Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Anne Gibson Boardroom, City Hospital **Date** 31 May 2012; 1530h - 1730h

Members			**In Attendance**		
Mr R Samuda	(RS)	[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)		**Secretariat**		
Mr J Adler	(JA)		Mr S Grainger-Payne	(SGP)	[Secretariat]
Dr D Situnayake	(DS)				
Mr R White	(RW)		Guests		
Miss R Barlow	(RB)		Mr J Pollitt	(JP)	[Items 7 & 8]
Miss R Overfield	(RO)		Dr J Berg	(JB)	[Item 11]
Mr M Sharon	(MS)		Dr N Ratnaraja	(NR)	[Item 12.3]
			Mrs J Dunn	(JD)	[Item 14.2]

Item	Title	Reference Number	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 26 April 2012 as a true and accurate record of discussions*	**SWBTB (4/12) 081**	**Chair**
4	**Update on actions arising from previous meetings**	**SWBTB (4/12) 081 (a)**	**Chair**
5	**Chair and Chief Executive's opening comments**	**Verbal**	**Chair/ CEO**
6	**Questions from members of the public**	**Verbal**	**Public**
	PRESENTATION		
7	**Widening Participation**	**Presentation**	**JP/RO**

8	**Update on Learning & Development**	**SWBTB (5/12) 090** **SWBTB (5/12) 090 (a)**	**JP**
MATTERS FOR APPROVAL			
9	**Register of Interests**	**SWBTB (5/12) 084** **SWBTB (5/12) 084 (a)**	**SG-P**
10	**Single Tender Action – recharge for academic posts salaries**	**SWBTB (5/12) 085** **SWBTB (5/12) 085 (a)**	**RW**
11	**Business case for integrated blood sciences**	**SWBTB (5/12) 086** **SWBTB (5/12) 086 (a)**	**JB**
MATTERS FOR CONSIDERATION AND NOTING			
12	**Safety, Quality and Governance**		
12.1	Quality report	To follow	RO, KD & DS
12.2	Approved minutes of the meeting held on 22 March 2012 and update on discussions held at the meeting held on 24 May 2012	SWBQS (3/12) 034	DA/RT
12.3	Annual Infection Control report	SWBTB (5/12) 087 SWBTB (5/12) 087 (a)	NR
12.4	Integrated risk report	SWBTB (5/12) 088 SWBTB (5/12) 088 (a)	KD
12.5	Being Open policy	SWBTB (5/12) 089 SWBTB (5/12) 089 (a) SWBTB (5/12) 089 (b)	AB
12.6	Assurance Framework – Quarter 4 update	SWBTB (5/12) 083 SWBTB (5/12) 083 (a)	SG-P
12.7	National inpatient survey	SWBTB (5/12) 091 SWBTB (5/12) 091 (a)	JK
13	**Performance Management**		
13.1	Monthly finance report	SWBTB (5/12) 092 SWBTB (5/12) 092 (a)	RW
13.2	Draft minutes from the meeting of the Finance & Performance Management Committee held on 24 May 2012	To follow	RT
13.3	Monthly performance monitoring report	SWBTB (5/12) 093 SWBTB (5/12) 093 (a)	RW
13.4	NHS Performance Framework report	SWBTB (5/12) 094 SWBTB (5/12) 094 (a)	RW
13.5	Performance Management Regime – monthly submission	SWBTB (5/12) 095 SWBTB (5/12) 095 (a)	MS
13.6	Update on the delivery of the Transformation Plan	Verbal	RB

13.7	Medical Revalidation: Update of Organisational Readiness and Next Steps	SWBTB (5/12) 096 SWBTB (5/12) 096 (a) SWBTB (5/12) 096 (a)	DS
14	**Strategy and Development**		
14.1	'Right Care, Right Here' programme: progress report including update on decommissioning	SWBTB (5/12) 097 SWBTB (5/12) 097 (a)	MS
14.2	Clinical reconfiguration update		
▶	Progress report	SWBTB (5/12) 098 SWBTB (5/12) 098 (a)	JD
▶	Equality Impact Assessment for Vascular Surgery Reconfiguration and high level implementation plan	SWBTB (5/12) 099 SWBTB (5/12) 099 (a)	JD
▶	Update on discussions from the Clinical Reconfiguration Board held on 17 May 2012	Verbal	GH
14.3	Workforce strategy and annual workplan	SWBTB (5/12) 100 SWBTB (5/12) 100 (a)	MS
14.4	Foundation Trust application programme		
▶	Programme Director's report	SWBTB (5/12) 105 SWBTB (5/12) 105 (a)	MS
14.5	Midland Metropolitan Hospital project: Programme Director's report	Verbal	GS
15	**Update from the Committees**		
15.1	Audit Committee		
▶	Approved minutes of the meeting held on 9 February 2012 and update on discussions held at the meeting held on 17 May 2012	SWBAC (2/12) 016	GH
15.2	Charitable Funds Committee		
▶	Approved minutes of the meeting held on 9 February 2012 and update on discussions held at the meeting held on 17 May 2012	SWBCF (2/12) 003	SS
16	**Any other business**	**Verbal**	**All**
17	**Details of next meeting** *The next public Trust Board will be held on 7 June 2012 at 1200h in the Anne Gibson Boardroom, City Hospital*		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.2

Venue Boardroom, Sandwell Hospital **Date** 26 April 2012

Present

Mr Richard Samuda (Chairman)
Mr Roger Trotman
Mrs Gianjeet Hunjan
Dr Sarindar Sahota OBE
Mr Phil Gayle
Mr John Adler
Mr Robert White
Miss Rachel Barlow
Miss Rachel Overfield
Mr Mike Sharon
Dr Deva Situnayake

In Attendance

Miss Kam Dhami
Mrs Jessamy Kinghorn
Mr Graham Seager
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 and Mrs Olwen Dutton.	
2 Declaration of Interests	**Verbal**
The Board was asked to note the Chairman's entry for the register of interests that had been circulated.	
3 Minutes of the previous meeting	**SWBTB (3/12) 053**
The minutes of the previous meeting were presented for approval and were accepted as a true and accurate reflection of discussions held on 29 March 2012.	

AGREEMENT: The Trust Board approved the minutes of the last meeting	
4 Update on actions arising from previous meetings	**SWBTB (2/12) 025 (a)**
The updated actions list was reviewed and it was noted that the action concerning the 'walk through' of a complainant's experience would be built into the revised Complaints Handling policy that was currently under development.	
5 Chair's opening comments	**Verbal**
Mr Richard Samuda thanked the Board for making him welcome in his role of new Chairman. He thanked Mr Trotman for his time as Acting Chair.	
6 Questions from members of the public	**Verbal**
There were no questions.	
Items for Approval	
7 Ward Leadership capacity expansion plan	**SWBTB (4/12) 070** **SWBTB (4/12) 070 (a)**
Miss Overfield presented a proposal to expand and extend management capacity and capability on the Trust's wards. It was reported that the proposal had been reviewed and supported by the senior nursing teams. The key drivers behind the proposal were outlined to concern the significant scrutiny and comment on nursing leadership recently as a consequence of national imperatives that had been introduced and other events such as reviews by the Care Quality Commission and the frail and elderly agenda. It was highlighted that the demands on nursing leaders had also increased as a result of announcements by the Prime Minster expanding the range of national metrics against which Trusts would be judged and the expected requirements of the Francis report, which was expected to make recommendations around nurse staffing and senior leadership. Other reasons behind the development of the proposal concerned the bias of the CQuIN targets to nursing practice, including the introduction of the Patient Safety Thermometer, the Net Promoter Score and the eradication of pressure sores. The Board was advised that little time was currently available to ward leaders to focus on this range of requirements and national focus. Miss Overfield advised that the matron positions currently in place, had been introduced as a result of a national mandate proposed by the Secretary of State for Health some years ago, with the positions currently co-ordinating resources across a number of wards. The pay bands of the senior nursing staff were reported to be Agenda for Change (AfC) 7 and 8a for ward managers and matrons respectively. The key element of the proposal was highlighted to propose that the ward manager and matron roles be merged, to create a position at a senior level which was focussed on 30-40 beds, supported by Band 7 senior sisters or charge	

nurses. As a result of this proposal, the Board was advised that a number of Band 5 nurses would need to be recruited to back fill the time available for clinical care. Additionally, it was proposed that that two Assistant Heads of Nursing be recruited to handle wider operational and divisional issues, such as the Transformation Plan requirements. Further administration support for the ward managers was also proposed.. The Board was informed that the proposal required an investment of £700k. It was highlighted that the cost of the proposal had been built into the financial plan for 2012/13 and had received approval by the Strategic Investment Review Group (SIRG). In terms of timescales for delivering the plans, the Board was advised that the new structure would be implemented by July 2012, in line with the bed reconfiguration plans. The Chairman asked whether a comparable model was in place in any other organisations. Miss Overfield advised that an identical model was not in place and that other colleagues across the region had been in contact to gain an insight into the plans. Mr Gayle asked whether the new posts would cover both sites. He was advised that this was the case. Dr Sahota remarked that the proposals were clear and concise and suggested that it was a good time to introduce any changes needed. He asked whether an opportunity for progressing matters such as addressing the currently high rate of sharps injuries was available as part of the plans. Miss Overfield confirmed that it was a good opportunity to address issues such as this. She reported that a Standard Operating Procedure (SOP) would be developed for each ward, which would be owned by the senior ward leaders and would co-ordinate the work of the multi-disciplinary team. Referencing the recent Prime Minister's review, Mrs Hunjan asked when the outcome would be known. Miss Overfield advised that this was expected shortly and was anticipated to propose best practice and a set of standards on nursing care. Furthermore, it was suggested that a target for nurse staffing levels was expected to be set. Mr Trotman asked whether the benefits of the proposal could be measured. He was advised that this was the case and it was agreed that a Post Project Evaluation should be prepared for review by the Board in April 2013.	
ACTION: **Miss Overfield to prepare a Post Project Evaluation for the ward leadership capacity expansion plan for review by the Trust Board in April 2013** **AGREEMENT: The Trust Board approved the investment required for the ward**	

leadership capacity proposal	
8 Application of the Trust Seal to the Community Contract Deed of Variation	**SWBTB (4/12) 074**
Mr White asked for and was given the Board's approval to arrange for the Trust Seal to be applied to the nationally directed deed of variation for the Community Service contract.	
AGREEMENT: The Trust Board gave its approval to the application of the Trust Seal to the Deed of Variation for the Community Service contract	
9 Safety, Quality and Governance	
9.1 Quality Report	**Tabled paper**
The Trust Board was asked to review and consider the latest version of the Quality Report. Miss Overfield reported that the Safety Thermometer had been launched in March 2012, as part of which over 1000 patients had been audited against four harm events. The target was reported to be 95% harm free care and the Board was advised that the Trust had performed well against this target. It was highlighted that as a result of introducing the Safety Thermometer, one the CQuIN targets for 2012/13 had already been met. Miss Overfield advised that a 28% reduction in the number of falls had been seen in comparison to the previous year. However, an upward trend at Sandwell Hospital was reported to have been observed, therefore further investigation was underway. All nutrition standards were reported to have been met. Infection control targets were likewise reported to have been achieved. Improved performance against the missed drugs doses target was pointed out to the Board. The Chairman asked for further information on the way in which this judgement had been made. He was informed that audits were undertaken to determine whether there had been missed drugs doses. Miss Overfield advised that further work was required to address the coding used in instances where drugs had not been given. Dr Situnayake reported that a Never Event had occurred as part of an Ophthalmology procedure, which concerned the implantation of an incorrect lens. The Board was informed that all five steps of the Safer Surgery checklist had been undertaken in this instance and that the patient had been fully briefed on the error. It was highlighted that the patient had appeared to have suffered no adverse consequences following the rectification of the situation. To prevent a reoccurrence of the Never Event, the Board was informed that a quality control process would be introduced into areas where the checklist was being used. The Board was advised by Dr Situnayake that there was currently good	

compliance with the use of the World Health Organisation (WHO) checklist, with the position being 98% completion of the three key requirements. Compliance with all five elements of the Safer Surgery policy was reported to be 87% however, therefore further work was required to address the position.

The Trust's position against the Hospital Standardised Mortality Rate (HSMR) was reported to be continuing to fall (improve) and a commitment to undertake a senior review of deaths as part of the mortality review process was advised to be in place. The Board was informed that as part of this work, Sepsis was being reviewed, with processes being put into place to improve the Trust's performance in this area.

Miss Overfield advised that the use of nurse bank staff had increased during the period, and it was highlighted that there was a concern that a slippage in some nursing standards would be seen in the next round of nursing reviews, given the recent operational pressures and capacity issues.

Approximately 1000 patients were reported to have responded to the internal inpatient satisfaction survey, although the number of patients rating the quality of care as excellent was reported to have declined. Likewise, the Board was informed that the Net Promoter Score had decreased, with 59.5% of patients and relatives positively promoting the Trust to friends and other relatives.

Miss Dhami reported that as at the end of March 2012, 77 complaints were in breach of the failsafe response time parameters, however the Board was informed that this had recently reduced to 55 cases. It was reported that a formal report had been received from the Care Quality Commission (CQC) confirming compliance with Outcome 17, Complaints.

Miss Overfield reported that in terms of targeted support, the Emergency Assessment Unit at Sandwell Hospital was making steady progress in improving performance against standards. Lyndon 5 was reported to have been closed in line with winter bed plans. Significant improvement on Newton 1 and Newton 4 wards was highlighted, although it was noted that the improved position did not appear to be being recognised by the public at present, as evidenced by the feedback in the inpatient survey results for these areas. Mrs Powney asked whether the patient experience surveys were subjective. Miss Overfield advised that they were based on experience across a number of measures and in terms of objective measures, the wards were performing on a comparable level to others.

Mr Trotman sought further clarity on the position regarding compliance with the Safer Surgery steps. Dr Situnayake advised that the Trust was currently relatively weak in terms of the use of the pre-operative briefings and post-operative debriefings.

Mr Gayle asked how many complaints progressed to litigation. Miss Dhami offered to determine the position.

Dr Sahota asked how the progress with addressing the mortality alerts was being monitored. Dr Situnayake advised that this was undertaken by the Mortality and Quality Alerts Committee. Mr Sharon suggested that the inclusion of a trend position in terms of the Net Promoter Score would be useful in future reports. The Chairman suggested that the format of the report should be considered in terms of the requirements of the Trust's commissioners. Miss Dhami advised that the format and content of the report would also be informed by the recent external assessment of the Trust's position on quality governance. The Chairman asked how the report linked with the Quality Account. Dr Situnayake advised that there was a clear link between the two documents, in terms of content. In terms of the inpatient satisfaction survey outcome which suggested that many patients did not know the name of their consultant, Dr Situnayake advised that a Trust-wide communiqué had been issued to all consultants to make them aware of this finding and to attempt to improve the position. Dr Sahota advised that a Board Walkabout had identified that consultant names were not always on bed boards, however the position had appeared to have improved recently. Mrs Powney suggested that the consultant name could be included on the patient's wristband. Mrs Kinghorn advised that a greater use of NHS Choices to voice opinion had been seen recently.	
ACTION: **Miss Dhami to determine the number of complaints cases progressing to litigation**	
9.2 Care Quality Commission's report into Outcome 17 and the complaints handling position	**SWBTB (4/12) 056** **SWBTB (4/12) 056 (a)**
Miss Dhami asked the Board to receive and note the report issued by the Care Quality Commission confirming the Trust's compliance with Outcome 17, Complaints. The Board was informed that since the backlog of complaints had been addressed in December 2011, revised, more stringent, failsafe targets had been introduced, which had created an increase in the number of breaches seen. The reasons for the increase in the number of breaches was outlined to concern the current staffing structure of the Complaints Team, the centralised handling of complaints and the portfolio of work handled by the team. It was reported that the CQC and the Parliamentary Health Service Ombudsman (PHSO) were being appraised of the situation.	

Miss Dhami reported that consideration was being given to the devolution of less serious complaints to divisions and that the staffing model currently employed was being reviewed. The Chairman noted that the plans to devolve complaints handling would be supported by the proposed revisions to the senior nurse staffing structure, outlined earlier by Miss Overfield. Mrs Hunjan asked how many staff were employed in the Complaints Team. She was advised that the team consisted of four investigating officers, together with the Head of Complaints, PALS and Litigation. Mrs Hunjan suggested that it would be helpful to know when the proposed changes to the complaints handling process and the team structure would be delivered. Miss Dhami offered to provide a further update at the next meeting. Mr Gayle asked whether there was sufficient capacity to handle complaints effectively at present. Miss Dhami advised that this was not the case with the current staffing model and that handling of inquests and litigation in particular needed to be given further thought. Mrs Powney asked whether complaint trends were analysed. She was advised that this was the case and that these were discussed by the Quality and Safety Committee.	
ACTION: **Miss Dhami to provide an update on complaints handling at the next meeting**	
9.3 Care Quality Commission revised regulatory approach 2012/13	**SWBTB (4/12) 057** **SWBTB (4/12) 057 (a)**
Miss Dhami informed the Board that the CQC was planning to change its approach to shift to a more proportionate approach. It was reported that regular inspections would be held, including an annual inspection against CQC Essential Standards. As such, it was highlighted that the approach moved away from the current model of self-regulation. It was reported that the reviews would not cover all Essential Standards but would be confined to five. The Board was advised that the Provider Compliance Assessment (PCA) would not be requested as a matter of course, however Quality Assurance systems would be needed to be in place to ensure continued compliance. It was highlighted that the Judgement Framework would continue to be used and the use of enforcement powers would be more likely. As a consequence of the new approach, the Board was advised that it was paramount to ensure that up to date real time information was available to confirm compliance. It was reported that the purchase of a Software solution for this purpose was being investigated at present. It was suggested that the profile of the CQC Essential Standards across the Trust needed to be raised and therefore discussions would be included within the agendas of divisional and directorate performance reviews.	

Mr Adler advised that there was a direct connection with the work to the FT Compliance Framework, the Provider Management Regime returns, the NHS Performance Framework and therefore the Trust's application for Foundation Trust status. The Chairman asked what timescale was involved with securing the software solution to support the work. Miss Dhami advised that it was likely a decision would be made within a few weeks.	
9.4 Register of Seals	**SWBTB (4/12) 058** **SWBTB (4/12) 058 (a)**
Mr Grainger-Payne presented the register of sealed documents covering the period 1 April 2011 to 31 March 2012 for receiving and noting by the Board.	
10 Performance Management	
10.1 Monthly finance report	**SWBTB (4/12) 059** **SWBTB (4/12) 059 (a)**
Mr White reported an unaudited surplus of c. £1.9m had been achieved at the year end, against a plan of £1.8m. It was reported that the draft annual accounts, together with the Annual Governance Statement and directors' remuneration report had been submitted to the External Auditors. In terms of performance in Month 12, the Board was informed that income variances had been seen, which were associated with Department of Health funds received and year end settlements made with the PCTs. The Board was asked to note the accelerating spending against the Capital Expenditure plan was reflected in the Trust's cash position. The Board was pleased to note that the two divisions which had had problems in Quarter 1 (and one of which had been placed in Special Measures) had delivered a performance in line with the revised control totals that had been set. Mr Trotman asked whether there was an expectation that the Medicine & Emergency Care and the Surgery, Anaesthetics & Critical Care divisions would perform adequately without the benefit of central funding in 2012/13. Mr White advised that this appeared to be the case and that there would be increased flexibility to introduce new Transformation Savings Plan schemes during the year if required. It was reported that it had been made clear to all divisions that there was little financial flexibility in the form of central funds in 2012/13. Mr White reported that in terms of the Shadow Financial Risk Rating, the Trust had achieved a level 3 based on its performance. Mr Trotman questioned the average number of employees position report. Miss	

Overfield advised that this was reflective of the additional beds open during the year due to operational pressures. It was suggested that this should be clarified within future reports if necessary. Mr White provided an explanation of the handling of asset impairments that had been funded centrally.	
10.2 Monthly performance monitoring report	**SWBTB (4/12) 060** **SWBTB (4/12) 060 (a)**
Mr White reported that all cancer waiting times had been met, however the number of 62 day referrals had been noted to be lower than anticipated. The position against the cancelled operations target was reported to have improved and Delayed Transfers of Care had moved to a more acceptable level. The performance against the stroke care targets was reported to have been pleasing. In terms of infection control, the Board was asked to note that there had been 95 *C difficile* incidents against a trajectory of 109 over the year. Miss Overfield added that the new testing regime introduced by the Strategic Health Authority would mean that the Trust would be required to report against a single test, rather than using the current dual test approach, although this would be maintained internally. Mr Adler emphasised that this did not involve a change to the Trust's clinical practice, but reflected a change to the reporting requirements. It was highlighted that there had been no breaches of Single Sex Accommodation guidance. Sickness was highlighted to have reduced and much attention was noted to be being given to PDRs and Mandatory Training compliance. The Board was particularly pleased to note that the Trust had met all CQuIN targets. The Chairman summarised that the Trust had performed strongly against the bulk of national targets and asked that thanks be conveyed to the appropriate staff. Mr Trotman highlighted that there was an expectation that the performance monitoring report would be presented in full on a quarterly basis. Mr Grainger-Payne offered to arrange. Mr Adler advised that refresh of the performance report was planned shortly. Miss Dhami reported that there were some points raised through the recent external review of the Trust's quality governance systems which would feed into this work. Dr Sahota asked that further narrative be included against those indicators flagged as at red status.	
ACTION: Mr Grainger-Payne to arrange for the corporate performance	

monitoring report to be considered by the Board on a quarterly basis	
10.3 NHS Performance Framework	**SWBTB (4/12) 061** **SWBTB (4/12) 061 (a)**
Mr White presented the NHS Performance Framework update for receiving and noting. It was highlighted that the Trust's performance classified the Trust as a 'performing' organisation.	
10.4 NHS Performance Framework for 2012/13 and mapping of Quarter 4 performance (2011/12) to new indicators	**SWBTB (4/12) 062** **SWBTB (4/12) 062 (a)**
Mr White presented the planned changes to the NHS Performance Framework, which he highlighted incorporated user experience and the views of the CQC. A revised approach to the escalation of poor performance was reported to be introduced into the new framework. Mr Adler added that the process involved swift intervention and the possibility of disrupting trusts' applications for Foundation Trust status. When the Quarter 4 performance was mapped to the new framework, the Board was asked to note that the position against the Accident & Emergency target was at red status. Overall, however the position was noted to be pleasing.	
10.5 Provider Management Regime (PMR) – monthly submission	**SWBTB (4/12) 064** **SWBTB (4/12) 064 (a)**
The Trust Board was asked to note by Mr Sharon the improved performance against a number of the acute governance metrics. In terms of the Learning Disability issue that was flagged, complaince was reported to be declared in May 2012. Compliance against the use of the WHO checklist was noted to be at 99%. The Chairman asked what the expectation was in terms of meeting 100% against this indicator. He was advised that work was underway to finalise the suite of areas in which the checklist should be used, in an effort to gain 100% compliance. In terms of the position regarding training in Information Governance, it was reported that there was a plan to be compliant by September 2012. Mr Adler advised that all members of staff needed to be trained using an e-learning package, which presented logistical difficulties for some staff groups. It was reported that there was an expectation that the submission in May, might be amended to align the Board statements to those within the Annual Plan and Monitor's Compliance Framework statements. The Trust Board approved the submission of the monthly Provider Management Regime return.	

AGREEMENT: The Trust Board approved the monthly PMR return	
10.6 Outturn position on delivery against Corporate Objectives 2011/12	**SWBTB (4/12) 063** **SWBTB (4/12) 063 (a)**
Mr Sharon reported that of the 33 corporate objectives, the outturn delivery position had been assessed to be green for 22 objectives; amber for 7 objectives; and red for 3 objectives. Mr Trotman suggested that it was unrealistic to declare a red status against the 'Right Care, Right Here' trajectory and the new hospital objective, given that external factors had influenced the delivery in these areas.	
10.7 Update on the delivery of the Transformation Plan	**Verbal**
Miss Barlow reported that a full set of Transformation Savings Plans had been identified for 2012/13 and that the delivery of the cross cutting themes had gained momentum. The Board was advised that bed reconfiguration plans were under development and demand & capacity models had been developed for theatres. In terms of Urgent Care, Miss Barlow advised that a GP triage model had been introduced as a pilot. Much work was reported to be underway concerning workforce efficiency planning and agile working. Mrs Powney advised that the progress with the Transformation Plan was being included within LINks newsletters.	
11 Strategy and Development	
11.1 'Right Care, Right Here' programme: progress report including an update on decommissioning	**SWBTB (4/12) 065** **SWBTB (4/12) 065 (a)**
Mr Sharon reported that there had been an increase in activity in the Accident & Emergency area. It was reported that the Trust remained committed to working with the Clinical Commissioning Groups (CCGs) on the recommissioning programme, although progress was noted to be slower than planned at present. Mr Adler confirmed that the CCG was embracing the 'Right Care, Right Here' agenda.	
11.2 Foundation Trust application: progress update	
Programme Director's report	**SWBFT (4/12) 045**
Mr Sharon presented the Foundation Trust Programme Director's report for receiving and noting.	

It was highlighted that the overall status of the programme remained red in reflection of the outstanding agreement needed on the Tripartite Formal Agreement with the Strategic Health Authority. Some substantial pieces of work were reported to have been completed, including finalising activity and capacity assumptions. The revised Integrated Business Plan (IBP) was reported to provide a five year view, which uncoupled the strategy from the critical path of the new hospital project.	
11.3 Midland Metropolitan Hospital project: progress report	**Verbal**
Mr Seager reported that there had been no further announcement on the outcome of the Treasury's review of Private Finance Initiative (PFI).	
12 Operational Management	
12.1 Sustainability update	**SWBTB (4/12) 067** **SWBTB (4/12) 067 (a)**
Mr Seager provided an update on progress with delivering the sustainability agenda in the Trust. He advised that an energy reduction report would be presented at a forthcoming meeting of the Finance & Performance Management Committee. The review of carbon production in connection with drugs used by the Trust was reported to be evolutionary, however it was noted that a plan was in place to address this requirement. Mr Adler noted that procurement represented a considerable influence on the Trust's energy usage. Mr White advised however that the majority of stock arrived at the Trust in a unified way, although there was no certainty that beyond this the position was as efficient as possible.	
12.2 National staff survey and action plan	**SWBTB (4/12) 068** **SWBTB (4/12) 068 (a)**
Mr Sharon presented the Board with the results of the national staff survey. He advised that the outcomes were used by the CQC as part of the evidence to information the Trust's Quality and Risk Profile (QRP). It was noted that the response rate was below the national average, however the report presented a good improvement against seven of the key indicators and the Trust's results compared well with neighbouring organisations. The staff engagement position in particular was highlighted to be better than the national average. The responses given to questions around 'Listening into Action' was reported to have stabilised and therefore further work was reported to be	

planned to further improve the engagement approach at team level. The action plan to address the areas requiring attention was presented. It was highlighted that the actions would not be delivered through a specific development programme, however the they would be incorporated into existing workstreams in place within the Trust. Mr Adler observed that significant shifts in results had been seen previously, and this trend was continuing. It was agreed that the position on the action plan should be reviewed in October 2012. The Board was informed that a census of all staff rather than a sample was planned for the next survey which would provide richer information. Miss Overfield advised that 'pulse checks' of staff satisfaction would be undertaken to review targeted samples.	
13 Any other business	**Verbal**
Mr Trotman advised that a letter had been received from the Sandwell branch of the League of Friends advising that during the year £62,335.83 had been donated through this cause. Mr Grainger-Payne was asked to thank the League of Friends for this generous donation.	
ACTION: Mr Grainger-Payne to thank the Sandwell League of Friends for their donation	
14 Details of the next meeting	**Verbal**
The next public session of the Trust Board meeting was noted to be scheduled to start at 1530h on 31 May 2012 and would be held in the Anne Gibson Boardroom at City Hospital.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 31 May 2012, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

26 April 2012, Boardroom @ Sandwell Hospital

Members present: Mr R Samuda (RS), Mr R Trotman (RT), Dr S Sahota (SS), Mrs G Hunjan (GH), Mr P Gayle (PG), Mr J Adler (JA), Mr R White (RW), Miss R Barlow (RB), Mr M Sharon (MS), Miss R Overfield (RO)

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

Apologies: Prof D Alderson, Mrs O Dutton (OD)

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 25 May 2012

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~~ 22/03/2012	Process flow of complaints process being developed at as part of the revised Complaints Handling strategy which will be shared with the ~~Trust Board~~ Quality and Safety Committee in ~~December February March April May~~ July ~~2011~~ 2012	A
SWBTBACT.220	Ward Leadership capacity expansion plan	SWBTB (4/12) 070 SWBTB (4/12) 070 (a)	26-Apr-12	Prepare a Post Project Evaluation for the ward leadership capacity expansion plan for review by the Trust Board in April 2013	RO	01/04/13	ACTION NOT YET DUE	G
SWBTBACT.218	Monthly performance monitoring report	SWBTB (11/11) 228 SWBTB (11/11) 228 (a)	24-Nov-11	Discuss the additional material needing to be included within the performance exceptions report with Mr White	JK	~~26/01/2012~~ ~~23/02/2012~~ 31/05/2012	Wider discussion to be held including comments from Executive Directors not in attendance at F & PMC to include more detailed quality metrics. Superseded by discussion around the revised performance report.	B
SWBTBACT.221	Quality Report	Tabled paper	26-Apr-12	Determine the number of complaints cases progressing to litigation	KD	31/05/12	Deatil included wihtin the quarterly integrated risk reports	B
SWBTBACT.222	Care Quality Commission's report into Outcome 17 and the complaints handling position	SWBTB (4/12) 056 SWBTB (4/12) 056 (a)	26-Apr-12	Provide an update on complaints handling at the next meeting	KD	31/05/12	Included as part of Quality Report	B
SWBTBACT.223	Monthly performance monitoring report	SWBTB (4/12) 060 SWBTB (4/12) 060 (a)	26-Apr-12	Arrange for the corporate performance monitoring report to be considered by the Board on a quarterly basis	SG-P	31/05/12	Scheduled for July and October 2012	B

SWBTBACT.224	Any other business	Verbal	26-Apr-12	Thank League of Friends for the donation	SG-P	31/05/12	Written letter of thanks to Janet Dearn 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: 31 May 2012, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

26 April 2012, Boardroom @ Sandwell Hospital

Members present: Mr R Samuda (RS), Mr R Trotman (RT), Dr S Sahota (SS), Mrs G Hunjan (GH), Mr P Gayle (PG), Mr J Adler (JA), Mr R White (RW), Miss R Barlow (RB), Mr M Sharon (MS), Miss R Overfield (RO)

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

Apologies: Prof D Alderson, Mrs O Dutton (OD)

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 25 May 2012

Reference No	Item	Paper Ref	Date	Agreement
SWBTBAGR.269	Minutes of the previous meeting	SWBTB (3/12) 053	26/04/2012	The minutes of the previous meeting were accepted as a true and accurate reflection of discussions held
SWBTBAGR.270	Ward Leadership Expansion Plan	SWBTB (4/12) 070 SWBTB (4/12) 070 (a)	26/04/2012	The Trust Board approved the investment required for the ward leadership capacity proposal
SWBTBAGR.271	Application of the Trust Seal to the Community Contract Deed of Variation	SWBTB (4/12) 074	26/04/2012	The Trust Board gave its approval to the application of the Trust Seal to the Deed of Variation for the Community Service contract
SWBTBAGR.272	Provider Management Regime (PMR) – monthly submission	SWBTB (4/12) 064 SWBTB (4/12) 064 (a)	26/04/2012	The Trust Board approved the monthly PMR return

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Learning and Development Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Overfield, Chief Nurse**
AUTHOR:	**James Pollitt, Head of Learning and Development**
DATE OF MEETING:	**31 May 2012**

EXECUTIVE SUMMARY:

This report gives an overview of activity taking place within the L&D department and provides assurances that the department is:

1. Complying with current statutory and regulatory requirements relating to training.
2. Meeting CQC and NHSLA standards.
3. Delivering leadership and management development training for leaders at all levels.
4. Developing the current workforce.
5. Creating opportunities for apprenticeships across the trust.
6. Developing a widening participation strategy to meet future workforce requirements.
7. Providing work experience and work placement opportunities for local people via a central learning hub.
8. Engaging with partners to deliver the Right Care Right Here agenda relating workforce and widening participation.
9. Supporting service with workforce development and new roles.

