Qualitative Assessment 2011	**SWBAC (9/11) 047** **SWBAC (9/11) 047 (a)**
Mr Ferguson presented the latest position regarding the Qualitative Assessment for 2011. He advised that the submission had been made on 6 May 2011 and that results were anticipated by October 2011. The Committee was advised that the Qualitative Assessment process would not be used in future years by NHS Protect and that a new process was likely to be introduced in future. Mr Ferguson was asked to update the Committee on any further developments when known.	
ACTION: Mr Ferguson to present an update on the outcome of the Qualitative Assessment and plans to replace the process nationally at the next meeting	
5.6 Progress with the Qualitative Assessment action plan 2010	**SWBAC (9/11) 047** **SWBAC (9/11) 047 (a)**
Mr Ferguson advised that as part of the Qualitative Assessment action plan 2010, the Counter Fraud policy was to be amended and would be presented for approval shortly.	
6 Governance matters	
6.1 Proposed changes to the Trust's SFIs/SOs and Scheme of Delegation	**SWBAC (9/11) 043** **SWBAC (9/11) 043 (a)** **SWBAC (9/11) 073 (b)**
Mr White reported that a comprehensive review of the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation had been undertaken. He advised that the authorisation limits had not been amended significantly, however he asked the Committee to review and approve the proposed changes that were highlighted. Mrs Hunjan noted that there needed to be a consistent use of the title 'the Director with responsibility for Estates' on page 62. Mr Wharram was asked to explain more fully the process for virements. He advised that the Scheme of Delegation needed to report the arrangements in oversight only. Mr Capener remarked that he was comfortable that the level of detail proposed in connection with this matter discharged the recommendation that had been raised in the relevant Internal Audit review. It was noted that a number of the proposed changes reflected the amended responsibilities of the Trusts Board's Committees. Mr White	

highlighted that codification of the requirement for the Director of Finance to be a qualified accountant had been built into the Standing Orders. Subject to minor amendment, the Committee approved the proposed changes to the SFIs/SOs and Scheme of Delegation and agreed to recommend their acceptance to the Trust Board.	
AGREEMENT: Subject to minor amendment, the Committee approved the proposed changes to the SFIs/SOs and Scheme of Delegation and agreed to recommend their acceptance to the Trust Board	
6.2 Letter from the Chair of NHS West Midlands: Data Quality Assurance	**SWBAC (9/11) 045** **SWBAC (9/11) 045 (a)**
Mr White presented a letter received from the Trust from the Chair of NHS West Midlands concerning assurance on data quality. He highlighted that the requirements of the letter were consistent with the Audit Commission's earlier publication, 'Taking it on Trust'. The Committee was asked to note the letter and accept that an update on the plans to address the recommendations in the letter would be presented at the December 2011 meeting. Mr Capener remarked that assurance on the overall data quality process to fulfil these actions would be required.	
ACTION: Mr White to present an update on the plans to address the recommendations within the letter received from NHS West Midlands concerning data quality assurance at the December 2011 meeting of the Audit Committee	
7 Minutes from Trust Board Committees	
7.1 Finance and Performance Management Committee	**SWBFC (4/11) 041** **SWBFC (5/11) 051** **SWBFC (6/11) 065** **SWBFC (7/11) 081** **SWBFC (8/11) 089**
The Committee noted the minutes of the Finance and Performance Management Committee meetings held on the 21 April 2011, 19 May 2011 and 23 June 2011, 21 July 2011 and 18 August 2011. Mr White highlighted that two Divisions were currently in formal financial recovery and that the Finance and Performance Management Committee was monitoring the recovery plans robustly. Mrs Hunjan reported that the Non Executive membership of some of the Trust Board Committees had changed recently.	

7.2 Charitable Funds Committee	**SWBCF (5/10) 012**
The Committee noted the minutes of the Charitable Funds Committee meeting held on 12 May 2011.	
7.3 Quality and Safety Committee	**SWBQS (5/11) 015** **SWBQS (7/11) 027**
The Committee noted the minutes of the Quality and Safety Committee meetings held on 19 May 2011 and 21 July 2011.	
9 Any Other Business	**Verbal**
Mrs Hunjan asked whether Internal and External auditors were CRB checked. Mr Capener advised that a number of CW Auditors were checked, particularly for roles where reviews undertaken required contact with sensitive information. Mrs Moore advised that there was little requirement for External Audit to be CRB checked, given that the auditors have no clinical involvement or access to patients. It was noted that the responsibility for arranging CRB checks for the auditors lay with CW Audit and KPMG. Mr White asked that the plans to complete CRB checks by their host organisations be determined by the auditors.	
ACTION: Mr Capener and Mrs Moore to determine the plans for undertaking CRB checks for auditors	
10 Date and time of next meeting	**Verbal**
The date and time of the next meeting will be 1 December 2011 at 1100h in the Executive Meeting Room, City Hospital.	