REPORT RECOMMENDATION:

That Trust Board accepts this report as a reflection of activity that has taken place within the L&D department over the reporting period.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
x		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

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

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Aligns to all corporate objectives, NHSLA standards and CQC regulations.

PREVIOUS CONSIDERATION:

Trust Management Board on 22 May 2012

Learning and Development Department Annual Progress Report 2011/12

By James Pollitt
Head of Learning and Development

1. Introduction

1.1 It has been a challenging year for the L&D department with many changes taking place within the team, the management structure and the working environment. External visits such as NHSLA Level 2 assessment and CQC reviews have been the drivers for significant change in the way the L&D department operates. The department also needs to meet the Trusts strategic objectives and financial efficiency savings. This report gives the Trust Management Board an overview of how the L&D team have raised to the challenge of meeting the objectives set and how it continues to develop to meet the difficult challenges of the future. The report is broken down into different sections covering major work streams with conclusions and recommendations at the end of each section.

2. Performance Review

2.1 **NHSLA assessment.** This took place in February 2011 and the Trust was awarded full compliance at level 2. However, attached to the compliance was a list of recommendations and actions that had to be addressed. The main concern for L&D was Induction and Statutory/Mandatory training where it was recommended that the Trust policy be split and the process for induction and mandatory training be revised as it was to complex. As such, the policies for induction and mandatory training have been reviewed along with the Training Needs Analysis (TNA) for risk management training.

2.2 As a consequence of this work there are now stand alone policies for Induction and Risk Management Training. The TNA was also reviewed which has resulted in a significant reduction in the number of days staff are required to attend mandatory training. This was achieved by introducing different modes of training delivery such as e-learning, assessing the frequency staff needed to attend the training, complying with national guidance rather than local policy and targeting the training delivered to specific staff groups.

2.3 **Mandatory Training.** Attendance figures for mandatory training have dropped slightly since the assessment. More robust monitoring arrangements have been put in place to address non attendance of mandatory training and the failure of staff to attend booked courses. The introduction of the new Mandatory Training programme from October 2011 has seen a reduction in the amount of time spent on the training however there has also been a reduction in attendance figures. Measures have been put into place by the CEO to performance manage this activity at a divisional level with individual managers being made accountable. Current compliance figures are 74% with a target of 95% by February 2013. Details of the amount of time now required to be compliant with mandatory training is at Appendix A. It should be noted that there has been a significant reduction in the amount of time needed for individuals to maintain their levels of compliance.

2.4 **Induction.** The revised policy and procedure for induction is now in place. Delivery of the Corporate Induction Programme changed significantly and

has proved successful. Feedback on the current corporate induction programme has been good with positive comments being received. Performance figures show that the Trust is compliant with NHSLA standards for corporate induction and local induction for permanent staff. Compliance for the induction of temporary staff is measured mainly by Trust Nurse Bank and Medical Staffing.

2.5 **Widening Participation.** Widening Participation is an overarching term used to describe pre-employment, work experience and bands 1 – 4 development.

2.6 **Apprenticeships.** The L&D department produced an Apprenticeship Strategy that was agreed by TMB in August 2011. The main recommendation was that the Trust should routinely consider the option of using and Apprentice whenever recruiting to a job covered by Agenda for Change Bands 1 to 4. As a result of this strategy a pilot apprenticeship scheme was set up designed to recruit 9 new apprentice HCA's to support the Medicine Division. The programme started on the 7th November with 9 apprentice HCA's. The pilot is proving very successful and to date the feedback is very positive. Lots of hard work has been done by many staff from different departments to make the pilot a success. It is hoped that the outcomes will have made it worthwhile. The Trust currently has a total of 106 staff on apprenticeships covering a wide range of disciplines including Domestic Science, Security Services, Business Administration, Customer Service, Care and soon to start one in Horticulture.

2.7 The other apprenticeships are funded via the Skills Funding Agency (SFA). Because our contract with the SFA has been reduced, these enrolments will be considered 'over performance' and a business case will be submitted to the SFA requesting the additional funding to support the learners. It is anticipated that we will receive some if not all of the funding requested however at this moment in time the amount is unknown.

2.8 Unfortunately no additional clinical placements have been identified for apprenticeships. The vacant positions have been either taken for CIP or ring fenced for at risk staff. The strategy for apprenticeships continues and will enable service managers to succession plan effectively whilst supporting the employment of young people.

2.9 **Key skills development – literacy/Numeracy.** Delivery of key skills training continues and supports service by improving the numeracy and literacy of currently employed staff. The team are also involved in the recruitment and selection processes and support the apprenticeship strategy by delivering the functional skills element of the apprenticeship framework.

2.10 **Work Experience/ Placements.** A new policy has been developed for work placement/ experience which is currently out to consultation.

2.11 A pilot scheme for work experience has been developed and piloted within the Trust. Development was in partnership with Job Centre Plus, Sandwell College and with the support of the Trade Unions. This programme offers the long term unemployed meaningful work experience over a limited period

of time. The programme is not a process for securing cheap labour; it is about providing opportunities for the unemployed and supporting them back into employment. As one of the largest employers in the area it is our corporate social responsibility to help.

2.12 Six unemployed people have been on placement within the Trust supporting wards. The 10 week programme has been very successful with three participants securing permanent employment outside the Trust due to the experience gained whilst on the programme.

2.13 The widening participation team are currently working with local schools to broaden and enhance the wider work experience agenda. The Trust needs to develop a strategy around work experience to support the Organisational Development agenda.

2.14 **The Learning Hub**. Collaboratively with our RCRH partners we have developed a proposal for a learning hub for the Sandwell area. The business case has been approved by SIRG and it is hoped that the learning hub will be operational by the end of July. A building has been identified to serve as the hub opposite the Grove Lane site.The Learning Hub would bring all Widening Participation activity together in one place. This will provide local residents and partner organisations access to employment opportunities and offer shared resources and joint L&D activity. The building will have a partner tenant in a voluntary sector organisation, Friends & Neighbours.

2.15 **Assistant Practitioner**. The assistant Practitioner is a worker with a level of knowledge and skill beyond that of the traditional healthcare assistant or support worker who delivers elements of clinical work that have previously lain within the remit of registered professionals. The role may transcend traditional professional boundaries and can help organisations ensure that their workforce has the flexibility required to meet the changing needs of complex patients. The role of assistant practitioner role also provides a career pathway for the non-registered workforce in response to the Widening Participation agenda.

2.16 Since 2009 the Trust has supported Assistant Practitioner development through the Trainee Assistant Practitioner (TAP) Programme which requires the TAP to complete a Foundation Degree in Health and Social Care, currently delivered by Birmingham City University, alongside a work-based clinical competency package.

2.17 Fourteen AP's are currently on the Trust register following successful completion of the programme. Of the 62 candidates who have commenced the programme since 2009 six have withdrawn. Candidates are enrolled on the programme twice yearly, in April and October, and at present a further 42 TAP's over 6 cohorts (37 Nursing, 2 Imaging, 3 AHP) remain on programme. Ten candidates have just been recruited for Cohort 7, including 5 from the Community Division.

2.18 Funding for HEI course fees for the TAP programme has in the past been supported by JIF/SHA funding however HEI costs from September 2012 appear likely to triple and future SHA funding is unclear. Future

arrangements for the training and development of AP's within the organisation need to be agreed.

2.19 **Learning Beyond Registration.** As a result of training plans being submitted to the SHA, non medical post-registration training contracts are set up with Universities by the SHA on our behalf. These contracts have been monitored by Workforce and L&D. Before this current year about 30% of the total funding went unspent every year. This year measures are in place to ensure all the monies are spent.

2.20 **Study Leave Requests.** This year has seen the introduction of the electronic study leave request. This will enable the Trust to report more effectively on expenditure relating to study leave and monitor who is accessing study leave. The total cost of study leave including LBR can be seen at Appendix B.

2.21 **Leadership Development.** Whilst the leadership framework is a corporate document with responsibility spread across a number of executives and departments, responsibility for monitoring leadership development activity rests with the L&D Committee. Progress against the leadership action plan as far as L&D activity is concerned is as follows

Action Centred Leadership (Team Leader) – a number of cohorts have received ACL training with several more scheduled over the coming months. It is anticipated that around 300 staff will have attended the ACL Team Leader training by October 2012. Several Trust staff have been trained as Trainers to ensure sustainable delivery of this foundation leadership programme. An ACL development/assessment centre will be piloted with a small group of staff.

Operational Leadership – Based on ACL team leader training this is designed for operational Leaders. This is currently under development and will be delivered when the Trust has trained delivery teams. (Training taking place in June)

Strategic Leadership – discussions are taking place with Adair International to deliver Strategic Level ACL to senior staff

Leadership in Management in Healthcare – progressing (Medical Director).

Ward Management toolkit of development – 1st cohort complete, second being recruited (www.wardmanager.com). A further 'Preparing to Lead' programme for Band 6 nurses is being delivered in conjunction with the Nursing Division and Wolverhampton University.

BTEC Award in Team Leading – commenced for junior team leaders/Supervisors and delivered by L&D. Team Leaders and management apprenticeships are being provided for one cohort.

Coaching - A pilot scheme for coaching was commissioned with ten members of staff have being offered one – one coaching for their personal development. This has proved to be a great opportunity and further development is required in this area. Some availability is available via the SHA and advertised for BME staff, details of which are circulated around the Trust.

2.22 **Graduate Profession – Nursing.** The move towards an all graduate nursing qualification began with the admission of students to BCU and Wolverhampton Universities in September and October respectively. Following a period of study at the University Wolverhampton University Students commenced Placement 10th October 2011. On City site students from Birmingham City University commenced their first placement on 21st Jan 2012, and have just successfully completed this first placement. Wolverhampton University had their second intake on Jan 21st and they commenced placement on 12th March 2012.

3 Key Risks/Issues

3.1 Other than risks/issues picked up already within this report the L&D Committee have identified the following as future risks/issues:
NHSLA re-assessment.
On-going educational funding.
MPET changes and creation of skills networks.
TSP's. Due to the TSP programme, the at risk staff are being offered positions that have been identified for apprenticeships thus reducing the uptake.

4 Conclusion

4.1 It has been a very successful year for the L&D department. The service has transformed from being reactive to a pro active in the support of other services. The L&D Committee is now an established forum for co-ordinating and managing corporately L&D activity. A greater understanding is now in place of L&D issues, agenda and funding sources. The committee is also the corporate review and decision making body in relation to L&D activity and from where issues can be escalated as appropriate. Good links have been made with workforce planning, RCRH programme and professional leads, however there needs to be more engagement from the medical profession on education and development issues.

Reporting to the wider organisation has commenced with a presence on TMB and the publication of the L&D newsletter. The Apprenticeship Strategy is working but can be improved upon with continued support of the strategy from divisions and service mangers.

APPENDIX A. MANDATORY TRAINING GUIDE FOR STAFF

MANDATORY TRAINING GUIDE FOR STAFF

	Delivery Method	Compliance Period	Nursing		Admin
			Matron, Nurse Manager, Nurse, Midwife	HCA, Nursery Nurse Clinical	Patient facing front line admin staff
3 day Induction **Day 1** corporate message, Equality & Diversity, Counter Fraud, Library Services **Day 2 - Mandatory Training** (see below) **Day 3 Conflict Resolution**	Classroom	once	22.5	22.5	22.5
Mandatory Training Day - Fire, Manual Handling (theory), governance, slips trips & falls, Infection Control/Hand Hygiene, Incident Reporting, Harrassment & Bullying, Resus, Medicines Management, Blood transfusion	classroom	2 yearly	7.5	7.5	7.5
Conflict Resolution	classroom	3 yearly	3	3	3
Consent	leaflet/elearning		7.5	-	-
Equality & Diversity	3 hours	once only then reviewed via PDR annually	3.5	-	-
Investigateing incidents, complaints and claims	classroom	once only	2	-	-
Information Governance	elearning	once only	2	2	2
Information Governance - Refresher	elearning	annually	1	1	1
Medical Devices	competency	3 yearly	dependant on individual - localised		
Moving & Handling - full Day	classroom	one off	7.5	7.5	-
Moving & Handling - Refresher	classroom	annually	3	3	
Rescusitation	classroom	annually	3	3	-
Safeguarding Adults	classroom	3 yearly	3	3	leaflet
Safeguarding Children	classroom	3 yearly	3	3	leaflet
Violence & Aggression: Breakaway Training	5 hours	3 yearly	dependant on area of work/job role		
	on appointment		**48**	**35**	**24.5**
	up to 35 months		**21.5**	**21.5**	**9.5**
	36-71 mths/every 3 yr period		**34.5**	**34.5**	**12.5**

NB:

leaflets have not been allocated time
3 hours safeguarding has been included dependant on are of work ie child/adult for all nursing posts

Average Mandatory Training PA	**11 hours**

Appendix B. Study Leave Expenditure

Division	Spending via L&D Cost Code (NICEN)	LBR Allocation Core & Devolved	LBR Core Spent	LBR Devolved Spent	Remaining LBR Allocation Core & Devolved	Other Cost Code Spent		Total Study Leave Spending by Division
						Divisional Spending	*Trust Fund Spending*	
Adult Health - Community	£380.00	£47806.00	£13118.00	£27578.00	£7110.00	£48726.25	£282.90	£90085.15
Chief Exec	£0.00	£0.00	£0.00	£0.00	£0.00	£1425.74	£0.00	£1425.74
Development & Cancer	£0.00	£0.00	£0.00	£0.00	£0.00	£19.70	£10.00	£29.70
Facilities	£805.00	£0.00	£0.00	£0.00	£0.00	£34552.40	£0.00	£35357.40
Finance	£0.00	£0.00	£0.00	£0.00	£0.00	£15071.29	£0.00	£15071.29
Governance	£0.00	£0.00	£0.00	£0.00	£0.00	£5198.25	£0.00	£5198.25
IM&T	£95.00	£0.00	£0.00	£0.00	£0.00	£6323.60	£0.00	£6418.60
Imaging	£4900.00	£9160.00	£2750.00	£0.00	£6410.00	£30969.86	£5643.73	£44263.59
Medicine	£20020.00	£62348.00	£45500.00	£11090.00	£5758.00	£33544.89	£17390.05	£127544.94
Nursing & Therapy	£7400.00	£15485.00	£7163.00	£14088.40	£5766.40	£16057.14	£17784.00	£62492.54
Operations	£2980.00	£3635.00	£490.00	£1575.00	£1570.00	£37815.97	£1635.00	£44495.97
Pathology	£2881.40	£11415.00	££2710.00	£7035.00	£1670.00	£19280.02	£132692.80	£45599.22
Surgery A & ACC	£18810.00	£69315.00	£64280.00	£11360.50	£6325.50	£5675.60	£6437.00	£106563.10
Surgery B	£0.00	£11260.00	£5365.00	£900.00	£4995.00	£15470.60	£1000.00	£22735.60
Women & Child	£21750.00	£62632.50	£30494.00	£26363.00	£5775.50	£6847.00	£4352.00	£89806.00
Workforce	£22665.62	£0.00	£0.00	£453.00	£453.00	£13092.12	£0.00	£36210.74
	Total L&D Spent	**Total LBR Allocation Core & Devolved**	**Total Core Spent**	**Total Devolved Spent**	**Total LBR Allocation Remaining Core & Devolved**	**Total Divisional Spending**	**Total Trust Fund Spending**	**Grand Total**
	£102687.02	£293056.50	£171870.00	£100442.90	£20743.60	£290070.43	£68227.48	£733297.83

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Register of Interests**
SPONSOR (EXECUTIVE DIRECTOR):	**Kam Dhami, Director of Governance**
AUTHOR:	**Simon Grainger-Payne, Trust Secretary**
DATE OF MEETING:	**31 May 2012**

EXECUTIVE SUMMARY:

A refreshed version of the Register of Interests is presented for approval, which has been amended to take into account recent changes in the Board membership and revised interests.

Additions to the Register are highlighted in blue text.

REPORT RECOMMENDATION:

The Board is requested to approve the amendments to the revised Register of Interests.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	X	

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

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

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

None specifically, although represents good governance practice

PREVIOUS CONSIDERATION:

Last considered by the Trust board at its meeting in January 2012.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

REGISTER OF INTERESTS AS AT MAY 2012

Name	Interests Declared
Acting Chairman	
Richard Samuda	▪ Non Executive Chairman – Horton's Estates Ltd. ▪ Director – 'Kissing It Better' ▪ Non Executive Director – Warwick Racecourse ▪ Trustee & Non Executive Director – Abberley Hall
Non Executive Directors	
Roger Trotman	▪ Non-Executive Director – Stephens Gaskets Ltd ▪ Non-Executive Director – Stephens Plastic Mouldings Ltd.
Gianjeet Hunjan	▪ Governor – Great Barr and Hamstead Children's Centre ▪ Governor – Ferndale Primary School ▪ Community Governor – Oldbury College of Sport ▪ Member – GMB Trade Union ▪ Member – Managers in Partnership/UNISON ▪ Treasurer – Ferndale Primary School Parents Association ▪ Lay member – West Midlands Deanery
Sarindar Singh Sahota OBE	▪ Trustee – Acorns Hospice ▪ Director – Sahota Enterprises Ltd ▪ Director – Sahota Properties Ltd ▪ Member – Birmingham Chamber of Commerce Council ▪ Member – Smethwick Delivery Board ▪ Governor – Nishkam Education Trust
Derek Alderson	Member – Council of Royal College of Surgeons of England
Phil Gayle	CEO New Servol
Olwen Dutton	▪ Partner – Bevan Brittan LLP ▪ Fellow – Royal Society of Arts ▪ Member – Lunar Society ▪ Member – Midland Heart – Care and Support Committee
Executive Directors	
John Adler	Adviser – Guidepoint Global
Rachel Barlow	None
Rachel Overfield	None
Mike Sharon	None
Robert White	▪ Director – Midtech clg ▪ National Committee Member – HFMA Financial Management & Research Committee

Associate Members	
Graham Seager	None
Kam Dhami	None
Jessamy Kinghorn	None
Trust Secretary	
Simon Grainger-Payne	None

May 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Single Tender Approval – Recharge of Salaries from the University of Birmingham**
SPONSOR (EXECUTIVE DIRECTOR):	**Robert White, Director of Finance and Performance Mgt**
AUTHOR:	**Robert White, Director of Finance and Performance Mgt**
DATE OF MEETING:	**31 May 2012**

EXECUTIVE SUMMARY:

The Trust has received the annual agreement for the recharge of salaries from the University of Birmingham medical school for clinical academics based at SWBH NHS Trust.

The value is anticipated to be £1,478,389 and this has been provided for within the budget for 2012/13. At the Board meeting in May 2011 approval was sought against a value of £1,604,976.

As the gross expenditure is above £500,000 and requires the waiving of competitive tendering (as this is not appropriate in these circumstances) the Trust Board is asked to agree to the waiver and renew the agreement for the 2012/13 financial year.

REPORT RECOMMENDATION:

Trust Board is asked to approve a single tender action for the salary recharge payment of £1,478,389.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	x	x

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

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

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

None specifically

PREVIOUS CONSIDERATION:

Trust Board in May 2011

UNIVERSITY OF BIRMINGHAM
College of Medical & Dental Sciences

Finance & Planning

SB/slw

16th May 2012

Mr Robert White
Sandwell & West Birmingham Hospitals NHS Trust
City Hospital
Dudley Road
Birmingham
B18 7QH

Dear Mr White

Agreement for the Support of Posts Associated with Medical Education at the University of Birmingham

Please find enclosed two copies of the Agreement for the Support of Posts Associated with Medical Education at the University of Birmingham for 2012/2013. These include a schedule of forecast costs, which will form the basis of invoices to be raised in the first part of this year. I would be grateful if you could sign and return one copy of the Agreement for our records. The forecast will be reviewed periodically through the year, and invoices adjusted accordingly.

In regard to the forecast, please note:

- Vacant posts have no costs, including those posts which are currently vacant but which it is anticipated will be filled in-year
- Consultant and Clinical salaries have not been uplifted
- Non-clinical salaries have been uplifted by 1%
- The location of clinical lecturer posts on training rotations have been included using the best information available, but may be subject to change

I look forward to receiving the Trust's signed copy of the contract in due course.

Yours sincerely

Suki Basra
NHS Liaison/Finance Manager

Enc

University of Birmingham Edgbaston Birmingham B15 2TT United Kingdom
T: 0121 414 3490 F: 0121 414 7149 E: s.basra@bham.ac.uk W: www.bham.ac.uk

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Business Case for Integrated Blood Sciences Laboratory**
SPONSOR (EXECUTIVE DIRECTOR):	**Mr Mike Sharon, Director of Strategy & Organisational Development**
AUTHOR:	**Dr Jonathan Berg, Pathology Director**
DATE OF MEETING:	**31 May 2012**

EXECUTIVE SUMMARY:

- A Blood Sciences laboratory is a natural progression of our Pathology services reconfiguration. This project brings four currently separate laboratories into a single functional unit enabling substantial transformation plan savings to be realised.
- The proposal uses a vacant part of the old Pathology laboratory at Sandwell Hospital to produce an integrated Blood Sciences Laboratory.
- In the last 12 months a joint working group between Capital Projects and Pathology has undertaken the detailed planning and a full tendering exercise. The final project lies within the £2,995 million capital allocation.
- Proceeding with this project now offers us the chance of retaining our pathology services to GPs, and enables us to work with Dudley Group on joint Pathology initiatives and gives the ability to respond to any tendering of our primary care work
- The Investment appraisal shows a pay back of capital in 7 years

REPORT RECOMMENDATION:

- The Board is recommended to **APPROV**E the capital expenditure of £2.995 over two years to develop the Integrated Blood Science facility

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	X	

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

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

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

This project fits with the Right Care Right Care programme and all foreseen scenarios regarding the Midland Metropolitan Hospital.

PREVIOUS CONSIDERATION:

The Board has previously discussed and approved the development of a closer relationship of the Pathology departments with Dudley Group FT

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Trust Board Report

Integrated Blood Sciences Laboratory

May 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality and Safety Committee – Version 0.1

Venue Executive Meeting Room, City Hospital **Date** 22 March 2012; 0900h – 1100h

Members Present

Prof D Alderson [Chair]
Mr R Trotman
Mrs O Dutton
Mr J Adler
Miss K Dhami
Mr R White
Miss R Barlow
Dr D Situnayake

In Attendance

Miss A Binns
Mr S Parker
Mrs H Mottishaw
Mrs D Talbot

Secretariat

Mr S Grainger-Payne

Observer

Ms E Foreman [Deloitte LLP]

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received apologies for absence from Dr Sarindar Sahota and Miss Rachel Overfield.	
2 Minutes of the previous meeting	**SWBQS (1/12) 015**
Subject to minor amendment, the minutes of the Quality and Safety Committee meeting held on 19 January 2012 were approved as a true and accurate reflection of discussions held.	
AGREEMENT: Subject to minor amendment, the minutes of the previous meeting were approved	
3 Matters arising from the previous meeting	**SWBQS (1/12) 015 (a)**
The updated actions list was noted by the Committee.	

CLINICAL EFFECTIVENESS	
4 Compliance with the use of the WHO Surgical Safety Checklist update	**SWBQS (3/12) 030** **SWBQS (3/12) 030 (a) - SWBQS (3/12) 030 (c)**
Dr Situnayake reported that systems had been introduced into the Trust to ensure improved compliance with the use of the World Health Organisation (WHO) checklist, however further measures were needed to further embed the systems. It was reported that work was being undertaken to finalise the denominator, in terms of which teams should be using the checklist and which are exempt from the policy. Mr Parker advised that once it had been decided in which areas the checklist should be used, an automated return would be generated and an assessment made of responses received against those expected would be undertaken. Professor Alderson remarked that it appeared that an improvement in the use of checklist was needed in Cardiology in particular. Mr Parker advised that this was an area in which the use of the checklist was still to be agreed. It was highlighted that the same situation applied in Obstetrics. Professor Alderson asked whether monitoring arrangements were in place. DS advised that further work was to be undertaken to ensure that the arrangements were robust. Miss Dhami recommended that this work be reflected within the WHO checklist action plan. Mrs Dutton noted that the level of compliance reported represented an improved position, however she questioned why the culture within the Trust had initially led to a situation of non-compliance. Dr Situnayake advised that the situation reflected the rapidity with which the policy had been introduced some time ago. Mrs Dutton suggested that as it was likely that other measures would need to be introduced quickly in future learning from the situation needed to be clearly understood and built into plans where possible. Mr Adler summarised that overall performance regarding the use of the WHO checklist was pleasing. He highlighted that in terms of the situation in Cardiology, that this related specifically to interventional Cardiology. Miss Binns advised that the Clinical Director was supportive of the approach and therefore improved compliance in the area was anticipated in future. Professor Alderson remarked that the use of the term 'Five Steps to Safer Surgery' may not be clearly reflective that the policy applied to areas in addition to traditional surgical areas. Mr Adler advised that an assessment of compliance with the use of the WHO checklist was included as part of the monthly Provider Management Regime	

return. Mrs Dutton asked if the Trust Board was to be appraised of the current position. She was advised that this was the case and would be included within the monthly Quality report.	
5 CQC mortality outlier alerts and action plans	**SWBQS (3/12) 026** **SWBQS (3/12) 026 (a) - SWBQS (3/12) 026 c)**
Mr Parker advised that notification that the Trust was an outlier in two diagnoses, emergency admission with a primary diagnosis of pneumonia or cerebrovascular disease had been received in October 2011. The Committee was advised that following this notification, an investigation had been undertaken which had demonstrated that there were no clear concerns in relation to clinical care and as such the outcome of the review had been submitted to the CQC. The CQC was reported to have subsequently asked for a review of the action plan to ensure that all findings had been addressed. Further information concerning stroke mortality was reported to be have been requested in addition. A revised action plan was reported to have been submitted to the CQC which subsequently confirmed that there was no further action required, however regular updates were to be supplied to the regional team. Mr Parker reported that as at the end of February 2012, work was on target to conduct the next round of audits in connection with the pneumonia diagnosis. Regarding stroke however, it was highlighted that there had been a degree of delay. It was reported that there were challenges with reviewing the DNAR orders, however there was a need to demonstrate that they had been appropriate placed. As such, it was reported that practices in other trusts had been reviewed. Mrs Talbot advised that a programme of auditing DNAR orders was underway within the remit of the Resuscitation Committee. Mr Adler asked whether appropriate consultation with families was being considered as part of this work. Mrs Talbot advised that this was the case. Dr Situnayake advised that the mortality review system would specifically focus on situations such as that in stroke care, to review the care pathway bundles. It was noted that this practice was in line with the SINAP audit requirements and would feed into the work of the Stroke Action Team. Professor Alderson noted that a significant amount of information was being collected as part of the work and asked whether it was being collected methodically. Dr Situnayake advised that the information collection had been in place for some time and a national and local expert opinion was available should this be required. Mr Trotman asked whether the information was being used as a learning tool. Dr Situnayake confirmed that this was the case and that crucial lessons were being collected. Mrs Dutton asked how these lessons learned were being communicated. Dr Situnayake advised that this was through the Stroke Action Team. Mrs Dutton asked whether the audit practice within the stroke care team was transferrable to other areas. Dr Situnayake advised that the Trust had in place an integrated stroke delivery plan, which considered a list of 'RAG' rated actions together with the accountabilities for delivery.	

6 Clinical Audit forward plan: monitoring report	**SWBQS (3/12) 022** **SWBQS (3/12) 022 (a)**
Mr Parker presented the latest view of progress with delivery of the Clinical Audit forward plan and highlighted that there were a small number of audits that were expected to not be completed as planned. It was reported that the foetal monitoring audit was expected to be completed in March 2012, not in December 2011 as originally planned. It was reported that in connection with the audit into the use of drugs by night services, there had been difficulty making contact with the appropriate individuals within the community to commence the data collection and therefore it was anticipated that the audit would not be completed until May 2012.	
PATIENT SAFETY	
7 Risk management strategy	**SWBQS (3/12) 025** **SWBQS (3/12) 025 (a)**
Miss Binns presented the draft risk management strategy, advising that it supported the high level Quality and Safety strategy. The key changes to the strategy were highlighted to concern the change to the Board processes for the consideration of risks and that it was intended that the risks should be categorised as part of the risk registers and risk assessments developed. The Committee was advised that there was an intention for the Board to be presented with the risk register in a monthly basis and it would be asked to decide whether to treat or tolerate the risks. It was reported that the process for incorporation of risks onto the risk register would be strengthened. The Committee was informed that all Board members would receive training in risk management. Mr Trotman suggested that the frequency of the training needed consideration to ensure that any changes to legislation for instance, were current. Mr Trotman questioned whether the key responsibilities for individuals in relation to the strategy were sufficiently clearly identified. It was agreed that the responsibilities for risk management needed to be strengthened within contracts of employment. The risk severity matrix was highlighted to remain unchanged, although the financial information as part of the assessment required consideration. Mrs Dutton noted that the strategy did not reflect the responsibilities of the Chair or the Non Executive Directors. She also queried whether the strategy included sufficient clarity in terms of the responsibilities of temporary employees and agency staff. Mr Adler advised that risk management training was included as part of the Mandatory Training suite. It was suggested that the training needed to be tailored according the band and role of staff. Mr Adler asked where the strategy would be considered subsequently. He was advised that the Governance Board and Trust Board would receive the strategy for	

approval in April 2012. Professor Alderson suggested that a flow chart should be included to depict the key elements of the narrative. Miss Dhami advised that this level of detail was included within the risk assessment and risk register policy. Mrs Dutton suggested that risks due to negligence needed to be built into the strategy where possible. Dr Situnayake asked that a reference to the work of the Mortality and Quality Alerts Committee be built into the policy. It was further suggested that the detail of the considerations by the Risk Management Group needed to be revised slightly.	
ACTION: Miss Binns to revise the Risk Management Strategy to reflect the suggestions made at the meeting	
8 Integrated risk report – Quarter 3	**SWBQS (3/12) 021** **SWBQS (3/12) 021 (a)**
In connection with this item, Mrs Dutton declared an interest given her work with Bevan Brittain LLP, the firm acting on behalf of the NHS Litigation Authority. Miss Binns reported that the number of incidents reported had increased, although this was not necessarily in the desired areas. Better reporting of medication incidents was highlighted. It was noted that there were plans to better identify those deaths arising from incidents. The Committee was advised that electronic reporting of incidents had been introduced. Mrs Mottishaw reported that there had been a fall in the number of complaints, which reflected the redirection of some enquiries to the PALS team or categorisation of the concern as an enquiry rather than a complaint. The majority of complaints received were reported to be green or yellow in severity. Clinical claims were reported to have increased as had disclosure of records requests. Mr Trotman remarked that it appeared that fewer compliments had been received by the Trust. Miss Dhami advised that the information included in the report reflected those compliments of which the team had been notified and not the total number that were expected to have been received across the Trust. It was suggested that as the data was in this sense, not of great value, it should be removed from future reports. Professor Alderson asked whether the current incident reporting was acceptable to the Executive Team. Mr Adler advised that it was encouraging to see that the Trust had moved upwards in terms of the national position on incident reporting, now being within the middle percentile.	
9 NPSA safety alerts	**SWBQS (3/12) 031** **SWBQS (3/12) 031 (a)**
Miss Binns reported that the NPSA safety alert concerning the acknowledgement of radiological imaging alert had been signed off and compliance with the alert would	

be monitored and audited. In terms of the safer spinal needles alert, the Committee was advised that a preferred option had been identified, however the manufacturers had not yet developed needles for Paediatric treatment or manometers. Miss Binns advised that the Trust would be working with the manufacturer to ensure that a fit for purpose solution was developed. It was reported that the feedback from the NPSA suggested that the matter needed to be added to the Trust Risk Register. Mr Adler asked whether the Strategic Health Authority had been appraised of the situation. Miss Binns advised that a scoping exercise was underway to determine how other organisations across the region were handling the position.	
10 Never Events	
10.1 Misplaced oro-gastric tube	**SWBQS (3/12) 024** **SWBQS (3/12) 024 (a)**
Miss Binns advised that a Never Event had occurred which concerned a misplaced oro-gastric tube. The Committee was advised that remedial action had been taken swiftly and a new process had been introduced, aimed to ensuring that a reoccurrence of the event was prevented.	
10.2 Retained screw	**SWBQS (3/12) 024** **SWBQS (3/12) 024 (a)**
Miss Binns reported that a Never Event concerning a retained scleral plug had occurred during a procedure being performed on an Ophthalmology patient. It was reported that the incident had been raised by the patient in the form of a complaint. In response, the Committee was advised that a 'task and finish' group had been established to devise an action plan aimed at preventing a reoccurrence of the matter. Dr Situnayake advised that there had been clear evidence in this case that there had been compliance with the use of the WHO checklist. Mrs Dutton asked whether the patient had been involved in the Table Top Review and as such, whether comments had been requested. Miss Binns advised that the patient had been informed that the matter would be fully investigated. Mrs Dutton suggested that the patients' involvement should be integral to the review process. Mr Adler agreed that this consideration needed to be built into the Being Open policy. Miss Binns advised that a further Never Event had occurred, where an incorrect lens had been fitted as part of an Ophthalmology procedure. It was reported that an explanation of the situation had been given to the patient and that all five steps of the Safer Surgery policy had been followed.	
11 NHSLA/CNST assessment preparations	**Verbal**
Miss Binns reported that accreditation against CNST Level 1 maternity standards had been achieved and the assessment against level 2 standards had been booked	

for December 2012. Miss Dhami advised that this date was tentative however, with the possibility of moving this back to a later date to provide greater time to prepare for the assessment. Mr White reported that financial benefit of the achievement of the Level 2 maternity standards accreditation was incorporated within the Transformation Plan 2012/13. Miss Binns advised that the reassessment against Level 2 general standards was planned for 27 and 28 February 2012.	
PATIENT EXPERIENCE	
12 Being Open policy	**SWBQS (3/12) 023** **SWBQS (3/12) 023 (a)**
Miss Binns presented a working draft of the Being Open policy for consideration and comment. She advised that the policy incorporated the outcome of the Department of Health consultation on Duty of Candour. It was highlighted that the process had been amended to ensure that if an incident occurred which leads to moderate or more severe harm, then the Being Open process was initiated by the Risk Management Team. As part of the process, it was highlighted that an invitation to the patient or relative to be involved in the investigation and review process could be issued. It was suggested that the process may need to be triggered for some incidents causing less than moderate harm. It was highlighted that the use of an apology was more clearly articulated within the policy. Mr Adler suggested that the involvement of the patients and relatives should be made more explicit. It was suggested that the flow chart should be amended to show more clearly how lessons learned are fed back into the process and future practice. Miss Binns proposed that that this suggestion be built into the incident reporting process to ensure that the policy retained the focus on Being Open. Mrs Talbot advised that some staff appeared to be reluctant to share information around an incident and therefore appropriate awareness and training was needed. Miss Binns advised that the Risk Management Team needed to support the process and provide a supportive network for suggestions such as this. Mr Trotman suggested that the policy should be amended to strengthen the requirement to undertake note writing and the use of appropriate proforma. Professor Alderson remarked that apologising was distinct from disclosure of matters going wrong, with the latter having legal implications. Mrs Mottishaw concurred with this view. The name of the policy was discussed, with it being suggested that this should be changed to ‘Being Open When Things Go Wrong’.	

ACTION: **Miss Binns to amend the Being Open policy to incorporate the suggestions made at the meeting**	
13 Complaints	
13.1 Complaints referred for independent review	**SWBQS (3/12) 027** **SWBQS (3/12) 027 (a)**
Mrs Mottishaw presented the details of complaints referred for independent review by the Parliamentary Health Service Ombudsman. The Committee was advised that one complaint was newly referred.	
13.2 Draft report from the Care Quality Commission (CQC) concerning Outcome 17	**SWBQS (3/12) 033** **SWBQS (3/12) 033 (a)**
Mrs Mottishaw reported that a draft report had been received from the Care Quality Commission confirming that the Trust was compliant with Outcome 17, complaints, as a result of the actions taken to address the complaints handling issues.	
13.3 Complaints position statement	**SWBQS (3/12) 028** **SWBQS (3/12) 028 (a)**
Mrs Mottishaw reported that there were an increased number of complaints in breach of the revised failsafe targets. Key factors behind this position were highlighted to concern an increased number of complaints received by the Trust, reduced staffing and the demands of the new failsafe targets. Mrs Dutton asked whether the complaints team members that had left the department would be replaced. She was advised that secondments would be used to bolster the staffing levels. The Committee was advised that a routine update on complaints handling was provided as part of the Trust's Quality Report. Professor Alderson asked how the current backlog of complaints would be handled. Mrs Mottishaw reported that the complaints backlog had been cleared as of 1 January 2012 and ownership of the cases was now more robust and controlled. Miss Dhami advised that tighter management of the complaints handling process had been implemented. Mr Adler confirmed the need to maintain close scrutiny on the position. Mrs Mottishaw reported that the fast track complaints handling for less severe cases was working well.	
13.4 Lyndon 4 and EAU complaints	**SWBQS (3/12) 029** **SWBQS (3/12) 029 (a)**
Mrs Talbot reported that a cluster of complaints covering the period November 2010 to December 2011 had been reviewed.	

In terms of the situation in the Emergency Assessment Unit at Sandwell Hospital, it was reported that a condition report had been instigated by the division and the unit was reported to have been placed in Special Measures. It was highlighted that the number of complaints concerning the area was a key factor in this course of action. Regarding Lyndon 4, it was reported that the complaints did not appear to be symptomatic of a systemic issue. It was highlighted that the ward's performance was improving in general terms. Mrs Dutton encourage a log to be kept of investigations such as this to act as a cross reference for any issues raised in future.	
GOVERNANCE/ASSURANCE	
14 Corporate Risk Register – Quarter 3	**SWBQS (3/12) 029** **SWBQS (3/12) 029 (a)**
Miss Binns presented the Corporate Risk Register detailing the position as at the end of Quarter 3. It was highlighted that two new risks had been added from the Pathology division. The Committee was informed that following Quarter 4, the new risk management process would be implemented. Miss Binns was asked whether the mitigating activities and strategies were regarded as being appropriate. She advised that the process would be made robust, following the implementation of the revised policy. The Committee was informed that much work had been undertaken to inform the risk sections of the Integrated Business Plan and Annual Plan.	
15 Assurance Framework	**SWBQS (3/12) 017** **SWBQS (3/12) 017 (a)**
The Committee was asked to receive and note the latest position concerning the actions taken to close the gaps in control and assurance against the delivery of the Trust's corporate objectives. Mr Grainger-Payne advised that good progress had been made with delivery of the actions required.	
16.1 – 16.3 Minutes from Governance Board	**SWBGB (1/12) 193** **SWBGB (2/12) 017** **SWBGB (3/12) 017 (a)**
The Quality and Safety Committee received and noted the minutes from the Governance Board meeting held on 13 January 2012 and 3 February 2012. The Committee also noted the actions list that was discussed at the meeting held on 2 March 2012.	

17.1 & 17.2 Minutes from Clinical Quality Review Group	**SWBQS (3/12) 019** **SWBQS (3/12) 020**
The Quality and Safety Committee received and noted the minutes from the Clinical Quality Review Group meeting held on 1 January 2012 and 1 February 2012.	
18 Any other business	**Verbal**
Mrs Mottishaw provided the details of three Best Interest cases in which the Trust was currently involved.	
19 Details of the next meeting	**Verbal**
The date of the next meeting of the Quality and Safety Committee was reported to be 24 May 2012 at 0900h in the Executive Meeting Room, City Hospital.	

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Infection Prevention and Control Annual Report (April 2011–March 2012)
SPONSOR (EXECUTIVE DIRECTOR):	Rachel Overfield – Chief Nurse. Director of Infection Prevention and Control
AUTHOR:	Rebecca Evans – Head of Infection Prevention and Control Nursing Services Richard Anderson – Informatics Officer Dr Natasha Ratnaraja – Consultant Microbiologist/Infection Prevention and Control Doctor. Dr Conor Jamieson – Antibiotic Pharmacist
DATE OF MEETING:	31 May 2012

EXECUTIVE SUMMARY:

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

The Trust met its annual target for both MRSA (2 against a total allowance of 6) and *C.difficile* (95 against a trajectory of 109). Targets for 2012/2013 have been set at MRSA – total allowance of 2 and *C.difficile* 57. Whilst the organisation has met its target for 2011-2012 achieving and improving on the new targets will prove a major challenge for 2012/2013.

The Infection Prevention and Control Services (IPCS) continues to adopt a proactive approach to the prevention and control of HCAI's through:- surveillance of target organisms; monitoring compliance against infection control practices to include:- root cause analysis of specific cases, investigation of outbreaks and increased incidence of infection, audit of both clinical and non clinical practice, antibiotic stewardship and education and training.

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.

REPORT RECOMMENDATION:

The Trust Board is asked to note the work undertaken by the Infection Prevention and Control Service at Sandwell & West Birmingham Hospitals NHS Trust for the period April 2011-March 2012.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

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

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
This report contains infection control trajectories as determined by the SHA
PREVIOUS CONSIDERATION:
Routine annual update.

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Appendices

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1. Executive Summary

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

The Trust met its annual target for both MRSA (2 against a total allowance of 6) and *C.difficile* (95 against a trajectory of 109). Targets for 2012/2013 have been set at MRSA – total allowance of 2 and *C.difficile* 57. Whilst the organisation has met its target for 2011-2012 achieving and improving on the new targets will prove a major challenge for 2012/2013.

The Infection Prevention and Control Service continues to adopt a proactive approach to the prevention and control of HCAI's through:- surveillance of target organisms; monitoring compliance against infection control practices to include:- root cause analysis of specific cases, investigation of outbreaks and increased incidence of infection, audit of both clinical and non clinical practice, antibiotic stewardship and education and training.

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.

2. Management and Organisation

The Infection Prevention and Control Service (IPCS) is a fully integrated service. 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.

During 2011-2012 Infection Prevention and Control continue to work closely with clinical and non – clinical departments, focusing on key areas of practice to help facilitate the prevention and control of HCAI's. The overall organisation of infection control within the Trust continues to works well, with the Infection Control Operational Committee leading on developing and reviewing the action plan, reviewing new policies and ensuring compliance with all requirements of the Code of Practice. Partnership working with the Primary Care Trusts, Strategic Health Authority and Health Protection Agency through the Health Economy Groups for Infection Prevention and Control continues to thrive.

Within the Trust the IPCS continues to adopt a proactive approach to the prevention and control of Healthcare Associated Infections (HCAIs), liaising with all designations of staff to monitor and improve practices and activity that have a positive impact on patient care. This includes: - improving clinical practice, reviewing practices relating to decontamination of equipment the environments, policy development, audit and education and training to all healthcare workers both internal to the organisation and external to the organisation e.g. teaching of pre and post registration medical and nursing staff. The continued focus on training doctors has paid major dividends in terms of quality measures such as improved antibiotic prescribing and reductions in numbers the numbers of contaminated blood cultures.

The team continues to have strong links with external agencies to include the Strategic Health Authority, Primary Care Trusts and Department of Health and Health Care Economy Groups.

The Infection Prevention and Control Service have developed a new programme of activities for 2012/2013 which has been approved by the Infection Control Operational Committee and will be closely monitored at Infection Control Team meetings. The programme involves the updating or review of a large number of infection prevention and control policies, a major commitment to surveillance of a wider range of HCAIs and related infection prevention and control initiatives, and a strong focus on audit and training.

3. Surveillance

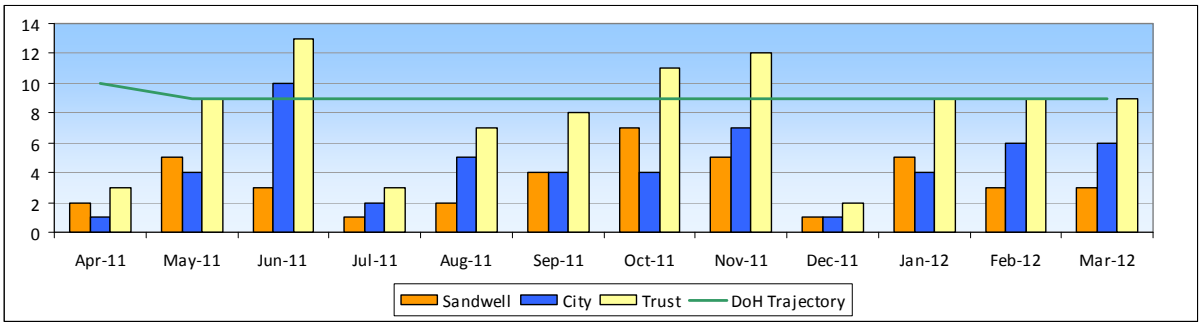
Microbiological surveillance is undertaken by the IPCS identified from clinical specimens received in the hospital laboratory and focuses on organisms which are known to have the ability to cross-infect, or are multiple antibiotic-

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 (Director of Infection Prevention and Control) outlining progress against target organism surveillance and key actions required.

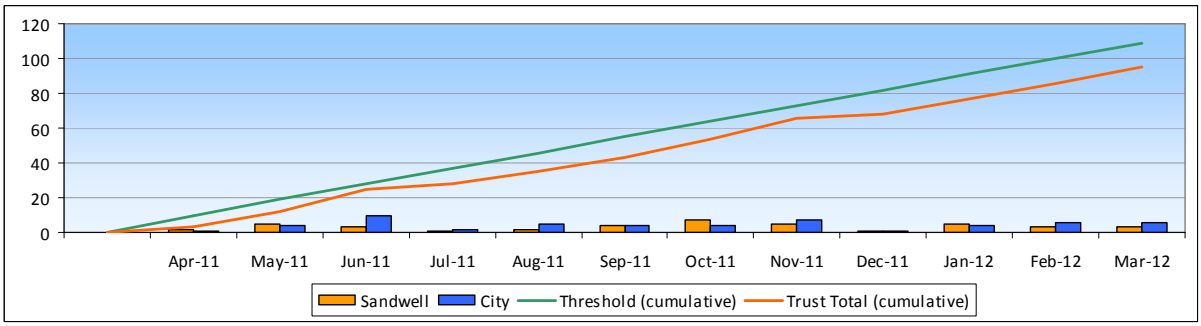
In addition to this the IPCS focus on specific target organisms that are monitored against national targets i.e. MRSA, *C.difficile,* and MRSA screening compliance. Outlined below is progress against key target organisms for the period 2011- 2012.

3.1 *Clostridium difficile* infections

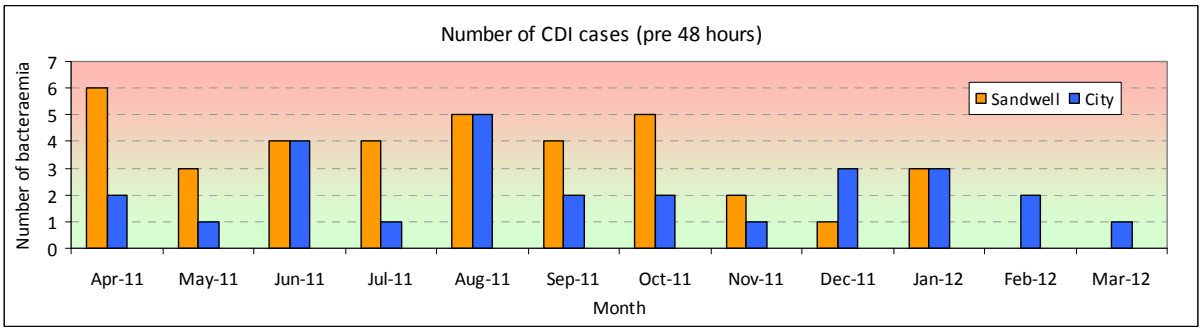
3.1.1 Number of Post 48hrs *Clostridium difficile* infections (CDI) for the period April 2011- March 2012



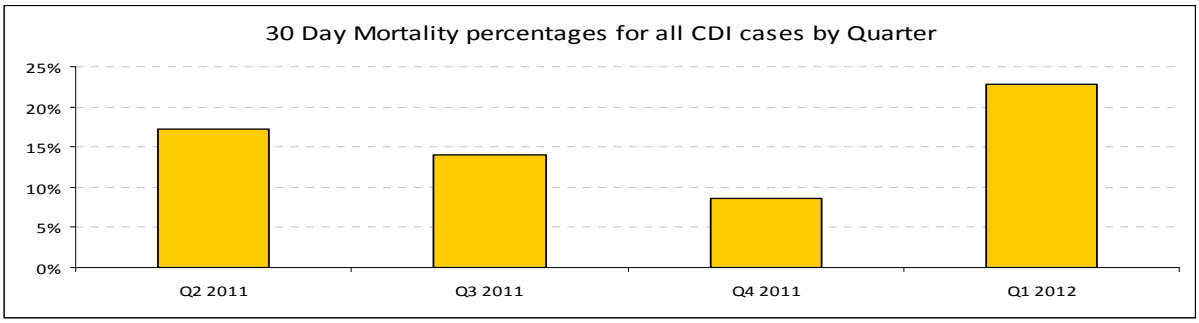
3.1.2 Cumulative number of Post 48hrs *Clostridium difficile* infections (CDI) against trajectory



3.1.3 Number of Pre 48hrs *Clostridium difficile* infections (CDI) for the period April 2011- March 2012

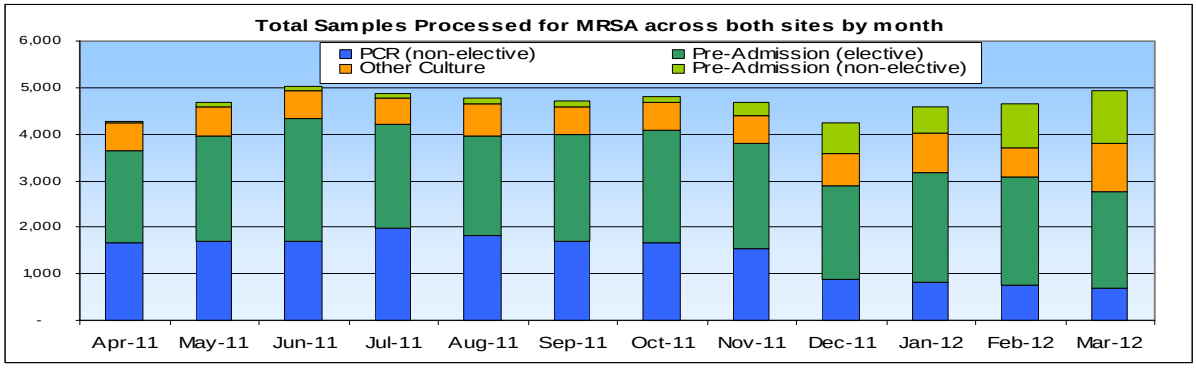


3.1.4 *Clostridium difficile* 30 day Mortality

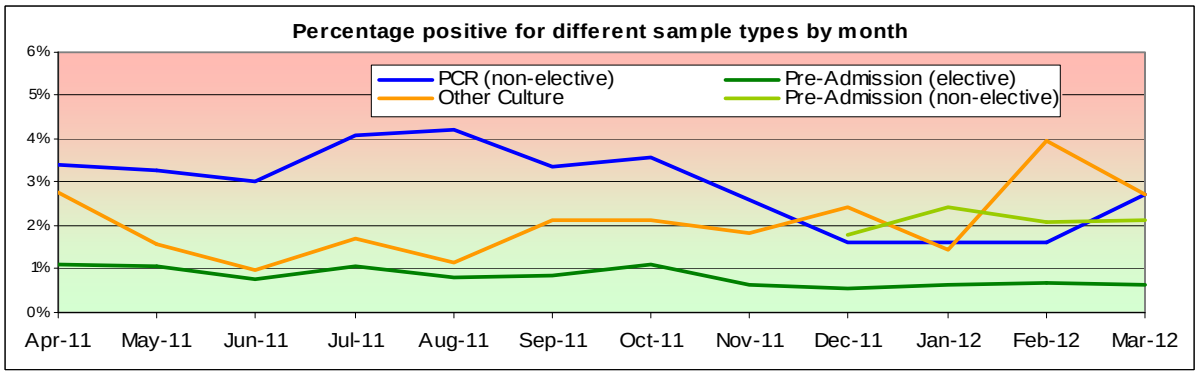


3.2 Meticillin Resistant *Staphylococcus aureus* (MRSA)

3.2.1 Number of MRSA Screening undertaken by month for the period April 2011- March 2012

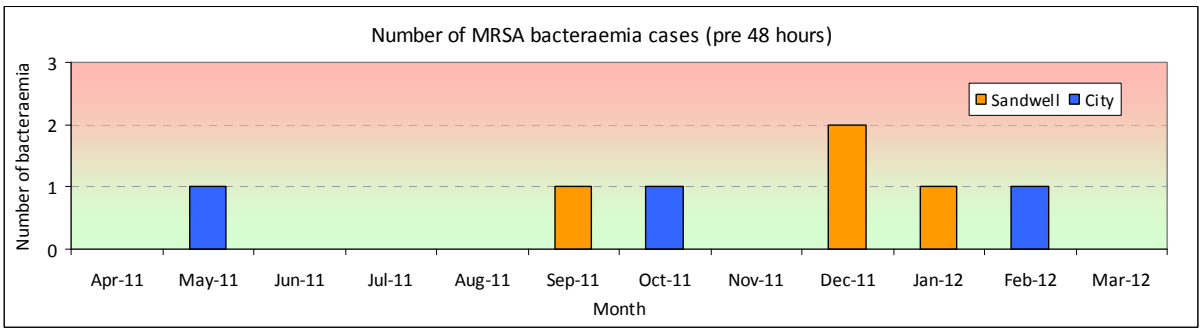


3.2.2 Graph to identify the percentage positively rate of MRSA screens by month for the period April 2011- March 2012

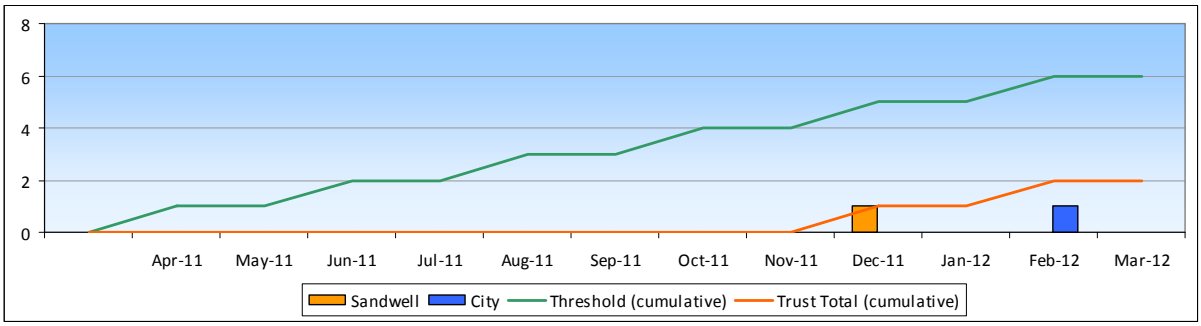


3.2.3 Number of MRSA Bacteraemia's for the period April 2011- March 2012

3.2.3.1 *Mandatory Reporting of MRSA bloodstream infections (pre-48hrs)*

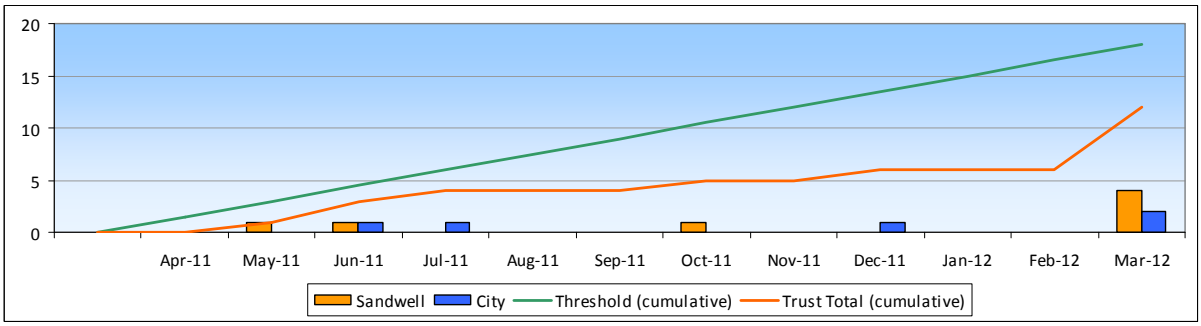


3.2.3.2 *Mandatory reporting and cumulative number of Post 48hrs MRSA Bacteraemia against trajectory*

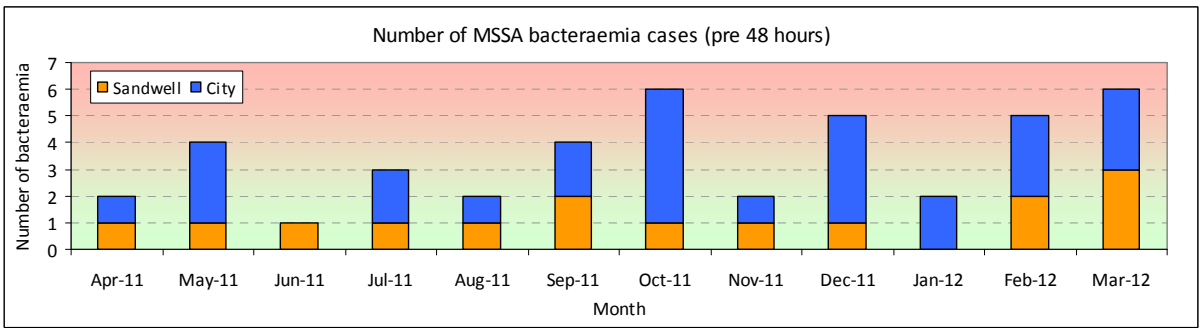


3.3 Number of Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia's by month for the period April 2011- March 2012

3.3.1 Post 48 Hours MSSA

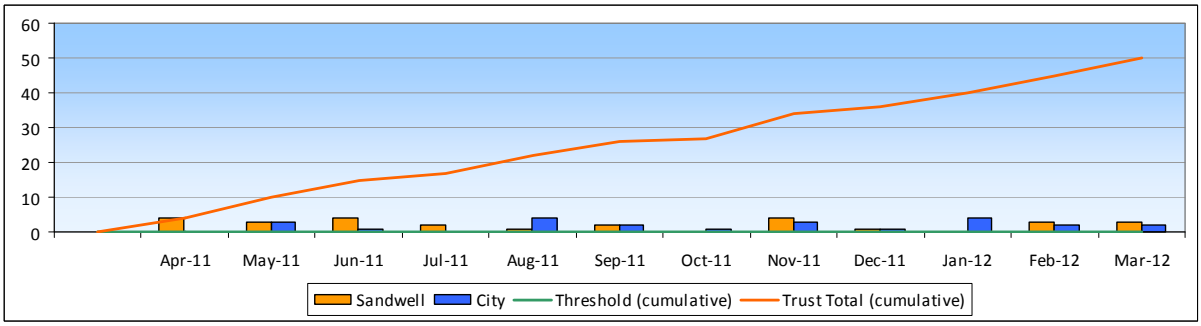


3.3.2 Pre 48 Hours MSSA

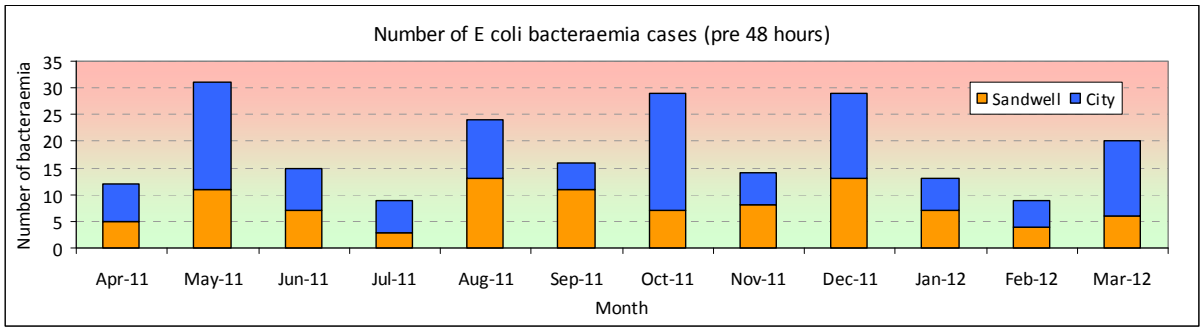


3.4 *Escherichia coli* (E. Coli) bacteraemia's by month for the period April 2011- March 2012

3.4.1 Post 48 Hours E. coli Bacteraemia's



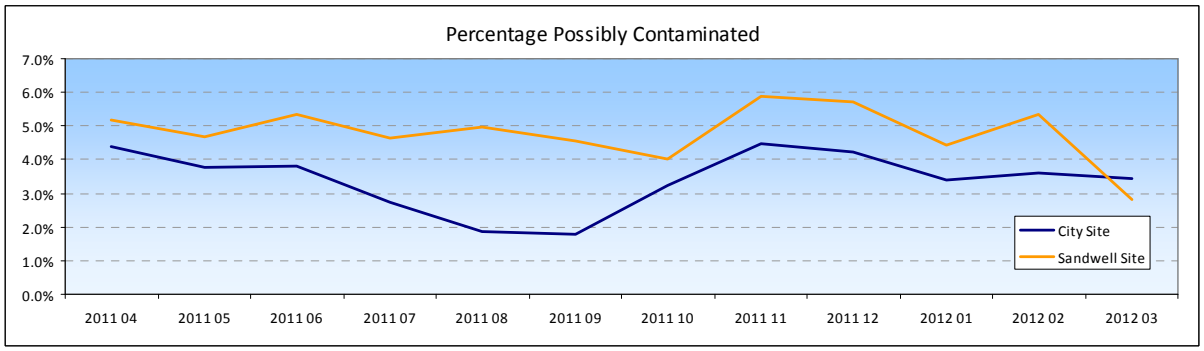
3.4.2 Pre 48 Hours E. coli Bacteraemia's.