Signed:……..

Name:……

Date:……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Charitable Funds Committee – Version 0.1

Venue Executive Meeting Room, City Hospital **Date** 8 September 2011 at 0930h

Present		**In attendance**	
Dr S Sahota	[Chair]	Mr P Smith	
Mrs G Hunjan		Mr M Burgess	[Barclays Wealth]
Mrs S Davis			
Mr R White		**Secretariat**	
Mr M Sharon		Mr S Grainger-Payne	
Mr D O'Donoghue [Part]			

Minutes	**Paper Reference**
1 Apologies	**Verbal**
Apologies were received from Mr Roger Trotman, Mrs Olwen Dutton, Prof Derek Alderson, Mr John Adler, Miss Rachel Overfield and Miss Rachel Barlow.	
2 Minutes of the previous meetings	**SWBCF (5/11) 012**
The minutes of the meeting held on 12 May 2011 were approved subject to minor amendment.	
AGREEMENT: The minutes of the previous meetings were approved subject to minor amendment	
3 Matters arising from the previous meeting	**SWBCF (5/11) 012 (a)**
The Trustees received and noted the updated actions log. The Committee was advised that following discussions at the last meeting, the role description for a fundraising manager was being developed by the Head of Communications and that the recruitment to this post would be progressed shortly.	
4 Investment update – Barclays Wealth	
4.1 Investment review and valuation from Barclays Wealth for the three	**SWBCF (9/11) 014**

month period 1 April 2011 to 30 June 2011	
Mr Burgess reported that in terms of the economic climate, a number of the uncertainties tested at the previous meeting remained current issues. The downgrading of the United States' credit status was noted to have been a key event during the period since the last meeting, although the impact on the UK economy was reported to have been negligible. The Committee was advised that a number of economies had been previously downgraded, however had been returned to their previous status in due course. Mr Burgess reported that the event had however, encouraged greater scrutiny on the Greek and more latterly the Spanish economies. The Committee was informed that should the Greek economy be adversely impacted, this would have limited impact on the UK economy, however issues with the Spanish or Italian economy may have a more serious effect. The Committee was advised that the FTSE had fallen during the period and although it had recovered to some degree, there remained some volatility. As such, Mr Burgess reported that the value of the Trust's investment portfolio had fallen from £4.84m to £4.54m as at the end of June 2011. The reduced equity content of the portfolio and the increased amount of bonds was noted to have assisted with creating some stability. The Committee was advised that the reduction in asset values was across a range of products, with the exception of government bonds and gold. During the last quarter, Mr Burgess reported that there had been an underperformance on the portfolio, attributed predominantly to the poor performance of the Sterling fixed interest element, corporate bonds. It was highlighted that if the economic environment persisted as it was currently, there was a likelihood that the underperformance could continue due to the inclusion of corporate bonds element within the portfolio. In the long to medium term, the Committee was advised that the return from government bonds would be poor, whereas that from corporate bonds was anticipated to be better. As such, Mr Burgess reported that he did not advocate a change to the asset classes at present. Mr White noted that it had previously been agreed to move a significant proportion of the portfolio out of equities and into other asset classes. Mr Burgess confirmed that this was the case and that this action had proved to have been a positive measure. Dr Sahota asked whether consideration should be given to moving some of the portfolio into stocks that would be likely to yield a good return when markets had recovered. Mr Burgess advised that the balance of the portfolio needed to be maintained, however he suggested that providing the emerging markets were expected develop further, then investment in the mining sector could be considered. Dr Sahota asked whether it would be prudent to increase the investment into emerging markets. Mr Burgess advised that 8% had been considered to be an appropriate level of investment and that the portfolio was	

indirectly exposed to the emerging markets in any event. The Committee was advised that it was likely that the UK would not suffer a 'double dip' recession, however the risks of this had increased. Corporate profitability was highlighted to remain strong at present. Mr Sharon asked what strategy would be recommended should the UK enter a 'double dip' recession. He was advised that all portfolios would need to be revisited to ensure that investment was in those companies that were best insulated from the likely impact on the Euro as a result of the recession. Mr Burgess reiterated that there remained a belief that the recession would be avoided, however contingency measures were being developed. Dr Sahota asked whether growth in German markets was anticipated. He was advised that this was uncertain at present. Mr Burgess suggested that consideration might need to be given to reinvesting income into the portfolio in future. Mr Burgess was thanked for his useful advice and presentation.	
5 Quarterly finance report	**SWBCF (9/11) 016** **SWBCF (9/11) 016 (a) - SWBCF (9/11) 016 (d)**
Mr Smith reported that during the quarter, income of £196k had been received, of which £131k related to donations of £1k or greater. Expenditure during the period was reported to be £292k, £265k of which related to payments of £1k or greater. The cash balance of the portfolio was reported to be £427k as at 30 August 2011, although £302k was owed to the Trust's exchequer account, leaving £126k Charitable Funds cash available. The Committee was asked to note that at present, expenditure was higher than income. Mr Smith reported that measures had been taken to ensure that the list of fund managers was amended in the light of the information available concerning staffing leaving the Trust. The Committee was asked to note that the list of funds now reflected the decision made at the previous meeting to amalgamate funds with a value of less than £500. Dr Sahota noted that some funds had only one fund manager assigned to them. Mrs Davis suggested that for the next meeting, a description of the funds with a value above £50k be presented. Mr Smith advised that for some of these funds, there would be little such information available. Mr White proposed that a briefing note should be brought to the next meeting detailing the guidance available as to how such funds should be handled. Mrs Hunjan noted, in connection with Fund 96, that three payments for tuition fees had been made from the fund and asked how these had been authorised. Mr	