3.5 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.

3.5.1 Percentage of all positive blood cultures that are possible contaminates by month for the period April 2011- March 2012



3.6 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). The Trust also cares for an increasing number of complex patients with multiple co-morbidities, socio-economic issues and complicated TB infection.

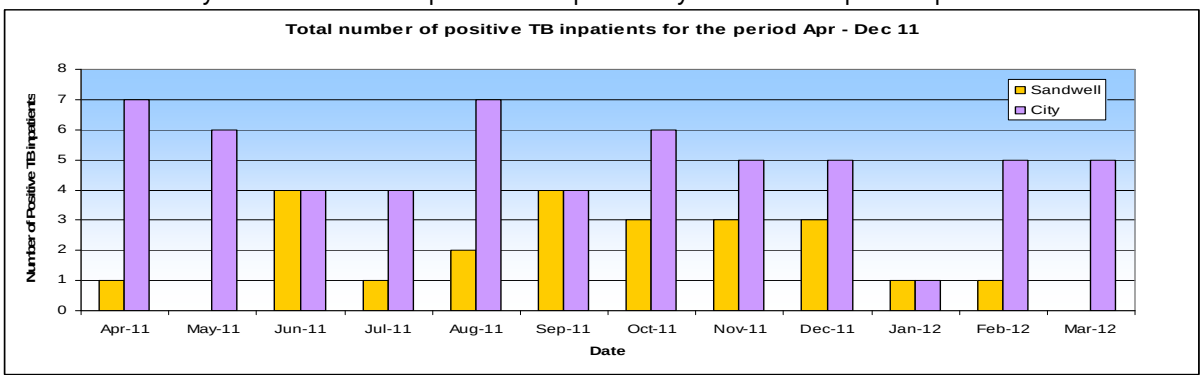
Patients with TB are identified to the IPCS from either clinical specimen received in laboratory or by clinical diagnosis at ward/departmental level (i.e. imaging) or via the community chest clinics/GP's. All patients with TB are nursed in line with respiratory and infection control guidance. All patients 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 97 in patients diagnosed with TB for the period April 2011- March 2012. Of these, 82 were diagnosed with pulmonary TB from positive laboratory isolates (e.g. Sputum specimens, bronchial washings), 12 were confirmed as non-pulmonary TB or clinically diagnosed cases, and 3 were confirmed as Multi-drug resistant figures (MDR-TB) from positive laboratory isolates (e.g. Sputum specimens, bronchial washings).

Outlined below are a series of tables identifying: - 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.

The Multi-drug resistant figures (MDR-TB) are those patients with confirmed MDR-TB, though their initial TB diagnosis may have been some time previous to the date when MDR-TB was confirmed.

3.6.1 Chart to identify the total number of positive TB inpatients by month for the period April 2011- March 2012



3.6.2 Number of confirmed cases of drug sensitive PTB as inpatients

PTB	Apr 2011	May 2011	Jun 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2011	Feb 2011	Mar 2011	Total
Sandwell	1	0	4	1	2	4	3	3	3	1	1	0	23
City	7	6	4	4	7	4	6	5	5	1	5	5	59
Total	8	6	8	5	9	8	9	8	8	2	6	5	82

3.6.3 Number of confirmed cases of MDRTB as inpatients.

MDR TB	Apr 2011	May 2011	Jun 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2011	Feb 2011	Mar 2011	Total
Sandwell	0	0	0	0	0	0	0	0	0	0	0	0	0
City	0	1	1	1	0	0	0	0	0	0	0	0	3
Total	0	1	1	1	0	0	0	0	0	0	0	0	3

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

Non PTB	Apr 2011	May 2011	Jun 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2011	Feb 2011	Mar 2011	Total
Sandwell	0	0	0	0	1	0	1	1	1	0	0	0	4
City	0	0	1	1	1	2	0	0	2	0	1	0	8
Total	0	0	1	1	2	2	1	1	3	0	1	0	12

4. Antibiotic stewardship

Antibiotic stewardship

The Antibiotic Management Group (AMG) meets regularly to monitor antimicrobial consumption, develop guidelines and promote antimicrobial stewardship. The group has traditionally been made up of consultant microbiologists and antibiotic pharmacists, but the membership is being expanded to include representation from junior medical staff and nursing staff.

In November 2011, the Advisory Committee on Resistance and Healthcare Associated Infections (ARHAI) released guidance on antimicrobial stewardship called 'Start Smart then Focus'. The launch coincided with European Antibiotic Awareness day, and was marked in the trust by presentations to medical staff at grand round and physician meetings. The AMG is continually working to ensure that antimicrobial stewardship within the Trust meets the recommendations of 'Start Smart then Focus' and has a work plan in place to address any gaps.

The importance of appropriate antibiotic prescribing is outlined to all new doctors during induction and throughout the year during dedicated teaching sessions. All doctors receive a pocket sized summary of the antibiotic

guidelines, and a dedicated antibiotic guidelines website has been created to allow ease of access to guidelines and supporting information. All wards have poster copies of the guidelines for quick reference during ward rounds.

In 2011-2012, major sections of the Trust antibiotic guidelines were updated, including sections on respiratory and gastroenterology infections in adults, guidance on therapeutic drug monitoring in neonates, and antibiotic prescribing for paediatrics. These updates were approved by the Drugs & Therapeutics committee and the relevant governance bodies.

Pharmacists are encouraged to challenge inappropriate prescribing and receive an annual update in appropriate prescribing. All new starters now receive a dedicated antibiotic induction. The pharmacy department has a procedure for stopping antibiotics which have not had a stop/review date specified after five days, approved by the Drugs and Therapeutics Committee, which helps to limit inappropriate antibiotic durations, reducing the risk of side effects, resistance development and super infection with organisms such as *Clostridium difficile*. Ward pharmacists take part in a monthly antibiotic snapshot survey, which gathers data on a number of indicators including proportion of patients on antibiotics, proportion with allergy status recorded, proportion on IV antibiotics etc. Work is ongoing to build a system to feed this information back to wards and prescribers. The antibiotic stewardship CQuIN target for 2012-2013 will provide a mechanism to achieve this.

Patients receiving antibiotics for greater than five days are monitored periodically to assess compliance with Trust antibiotic guidelines. 'Start Smart then Focus' recommends a number of audits to demonstrate antibiotic stewardship, and those not currently being performed will be included in the annual audit plan for the AMG.

A number of guidelines have been developed over the last financial year, including:

- Guidelines for the use of narrow spectrum antibiotics (vancomycin and gentamicin) in neonatal patients
- Updated guidelines for the diagnosis and management of respiratory tract infections
- Guidelines for the diagnosis and management of skin and soft tissue infections
- Guidelines for the diagnosis and management of gastroenterology infections
- Guidelines for the diagnosis and treatment of infections in neonates
- Guidelines for the diagnosis and treatment of infections in children

Restricted antibiotic consumption is monitored closely and also reported on a monthly basis to the D&T (Drugs and Therapeutics) Committee. Incident reports relating to antibiotics are monitored quarterly and reported to the Antibiotic Management Group. Surveillance forms a key part of antimicrobial stewardship, and in September/October 2011 members of the infection control team and an antibiotic pharmacist took part in a European wide point prevalence survey of healthcare associated infection and antimicrobial consumption, organised by the Health Protection Agency (HPA). All inpatients were surveyed. The final report from the HPA is awaited, which will provide a comparison between SWBH NHS Trust and other similar trusts in England.

The aim of the Antibiotic Management Group for 2012-2013 is to complete the update of the Trust antibiotic guidelines to provide information on diagnosis, treatment and monitoring for the types of infections seen within the Trust. Ensuring that the antibiotic stewardship CQUIN is met is a key priority; completing this will help to further inculcate antibiotic stewardship within the organisation.

Consideration is being given to developing an antibiotic guidelines app for Smartphones and android operating system phones, which would allow ease of access for users of Smartphone technology as well as a simple way to ensure guidelines were up to date and accessible at all times. The expertise to develop this lies outside the AMG and support will be required from IM&T to progress this in 2012-2013.

5. Summary of Outbreaks/Investigations/Periods of Increased Incidence (PII) and Increased incidence of infection.

The management of outbreaks and PII's is an intrinsic feature in the practice of the Infection Prevention and Control Services. The severity of an outbreak is generally dependent on the type of infective organism and its virulence. Small outbreaks occur reasonably frequently requiring immediate investigation and control measures. On the other hand, large or protracted outbreaks can be extremely expensive and offsetting to the hospital. All outbreaks present an increased cost to healthcare settings and thus require quick action and a structured management approach to

control their impact. Communication with the wider health economy (e.g. HPU, PCT) is intrinsic to the management of outbreaks.

	Outbreak	Summary
5.1.	Diarrhoea and/or vomiting	In order to prevent the spread of enteric infections it is policy to isolate any patient admitted with, or developing symptoms of diarrhoea and/or vomiting into a side room implementing enteric precautions. Outbreaks of diarrhoea and /or vomiting are monitored by infection control on an ongoing basis in line with national and local guidelines. The measures taken to control outbreaks are based on the severity of the outbreak and the ability for organisms to cross infect. During the period March 2011- April 2012 there were a total of 28 occasions where ward closures were required attributed to D&V. Of those 28 occasions, closures by site equated to City 15, Sandwell 12 and Intermediate Care 1. The outbreaks involved a total of 307 patients and 85 staff. Wards were closed for a total period of 217 days with a range of between 2 and 17 days dependent upon severity of the outbreak (see appendix 1)
5.2	Meticillin Resistant *Staphylococcus aureus* – Henderson Intermediate Care Facility	An infection control investigation was undertaken on the Henderson Unit at Rowley Regis Hospital in February 2012 following the identification of 9 patients colonised with Meticillin Resistant *Staphylococcus aureus* (MRSA) from 28 day post admission screening specimens taken in line with the Trust MRSA Policy (see appendix 1). No patients had any signs of clinical infection. Following identification of the cluster, all patients were screened for MRSA (all other patients were negative for MRSA on screening) and all MRSA positive patients received decolonisation treatment. The Unit was closed for 4 days to facilitate a deep clean programme. A detailed Action Plan was produced and infection control measures have been implemented. Hand hygiene has been reinforced and training for all of the staff on the unit has been commenced.
5.3	<u>Mycobacterium tuberculosis</u> The catchment area served by SWBH Trust has one of the highest prevalence of tuberculosis in the country. Both the Department of Health and World Health Organisation have set new guidance for the diagnosis and management of TB, with recommendations for auditing practice. The ICS and Microbiology Department will continue to audit practice within the Trust, especially appropriate isolation of patients with suspected or confirmed tuberculosis and use of appropriate personal protective equipment. The ICS will continue to advise on the management of these patients and co-ordinate contact tracing for exposures occurring within the Trust, as well as co-ordinating meetings for cases of multi-drug resistant tuberculosis	
5.3.1	TB Maternity Case #1	A case of smear positive (infectious) TB in a post natal patient was diagnosed in May 2011. On further questioning the patient had been symptomatic during her pregnancy but had chosen not to disclose her symptoms. Her history included several stays on both the antenatal and postnatal wards, Serenity and Labour wards. A full investigation was undertaken in conjunction with both HPUs (Health Protection Units) and both Sandwell and Birmingham and Solihull PCTs as she was a healthcare worker in another PCT. An Incident meeting was convened (represented were Infection Control, Maternity medical consultants, midwives and community midwives, Occupational Health (OHD), Consultants in Communicable Disease Control, Primary Care Trusts and Health Protection Agency). An extensive contact tracing was undertaken including all staff, patients and babies potentially exposed to the patient. 29 cases (31 babies including 2 sets of twins) were identified as potentially exposed and followed up. Several follow up meetings were held to ensure that the follow up of the patients was completed. To date there have been no confirmed cases of TB as a result of this incident.
5.3.2	TB Maternity Case #2	A second case of smear positive TB in a post natal patient was diagnosed in August 2011. This patient had also been symptomatic prior to her pregnancy but had chosen

	Outbreak	Summary
		not to disclose her symptoms to the antenatal clinic. She had also spent several hours on the antenatal and postnatal wards, as well as Serenity and Labour Wards. An Incident meeting was convened (represented were Infection Control, Maternity medical consultants, midwives and community midwives, Occupational Health (OHD), Consultants in Communicable Disease Control, Primary Care Trusts and Health Protection Agency). A full investigation was undertaken. 7 babies and 7 mothers were potentially exposed. To date contact tracing has not revealed any confirmed cases of TB as a result of this incident. One of the outcomes of these two incidences was a campaign to increase awareness of TB in antenatal patients in both the acute and community settings, and to address the social stigma that may be associated with this condition. Teaching sessions were held to highlight the problem.
5.3.2	TB cluster - Birmingham	As part of the process of diagnosing TB infection, positive isolates are typed using a sophisticated typing system. Where typing results show a cluster of the same strain, an investigation is undertaken to see if the cases can be linked. In March 2011, such a cluster was determined, with a unique strain of TB. The cluster involved 2 members of the same family (spouses) plus a close friend of the family, plus a healthcare worker within the Trust. A fifth person was also identified, who had no apparent links with the other cases and who was diagnosed post-mortem. A cluster meeting was convened, with Infection Control, Consultants in Communicable Diseases and TB nurses in attendance. An investigation was undertaken and it was determined that the 3 cases within the family were likely to be linked to each other, but there was no link between them and the healthcare worker (who had not cared for any of these patients) or the patient who had died. There have been no further cases of TB due to this strain within the region.
5.4	Invasive Group A Streptococcus Infection (*BHSA*)	On the 17th May 2011, three patients on ward Lyndon 5 at Sandwell hospital were identified as either having or have had a Group A Streptococcal (GAS) infection in the preceding 27 days. Two patients were positive in their blood cultures (invasive Group A Streptococcus [iGAS]) and one in their sputum specimen (GAS). A full investigation was undertaken and action taken to include:- Isolation of patients in side rooms on the ward, contact tracing and screening undertaken and decontamination of the environment and equipment. An outbreak meeting was convened(represented were Infection Control, Lyndon 5 medical consultants, Occupational Health (OHD), Consultants in Communicable Disease Control, Primary Care Trusts and Health Protection Agency. Subsequent typing showed they were the same strain for all 3 patients. Information from the reference laboratory states that this strain is found in a higher incidence rate in the West Midlands compared to the rest of the country.
5.5	Pseudomonas in waters	In January 2011 the neonatal unit (NNU) started screening for the presence of *Pseudomonas aeruginosa* in faecal screens, in addition to the usual screening for MRSA, gentamicin resistant coliforms and extended spectrum beta lactamase producing (ESBL) organisms. Several babies were identified to be colonised with *Pseudomonas aeruginosa* every month, although no baby ever exhibited signs of infection with this organism. As a result of this, in July 2011, Infection Prevention and Control and Microbiology, in conjunction with NNU and Estates, undertook and extensive investigation to

	Outbreak	Summary
		determine any possible sources of this organism. Environmental screening was negative; however water from the electronic sensor mixer taps on the unit showed heavy colonisation with *Pseudomonas aeruginosa.* These taps all had a plastic flow straightener contained in the tap outlet to control flow of water; these were also found to be heavily colonised with *Pseudomonas aeruginosa.* An outbreak meeting was convened with representation from Infection Control, NNU Consultants, Estates, Facilities, Consultants in Communicable Disease Control, Primary Care Trusts and Health Protection Agency. An action plan was implemented to: i/ remove all of the flow straighteners ii/ thermally disinfect all of the taps iii/ increase both the flushing time and flushing frequency of all of the taps. This was in conjunction with heightened awareness of infection control practices, although no breaches were found on investigation. A two step cleaning regimen for the sinks was reinforced. All babies were initially bathed with sterile water and all staff use alcohol hand rub after washing their hands. These measures have proved to be successful in reducing the level of *Pseudomonas aeruginosa* in the water coming out of the taps on NNU to zero and levels have remained undetectable for several months. The incidence of *Pseudomonas aeruginosa* on faecal screens has dropped significantly to less than one a month. Following this incident, it was felt that the same investigations should be undertaken on our other augmented care units, namely the two Intensive Care Units, even though there had been no concerns on surveillance of clinical specimens about the presence of *Pseudomonas aeruginosa.* Both units were found to have the same problem and an extensive tap replacement and disinfection programme has been undertaken. In March the Department of Health issued guidelines for water sampling and management of *Pseudomonas aeruginosa* in tap water on augmented care units. The actions and practices outlined are similar to those already adopted on our augmented care units. We continue to monitor for the presence of this organism on our augmented care units and are currently undertaking water testing on Newton 5, our Haematology unit.

6. Audit

Audits are seen as a central approach to maintaining clinical effectiveness and as such plays an integral part of Infection Prevention and Control in the prevention, control and management of infections. Audits undertaken comply with current guidelines and legislation (Essence of Care, the NHS Plan and the National Standards of Cleanliness in the NHS). Audits undertaken cover all areas of clinical and non-clinical practices in relation to infection control. Monitoring of compliance with laid down infection control practices, policies and standards in clinical settings have been established as an effective method of identifying examples of good practice and areas where improvements in practice are required. This helps to improve the quality of care delivered to patients and decreases the risk of cross infection to and from patients and staff. In addition to the audit programme the IPCS will undertake specific audits as part of investigations of outbreaks and increased incidence of infection. All audits are feed back to the person in charge at time of audit followed by a written report to the ward manager and matron and a corporate summary report (see appendix 2)

7. Decontamination.

Decontamination is a key function in reducing healthcare care associated infection. Issues relating to decontamination have been identified though various methods to include:- observation of practices, audit using both the Department of Health/ Infection Prevention Society (formally Infection Control Nurses Association) tool and individual audits dependent upon the type of practice or equipment involved. All audits are aimed at ensuring

practices applied by the trust comply with National recommendations to include:- Health Technical Memorandum, NICE Guidance and Legislation.

The decontamination manager advises the decontamination lead on issues relating to decontamination including the annual decontamination programme in relation to the organization ensuring that it takes proper account of relevant national guidelines. Each year during February, a decontamination progress report is circulated. Please see appendix 3 for the update of the status of the 2011 Decontamination program. Objectives that are not completed will be carried over as part of the next annual decontamination program.

The decontamination programme for 2012/13 is monitored for progress via the infection control operational committee and the medical device committee meetings.

8. Education and Training.

Education and training is seen as an integral part of improving and maintaining both good clinical and non practice across the organisation and facilitating the prevention and reduction of HCAI's. During 2011-2012 infection prevention and control have continued to promote best practice through formal and informal teaching on wards and departments. To improve compliance Infection prevention and control has continued to develop the role of the 'Infection Control Champions' with bi monthly workshops. These workshops are aimed at both updating the champions on key infection control issues and empowering champions to promote good infection control practices in the workplace.

In addition to the above, the IPCS continues to support the mandatory training and induction programme. They specifically undertaking focused training for medical staff on both their mini inductions and annual induction, where in conjunction with the IV Team, all new doctors to the organisation are trained in hand hygiene and the taking of blood cultures to determine level of competency with an aim of obtain blood cultures that are clinically significant and reducing the number of blood culture contaminants.

In addition to supporting medical staff the IPCS have a commitment to training student nurses both internally to the organisation, with teaching undertaken in the classroom and as part of their allocation to the IPCT as part of their time spent on the isolation ward and externally to the organisation, supporting Birmingham City University.

9. Informatics

Microbiology Informatics has continued to provide a wide range of support to and for Infection Prevention and Control through a combination of standing, bespoke and innovation outputs.

Standing information is centred on a number of daily, monthly, quarterly and annual data outputs which provide on-going knowledge of trends in infectious disease, monitoring, prevention and quality and input of mandatory surveillance data to the HPA e.g. Numbers of MRSA bacteraemias and *C. difficile* cases

Principle amongst these outputs is the Informatics contribution to the Monthly Infection Prevention and Control Report which provides accumulative surveillance in a number of key areas. These include monitoring MRSA and MSSA rates in situations including bacteraemia, general infection and screening, Blood Culture specimen contamination rates, E. Coli bacteraemias, C.dif and other alert organism monitoring. In particular Informatics maintains a highly developed in-house database of *Clostridium difficile* reports which enables on-going monitoring of mortality and survival rates.

During 2012 Microbiology Informatics has been involved in a number of innovation projects to enhance the quality of infection prevention and control reporting. These include the timely delivery of infectious disease related information by email directly from the laboratory Information System. Included in these are alerts generated from positive findings made during ante-natal screening, the responsibility for which has recently passed to SWBH following cessation of NBS provision. In a joint project with SWBH Trust IT, a system was devised whereby positive results are flagged by an automatically generated code which is captured in the main Trust Interface and pointed at an nhs.net email address group containing the address of relevant staff. This system and similar ones, now fully established, have and are being extended to other areas, including infections disease findings for units overseen by client administrative authorities including Birmingham Community Services, Sandwell PCT, HMP Winston Green and Birmingham and Solihull Mental Health Trust. In a similar vein a new reporting mechanism using direct email

has been introduced to aid environmental water monitoring throughout the Trust. Reports are forwarded, without paper copies, to relevant parties and are so constructed as to be able to be printed off and used as local action sheets.

10. Future Plans

The IPCS will continue to work closely with other health care professionals both within the Trust and externally to develop, promote and maintain areas of good practice.

As part of the infection control programme for 2012-2013 the IPCS will focus on the following objectives:-

- Review and update infection control policies
- Review and update patient information.
- Review and update infection control pages on both the internet and intranet.
- Review and update the Mandatory programme with a focus on e-learning
- Review and update the Induction programme for infection prevention and control.
- Continue to promote good antibiotic stewardship.
- Continue to undertaken 'target organisms' surveillance.
- Monitor compliance against:-
    - Nationally agreed standards e.g. MRSA, C.difficile.
    - E. Coli bacteraemias – urinary related.
    - Extended Spectrum ßeta lactamase producing organisms
    - Meticillin Sensitive *Staphylococcus aureus*
- Review and update surgical site surveillance programme with particular attention to caesarean sections.
- Continue to review, monitor and standardise effective decontamination across the organisation to ensure systems of monitoring are in place where appropriate.
- Continue to promote infection prevention and control practices through education and training.
- Continue to inform the public of infection control initiatives through road shows and public information campaigns.
- Develop work as part of vertical integration with the provider arm of Sandwell PCT.
- Collaborative working with community colleagues to standardise infection control practices across the health economy.
- Informatics
    - Continue to support the IPCS through the production and development of reports
    - Develop systems for antibiotic monitoring, with a view to collaborative working with the West Midlands HPA to provide a regional approach
    - Further develop electronic reporting, particularly as part of a LEAN reorganisation of Tuberculosis testing. Utilising recent development in the capability to deliver emails on non-registered patients makes this possible, so that Consultants and Specialist Nurses will receive personal email reports seconds after their authorisation

Appendix 1

Table to identify a summary of outbreaks/Period of increased incidence (PII) and ward closures for the period April 2011–March 2012

Month outbreak/PII started	Ward	Predominant symptoms.	Number of patients involved	Number of staff Involved	Did the ward close?	No. of days ward closed	Causative organism identified
Mar-11	P5	D&V	15	7	YES	8	Norovirus
Apr-11	D17	D&V	14	4	YES	16	Norovirus
May-11	N3	D&V	8	7	YES	9	Norovirus
May-11	D47	D&V	17	3	YES	17	Norovirus
May-11	P3	D&V	19	3	YES	11	Norovirus
May-11	N4	D&V	19	9	YES	16	Norovirus
May-11	P4	D&V	22	2	YES	15	Norovirus
May-11	L4	D&V	9	1	YES	3	Not identified
May-11	D7	D&V	13	5	YES	11	Norovirus
May-11	D5	D&V	9	6	YES	8	Norovirus
Aug-11	EAU	D&V	11	1	YES	4	Not identified
Aug-11	CCU	D&V	3	1	YES	4	Not identified
Aug-11	P5	D&V	3	0	Bay 2 only	3	Not identified
Sep-11	D7	D&V	12	9	YES	11	Norovirus
Oct-11	D17	D&V	12	0	YES	2	Not identified
Nov-11	D18	D&V	9	0	YES	10	Norovirus
Jan-12	D16	D&V	20	10	YES	14	Norovirus
Jan-12	D26	D&V	4	3	YES	3	Norovirus
Feb-12	D27	D&V	4	0	YES	3	Not identified
Feb-12	D26	D&V	2	0	YES	1	Not identified
Feb-12	D20	D&V	2	0	YES	1	Not identified
Feb-12	P5	D&V	21	12	YES	17	Norovirus
Feb-12	Leasowes	D&V	8	0	YES	6	Not identified
Feb-12	D7	D&V	10	0	YES	6	Not identified
Feb-12	D17	D&V	15	1	YES	8	Not identified
Feb-12	N4	D&V	11	0	YES	5	Not identified
Feb-12	Henderson	MRSA	9	0	YES	4	MRSA
Feb-12	N3	D&V	8	1	No	0	Not identified
Mar-12	Ly1	D&V	7	0	YES	5	Rotavirus
Total	-	-	316	85	-	221	-

Appendix 2

Summary of audits undertaken by Infection Prevention and Control Service 2011/12

	Category	Name of Audit	Status
INFECTION CONTROL	Clinical Practice Audits	PPE	Completed
		Hand Hygiene	Completed
		Isolation Precautions/risk proforma	Completed
		Enteral Feeding	Completed
		Peripheral lines	Completed
		Short term non-tunnelled CVCs	Completed
		Short term urethral catheters	Completed
		Blood Culture Stations	Completed
	General	Handling and Disposal of Linen	Completed
		Documentation	Completed
		Safe handling and disposal of sharps	Completed
		Dept Waste handling and Disposal/waste	Completed
	Food Hygiene	Main kitchens and outlets	Completed
		Ward/dept kitchens	Completed
	Decontamination	Environment	Completed
		Patient Equipment (General)	Completed
		Patient Equipment (Specialist areas)	Completed
		Decontamination of Scopes	Completed
		Review of endoscopy in line with national standards	Completed
		Decontamination of specialist beds	Completed
		Review of laundry facilities	Completed
		Review of patient transport	Completed
		Review of NNU decontamination	Completed
		Theatres	Completed
		Review of Mortuary	Completed
		Review of Ophthalmology OPD	Completed
		Review of Hydrotherapy	Completed
		Review of Hotel Services monitoring of cleaning standards in relation to using ATP monitors	Completed
		Oral Surgery	Completed
		Imaging (Including Mobile Breast Screening)	Completed
ANTIBIOTIC PHARMACIST	Audit	Antibiotic prescriptions of greater than 5 days duration	Completed
		Time delay between prescribing and administration of IV antibiotics	Completed
	Surveillance	HPA Point Prevalence Survey of Healthcare Associated Infection and Antimicrobial Consumption	Completed
		Monthly point prevalence surveys of antimicrobial consumption	Completed
		Surveillance of restricted antibiotic consumption and monthly report to Drugs & Therapeutics Committee	Completed

Appendix 3

The table below identifies the progress status of the 2011 Decontamination program.

Key to action plan	
Status	
Dark Green	Complete
Light Green	On track
Amber	Some delay but expected to complete as planned
Red	Significant delay
White	Not yet commenced

	OBJECTIVE	STATUS	OUTCOME
1.	Centralize decontamination of nasendoscopes on the Sandwell site by utilizing the facilities within endoscopy.		• Manual local decontamination has been removed from Sandwell ENT OPD.
2.	Centralize decontamination of Transoesophageal Ecocardiography (TOE) probes (Cardiology) by utilizing the facilities within endoscopy City site.		• Manual decontamination of TOE probes used in Cardiology departments has been removed.
3.	To identify decontamination practices within the community for Medical Devices		• List of equipment, location and current practices provided by Infection Control nurse working in the community.
4	Manual handling equipment No guidance for the use and decontamination of Manual handling equipment		• Partnership working with trust ergonomics advisor to provide all wards/departments with a hard copy listing equipment, how to use and decontamination method.
5	Macerator breakdowns – Trial Maceratable wipes		Issue Identified: Blocked macerators continue to cause immediate and more extensive problems to the ward. Infection control and the supplies department were requested to review the supplier market and source some Dry Maceratable wipes to review their suitability. Actions included a two phase trial 1) Gauge the opinion of the ward staff regarding suitability, identify a preferred wipe. 2) Trial preferred wipe in 4 areas and ascertain if there is any improvement to the macerators. • 4 wards chosen (D11,D47,EAU and Lyndon 3) • 3 suppliers identified • Each product trialled for 2 weeks and evaluated Supplies provided a cost analysis of the wipes (fig 1) and estates was asked to provide to supplies costing relating to the manpower hours used, number of contractor call outs and the out of hours calls. Fig 1. Current usage • VJT050 (DRY CONTI WIPE) 54,684 (packs of 100) £62,339.76 • VJT135 - Robinsons 109,368 (packs of 50) £147,646.80 Cost pressure of £85,307.04 (£1.35 per pack) Conclusion - The monies spent by estates did not equate to the organisation cost pressure therefore any change was not viable
6	Disposable Pulp trial		Pulp Standardised Trust wide Saving £22,609.00
7	Review sanitising wipes		Product change Trust wide Saving £25.000.00

8	Hydrogen peroxide Environment Decontamination		Assisted hotel service with evaluation of products Current product continually breaking down. Hotel services requested that a joint venture be undertaken to review and evaluate two products capable of decontaminating the environment using hydrogen peroxide. Following the evaluation Hotel services would work with the successful supplier to ensure that enough machines were purchased to safely decontaminate areas, train staff and produce operational protocols.
9	Point of Care Testing - Decontamination Instructions for the Urine analysis		External company audit identified that Equipment was contaminated. Decontamination instructions provided to areas.
10	Review of Hand Therapy Services within the Hallam Building Sandwell site		Functionality of the whole area needs to be decided and other aspects such as privacy and dignity to be addressed. • Carpets need to be removed from clinical areas. • Equipment needs to be decontaminated in between each patient and be stored correctly. • There needs to be a cleaning Schedule of the Environments and Equipment. Progress is being monitored by the Director of Infection prevention Control via the Infection Control Operational Committee.
11	Sampling of Tap water in augmented care areas (NNU, ITU)		Protocol and program for sampling tap water used in Hand Wash Basins is in place. Ongoing monitoring.
12	To act as a resource for the endoscopy Sandwell unit project group.		Project team have • Carried out an optional appraisal to identify location for the decontamination area and address privacy and dignity within the existing unit. • Carried out an option appraisal of Automated Washing Machines currently on the market. • Contributed as required to the business case.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Integrated Risk Report – Q4 2011-12**
SPONSOR (EXECUTIVE DIRECTOR):	**Kam Dhami – Director of Governance**
AUTHOR:	**Allison Binns – Head of Risk Management** **Hillary Mottishaw – Head of PALS, Complaints & Litigation** **Dally Masaun – Head of Health & Safety**
DATE OF MEETING:	**31 May 2012**

EXECUTIVE SUMMARY:

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

Key incident statistics:

- There were 3465 reported incidents during Q4 2011/12 (3029 in Q4 2010/11)
- Reported clinical incidents decreased from 2293 in Q4 2010/11 to 2211 in Q4 2011/12
- Reported health & safety incidents rose from 1145 in Q4 2010/11 to 1254 in Q4 2011/12.
- There were 49 incident forms received relating to red incidents (1.5% of the total), compared with 134 in Q4 2010/11 (4.5% of the total),

Key complaints statistics:

- During the reporting period the complaints team dealt with 243.

Key claims statistics:

- Of the 29 clinical claims received in Q4, there were 4 that had a reported clinical incident related to the case. 9 claimants had already raised their concerns via the complaints procedure.

- Of the 14 personal injury claims received, none had a reported clinical incident related to the case. 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 during the reporting period was 2234

REPORT RECOMMENDATION:

Note the contents

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

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

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
High Quality Care, NHSLA
PREVIOUS CONSIDERATION:
Governance Board on 4 May 2012 and Quality & Safety Committee held on 24 May 2012.

SWBTB (5/12) 088 (a)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Risk Management Report

Quarter 4 - 2011-2012

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

Where EVERYONE Matters

Integrated Risk, Complaints and Claims Report: Quarter 4 2011/12

1. Overview

This report highlights key risk activity including:

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

2. Introduction

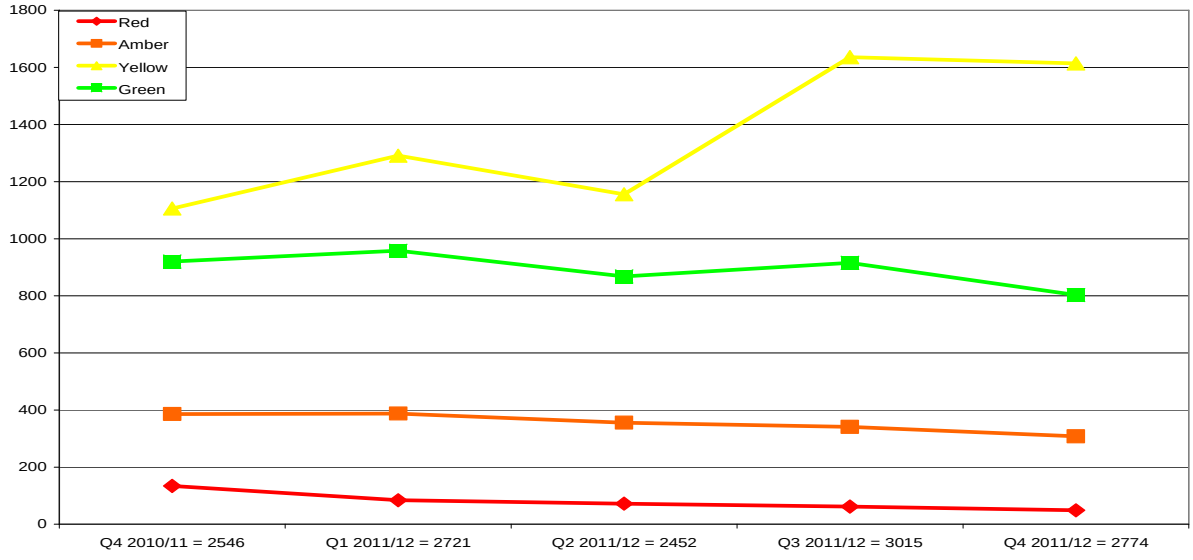
This report combines previous quarterly reports on incident/risk and complaints to implement the Policy for the Investigation, Analysis and Learning of Lessons from Adverse Events and meet NHS Litigation Authority assessment requirements. Where possible, comparisons across these areas of activity will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

3. Key Issues

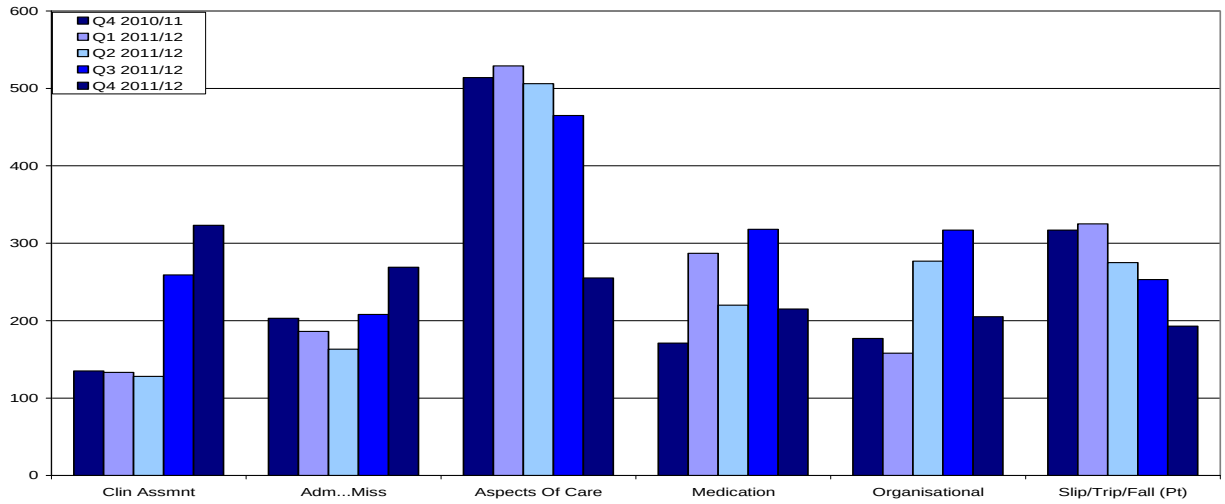
3.1 Review of Quarter 4 Incident Data

- There were 3465 reported incidents during Q4 2011/12 (3029 in Q4 2010/11)
- Reported clinical incidents decreased from 2293 in Q4 2010/11 to 2211 in Q4 2011/12
- Reported health & safety incidents rose from 1145 in Q4 2010/11 to 1254 in Q4 2011/12.
- There were 49 incident forms received relating to red incidents (1.5% of the total), compared with 134 in Q4 2010/11 (4.5% of the total),

Graph 3.1a - **Incident Trends** by risk score Q4 2010/11 – Q4 2011/12



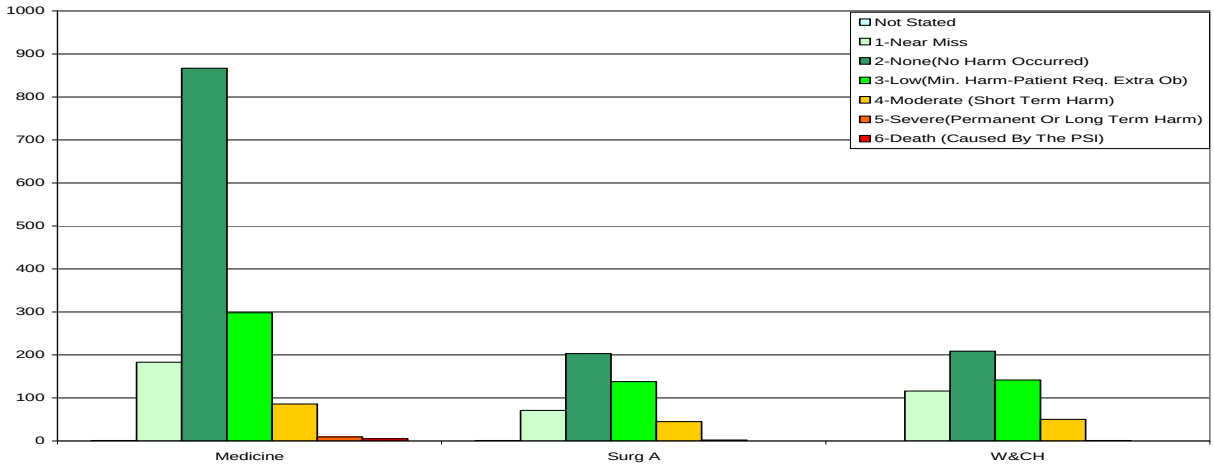
Graph 3.1b – Top 6 reported **clinical incidents** by quarter (Q4 2010/11 – Q4 2011/12)



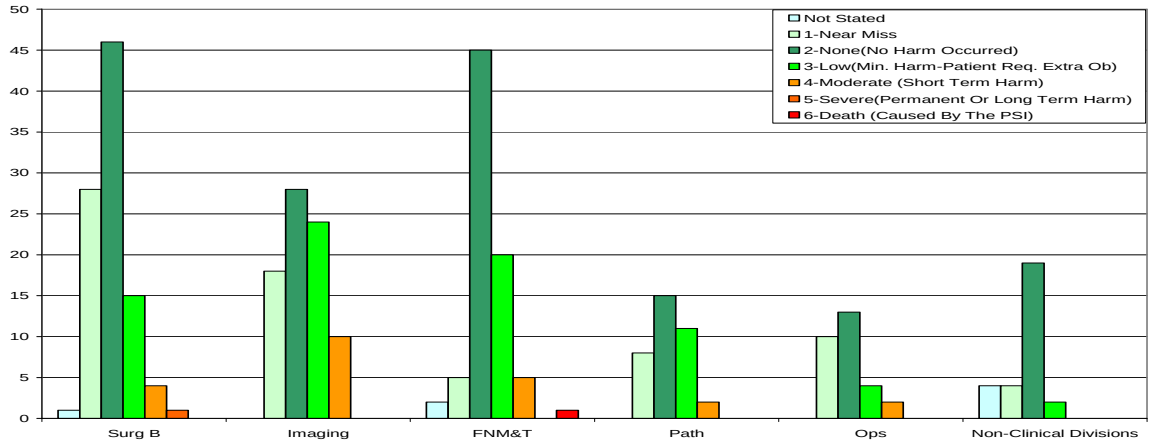
The top 6 most frequently reported categories remains consistent.

Graph 3.1c **Incidents** by reported impact by division within Q4 2011/12

Large Divisions



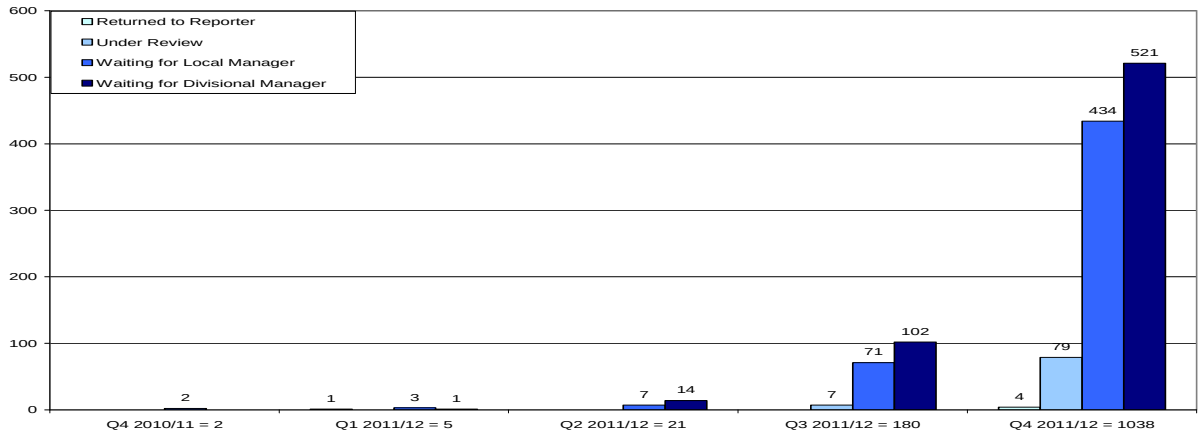
Smaller Divisions



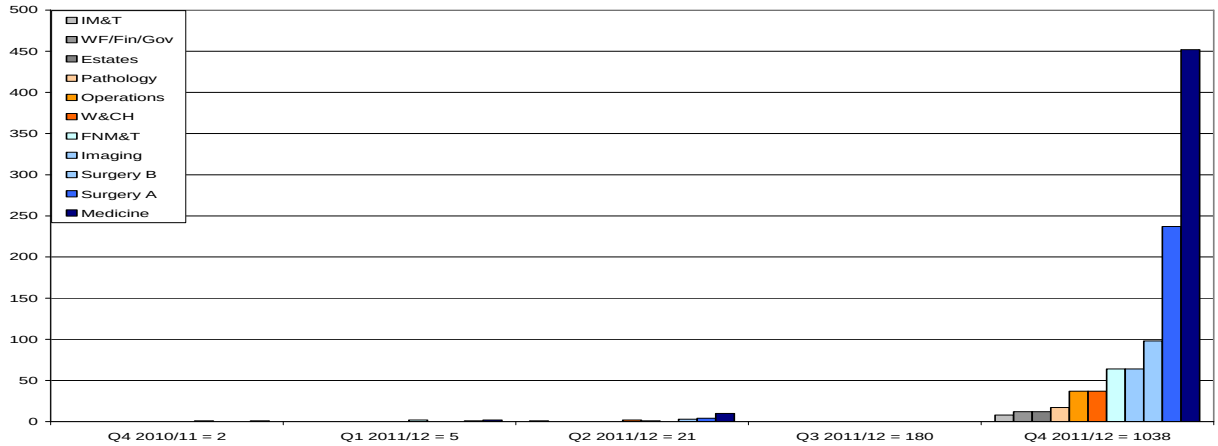
3.1.1 Web Holding

Following transition to the electronic reporting system within the hospital setting, incidents that are in the process of being “managed” are held in a virtual file before being merged into the live system. This file is called web holding.

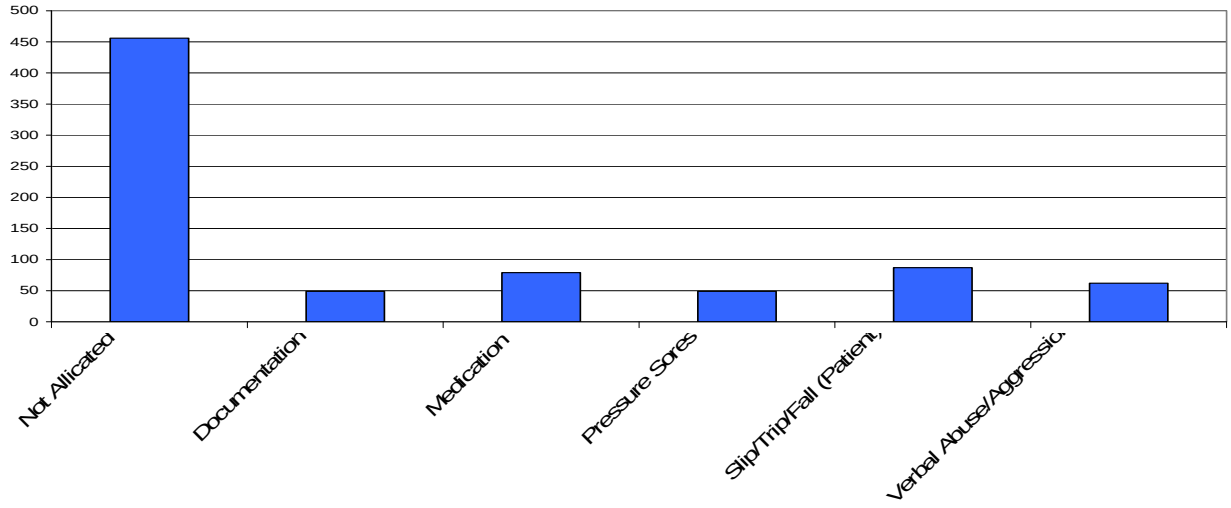
Graph 3.1.1a Incidents waiting to be managed in web holding



Graph 3.1.1b Incidents in web holding by division



Graph 3.1.1c Incidents in web holding More than 45 in Cause Group



3.2 Complaints

During the reporting period the complaints team received 243 new complaints contacts. By means of comparison, 256 contacts were received in Q4 2010/11, 252 in Q1 2011/12, 233 in Q2 2011/12, and 215 in Q3 2011/12

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

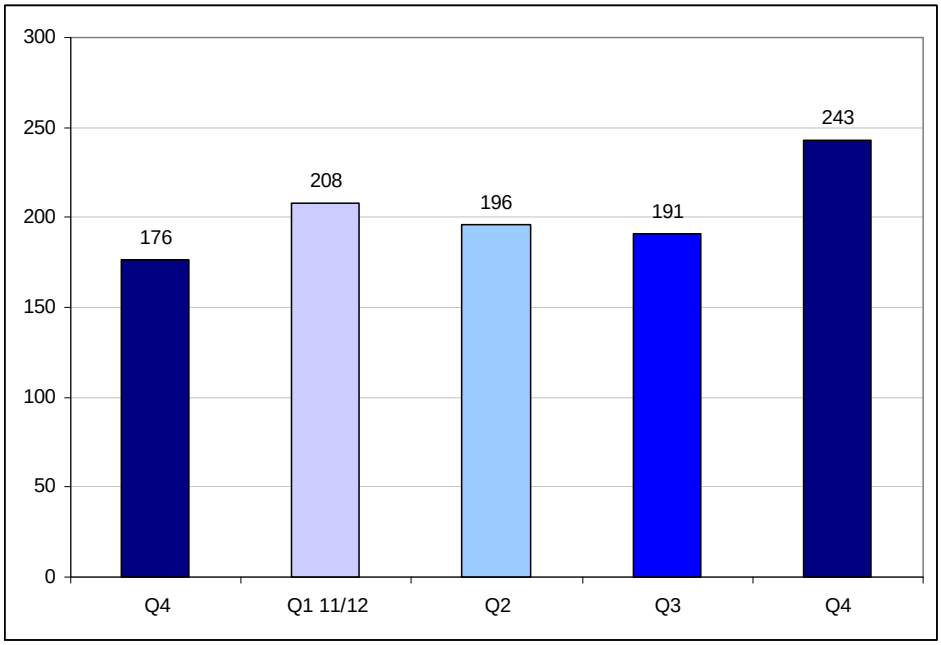
Table 3.2a Types of **Contact** during Q4

Types of Contact	Q4	Notes
Formal Complaints	196	Formal complaints with negotiated timescales
Can't Accept	8	Concerns not addressed (due to time elapsed since incident etc)
General Query/Feedback	19	Not dealt with formally (concerns/query addressed via letter)
GP/intra NHS Concerns	0	Concerns raised by GPs or other NHS organisations/staff members
Dealt with informally	0	Not dealt with formally (concerns/query addressed via phone or meeting)
Under Review	0	Pathway not finalised (e.g. reviewing records to establish whether a complaint can still be reviewed given time elapsed)
Withdrawn	20	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:

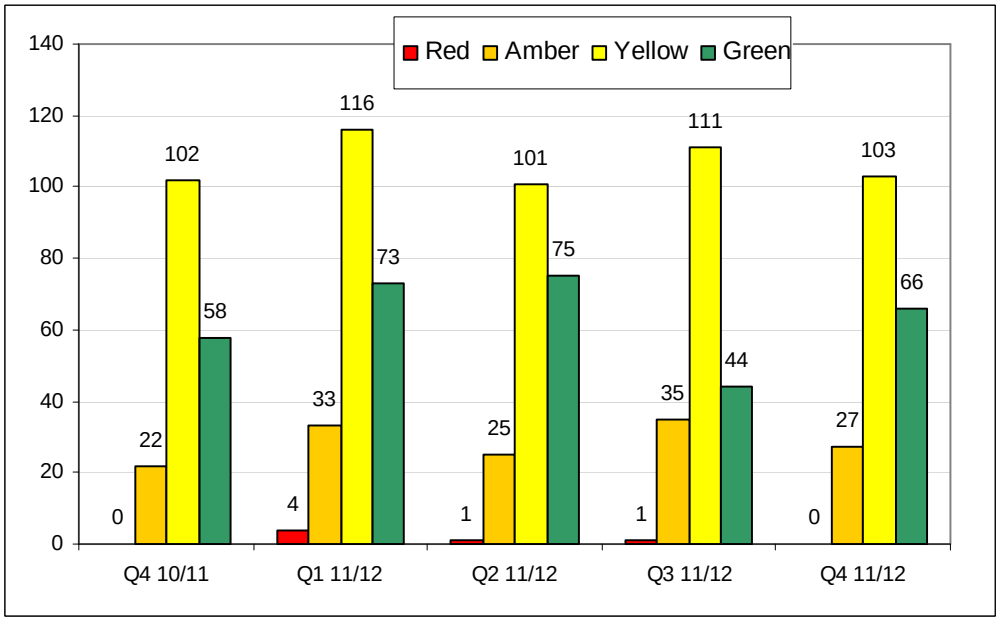
Types of Contact	Q1	Q2	Q3	Q4	Notes
Link Complaints	34	39	37	25	The complainant has received the substantive response to their complaint but has returned as they remain dissatisfied/or require additional clarification.

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 (Q4 2010/11 – Q4 2011/12)

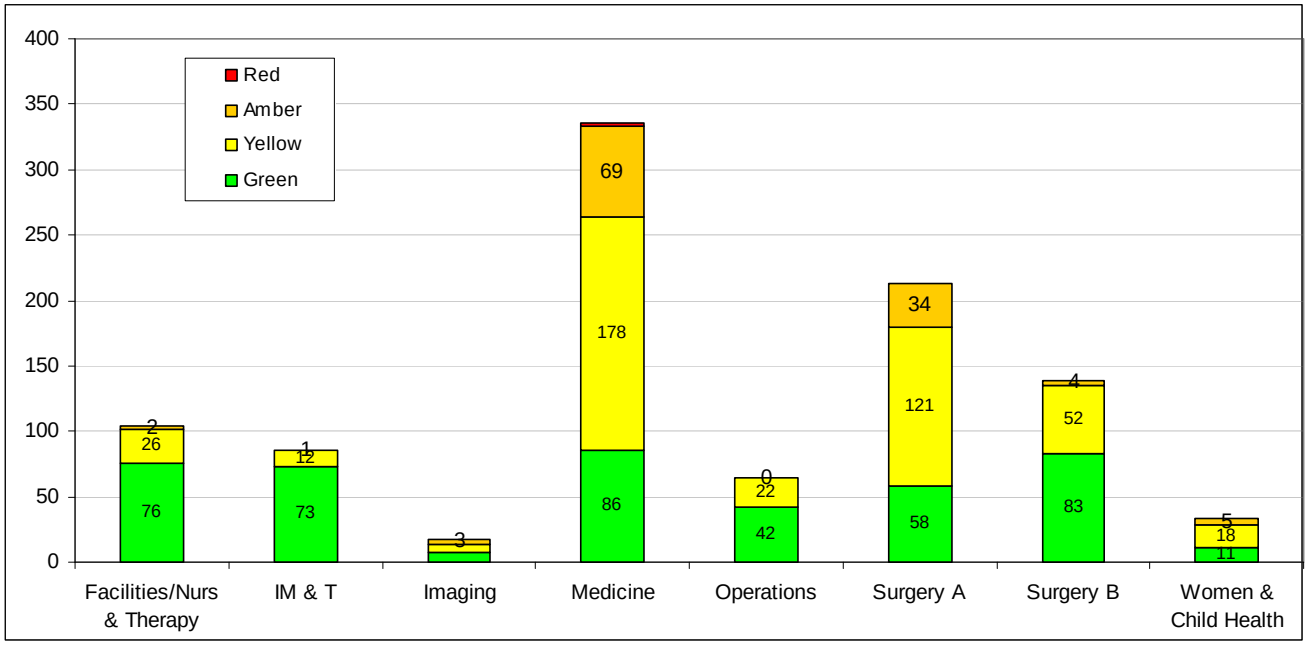


Action Plan Completion

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 March 2012. 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 Q4 2011/12)



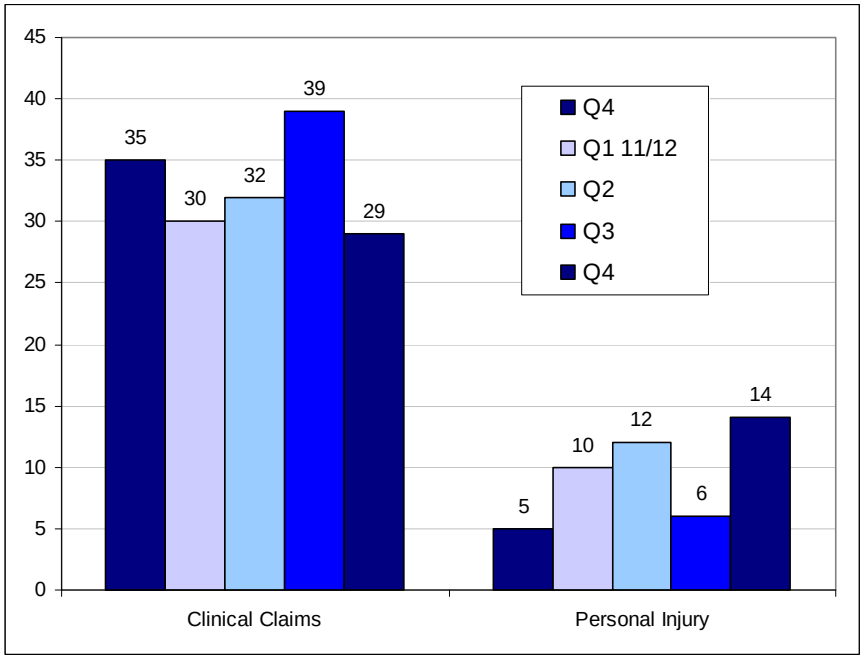
The results show overall increases in action plans outstanding when compared to previous reporting periods. This may be reflective of the current monitoring processes and communication with the divisions (excluding Woman and Child Health where the monitoring position is robust). Work will therefore continue to 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

Four cases were referred to the Ombudsman during the reporting period. Of these, the Ombudsman's decision remains awaited for two cases; the Ombudsman has requested additional information from and action by the Trust in one case and has returned one case to the Trust for efforts at local resolution.

3.3 Claims
The claims received are as follows:

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



Of the 29 clinical claims received in Q4, there were 4 that had a reported clinical incident related to the case. 9 claimants had already raised their concerns via the complaints procedure.