White offered to investigate.	
ACTION: **Mr Smith to present the details of funds with a value of £50k at the next meeting** **ACTION:** **Mr White to present a briefing note at the next meeting providing guidance as to how funds without a specific purpose are to be handled** **ACTION:** **Mr White to investigate the mechanism by which the tuition fees paid from Fund 96 are authorised**	
6 Draft annual report and accounts	**SWBCF (9/11) 017** **SWBCF (9/11) 017 (a)**
Mr White reported that the draft accounts were presented for the Committee's initial view and would be brought back to the December 2011 meeting for formal adoption prior to submission to the Charity Commission in January 2012. The Committee was advised that the audit of the accounts was ongoing at present. In terms of the key financial statements, the Committee was advised that £4,824k was carried forward as at 31 March 2011. The total income for the year was reported to be £1,116k, which was noted to be higher than that received in the previous year at £989k. Expenditure for the year was reported to be £1,104k. The gains made during the year were noted to be reflective of the improved stock market situation during the year. Mr Smith was asked whether mention of the transfer of community staff into the Trust needed to be included within the annual report. He agreed to check the position with the Trust's auditors. Dr Sahota asked whether any income had been received by the Sandwell's Helping Hands Charity. Mr Smith advised that he did not expect this to have been the case. Mrs Davis advised that this fund was not historically within the control of the Trust however given the TCS transfer in April 2011 this should be amalgamated into the suite of Trust funds. Mrs Hunjan asked whether any funds had transferred as part of the TCS transfer. Mr Smith advised that to his knowledge there were no additional charitable funds that had been transferred. Mr Smith was asked to confirm that Dr John Middleton's fund would be transferred when he moved from Sandwell PCT. Mr Sharon asked whether there were any rules that provided guidance on levels of income expected to maintain a healthy balance of funds and the recommended level of activity. Mr White advised that the clinicians were not engaged closely with investment activity and had not been requested to achieve a standard return on investment. It was suggested that fund managers should be encouraged to spend funds, although care needed to be taken to monitor overall expenditure in the context of the performance of the stockmarket.	

ACTION: **Mr Smith was asked to confirm that Dr John Middleton's fund would be transferred when he moved from Sandwell PCT** **ACTION:** **Mr Smith to check the position with the Trust's auditors in terms of whether the Charitable Funds annual report should reference the transfer of community staff into the Trust in April 2011**	
7 Proposal for the management of inactive funds	**SWBCF (9/11) 015** **SWBCF (9/11) 015 (a)**
Mr Smith presented a proposal for the management of inactive Charitable Funds. It was suggested and agreed that there needed to be an annual review of dormant funds at the September meeting of the Charitable Funds Committee. Mr Smith proposed that notification of the dormant funds should be made to the appropriate Divisional General Manager and Executive Director, with failure to respond with a plan to spend the funds prompting the closure of the funds and subsequent transfer to being within the control of the Trustees. Mrs Davis suggested that a reminder to fund managers to review funds should be included in a future 'Hot Topics' bulletin. Mr White suggested that this responsibility be built into the role of the Fundraising Manager. The proposal for managing the inactive funds was approved.	
AGREEMENT: The Trustees approved the proposal for managing the inactive Charitable Trust funds	
8 Any other business	**Verbal**
Mr Sharon asked whether, in the light of the recent local social unrest, some aspect of the Midland Metropolitan Hospital should be named after one of the individuals killed. He further suggested that consideration could be given to arranging a fundraising campaign around the tragedies. Mr O'Donoghue suggested that an alternative option was to consider naming a charitable endeavour or award after an individual, a proposal which was supported by the Trustees. It was suggested that wider consideration needed to be given to assigning parts of the new hospital, in terms of wards, floors and areas with names at an appropriate stage of the project.	
9 Details of the next meeting	**Verbal**
The next meeting is to be held on 1 December 2011 at 0930h in the Executive Meeting Room at City Hospital.	

Signed ……..

Print ……..

Date ……..