Of the 14 personal injury claims received, none 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 Q4	Personal Injury Q4
Burns/scalds/reactions	-	1
Delay in Treatment	6	-
Dissatisfied With Treatment	2	-
Drug Error	-	-
Failure Or Delay In Diagnosis	7	-
Failure to Recognise Complications	-	-
Fall/slip	-	3
Infection - Other	-	-
Lacerations/Sores	-	-
Late Diagnosis And Treatment	2	-
Lifting/moving/handling	-	4
Moving/falling Objects	1	2
Needlestick	-	1-
Not Known	12	1
Operation Carried Out Negligently	3	-
Other	3	-
Toxic Fumes	2	-
Treatment Carried Out Negligently	-	-
Violence and Aggression	-	2

At present the Trust has 407 Clinical claims and 126 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	5	-
Disclosure Of Records*	298	4
Early Stages	6	3
Letter Of Claim	30	92
Letter Of Response	4	-

Status Type	Clinical Claims	Personal Injury Claims
Liability Admitted	5	12
Liability Being Assessed	9	5
Liability Denied	5	-
Negotiate Settlement	12	3
Part 36 Offer	6	1
Proceedings Issued/served	4	1
Settlement Made	18	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*)

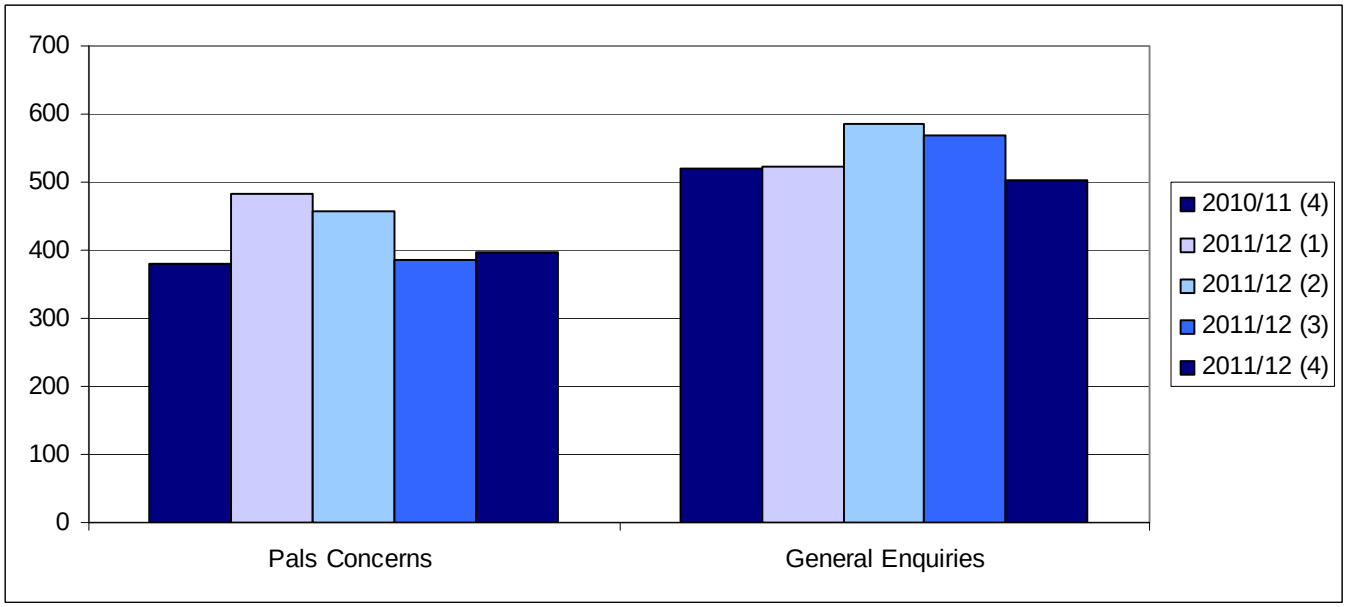
Division	Clinical Claims	Personal Injury Claims
Development/Cancer	37	-
Estates	-	22
Facilities	1	28
Finance	-	1
Imaging	4	-
IM&T	-	2
Medicine	100	29
Not Known/Stated	3	-
Operations	-	1
Pathology	5	1
SCAH	-	1
Surgery A	107	11
Surgery B	32	5
Women & Child Health	114	3

4. PALS

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

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

Graph 4.1a Trends of number of **enquiries** received (Q4 2010/11 – Q4 2011/12)



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 Q4 2011-12

Category breakdown	Number of Contacts Q4
APPOINTMENTS	
Appointment Cancellation	7
Appointment Delay	15
Appointment Notification	10
Appointment time	20
Appointment Booking (Choose and Book)	0
Appointment (other)	0

Category breakdown	Number of Contacts Q4
ATTITUDE OF STAFF	
Admin	5
AHP	4
Ancillary	2
Doctor/Consultant	2
Nurse	7
CLINICAL TREATMENT	
Clinical Care	0
Clinical Treatment	7
Delay in Investigations	1
Delay in Results	8
Delay in Surgery	5
Delay in Treatment	6
Delay in X-ray/Scan	6
Information – Condition	3
Medicines	7
Low Staffing levels	0
Support	0
Waiting time	0
Consent	0
COMMUNICATION	
Written	4
Verbal	24
ADMISSION/DISCHARGE/TRANSFER	
Admission Arrangements	0
Discharge Arrangements	14
Transfer arrangements	0
FORMAL COMPLAINTS	
Complaint advice	65
Complaint process	18
Complaint referral	15
Complaint Handling	2
Complaint response time	1
PERSONAL RECORDS	
Records – Access	9
Records – content	5
Records – Mislaid	0
GENERAL ENQUIRY	
Advice	10
Costs	1
Funding	1
Information	34
Referral	6
PERSONAL RECORDS	
Access	7
Content	4
Mislaid	0
ESSENCE OF CARE	
Continence	2
Hygiene	2
Mouth care	0
Nutrition	2

Category breakdown	Number of Contacts Q4
Pressure Ulcers	1
Privacy and Dignity	20
Safety	1
Safety of patient with MH	0
Self care	0

5. Recommendations

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Being Open following a patient safety incident Policy**
SPONSOR (EXECUTIVE DIRECTOR):	**Kam Dhami – Director of Governance**
AUTHOR:	**Allison Binns – Head of Risk Management**
DATE OF MEETING:	**31 May 2012**

EXECUTIVE SUMMARY:

This is an update on the previous being open policy. Consideration has been given to the DH consultation document on "Duty of Candour".

The process for being open has been further defined, to ensure that process steps allow for discussions and apologies to take place and evidence of this being present.

The policy provides guidance on:

- Acknowledgement that an incident has occurred
- Apologising, without an admission of liability
- Provision of an explanation
- Documenting the discussions
- Investigation and further discussions

The policy also requires that for each patient safety incident where the impact on the patient has been defined as "moderate", "severe" or where the patient has died, a being open proforma is completed of the discussions with the patient/family.

REPORT RECOMMENDATION:

To accept the policy and implementation plan that has been approved by the Trust Management Board

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
✓	✓	✓

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

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

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

High Quality Care

PREVIOUS CONSIDERATION:

Quality and Safety Committee – 22 March 2012 and Trust Management Board on 22 May 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

BEING OPEN FOLLOWING A PATIENT SAFETY INCIDENT POLICY

Policy author	Head of Risk Management
Accountable Executive Lead	Director of Governance
Approving body	Trust Management Board
Policy reference	SWBH/XXX/NNN

ESSENTIAL READING FOR THE FOLLOWING STAFF GROUPS:
1 – All patient facing staff

STAFF GROUPS WHICH SHOULD BE AWARE OF THE POLICY FOR REFERENCE PURPOSES:
All clinical staff.

POLICY APPROVAL DATE:
May 2012

POLICY IMPLEMENTATION DATE:
1 June 2012

DATE POLICY TO BE REVIEWED:
May 2015

DOCUMENT CONTROL AND HISTORY

Version No	Date Approved	Date of implementation	Next Review Date	Reason for change (e.g. full rewrite, amendment to reflect new legislation, updated flowchart, etc.)
2.0	May 2012	June 2012	May2015	To take account of “Duty of Candour” and to simplify processes.

BEING OPEN FOLLOWING A PATIENT SAFETY INCIDENT POLICY

KEY POINTS

1. It is good practice to advise patients and/or families and carers when an incident has happened, where low or no harm has occurred and to document the event.

2. Where a patient has suffered moderate or severe harm or has died as a result of the incident, the being open process **MUST** be initiated within 24 hours of the incident being detected and recorded.

3. It is a requirement of this policy to offer an apology for any incidents regardless of level of patient harm

4. Telling someone that you are sorry is not the same as admitting harm, when something hasn't gone quite as it should have.

5. Documentary evidence of the being open discussion **MUST** be made on every occasion where a patient has suffered moderate or severe harm or has died as a result of the incident.

6. It is acceptable to not know what happened and advise patients of this. The investigation process will aim to ensure that the patient is informed about events and any actions that will be taken.

7. During the being open discussions **DO NOT** speculate, attribute blame, deny responsibility or give conflicting information.

8. Ensure patients are safe and clinically cared for following the incident.

9. Patients, families &/or carers must be offered appropriate support or signposted to alternatives.

PLEASE NOTE THAT THIS LIST IS DESIGNED TO ACT AS A QUICK REFERENCE GUIDE ONLY AND IS NOT INTENDED TO REPLACE THE NEED TO READ THE FULL POLICY

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1. INTRODUCTION

1.1 Promoting a culture of openness is a prerequisite to improving patient safety and the quality of healthcare systems. The Department of Health, in conjunction with the NHSLA (National Health Service Litigation Authority) and NPSA (National Patient Safety Agency) requires that NHS Trusts implement a 'Being Open' policy to put systems in place to ensure that communication between healthcare staff and a patient (and/or their carers) is open and honest when a patient has suffered harm as a result of healthcare treatment.

1.2 This process is designed to provide an infrastructure to support patients, carers, healthcare staff and managers when things go wrong and to ensure patients receive the information they need to enable them to understand what happened and to provide reassurance that necessary actions will be taken to reduce the likelihood of a similar type of incident recurring.

1.3 This process supports the Trust's Incident reporting and management policy, which includes local and national incident reporting, the root cause analysis of incidents, learning from adverse events and sharing the learning to improve the quality of its services, in a "fair or just" accountability culture.

2. OTHER POLICIES TO WHICH THIS POLICY RELATES

- Policy for the reporting and management of incidents
- Complaints policy
- Claims policy
- Vulnerable adults policy
- Safeguarding children policy

3. GLOSSARY AND DEFINITIONS

Apology	Sincere expression of regret offered for harm sustained.
Being Open	Open communication of patient safety incidents that have resulted in moderate harm, severe harm or death of a patient whilst receiving health care.
Moderate harm	This has been defined by the NPSA as any moderate injury requiring professional intervention, an increase in length of hospital stay by 4-15 days or an event which impacts on a small number of patients.
Severe harm	This has been defined by the NPSA as any major injury leading to long-term incapacity/disability, an increase in length of hospital stay by >15 days or mismanagement of patient care with long-term effects.
Patient safety incident	Any unintended or unexpected incident that could have or did lead to harm for one or more patients receiving NHS-funded healthcare. The terms 'patient safety incident' and 'prevented patient safety incident' will be used to describe 'adverse events' / 'clinical errors' and 'near misses' respectively.

4. PRINCIPLES

4.1 *Being open* is a process rather than a one-off event. With this in mind the following principles have been drawn up to underpin the policy.

- **Principle of acknowledgement**
  All incidents should be acknowledged and reported as soon as they are identified.

- **Principle of truthfulness, timeliness and clarity of communication**
  Information about an incident must be given to patients/carers as soon as practicable in a truthful and open manner by a senior member of the clinical team, usually the consultant.

- **Principle of apology**
  Patients/carers should receive a sincere expression of sorrow or regret for the harm that has resulted from an incident.

- **Principle of professional support**
  Staff should feel supported throughout the incident investigation process because they too may have been traumatised by being involved.

- **Principle of confidentiality**
  Full consideration of, and respect for, the patient's/carer's and staff privacy and confidentiality will apply.

- **Principle of continuity of care**
  Patients are entitled to expect they will continue to receive all usual treatment and continue to be treated with respect and compassion.

5. ROLES AND RESPONSIBILITIES

5.1 As soon as the incident, complaint or claim has been detected and notified to the patient's responsible clinician, the following people will assume responsibility and leadership for ensuring that the *Being Open* process is followed. This means that they are accountable for ensuring that an appropriately skilled individual undertakes the discussions with the patient, family or carers as identified within this document and as soon after identification f the event as possible.

5.1.1 **The patient's responsible clinician**

The responsible clinician is normally the most senior person responsible for the patient's care and /or someone with experience and expertise in the type of incident that has occurred; this will usually be the patient's consultant.

The responsible clinician is responsible for ensuring that the patient, their family/carer are notified of the harm event, if not immediately apparent, and for advising them of the process to be followed to keep them informed.

The responsible clinician must ensure that the patient is safe and that they are offered care under an alternative clinician, team or even hospital if they are not happy to continue with current care provision.

The responsible clinician is responsible for ensuring that the discussions are documented in the patient's healthcare record either through the use of a proforma

(Appendix 2) or directly into the records. They must also send a copy of the documented discussion to the risk management team using swb-tr.riskmanagement@nhs.net

5.1.2 **Specialty team**

The responsible clinician and specialty Matron will:

- assess the incident to determine the level of immediate response;
- identify the most appropriate staff to meet with the patient and/or relatives;
- determine what initial patient support may be required (e.g. facilitator, patient advocate, PALS etc.);
- identify immediate support needs for staff involved;
- identify appropriately experienced individuals to meet with the patient & the staff to ensure a consistent approach and attendance at meetings.

5.1.3 **The Risk Management Team**

On notification of an incident which is graded for harm as moderate or severe or where the patient has died due to an incident, the risk management team will identify the patient's responsible clinician and send a 'Being Open' proforma. The risk management team will be able to provide the responsible clinician with advice and support to follow the Being Open process effectively and prepare for any meetings. The risk management team will collate all incidents graded to receive the Being Open process.

5.1.4 **The Complaints and Litigation Team**

The complaints and litigation team will be able to provide the responsible clinician with advice and support to follow the Being Open process effectively and prepare for any meetings. This may also include assistance from the Patient Advice and Liaison Service (PALS) manager.

6. BEING OPEN IN CONTEXT

6.1 Being Open involves explaining what happened and apologising to patients their family and/or carers as soon as possible when harm has resulted from their healthcare treatment. This may be identified following a recognised incident, a complaint or in some instances, following the notification of a claim.

6.2 Many organisations support the ethos of 'Being Open' and have for many years required clinicians to provide open discussions with patients and their families (Appendix 3).

6.3 Open disclosure about what has occurred and discussing patient safety incidents in adequate detail, promptly and compassionately can help patients cope better with the after-effects. This may also help prevent formal complaints and litigation claims in view of the fact that many litigants claim to have been motivated to sue because of a conspiracy of silence that meant they received no apology and no answers to their legitimate questions.

6.4 Being Open involves:

- Acknowledging when things have gone wrong and apologising to the patient/carers;

- Conducting a thorough investigation into the incident and reassuring patients/carers that lessons learned will help to reduce the likelihood of the incident recurring;
- Providing support with the physical and psychological consequences of what happened.

6.5 Not all incidents must be discussed with the patient and/or their family/carers. Clearly, it would not be practicable or beneficial to follow this course of action in the case of every patient safety incident that occurs. The Trust requires staff to report **all** patient safety incidents including near miss incidents, 'no harm' and 'low harm' incidents, but particularly those resulting in moderate harm, severe harm or death. The level of investigation required for the severity of the incident is identified in section 6 of the Incident reporting and management policy.

6.6 Similarly, this policy **does not** require all incidents to be discussed with patients or carers; near miss patient safety incidents or those which did not result in harm are excluded. This is not to say that incidents leading to no harm or low harm do not provide useful learning opportunities and should not be acknowledged and discussed with the patient/carers. In many cases this may be beneficial but the decision should be at the discretion of the local healthcare team based on the circumstances of the patient and the nature of the incident. Near miss incidents and no harm incidents should be dealt with in line with the Trust's Incident Reporting and Management Policy but will not be subject to the *Being Open* process.

6.7 The policy requires all incidents that result in moderate harm, serious harm or death to be subject to the Being Open process (See Appendix 1). Other incidents where no harm has occurred, but where learning can be shared, will be dealt with as per the Trust's Incident Reporting and Management policy.

6.8 The Being Open process begins with the recognition that a patient has suffered moderate harm, severe harm or has died, as a result of a patient safety incident and this includes harm received either through the processing of delivery of healthcare or through environmental hazards. The provision of prompt and appropriate clinical care or the prevention of further harm will be the priority when an incident has been identified. Appendix 4 provides further advice on what level of incident/complaint or claim triggers the being open process and Appendix 1 for a flowchart summary of the process.

6.9 Serious incidents must be notified and managed as per the Trust's incident reporting and management policy and escalated immediately.

7. SAYING SORRY

7.1 Whilst staff may be unclear about who should talk to patients when things go wrong and what they should say, fearing that they may be admitting liability, the NHS Litigation Authority (NHSLA) encourages healthcare staff to apologise to patients in this situation and makes it clear that an apology does not constitute an admission of liability (Appendix 3).

7.2 A sincere expression of sympathy and regret made verbally by those providing the care at an early stage, based on the facts known at the time, should be made even if an investigation is being carried out prior to findings being shared formally with the patient &/or carers. A delay in saying sorry is often the cause of anger and frustration and is a common reason given for patients seeking medico-legal redress. See Appendix 5 for advice on saying sorry without attributing blame.

7.3 It is recognised that explanations and apologies for minor complications often occur spontaneously in circumstances where it would be impractical to seek prior advice. However, the guiding principle should be if in doubt, be open and honest by notifying, and this principle should certainly apply where the high level Being Open process is to be formally undertaken.

8. MEETING WITH PATIENTS AND/OR THEIR FAMILIES/CARERS

8.1 The responsible clinician, in discussion with the specialty Matron, will arrange for a meeting with the patient and their family/carer to take place and identify the most appropriate clinician to lead that meeting. The identified member of staff should be supported by at least one other member of staff, such as specialty manager, Matron, ward manager or senior member of the healthcare team, such as the clinical lead for the specialty.

Members from both the risk management department and complaints and litigation department are available to provide advice in preparation for a meeting &/or support during.

8.2 Unless deemed absolutely necessary by the responsible clinician and Matron do not meet the patient/family/carer with more than three members of the healthcare team. More than this number can be daunting for the patient/family/carer and will prove harder to control in terms of the clarity and consistency of the message.

8.3 **How to approach the meeting**

The meeting is to take place as soon after the incident as possible (within 24 hours) giving consideration to:

- The clinical condition of the patient, if living;
- Availability of key staff and the patient's family/carers. Ask the patient/carers who they would like to be present to provide them with morale support;
- Patient preference in terms of when and where the meeting should take place and the healthcare staff to be present;
- Privacy and comfort of patient;

Consider the needs of patients with special circumstances (e.g. linguistic or cultural needs and disabilities). Patients with special needs may also need additional support.

Hold a pre-meeting amongst healthcare professionals so that everyone knows the facts and understands the aims of the meeting.

Arrange the meeting in a sensitive location offer a choice of times and ensure the details are clearly communicated to the patient and their family/carers.

8.4 **What should be discussed?**

- Speak to the patient/carers as you would want someone in the same situation to communicate with you or a member of your family.
- Do not use medical jargon or acronyms; use clear, straightforward language
- Introduce and explain the role of everyone present to the patient/carers and ask them if they are happy with all those present

- o Acknowledge what happened and apologise on behalf of the team and the organisation
- o Stick to the facts that are known at the time and assure them that if more information becomes available, for example as a result of an incident investigation, it will be shared with them. Do not speculate, attribute blame, deny responsibility or give conflicting information.
- o Ask the patient/relatives for their perspective on what happened, and understand what questions they would like answers to. (see incident reporting policy)
- o A formal apology should be made during the meeting.
- o Explain what will happen next in terms of the long-term treatment plan
- o Suggest sources of support and counselling if applicable
- o Check their level of understanding and answer any remaining questions
- o Provide a named contact to whom they can speak again if they wish
- o Subsequent meetings with the patient/carers may be necessary and this should be agreed with them as appropriate.

8.5 **Documentation**

One member of the healthcare team must be allocated to act as note-taker of the content of the discussion/meeting. A written record of the discussion must be made in the patient's health record, for incidents, or the Complaints Local Resolution Plan and should include the following information:

- The time, date and place as well as the names and relationships of all attendees;
- An summary of the explanations given;
- Action points agreed, responsibilities and deadlines;
- Plans for follow-up and offers of assistance;
- The plan for providing further information to the patient/carers.

A proforma (Appendix 2) must be completed in every instance. Available from (add hyperlink) on the intranet

The patient/family/carer(s) are entitled to a copy of the notes taken at any meetings and to be given the opportunity to agree the content of the record of discussion and this should be offered to them.

All incidents requiring a comprehensive root cause analysis investigation will require the final investigation report to be documented in the agreed format, which includes the need to identify the involvement of the patient/family/carer.

The involvement of the patient, their family or carer in an incident can also be captured on the incident reporting database(s) (Safeguard and Datix).

9. SUPPORT

9.1 Supporting patients, their families and/or carers

Reassurance should be provided to the patient and carers that they will continue to be treated according to their clinical needs even where there is a dispute between them and the healthcare team.

Patients and their carers should be involved in the investigation process (should they wish to do so). As part of the support offered to them, the opportunity to understand what happened from their perspective needs to be understood and supported.

When a patient has been harmed during the course of treatment and requires further therapeutic management or rehabilitation, they should be informed of the on-going management plan.

Patients may also need to be advised about alternative treatment providers and consideration given to offering to hand over care to another consultant team and transfer the patient to another ward, where patient/carer confidence has been lost.

Patients should also be advised of further suggested sources of support and counselling, if applicable.

Discharge letters to the referring GP or appropriate community care service should include summary details of the adverse clinical incident, current condition and continuing care needs.

9.2 Supporting staff

Patient safety incidents are almost invariably unintentional. The Trust promotes an open and fair culture which recognises that the attribution of blame is not conducive to openness and learning and that human error is very often the consequence of flaws in the healthcare system and not necessarily the individual and that where the error arose from individual lapses.

The Incident Reporting and Management policy states that an open and fair blame culture does not mean no accountability for an employee's actions or omissions. When a patient safety incident occurs, it is recognised that staff involved in the patient's care are also distressed by the occurrence and should be involved and consulted about actions which should arise from the lessons learnt from the adverse event.

If at any stage following an incident it is determined that harm may have been the result of a criminal or intentional act, the Chief Executive must be notified immediately and the individual(s) dealt with through the Human Resources Managing Conduct process.

10. FOLLOW UP

The initial *Being Open* discussion is often only the first part of an on-going communication process, particularly when the patient safety incident is to be subject to further investigation and root cause analysis.

A dialogue should be maintained with the patient/relatives by sharing new information and addressing any new concerns as they arise.

On the completion of the incident investigation feedback should take the form most acceptable to the patient, either in writing or a further meeting.

The patient's GP should be informed about the incident through the normal discharge documentation and in some cases, direct discussion or involvement may be necessary to ensure on-going clinician support from the patient and family where required.

11. DISCLOSURE OF FINDINGS

11.1 In cases where further investigation takes place there will normally be complete disclosure of the findings of the investigation and analysis to the patient/carers. In some cases information may be withheld or restricted, for example where releasing certain information may adversely affect the health of the patient, where coronial investigations are pending, or where specific legal requirements preclude disclosure. In such cases advice should be sought from a member of Complaints and Litigation Management team &/or Risk Management team and if necessary legal advice will be obtained. The patient or family/carers should be informed of the reasons for the restrictions.

11.2 Consideration needs to be given to the potential for adverse media interest in the incident, as a result of the number of people involved, e.g. a pathology screening error, or the family of a patient involved in an adverse event disclosing to the media.

12. CONSULTATION

12.1 This policy has been circulated to all clinical directorates for comment prior to being ratified by Trust Management and Governance Boards.

13. AUDITABLE STANDARDS/PROCESS FOR MONITORING EFFECTIVENESS

13.1 Every incident reported as Moderate, severe or where the incident has led to death of the patient, will have a being open discussion documented.

13.2 The risk management team will maintain a database of all such incidents. The Head of Risk Management will provide a quarterly report on directorate compliance to Governance Board.

14. TRAINING AND AWARENESS

14.1 No specific training is required for Being Open, but is provided as part of the Investigating incidents, complaints and claims training. Refer to the Trust's Training Needs Analysis.

14.2 All clinical staff must be aware of this policy and its implications for practice.

15. EQUALITY AND DIVERSITY

15.1 The Trust recognises the diversity of the local community and those in its employment. Our aim is, therefore, to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their need. The Trust recognises that equality impacts on all aspects of its day-to-day operations and has produced an Equality Policy Statement to reflect this. All policies are assessed in accordance with the SWBH Equality Impact Assessment Toolkit, the results for which are monitored centrally.

16. REVIEW

16.1 This policy will be reviewed after three years or sooner if either national standards or local requirements requires it or Trust practice is amended.

17. REFERENCE DOCUMENTS AND BIBLIOGRAPHY

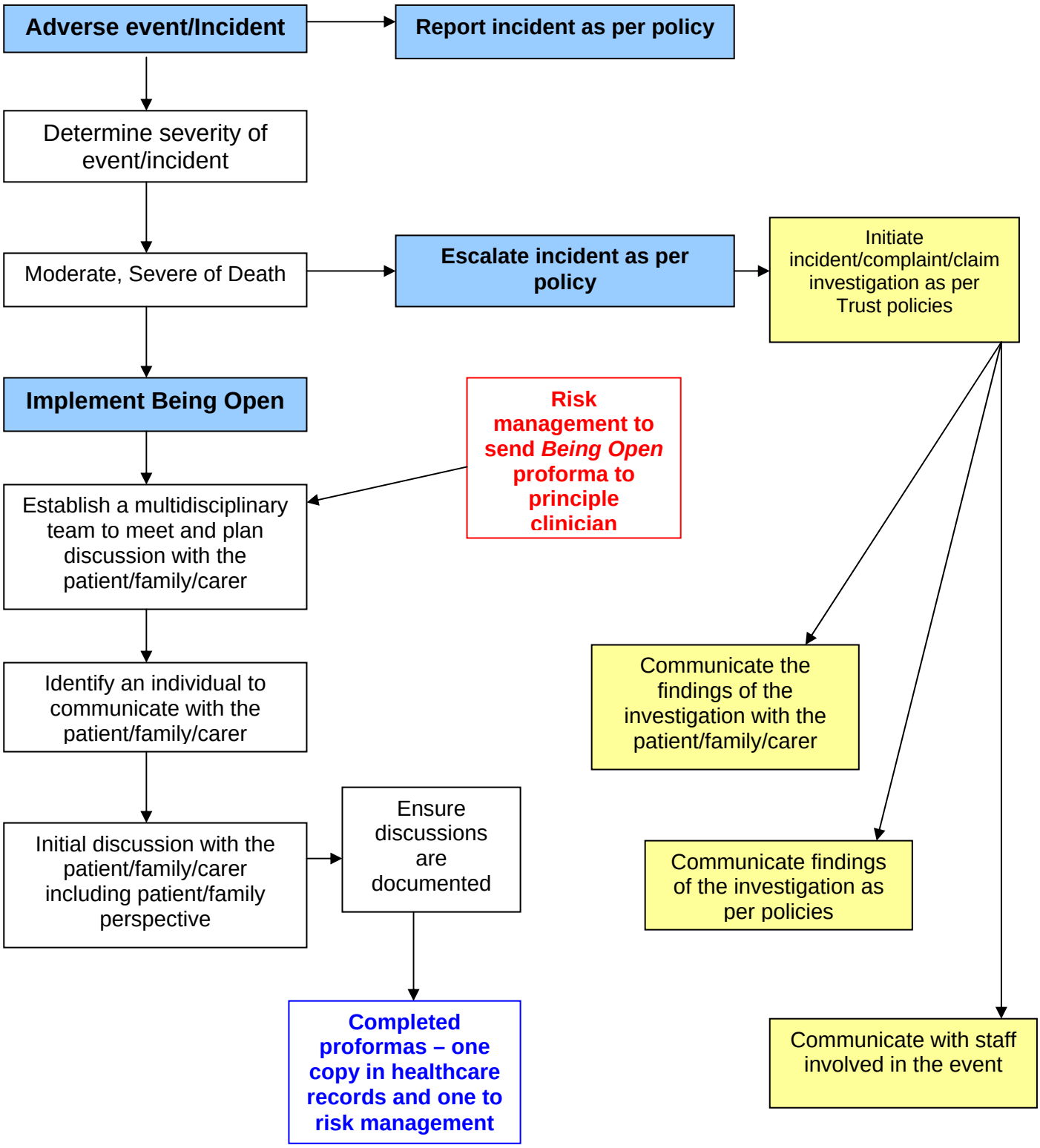
- NPSA, 2009. Saying sorry when things go wrong, Being Open: communicating patient safety incidents with patients, their families and carers
- NPSA, 2004. Seven Steps to Patient Safety
- NHS Litigation Authority Apologies and Explanations - Circular 02.2002.
- NHS Redress: Improving the response to patients. November 2005
- Making Amends – CMO consultation document. April 2004
- Implementing a 'Duty of Candour'; a new contractual requirement on providers – Consultation document. DH October 2011.

18. FURTHER ENQUIRIES

18.1 Further information and support for Being Open can be obtained from the departments of Risk Management or PALS, Complaints and Litigation.

Appendix 1

Being Open Flow chart



Appendix 2

Being Open Proforma.

Date:		**Time:**	

Venue:	

Responsible Clinician:	

Surname	Reg No
	Date of Birth
Forename	Cons
Sex	Ward/Dept
Address	Hosp
	NHS No
Incident/complaint/claim reference no:	

People in attendance	
Patient/Family/Carers (include relationship to patient):	**Staff:(name and job title)**

Summary of Explanations given and content of apology:

Summary of patient/family/carer perception of events

Surname	Reg No
	Date of Birth
Forename	Cons
Sex	Ward/Dept
Address	Hosp
	NHS No
Incident/complaint/claim reference no:	

	Action points agreed	By Whom	By When
1			
2			
3			
4			
5			
6			
7			
8			

Follow up arrangements:

Assistance and/or referrals offered:
How and who will provide further information following investigation:

Date copy of discussion offered:				
Accepted:	Yes		No	

DO NOT reprint this form from the policy. It is available on the intranet as a Trust form.

Existing requirements regarding openess

The **Health Act 2009** requires all NHS organisations to '*have regard'* to the NHS Constitution. The Constitution places an expectation on NHS staff to acknowledge mistakes, apologise for them, explain what happened and then put things right. All providers of NHS funded secondary or community care have an obligation under the NHS Standard Contract to have regard to the NHS Constitution. Primary care contractors have a direct duty to have regard to the NHS constitution under the Health Act.

The **professional codes** of practice for doctors, nurses and NHS managers contain similar duties:

a) The General **Medical** Council sets out in its Good Medical Practice:
'*If a patient under your care has suffered harm or distress, you must act immediately to put matters right, if that is possible. You should offer an apology and explain fully and promptly to the patient what has happened, and the likely short-term and long-term effects*'.

b) Similarly the **Nursing and Midwifery** Council states in its code:
'*You must act immediately to put matters right if someone in your care has suffered harm for any reason…You must explain fully and promptly to the person affected what has happened and the likely effects'*

c) The code of conduct for NHS **Managers** states:
'*I will accept responsibility for my own work and the proper performance of the people I manage. I will seek to ensure that those I manage accept that they are responsible for their actions to: patients, relatives and carers by answering questions and complaints in an open, honest and well researched way and in a manner which provides a full explanation of what has happened, and of what will be done to deal with any poor performance and, where appropriate giving an apology'.*

The **National Patient Safety Agency** (NPSA) has published policy guidance, called *Being Open*, which sets out a framework for openness and a template policy for NHS organisations to adopt, together with the principles of communication and the processes that organisations should follow to ensure incidents are communicated to patients. It also provides a training programme on how to communicate with patients when things go wrong. While the NPSA is to be abolished as part of the Health and Social Care Bill currently before Parliament, the principles of this policy will continue to hold true.

The **Care Quality Commission** registration requirements as set out in regulation and detailed in *Guidance about compliance: Essential standards of quality and safety* place a number of requirements on providers to be open with service users about the care they receive;

- they require providers to analyse incidents that could have caused harm;
- require providers to involve service users in making decisions about their care;
- require providers to have an effective complaints procedure;
- require providers to notify CQC of a range of incidents resulting in harm to service users or with the potential to harm service users;
- and crucially, require providers to reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment. This final duty therefore means that providers should comply with the '*Being Open'* policy published by the National Patient Safety Agency, which makes the requirement to tell patients when something goes wrong quite clear.

CQC's *Guidance about compliance: Essential standards of quality and safety* further details that people who use services should benefit from a service which ‘’*informs them, or others acting on their behalf, if an adverse event, incidents or error has occurred in their care, treatment or support that has caused, or may result in, harm and offers a full explanation of what happened along with an appropriate apology or expression of regret*.’’

The **NHS Litigation Authority** issued a letter on apologies and openness to all chief executives and finance directors of NHS bodies, reiterated in May 2009. The letter states that;
“*It is most important to patients that they or their relatives receive a meaningful apology. We encourage this, and stress that apologies do not constitute an admission of liability. In addition, it is not our policy to dispute any payment, under any scheme, solely on the grounds of such an apology*”

This point is also made clear in the ***Compensation Act 2006***;
’’An apology, an offer of treatment or other redress, shall not of itself amount to an admission of negligence or breach of statutory duty.’’

The NHSLA letter goes on to discuss explanations provided to patients and their relatives and states;
“*the NHSLA will not take a point against any NHS body or any clinician seeking NHS indemnity, on the basis of a factual explanation offered in good faith before litigation is in train. We consider that the provision of such information constitutes good clinical and managerial practice.”*

In the same letter, the **Medical Defence Union** similarly endorses this approach;
“Any patient who has had the misfortune to suffer through an error of whatever nature should receive a full explanation and a genuine apology. We encourage members to adopt this approach. There are no legal concerns about taking this course of action: it is quite different from admitting liability.”

The **Data Protection Act 1998** also gives individuals the right to access information held about them and to be given a copy of the information and an explanation of any technical or complicated terms. This would include written information regarding a patient safety incident in their healthcare or an investigation into their care following an incident.

A guide to the grading of patient safety incidents to determine the level of Response.

The Trust's Incident Reporting and Management Policy requires staff to categorise all reported incidents (green, yellow, amber, red) according to the actual consequence of the incident (severity of harm caused) on a 5X5 matrix. This categorisation process will alert staff to the requirement to consider the *Being Open* Policy in the event of a patient safety incident.

The table below gives added guidance on deciding whether the patient safety incident should be subject to the *Being Open* process:

Grading	Definitions	Action
No harm Including prevented patient safety Incidents	Not applicable	Patients are not usually contacted or involved in investigations and **these types of incidents are outside the scope of this policy.** (It is left to the discretion of individual care teams to decide whether it would be beneficial to discuss such incidents with patients/carers, depending on condition / circumstances of the patient and the type of incident)
Low harm	Minor treatment is defined as first aid, additional therapy, or additional medication. It does not include any extra stay in hospital or continued treatment over and above the treatment already planned, nor does it include a return to surgery or re-admission.	Unless there are specific indications or the patient requests it, the communication, investigation and analysis, and the implementation of changes will occur at local service delivery level with the participation of those directly involved in the incident. Communication should take the form of an informal open discussion between the staff providing the patient's care and the patient/carers.
Moderate harm, severe harm or death	**Moderate:** moderate increase in treatment defined as a return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or transfer to another area such as intensive care as a result of an incident. **Severe:** permanent harm **directly** related to the incident and not related to the natural course of the illness or underlying condition. Permanent lessening of bodily functions, sensory, motor, physiologic or intellectual, including removal of the wrong limb or organ, or brain damage. **Death:** the death **MUST relate** to the incident rather than the natural course of the patient's illness or underlying condition.	**The Trust's *Being Open* policy must be implemented**. The principle clinician, divisional and specialty manager and specialty Matron must be notified. The Head of Risk Management should be notified and a member of the risk management team will be available to provide support and advice during the Being Open process.

Appendix 5

Guidance on saying sorry

Plan ahead

Before approaching the patient, know exactly what you are going to say. It is wise to discuss it over with at least one other senior clinician and to approach the patient with one other manager or clinician.

Provide the right information

Ascertain what the patient/support person(s) know and what they want to know, to decide what information is required. Do not assume prior knowledge, medical knowledge or that you know what their concerns are! Patients and families who have serious concerns about their healthcare seek an honest, straightforward explanation.

Go slowly and genuinely

Allocate ample time to spend with the patient, support person and family

Use plain and simple English, avoiding medical or technical jargon or explain it where it is unavoidable.

Avoid words such as wrong, error, mishap, incorrect, mistake or accident when saying sorry.

Avoid going overboard; there is no reason to offer an overwrought and emotional apology. Systems errors are almost always the cause of adverse events. Clinicians should never say "I'm sorry; I made such a mess of things" or "I feel so guilty I don't care what happens to me."

The following are some key discussion areas and examples:

Discussion areas	**Examples of usage**
Acknowledge	"As you know, there has been a problem with your medication and I understand that you may be disappointed with what happened."
Apology	"I am very sorry that this happened." "I realise it has caused great pain/ distress/ anxiety/ worry/."
Known facts only	"We have been able to determine that…. "We are not sure exactly what happened at present; however, we will be investigating the matter further and will give you more information as it becomes available.
Patient story	"I'd really like to hear about things for your point of view. What do you already know about what happened? How do you feel about this?" "Mr [patient's name], can I just summarise what you have told me?" "You may have a few questions you would like to ask, and I will answer them as best I can at this stage". "You may have some ideas on how we should move forward from here."

Medical plan	“I have reviewed what has occurred and this is what I think we need to do next
Investigation	“We will be taking steps to learn what happened so that we can prevent this from happening to someone else.” *Explain the investigation process in plain English.*
Continuing contact	“Would you like me to contact you to set up another meeting?” “Here is my phone number if you feel you need to go over it again or if you have any other questions.” “What would be the best way to contact you so we can keep you informed?”

Frequently asked legal and insurance questions.

Irrespective of the level of response to the incident, the being open process must commence with the patient within 24 hours of identification of the incident.

What is an admission of liability / an apology?
The DH defines an apology as an expression of sympathy or regret, or of a general sense of benevolence or compassion, in connection with any matter whether or not the apology admits or implies an admission of fault in connection with the matter.
An apology does not constitute an expression or implied admission of fault or liability and is not admissible in any civil proceedings as evidence of fault or liability.

Do documents created during the Being Open process have any special status?
No.
Any document created during the Being Open process should be treated in the same way as any other part of the patient's healthcare record and retained in accordance with DH guidance on written medical notes.

Documents relating to the Being Open process may be provided to patients upon request, produced under Freedom of Information requests, or in answer to a subpoena. Patients can also request access to records relating to them, and request amendments to their records if the records contain incomplete or misleading information.

As with medical records, clinicians should take care when creating documents to ensure that they contain only facts & not conjecture, do not contain inappropriate language, and are accurate. As far as possible, only verified facts should be in the records. Documents should not:

- Attribute blame to any clinician or organisation.
- Record opinions, unless the opinions are expert opinions and based on supporting evidence.
- Contain statements which are likely to be perceived as defamatory

Documents created by an RCA team for the purpose of RCA investigations have a special statutory privilege and are not provided to patients. The RCA final report can be provided to the patient &/or their support person where permission has been given by the patient.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

POLICY IMPLEMENTATION PLAN

POLICY TITLE:	Being open following a patient safety incident policy
ACCOUNTABLE EXECUTIVE LEAD:	Kam Dhami, Director of Governance
POLICY AUTHOR:	Allison Binns, Head of Risk Management
APPROVED BY:	TMB
DATE OF APPROVAL:	22 May 2012

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

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

IMPLEMENTATION PLAN OWNER: _Allison Binns, Head of Risk Management_

REFERENCE	ACTION	RESPONSIBLE	COMPLETED? (YES/NO)	IF NO, PLANNED COMPLETION DATE	EVIDENCE	STATUS
1	*Communications and engagement*					
a	Place information about policy in Hot Topics	Allison Binns	No	June 2012	Copy of Hot topics	
b	Personal email to all consultants	Deva Situnayke	No	29 May 2012	Copy of email	
c	Presentation at Senior Nurse Forum	Allison Binns	No	21 May 2012	Notes of meeting	
d	Staff comms email to highlight that policy is reissued	Allison Binns	No	WB 28 May 2012	Copy of email	
2	*Training*					
a	Discussion with L&D regarding existing content of training programmes	Allison Binns	No	WB 21 May 2012	Confirmation email.	
b						
c						
d						
3	*Resources*					
a	Being open proforma to be available on intranet site	Allison Binns	No	29 May 2012	Screenshot of intranet site	
b						
c						
4	*Monitoring Effectiveness & Evaluation*					
a	Annual review of all patient safety incidents deemed, moderate, severe or death against proformas completed	Allison Binns	No	June 2013	Report	
b	Report of review circulated to divisions	Allison Binns	No	July 2013	Email of report	
c						

Final date when plan is expected to be fully implemented: _30 June 2013_

Status key:

Green	Fully on target	**Amber**	Some slippage but expected to meet timescale	**Red**	Significantly off target date or failed to complete	**Blue**	Completed

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Assurance Framework – Quarter 4 update**
SPONSOR (EXECUTIVE DIRECTOR):	**Kam Dhami, Director of Governance**
AUTHOR:	**Simon Grainger-Payne, Trust Secretary**
DATE OF MEETING:	**31 May 2012**

EXECUTIVE SUMMARY:

The Quarter 4 update on the plans to address the gaps in control and assurance against the risks to the delivery of the Trust's annual priorities is attached.

The format of the report has incorporated recommendations from the 2010/11 Internal Audit review of the Board Assurance Framework (BAF), including the need to track any changes made since the previous version.

The Board is asked to note the encouraging progress with completing actions to address any gaps in control and assurance identified.

Following recent external reviews of the BAF, it is planned to refresh the approach to updating and reviewing the document to ensure it fulfils its function as a key document on which the Trust Board and other corporate bodies can draw on for assurance.

REPORT RECOMMENDATION:

The Board is requested to receive and note the report.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

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

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

None specifically, although represents good governance practice

PREVIOUS CONSIDERATION:

Discussed at the Quality and Safety Committee meeting held on 24 May 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Board Assurance Framework (BAF) 2011/12

Introduction
The Board Assurance Framework (BAF) evidences Sandwell and West Birmingham Hospitals NHS Trust's control over the delivery of its principal objectives. The risks on the BAF are mapped to the risks on the Corporate Risk Register.

Function
The BAF is a tool for the Board corporately to assure itself (gain confidence, based on evidence) about successful delivery of the organisation's principal objectives. The framework is designed to focus the Board on controlling principal risks threatening the delivery of those objectives. The BAF aligns principal risks, key controls and assurances on controls alongside each objective. Gaps are identified where key controls and assurances are insufficient to reduce the risk of non-delivery of objectives. This enables the Board to develop and subsequently monitor action plans for closing gaps. The direction of the Board in these matters ensures appropriate allocation of resources to improve the effectiveness of management.

Strategic Context
The BAF is aligned to achieving the six Strategic Objectives and their relevant Annual Priorities as documented in the Annual Business Plan. It is aligned to the Statement on Internal Control, and has been cross-referenced to the Corporate Risk Register and other documents/reports which may cite the risks. It is the subject of annual enquiry by the Trust's host commissioning body and Internal and External Audit.

As a Foundation Trust it will be important that the Board Assurance Framework works as a tool to support the Board's assurances in terms of self-certification on compliance with its Terms of Authorisation.

Review
An Executive Director (ED) is allocated responsibility for each principal risk and progress against any related action plan is monitored and reported on within the Corporate Risk Register. Progress with implementing the actions required to address any gaps in control and assurance that the risk is being mitigated are reported on in this BAF.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

KEY:

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment		
								Pre-mitigation scores		
Which standard/ aim/ target does the risk relate to or in which other document is the risk reported?	What could prevent this corporate objective from being achieved?	What controls/systems are in place to assist with securing delivery of the objective?	Where can evidence be found that the controls/systems on which we are placing reliance are effective?	Where are we failing to put controls/systems in place? Where are we failing to make them effective?	Where are we failing to gain evidence that our controls/systems on which we are placing reliance are effective?	What action is required to address the gaps identified?	Timescale for completing the actions	Probability	Severity	Risk Score

Cross Reference

CQC	CQC Registration Requirements	**IBP**	Integrated Business Plan
CRR	Corporate Risk Register	**OF**	Operating Framework
FT	Monitor's Terms of Authorisation	**OT**	Other – Please specify

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
STRATEGIC OBJECTIVE 1: ACCESSIBLE AND RESPONSIVE CARE										
Annual Priority 1.1 Identify and implement specific ways of improving the health of the population we serve Exec Lead: MD										
Identify and implement specific ways of improving the health of the population we serve.	Lack of focus from Directorates	Directorate QMF Reviews Specific Objectives related to public health	QMF Dashboards	Directorate QMF reviews are not yet fully integrated into the performance management system	Directorate performance not yet comprehensively reviewed at corporate level	Refresh of performance management framework and integration of Directorate reviews and Divisional reviews Appoint clinical champion for prevention with DPH. Shortlisting completed and interviews planned for May 2012.	Medical Director March 2012	5	3	15
Annual Priority 1.2 Ensure close and effective relationships with local GP consortia, PCT clusters and Local Authorities Exec Lead: DSOD (with MD)										
	Failure to deliver medical	Medical engagement	Irregular review	No controls Developing CCG	No assurance	Regular reporting to be	Medical Director	3	3	9

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
	engagement action plan	action plan		infrastructure and capabilities		developed	March 2012			
	Failure to share intelligence effectively within the trust	BD produces irregular updates	Irregular reporting of external developments	No routine reporting and sharing of intelligence	No evidence of systematic sharing of information	~~Revised arrangements to improve intelligence being planned.~~ Business Dev team now attend monthly meeting of COO Team to provide updates. GP and patient survey commenced. Revised Bus Dev structure being implemented in Sept 12.	Director of Strategy and OD March 2012	2	3	6
	Failure to participate fully in Cluster activities	Leads identified for each meeting/activity	Feedback from cluster activities to Executive team	Not all meetings/issues are reported back so issues may be missed	Updates/papers circulated to executives	~~Revised arrangements to improve intelligence being planned.~~ Leads feed back key points from	Director of Strategy and OD March 2012	3	3	9

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
						meeting.				
	Failure to maintain close contact with Consortia	BD team ensure regular attendance at meetings and communication Attendance at PLT events GP focus published regularly Occasional meetings with CCG Leaders Variety of contact with Local Authority including through Right Care Right Here structures, Health and Wellbeing partnership and operational contact	Irregular reports back to execs and operations Publication of GP focus	No routine reporting	No systematic evidence	~~Revised arrangements being planned.~~ ~~LDP round will include wider range of representatives including clinical representatives from SWBH and CCGs.~~ Meetings held with CCG to agree new mechanisms for engagement. QIPP implementation group now agreed and reporting mechanism in development	Director of Strategy and OD March 2012	2	3	6
Annual Priority 1.3	Deliver Access performance measures including those set out in the Operating Framework for 2011/12						Exec Lead: COO			

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
OF, CRR, IBP	Risk access areas include A&E, Stroke/TIA, DTOC and 18 weeks(Orthopaedics)	A&E, Stroke~~/~~. /TIA and DTOC work streams all have action plans to deliver service improvements.	EDAT Project Board has CEO chair and Executive sponsorship. ~~ATOS also supporting transitional work to new future state.~~ Breach analysis via weekly ED meetings Trajectory for Stroke improvement agreed and ~~reported~~ ~~at~~reported at TMB. DTOC joint work with social services in train to reduce delays and improve performance.	Lack of effective operational escalation and variable pathways pan Trust. Orthopaedic project yet to be fully scoped.	Failure to recruit ED staff.	Overseas and domestic recruitment campaign for ED medical staff continues ~~with some success but vacancies remain.~~ ~~Rapid Improvement event and solutions to be determined for new ED processes in September / October. Outcome will include escalation processes.~~ ~~Patient flow and bed management system project to be~~	COO March 2012 ~~COO January 2011~~ ~~COO January 2011~~	4	5	20

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
			ATOS commissioned to support work ~~work~~ stream on effective patient flow and bed management. This is now part of the Transformation Programme and Urgent Care ~~workatream~~work stream. Over all access performance targets monitored weekly via waiting list meetings to monthly reporting to PMB, TMB, F&PC to Trust Board.		.	~~completed in Q3, to include escalation processes.~~ ~~Orthopaedic project to be determined by November.~~ ED integrated development plan reports into EDAT. Further divisional support for ED teams. Enhanced escalation measures in place for ED and stroke Implemented winter plan and a set of special measures in February to	~~COO November 2011~~ COO Completed COO Completed # COO Completed			

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
						support ED target. Patient flow and bed management project system project now part of Transformation Plan Integrated team with Social Services to be established at Sandwell Hospital. Joint working protocols in development. Similar work initiated with Birmingham social services. Orthopaedic pathway work agreed as part	COO March 2012 COO March 2012			

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
						of RCRH. Implementation timescale to be determined and Orthopaedics identified within the Transformation Plan project structure as a priority. Waiting list review underway to inform annual capacity planning for 2012/13.				
Annual Priority 1.4 Continue to improve outpatients booking systems Exec Lead: COO										
OF	DNA rate and cancellation reduction	• DNA Policy • Text reminders • Letter reminders • DNA leaflet goes out with all new appointments • Improved	~~Out patient~~Outpatient performance reported through waiting list meetings and ultimately via PMB, TMB to F&PC/ Trust	OP QUEP project to be reviewed as part of Transformation Plan to be launched in Quarter 3.	Transformation plan and reporting cycles to be developed to strengthen assurance pending Trust Board approval.	• ~~Hospital short notice cancellations need to be minimised as this causes increase DNAs. Review of~~	COO March 2011	4	4	16

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
		contact centre call waits, so patients aren't kept waiting when trying to change appointment • Cancellation on line service, to be rolled out with new appointment letters. Was due 1st September but delayed by IT dept • New FU booking system in BMEC~~.~~ (~~15.5~~15.5% to 9.85%)	Board. QUEP project plans and project reports. Governance arrangements of QUEP feed into PMB, TMB and TB.			~~clinic profiles in train. Text reminder system to be commissioned Quarter 3.~~Previous work to be incorporated into cross cutting project as part of the Transformation plan • ~~Divisions need~~Divisions need to reduce cancellations at short notice, strengthening annual leave controls.				
	Lack of engagement to review rotas and	• Local work streams at Divisional level	QUEP project plans and project reports.	OP QUEP project to be reviewed as part of	Transformation plan and reporting cycles	• Transformation plan cross cutting theme	COO March 2011	4	4	16

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
	job plans to profile clinics by teams to avoid cancellations		Governance arrangements of QUEP feed into PMB, TMB and TB. Transformation Plan Out Patients work stream reports to Transformation Plan Steering Group and onto Trust Board.	Transformation Plan and ATOS supported work.	to be developed to strengthen assurance pending Trust Board approval.	~~TBC in autumn~~launched in Q3.~~Risk assessment to be revised as cross cutting them is scoped and signed off.~~ This work will inform the approach to improvement in conjunction with the medical workforce project ~~(to be launched in Q4).~~ • Focus pilot work on ~~4~~four specialties in the Transformation Plan will inform a rapid review				

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
						process of clinics at specialty ~~level~~ level.				
Annual Priority 1.5 Improve patient flow from admission through discharge to home care/after care Exec Lead: COO										
OF, IBP	Inadequate systems and processes regarding patient flow Delayed discharges due to lack of community and social care provision	• Patient flow project – initially supported by ATOS looking at a whole system review of patient flow and effective bed management • Delayed Transfers of Care multi agency meeting with PCT and Social Services. Meets weekly workshops ~~scheduled~~ completed in~~for~~ August and	Project charter defines project. Process mapping and pilot work established. Reporting through ATOS QUEP currently. QUEP project plans and project reports. Governance arrangements of QUEP feed into PMB, TMB and TB. On-going DTOC service improvement work with	QUEP project to be reviewed as part of Transformation Plan and ATOS supported work.	Transformation plan and reporting cycles to be developed to strengthen assurance pending Trust Board approval.	~~Revise and implement~~Implementation of new patient flow and escalation protocols. Deliver Discharge training programme. Full use of live bed management system pan Trust. Visioning event ~~scheduled for January 2012.~~complete	COO ~~December 2011~~ March 2012	5	4	20

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
		September. Outputs include: Work up integrated discharge team model, joint protocols and escalation processes, single point of access for social service referrals, increased social service capacity	commissioners and social services. Action plans and minutes of meetings. Performance monitoring via F&PC to Trust Board. Transformation Plan workstream reports to Transformation Plan Steering Group and then on to Trust Board.			d in January to inform Patient Flow work as part of the Transformation Plan. 9 key projects in train to improve patient flow. Joint working with Sandwell established and similar work initiated with Birmingham.				
STRATEGIC OBJECTIVE 2: HIGH QUALITY CARE										
Annual Priority 2.1 Improve reported levels of patient satisfaction Exec Lead: CN										
	Insufficient staff to deliver care.	Funded establishments. Absence controls. Effective	Ratio reports. Ward reviews. Complaints numbers. Incident	Flexible beds. Insufficient bank staff to meet need.	None identified	No unplanned use of flexible beds.	CN/COO Continuously reviewed Continuously	5	4	20

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
		rostering. Establishment reviews. Ratio monitoring. Bank availability.	numbers. Clinical outcomes.			Winter planning. Over-recruitment of staff. Regular establishment reviews.	reviewed Continuously reviewed Annual review			
	Staff lack skills and competency to deliver care.	Training plans. Specific targeted training. Recruitment effective. PDR process.	Audit care. Training numbers. Ward Team Challenge.	Some areas of training under funded. Release of staff for training.	None identified	Various bids to secure funding. Review L&D function. New MT process.	CN Complete Complete Complete – new policy in place	4	4	16
	Poor staff attitude/ motivation.	Customer care training. Leadership development. Complaints/ PALS monitoring. Patient stories.	Complaints. Observations of care audits. Patient surveys. Patient feedback.	Effective leadership in all areas.	None identified	Reconfiguration of Ward Managers. Leadership development programme.	CN/MD Completed Ongoing	5	4	20
	Lack of clear	CQC standards.	Audits against	Performance	Action plans for	Quality and	Oct 2011	4	4	16

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
	standards and expectations.	HiA Nursing. Trust objectives. Individual and team objectives.	standards. CQC action plans. Job specs. Performance monitoring – ward/directorate /division.	system needs embedding at directorate level.	all CQC standards. Team objectives.	system implementation plan.	DG/MD/CN			
Annual Priority 2.2 Continue to embed Customer Care promises Exec lead: HCE										
	There are no resources identified to fund this work and those involved already have substantive roles with other priorities Staff reluctance to change attitude	Reporting to LiA Sponsor Group now replaced by OD Steering Group Ad hoc customer care sponsor group (membership revised May 2011) There is a communications and engagement governance group that meets bi-annually	Minutes from LiA sponsor groups/OD Steering Group (future meetings)	Customer Care sponsor group not adequately minuted No schedule of meetings for customer care sponsor group	Insufficient detail in minutes	~~Schedule of meetings produced for customer care sponsor group~~ Customer Care action plan under review Introduction of project management / admin support to customer care sponsor group and action plan	March 2012 HCE	3	2	6
Annual Priority 2.3 Improve the care we provide to vulnerable adults Exec Lead: CN										
	Staff unable to identify vulnerable adults	Safeguarding training. Dementia	WMQRS review. CQC review. Internal audit	Insufficient training to meet needs.	Profile at directorate and divisional level.	Record keeping	CN Completed	5	5	25

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
	due to lack of knowledge.	training. Policies. Action plans. Safeguarding team. Record keeping. Mental health and LD support.	findings. Referral data. Obs. of care audits. Ward reviews. LD external assessment planned	Poor documentation of assessment and care planned. Policies in draft. Poor support Sandwell MH and LD. Funding RAID.		review. Policies to Gov Board. Training bids. Work with partners for and support.	In progress ~~Bid included in cost pressures In progress.~~ Resolved			
	Please see risks re patient satisfaction as all are relevant to this standard.									
Annual Priority 2.4	Make improvements in A & E services			Exec Lead: MD						
	Lack of effective development and implementation of improvement plans (which incorporate all deliverables)	ED Action Team in place, chaired by CEO and also including COO and MD. Meets monthly and reports direct to Trust Board. Also reports to PCT Clinical Quality Group. External Consultancy commissioned to provide additional	Monthly reports to Trust Board Performance monitoring of key standards via Corporate Performance Report. Review by West Midlands Quality Review Service (external assurance).	None identified.	None identified.	Not applicable	Not applicable	3	3	9

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
		support and resource development of Integrated Development Plan.	External consultancy review of key processes.							
Annual Priority 2.5 Make improvements in Trauma and Orthopaedics services Exec Lead: COO										
IBP, CRR, OF	• Demand and capacity mismatch in service • Variance in productivity across service • Robustness of demand management from GPs	• Orthopaedic project – sponsored by Donal O Donoghue, Medical Director looking at a whole system review of patient flow and Directorate function. The full programme of change is yet to be determined. • Whole system pathway review in progress as	Demand and capacity modelling to be completed. Pathway redesign work ~~(~~ ~~part~~(part of RCRH programme) to be agreed in Quarter 3. Service level transformation and CIP schemes with monthly monitoring reporting to F&PC to TB.	Orthopaedic Project: A service review ~~scope and~~scope and project plan needs ~~defining~~(defining ~~to~~(~~be~~to be completed in Q3~~)~~ ~~.~~).	Assurance framework needs to include project board and robust governance reporting arrangements.	• Demand and capacity review ~~to be~~ completed in November 2011 and further revised in response to operating framework intentions. • ~~Implementation plan for Orthopaedic project to be agreed following initial scoping exercise in Q3. Change~~	MD / COO Review ~~November 2011~~March 2012	5	4	20

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
		part of the RCRH programme.				~~and a full organisational development programme is likely to take 9 – 12 months.~~ Team represented in key Transformation Plan work streams including patient flow and theatres. Local work reviewing theatre utilisation and scheduling to improve demand and capacity in train to be completed in				

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Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
						April. • Recruitment ~~of new Clinical Director in Q4.~~Associate Clinical Director recruited in Q4. ~~•~~Orthopaedic action team ~~Intention to~~TOR scoped and initial ~~meeitng~~meeting scheduled for April. ~~establish an MSK network to support service development and governance.~~				
Annual Priority 2.6 Make improvements in Stroke services Exec Lead: MD										
Make	This is a cross-	Accountability	Stroke	See 1.1 above.	None identified	See 1.1 above	MD	5	4	20

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Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
improvements in Stroke services.	cutting service that relies on good co-ordination of care or investigation by a number of departments	for performance now focused on COTE Directorate	Dashboard	Performance Management of Directorates remains immature						
Annual Priority 2.7 Embed the Quality and Safety Strategy incorporating the FT Quality Governance Framework Exec Lead: DG										
CQC / FT / IBP / NHSLA	Failure to identify, implement and achieve credible quality improvements	▪ Performance management reviews	▪ QMF Dashboard ▪ CQC QRP ▪ CQC registration ▪ CQUIN ▪ Quality reports to the Q+S Cttee and TB ▪ Key sources of local intelligence	▪ Corporate and directorate level quality goals ▪ Inconsistent governance arrangements at divisional / directorate level	▪ Not yet tested against quality element of Monitor's compliance framework.	~~▪ Develop an Annual Quality Improvement Plan~~ ~~▪ Undertake a self-assessment against Monitor's quality requirements and action areas for improvement – the review has commenced~~ ~~▪ Organisational governance~~	March 2012 DG March 2012 DG December 11 March 2012	**2**	**3**	**6**

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
						~~framework to be developed and rolled out~~FT Quality Governance Review Assessment completed. Following presentation of findings at the FT Programme Board in May, an action plan is to be developed. ▪ a) Revised Annual Priorities structure with a specific focus on quality goals	DG			
Annual Priority 2.8 Improve and heighten awareness of the need to report and learn from incidents Exec Lead: DG										
	Inability to learn leading to unsafe environment and practices for	Incident reporting. Investigation processes.	Quarterly Integrated risk reports. Specific	Not meeting deadlines for reporting and investigation of	Robust process for following up amber incidents and	Review of incident reporting and investigation	DG March 2012	2	5	10

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
	patients and staff	Sharing of incident data and lessons. Training.	committee minutes. Risk newsletters.	incidents. Risk management discussion/involvement at directorate/divisional level. Investigations of amber incidents consistently.	investigations. Serious incident report to the Trust Board – repeated incidents	policy. Due for presentation to TMB in May~~rch~~ 2012. Introduction of amber incident TTRs. Monitoring report on agenda of Adverse Events Cttee. Ownership of processes at divisional/directorate level. LiA event focussed on patient and staff safety				
Annual Priority 2.9 Deliver the CQUiN targets Exec Lead: CN/MD/COO										
	Poor data from Community division for: - Palliative care - Falls assessment	Business development unit. Corporate leads.	Monthly data.		Monthly data not available always.	BDU understand what is required. Clinical teams increased	March 12 Regular reporting of progress against CQuIN targets	5	2	10

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
	- HV visits					awareness.	included in monthly corporate performance report			
	End of life care CQUiN (Community) - Poor leadership team - Competence team	Review process in place. Link to acute team leader. Action plan.	Monthly data. Report to PEPAG.	None identified	Data not always available.	Consider team structure and reporting. Team moved to AND for Quality with acute team	March 2012 CN Complete	4	2	8
	Falls assessment community very low baseline, therefore a big improvement required.	BDU linked to corporate plan.	Monthly data and report.	None identified	None identified	Not applicable Falls assessment target met	March 2012. CN	3	3	9
	Failure to deliver MUST score improvement.	Training action plan. CQC standards. HIA standard.	Monthly data and report. Monthly audit.	None identified	None identified	Not applicable Target met	Sept 2011 CN	2	3	6
	Failure to deliver smoking cessation training.	L&D department. Project lead. Monitoring of progress. Training support PCT/leaflets.	Monitoring reports to L&D Committee.	Lack of staff to be trained	None identified	Support clinical teams to release staff.	March 2012 CN	3	2	6

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
	Failure to reduce medication omissions by 10%	Awareness training. Monthly audits. Project lead and group.	Monthly report.	None identified	None identified	Not applicable Target met	March 2012. CN	3	2	6
VTE	Lack of focus	Medical Director team monitors daily and intervenes	Trust Performance Dashboards	Nil identified	Nil identified	Not applicable	Medical Director	2	4	8
Smoking Cessation	Lack of focus	Medical Director team monitors weekly and intervenes as required	Trust Performance Dashboards	Nil identified	Nil identified	Not applicable	Medical Director	2	3	6
Enhanced recovery Stroke discharge	See 2.6 above	Accountability for performance now focused on COTE Directorate	Stroke Dashboard	See 1.1 above. Performance Management of Directorates remains immature	Nil	~~See 1.1 above~~ESD team and project ongoing	Medical Director Q4 11/12	4	4	16
STRATEGIC OBJECTIVE 3: CARE CLOSER TO HOME										
Annual Priority 3.1 Ensure a successful integration of adult and children's community services that has benefits for patients Exec Lead: COO (with CN)										
IBP, CQC	IBP~~,~~	Initial benefits and objectives agreed. Project scope defined.	Quarterly review process. Monthly Community	Further benefits consideration to be determined. Service level integration	None identified	Annual planning cycle to include community proposals at	COO~~RB December 2011~~ Completed	4	4	16

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
		Management Board dates planned. Quarterly review completed for Q1.	Management Board, reporting ultimately to PMB, TMB, and via F&PC to Trust ~~Board .~~Board.	opportunities not fully developed.		service level. Cross cutting project charters ~~to be~~ completed with project plan as part of Transformation Plan which was ~~to be~~ launched in Quarter 3 - 4. Peer review to be agreed.				
Annual Priority 3.2 Deliver the agreed changes in activity required as part of the 'Right Care, Right Here' programmeExec Lead: COO										
IBP, CRR	• Robustness of demand management from GP's • Clinical engagement to effect and deliver change • Robust project management related to	• Decommissioning schemes have been identified. Robustness of plans is being reviewed in August / September. • Regular decommissioning meetings with external	Project delivery plans for each scheme and monitoring process. Monthly monitoring with RCRH working group and Partnership Board.	None identified	Robustness of plans	~~Transformation Plan to move from current to future state to be agreed in Quarter 3. The delivery of the plan will be supported by the Transformation Support Office which will~~	COO~~RB December~~ March 201~~21~~	4	4	16

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
	decommissioning	stakeholders • RCRH pathway review programme and governance structure				~~provide processes, systems and expertise to ensure robust service transformation and project plans. Case to go to Trust Board in September with recruitment and launch by end Quarter 3. To include priorities in~~ Ccommissioning and contracting rounds for 2012/13 completed end March. ~~To meet~~Joint working ~~with~~ with CCG ~~needs~~leaders				

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores P	S	RS
						needs to be established to prioritise areas of work recommissioning and service developments. This is pending transition of the CCG working arrangements and governance functions.				
Annual Priority 3.3 Play a key role in the local community, actively promoting healthy lifestyles and health education Exec Lead: HCE										
	There are no resources identified to fund this work and those involved already have substantive roles with other priorities	Communications and engagement governance group meets bi-annually	Minutes from Comms and Engagement Governance meeting / team meetings~~next due Sept 2011~~	Existing governance meeting membership and frequency not sufficient	Insufficient detail available in meeting minutes	Future activity to be reported to the new OD Steering Group. Ongoing monitoring via Communications & Engagement ~~leaders~~ senior team group	HCE March 2012 ~~Communications & Engagement structure reviewed in October 2011 and revised governance structure to be in place by February 2012~~	4	1	4
Annual Priority 3.4 Develop a local response to the national plans for Heath Visiting Exec Lead: CN										

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Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
	Failure to improve numbers of HV in establishment to DH required levels.	Monitoring of established posts. Implementation plan. Effective recruitment. Marketing campaign. Retention strategies. Training places secured.	Monthly data of 'in post'.	Funding for required additional posts not agreed by Commissioners.	None identified	To strengthen assurance, requirement has been built into LDP process. Students recruited.	March 2012 CN/DFPM	3	4	12
Annual Priority 3.5 Make fuller use of the facilities at Rowley Regis Community Hospital to provide care closer to home Exec Lead: COO										
IBP	Lack of plans for use of estate spare capacity in the moderate term	• Facilities prepared for clinical service use. • Discussion in train with PCT to determine potential use in line with strategic objectives.	Assess / consider tender opportunities to utilise space.	Transitional plans for estate use need reviewing as part of service development cycle and annual planning.	Review of annual planning and service development to include use of Rowley Regis.	• Review transition plan to new hospital and use of Rowley Regis. • Include service review in annular planning rounds (~~to start~~started autumn 2011)	COO~~RB~~ / DE/NHP ~~December 2011~~ March 2012	4	4	16

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores P	S	RS
						and explore options for use of Rowley Regis. • Working with Sandwell PCT on development of a Primary Care pilot.				
STRATEGIC OBJECTIVE 4: GOOD USE OF RESOURCES										
Annual Priority 4.1 Deliver a £21.1m CIP and produce detailed plans to deliver a £20m annual CIP for a further three years							Exec Lead: DFPM			
	Delay in schemes required to produce benefit as from 1 April. Absence of acceptable replacement schemes where 'slippage' has occurred. Movement of schemes away from recurrent	Detailed line-by-line cost improvement programme established, reviewed and set at start of year. Prompt monitoring of delivery at PMB, F&PMC, divisional reviews.	Cost improvement reporting by line and theme. External and internal reporting of reporting of performance at variety of levels within organisation.	~~Project summary of each scheme could be strengthened and placed into a common format as recommended.~~ Robust monitoring in place via TPRS, although system requires	Consideration required for strengthening CIP reporting to the Board despite Board member attendance at F&PC where CIPs performance considered.	~~Revised benefits tracking proforma in place for use by budget managers. These link to the new Transformation Plans as supported by the modified~~	Improvements to be considered ~~– by the TSO Steering Group. Final documentation pack being developed, including format for high level reporting. To~~	3	3	9

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Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment		
								Pre-mitigation scores		
								P	S	RS
	impact to non-recurrent causing underlying problems into future year(s).Challenging targets over 3 year future period.	Established mechanism to capture deviations and set process for evaluating and approving corrective action. Programme supported by QUEP schemes aimed at bringing cross cutting actions together for monitoring and managing Trustwide. Additional resources identified to work on future year savings plans from a strategic startpoint leading to detailed benefits realisation.	Routine reporting on progress towards identifying future productivity, quality and efficiency gains. Next stage planning for future years well underway	modification so that future year plans are captured directly into the TPRS		~~financial tracking system for financial savings realisation.~~ Enterprise wide system introduced for project leads to update progress with separate financial deliverables monitored within Finance. Both sources brought together for the purposes of monitoring and managing performance both by the TP Steering Group and PMB, which is accountable to the Finance & Performance	~~ne signed off by PMB/TSO Steering Group in Q4.~~by the TSO Steering Group. Final documentation pack being developed for future years, including format for high level reporting. To be signed off by PMB/TSO Steering Group in Q1 (12/13)			

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
						Mgt Committee				
Annual Priority 4.2	Achieve a £2m surplus		Exec Lead: DFPM							
	Under-delivery of efficiency savings, unplanned costs arising especially where these are not offset by additional income for activity above targeted levels.	Budget management system, timely and robust reporting to Trust Board, F&PMC, PMB together with Qrtrly divisional reviews and attendance at F&PMC all provides robust system of checks and corrective action where necessary.	Audit Committee sign-off of independent internal and external audit plans that test functioning of financial systems. Transparent reporting of use of resources via detailed schedules to Finance Committee.	~~Final details of elective referral mechanism with main commissioners requires finalisation.~~None identified	None identified.	~~Financial terms on single speciality being agreed.~~ Audit Committee considered data quality of indicators reported within corporate scorecard	~~Resolution required in Quarter 4 for forecast purposes.~~Surplus target achieved	3	3	9
	CQUIN delivery below levels required placing commissioners in a position to withhold target related payments	Review of CQUIN delivery occurs at Trust Board, F&PMC, PMB and TMB as well as in direct routine meetings with divisions.	Clear reporting of the thresholds required and year to date activity.	~~Strengthen performance tracking within Chief Operating officer's meeting with general management teams.~~ None identified	Timely requirement to assure Board of the data quality and sources used in assessing performance.	~~COO toreview inclusion of dedicated CQUIN review in addition to attention paid at TMB~~ No further action required	~~Q3 for data assurance taking this to either AC or G&S – DFPM, also Q3 for formalising into COO processes - COO~~	3	3	9

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
Annual Priority 4.3 Reduce Premium Rate Working Exec Lead: COO										
IBP,	• Lack of filled training post from the Deanery • Reliance on additional list to meet performance targets • Inadequate systems and controls to authorise premium rate working • Financial pressure as premium rate working not funded	• Divisional level work in train to decrease premium rate working. • Demand and capacity review of Trauma and Orthopaedic in progress (see annual priority 2.5)	Assurance at service level in local CIP plans and related monitoring.	Authorisation at local level/ Divisional level only.	No pan Trust authorisation process or reports of additional capacity usage.	• Trust wide controls ~~to be~~ implemented to authorise premium rate working. • Productivity and efficiency opportunities to be realised through cross cutting themes of Transformation Plan ~~(TBA in September)~~	RB ~~October 2011~~ Completed	4	5	20
Annual Priority 4.4 Develop plans to improve the service line position of the Trust Exec Lead: DSOD										
	Inability to distinguish which HRGs within each specialty make a	SLR QUEP	QUEP reporting	Closer integration with SLM QUEP and CIP required	None	To strengthen assurance, work is underway on	DSOD	3	3	9

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
	contribution					strengthening of CIP and SLM project management through TSO creation				
	Factors outside of project control worsen SLR position eg tariff changes or other plans such as decommissioning	None	None	Decommissioning programme does not consider SLR position	None	Not applicable	DSOD	4	3	12
	Failure to deliver CIPs for the specialty	CIP management	CIP reporting	Closer integration with SLM QUEP and CIP required	None	Not applicable	DSOD	2	3	6
STRATEGIC OBJECTIVE 5: 21ST CENTURY FACILITIES										
Annual Priority 5.1 Begin to procure a new hospital Exec Lead: DENHP										
	Delay in project plan continues and impacts on FT application timescale, due to change in requirements, technical	Rapid response to all queries and requests for information from the DH and Treasury. Continue to work	Project Board minutes reports on progress. Gateway review reports.	None Known	None known	Not applicable	DE/NHP	4	4	16

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
	difficulties, change in staffing at DH, further delay in final part of approval process. Delay beyond October 2011 risks integrity of OBC	with senior stakeholders and decision makers to ensure best chance of approval.								
Annual Priority 5.2 Continue to improve current facilities Exec Lead: DENHP										
	Non-completion of capital schemes on agreed programme	Project teams established where necessary. All items on the capital programme have a nominated lead	Monthly reports to SIRG and Annual Estates Strategy to Trust Board	None identified	None identified	None applicable	DE/NHP	2	3	6
Annual Priority 5.3 Develop detailed plans for the development of the community estate Exec Lead: DENHP										
	Limited project resource capacity to develop plans, through clinical engagement, due to competing priorities on the same management resource	Project Plan for delivery of feasibility studies. Regular meetings with CPT to ensure completion of feasibility studies Monthly RCRH Community	Community Facilities Programme Team – reports on progress	None identified	None identified	None applicable	DE/NHP	4	3	12

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
		Facilities Programme Group to monitor progress. SRT and CPT utilising capacity available as a consequence of the delay to the Midland Metropolitan Hospital Business Case being approved. Identified key personnel in SRT and CPT for community workstream								
STRATEGIC OBJECTIVE 6: AN EFFECTIVE ORGANISATION										
Annual Priority 6.1 Make significant progress towards becoming a Foundation Trust Exec Lead: DSOD										
	Performance failure delays FT progress	*FT programme structure* *Performance management framework*	FT programme management Regular reports to FT programme Board and Trust	None identified	None identified	None applicable	DSOD	2	4	8

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
			Board Monthly risk assessment Deloitte review of readiness							
	Inability to resolve Outline Business Case approval and prudential borrowing code issues	Maintain contact with DH	Reporting of progress to Board members formally and informally	None identified	None identified	None applicable	DSOD	2	4	8
Annual Priority 6.2 Deliver a set of Organisational Development activities including a stronger voice for front line staff Exec Lead: DSOD										
	Failure to develop comprehensive OD framework	OD framework action plan	Irregular reporting of progress to Executive Team	No regular reporting and discussion	No comprehensive assurance	Development of OD steering group	Now established	3	3	9
	Failure to deliver model of staff engagement and incentive system	Owning the Future pilots and action plan	Irregular discussion at exec team Reporting of progress to CEO	No formal controls	No comprehensive assurance	OD steering group will oversee progress and receive regular reports	Now established	3	3	9
Annual Priority 6.3 Develop our clinical systems and processes to reduce variability and ensure safe, error free care Exec Lead: MD										
	Lack of Standards across the Trust	Development of standards and	Outputs from audit	Audit process not yet in place	Reporting process not yet	Introduction of self-assessment	Medical Director Q4	5	4	20

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
		ongoing audit methodology			developed	tool for directorates and clinical departments, with reporting through the QMF Audit process established but outcomes not yet reported	11/12			
Annual Priority 6.4 Improve staff satisfaction, health and wellbeing Exec Lead: CN (with DSOD)										
	Failure to deliver health and wellbeing action plan. Impact of organisational change faced by the organisation.	Sickness absence monitoring. Project plans. H&WB Committee. Workforce QuEP. Facilitator for H&WB. HR support. Sickness absence policy. Organisational change process to be managed via Workforce	Monthly reporting to Workforce Efficiency Programme and TMB. Quarterly to Diversity Steering Group. Annually to TB. Staff survey. 'Pulse checks'. OH referrals. Trend data. Revised sickness absence policy	Facilitator only funded to March 2013.	'Pulse checks' not in place yet. Development of evaluation methodology to determine impact of H & WB initiatives on sickness absence levels.	Funding bids for facilitator.	March 2012~~3~~. CN/DSOD	4	3	12

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
		Reduction workstream of Workforce Efficiency Programme.	approved and due to be launched in January 2012. Dedicated HR resource to support delivery of Workforce Reduction Programme.							
	Failure to improve staff survey results.	Action plan/matrix developed to ensure actions for improvement are identified and achieved. Ensure robust staff communication activity to highlight findings and actions being taken as a result	Monitor delivery of action plan and communication activity and provide regular reports to LiA Sponsor Group	None identified	None identified	Not applicable	DSOD	2	3	6
Annual Priority 6.5 Agree an IT strategy, including and affordable route to procurement of an Electronic Patient Record Exec Lead: MD										
	Uncertainty about capacity to develop and deliver a complex	Nil as yet	Nil as yet	No Controls in place as yet	Assurance processes not yet developed	Oversight of project group will be developed and	MD March 2012	3	5	15

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
	and affordable strategy					monitored through the OD strategy Review of capacity and capability undertaken by external resources which has informed the future plans for the function				
Annual Priority 6.6 Continue to develop and implement the Trust's approach to sustainability and transport and access Exec Lead: DE/NHP										
	Failure to meet carbon management targets for CO^2 reduction	Monthly monitoring via Sustainability Working Group and quarterly monitoring/ reporting to Trust Board	On-going work with sustainability champions at departmental level to assist in affecting a cultural change and implementing improvements in energy awareness and promoting	Plans are developed and reported on by same department (some external assurance form professional bodies)	Assurance on whole plan required	~~IA to assurance of plans required~~ CMP – Carbon Trust appointed to verify and update review of plan CRC – Internal Audit reviewed the Trust in 2011/12	First target completion of 15% reduction on 2008/09 baseline by 2013/14 and cultural change before move to new hospital – DE/NHP	4	3	12

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment		
								Pre-mitigation scores		
								P	S	RS
			alternatives modes of transport and travel. Target to achieve 20% increase in champion numbers in 2011 and by 2013/14 have a champion in all areas. Target to achieve 50% of champions with Level 2 qualifications by 2013/14. Implementation of carbon management software to produce accurate and live baseline information across the scope of utilities,			EUETS – verification by external verifier				

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
			transport and waste. Commence the measurement of procurement baseline in line with SCO2PE from DoH. Introduction of public transport plans with appointment letters							
Annual Priority 6.7 Develop a training plan that reflects service needs, is resources and supports the workforce plan Exec Lead: CN										
	Failure to develop training plan that meets service needs.	Annual process understood and in place. Lead manager. Template ~~etc~~etc. to support. PDR process to inform. L&D Committee.	Regular reports to L&D Committee.	None identified	None identified	Not applicable	CN	2	3	6

Cross Reference	Principal Risk	Key Controls	Key Assurances	Gaps in Control	Gaps in Assurance	Actions to Address Gaps	Timescale & Executive Lead	Risk Assessment Pre-mitigation scores		
								P	S	RS
	Failure to secure sufficient resources to support training needs.	Annual allocation from SHA. Some recurrent internal funding. L&D Department. Access to other funding sources. Locality Boards.	Regular reports to L&D Committee.	Insufficient funding to support all needs identified.	None identified	Funding bids. Reallocate and prioritise funding available. Purchase of Open 4 learning in order to identify wider funding support	March 2012. CN	4	2	8

Executive Lead

CE	Chief Executive
CN	Chief Nurse
COO	Chief Operating Officer
DE/NHPD	Director of Estates/New Hospital Project
DFPM	Director of Finance & Performance Mgt
DG	Director of Governance
MD	Medical Director
DSOD	Director of Strategy & Organisational Development
HCE	Head of Communications & Engagement

RISK SEVERITY MATRIX

Q1. PROBABILITY - What is the likelihood of the risk occurring? Use the table below to assign this incident a category code.

MEASURES OF PROBABILITY		
Descriptor	**Level**	**Description**
Rare	1	The event may only occur in exceptional circumstances
Unlikely	2	The event is not expected to happen but may occur in some circumstances
Possible	3	The event may occur occasionally
Likely	4	The event is likely to occur, but is not a persistent issue
Almost Certain	5	The event will probably occur on many occasions and is a persistent issue

Q2. SEVERITY - Identify the highest consequence of this risk? (Use this table as a general guide; you may need to apply similar methodology for consequences not considered here)

Descriptor	Potential Impact on Individual(s)	The Potential for complaint/Litigation	Potential Impact on Organisation	Number of Persons likely to be affected or Direct Cost to Trust
Insignificant **1**	• NO INURY OR ADVERSE OUTCOME	• Unlikely to cause complaint/ litigation	• No risk at all to organisation	0-1 Person **£0 - £25K**
Minor **2**	• SHORT TERM INJURY /DAMAGE e.g. injury that is likely to be resolved within one month	• Complaint possible • Litigation unlikely	• Minimal risk to organisation • RIDDOR reportable (>4 day absence from work)	2-4 **£25K - £100K**
Moderate **3**	• SEMI-PERMANENT INJURY/DAMAGE e.g. injury that may take up to 1 year to resolve. • Long term sickness e.g. 4 weeks	• Litigation possible but not certain. • High potential for complaint.	• RIDDOR reportable (Major) • Needs careful PR • MHRA reportable • Short term sickness • External investigation (e.g. HSE)	5-10 Persons **£100K - £0.5M**
Major **4**	• PERMANENT INURY i.e. disabling	• Litigation certain expected to be settled for < £1M	• Service closure • Threat to Divisional/Directorate objectives/priorities	10-20 Persons **£0.5M - £3M**
Catastrophic **5**	• Non-Clinical DEATH • Loss of body part(s)	• Litigation certain: expected to be settled for >£1M	• National adverse publicity • Threat to Trust objectives/priorities	Over 20 Persons **£3M & Above**

Q3 **Risk Score**- Use the matrix below to grade the risk.

e.g. 2 x 4 = 8 = ~~Yellow or~~Yellow or 5 x 5 = 25 = Red

	SEVERITY				
PROBABILITY	**Insignificant 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**
1 Rare	**1**	**2**	**3**	**4**	**5**
2 Unlikely	**2**	**4**	**6**	**8**	**10**
3 Possible	**3**	**6**	**9**	**12**	**15**
4 Likely	**4**	**8**	**12**	**16**	**20**
5 Almost Certain	**5**	**10**	**15**	**20**	**25**

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PERFORMANCE METRICS:

ty Care

Patient survey report 2011

Survey of adult inpatients 2011

Sandwell and West Birmingham Hospitals NHS Trust

The national survey of adult inpatients in the NHS 2011 was designed, developed and co-ordinated by the Co-ordination Centre for the NHS Patient Survey Programme at Picker Institute Europe.

picker
Institute Europe

Making patients' views count

National NHS patient survey programme
Survey of adult inpatients 2011

Re-design of the benchmark reports

This is a new style of benchmark report, replacing the previous reports produced for the national surveys which contained scores out of 100. We have designed this report using feedback from people who use the data. The data contained here uses the same scoring system as before but presents the data as a score out of 10, and displays trusts' performance in a different way to the previous reports, using a more robust statistical technique. The scores and groupings now match those presented under the organisational search tool available on the CQC website http://www.cqc.org.uk/surveys/inpatient.

The Care Quality Commission

The Care Quality Commission is the independent regulator of health care and adult social care services in England. We also protect the interests of people whose rights are restricted under the Mental Health Act. Whether services are provided by the NHS, local authorities or by private or voluntary organisations, we focus on:

- **Identifying risks** to the quality and safety of people's care
- **Acting swiftly** to help eliminate poor-quality care.
- Making sure **care is centered on people's needs** and protects their rights.

Survey of adult inpatients 2011

To improve the quality of services that the NHS delivers, it is important to understand what patients think about their care and treatment. One way of doing this is by asking patients who have recently used their local health services to tell us about their experiences.

The survey results are primarily intended to be used by NHS trusts to help them improve their performance. We have included data from the survey in the Quality and Risk Profiles for providers, which contributes to our assessment of compliance with the essential standards of quality and safety set by the government. The Department of Health will also use the results for performance assessment, improvement and regulatory purposes.

The ninth survey of adult inpatients involved 161[1] acute and specialist NHS trusts. We received responses from more than 70,000 patients, a response rate of 53%. Patients were eligible for the survey if they were aged 16 years or older, had at least one overnight stay during June, July or August 2011 [2] (sampling month chosen by the trust) and were not admitted to maternity or psychiatric units. Fieldwork took place between October 2011 and January 2012.

Similar surveys of adult inpatients were also carried out in 2002, 2004, 2005, 2006, 2007, 2008, 2009 and 2010. They are part of a wider programme of NHS patient surveys, which covers a range of topics including mental health services and outpatient services. To find out more about our programme and for the results from previous surveys, please see the links contained in the further information section.

The data in this report

This report provides the results of the ninth survey of adult inpatients in NHS trusts in England, and shows how a trust scored for each question in the survey, compared against the range of results from all other trusts that took part in the survey. It is designed to help to understand the performance of individual trusts, and to identify areas for improvement.

Results displayed in this report are a graphical representation of the results displayed for the public

[1] Although respondents from 162 trusts took part in the survey, these results are based on 161. One trust was excluded from the publication due to a sampling error.

[2] Some trusts who could not achieve the required sample size sampled back further.

under the organisational search facility on the CQC website. The same data is shown on the website in a more simplified way, identifying whether a trust performed 'better' or 'worse' or 'about the same' as the majority of other trusts for each question.

You can also find on the CQC website the national overall results for the 2011 survey compared to those from 2010, alongside a national summary highlighting the key issues.

Interpreting the report

The report provides a score for each question, and a score for each section. The scores for each question are grouped according to the sections of the questionnaire as completed by respondents. For example, the survey includes sections on 'the hospital and ward' and 'care and treatment', amongst others. At the end of the report you will find tables containing the data used for the graphs and background information about the patients that responded.

For each question in the survey, the individual responses were converted into scores on a scale of 0 to 10. A score of 10 represents the best possible response. Therefore, the higher the score for each question, the better the trust is performing.[3]

It is not appropriate to score all questions within the questionnaire, this is because not all of the questions assess the trusts in any way, or they may be 'filter questions' designed to filter out respondents to whom following questions do not apply. An example of a filter question would be Q51 "During your stay in hospital, did you have an operation or procedure?"

The graphs in this report display the scores for this trust, compared with the full range of results from all other trusts that took part in the survey. Each bar represents the range of results for each question across all trusts. In the graphs, the bar is divided into three sections:

- If your trust score lies in the orange section of the graph, your trust result is 'about the same' as most other trusts in the survey
- If your trust score lies in the red section of the graph, your trust result is 'worse' compared with most other trusts in the survey
- If your trust score lies in the green section of the graph, your trust result is 'better' compared with most other trusts in the survey.

A black diamond represents the score for this trust. The black diamond (score) is not shown for questions answered by fewer than 30 people because the uncertainty around the result would be too great. The trust will also not have a section score for the corresponding section, this is because the section data is not comparable with other trusts, as it is made up of fewer questions.

You may find that there is no red area, and/or no green area in the charts shown for some questions. This can occur in the analysis of the data and is an acceptable consequence of the statistical technique that is used. The size of the orange area is constructed by considering how different all trust scores are across the range, as well as the confidence we can have in that particular trust's score (by looking at the number of respondents to that question). In some cases, this will lead to such a wide margin of error that the 'expected range' (the orange section) will be very wide, and hence will also cover the highest or lowest scoring trusts for that question.

At the end of the report you will find tables containing the data used for the graphs and background

[3]Trusts have differing profiles of patients. For example, one trust may have more male inpatients than another. This can potentially affect the results because people tend to answer questions in different ways, depending on certain characteristics. For example, older respondents tend to report more positive experiences than younger respondents, and women tend to report less positive experiences than men. This could potentially lead to a trust's results appearing better or worse than if they had a slightly different profile of patients. To account for this, we 'standardise' the data. Results have been standardised by the age, sex and method of admission (emergency or elective) of respondents to ensure that no trust will appear better or worse than another because of its respondent profile. This helps to ensure that each trust's age-sex-admission type profile reflects the national age-sex-admission type distribution (based on all of the respondents to the survey). It therefore enables a more accurate comparison of results from trusts with different profiles of patients.

information about the patients that responded.

PLEASE NOTE: As the reports have been re-designed, these groupings are different from those used in the previous style of benchmark report, which showed the top 20% and bottom 20% of scores. These groupings here are instead based on a statistical analysis involving the use of adjusted Z scores and winsorisation. More detail can be found in the technical report, details in the 'further information' section below.

Methodology

The categories described above are based on a statistic called the 'expected range' which is uniquely calculated for each trust for each question. This is the range within which we would expect a particular trust to score if it performed 'about the same' as most other trusts in the survey. The range takes into account the number of respondents from each trust as well as the scores for all other trusts. This means that where a trust is performing 'better' or 'worse' than the majority of other trusts, this is likely to be a true reflection of all patients that have visited the trust, rather than being unique to those who responded to the survey.

A technical document providing more detail about the methodology and the scoring applied to each question is available on our website (see further information section).

Notes on specific questions

Please note that a variety of acute trusts take part in this survey and not all questions are applicable to every trust. The section below details modifications to certain questions, in some cases this will apply to all trusts, in other cases only to applicable trusts.

All trusts
Q8: ("Overall, from the time you first talked to this health professional about being referred to a hospital, how long did you wait to be admitted to hospital?") excludes patients who were not referred for a planned admission to hospital by a GP or health professional in England (i.e. their care was not bought or 'commissioned' in England but in Northern Ireland, Scotland or Wales). This is because waiting time policies differ outside of England.

All trusts
Q60 and Q61: The information collected by Q60 ("On the day you left hospital, was your discharge delayed for any reason?") and Q61 ("What was the main reason for the delay?") are presented together to show whether a patient's discharge was delayed by reasons attributable to the hospital. The combined question in this report is labelled as Q61 and is worded as: "Discharge delayed due to wait for medicines/to see doctor/for ambulance."

All trusts
Q62: Information from Q60 and Q61 has been used to score Q62 ("How long was the delay?") to assess the length of a delay to discharge for reasons attributable to the hospital.

Trusts with male and female patients
Q14 and Q17: The information collected by Q14 ("When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?") and Q17 ("After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?") are presented together to show whether the patient has ever shared a sleeping area with patients of the opposite sex. The combined question is numbered in this report as Q14 and has been reworded as "Did you ever share a sleeping area with patients of the opposite sex?"[4] [5]

[4]Please note that the information based on Q14 cannot be compared to similar information collected in the 2002, 2004 and 2005 surveys. This is due to a change in the questions' wording and because the results for 2006 onwards have excluded patients who have stayed in a critical care area, which almost always accommodates patients of both sexes. For further details, please see the technical document which shows the scores assigned to each question (available on our website).

[5]Trusts providing services for women only have been excluded when calculating the national average for Q14 (Did you ever share a sleeping areas with patients of the opposite sex) and Q19 (Did you ever use the same bathroom or shower area as patients of the opposite sex?).

Trusts with female patients only
Q14 and Q19: If your trust offers services to women only, a trust score for Q14 ("Did you ever share a sleeping area with patients of the opposite sex?") and Q19 ("While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?") is not shown.

Trusts with no A&E department
Q3-Q5 (The Accident and Emergency Department): The results to these questions are not shown for trusts that do not have an emergency department.

For further more detailed information on how questions in the survey are scored please see the technical document available on our website.

Further information

The full national results are on the CQC website, together with an A to Z list to view the results for each trust (alongside the technical document outlining the methodology and the scoring applied to each question):
www.cqc.org.uk/Inpatientsurvey2011

The results for the adult inpatient surveys from 2002 to 2010 can be found at:
www.nhssurveys.org/surveys/292

The 2002 survey of adult inpatient results (published by the Department of Health) can be found at:
www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSpatients/Nationalsurveyinpatients/index.htm

Full details of the methodology of the survey can be found at:
www.nhssurveys.org/

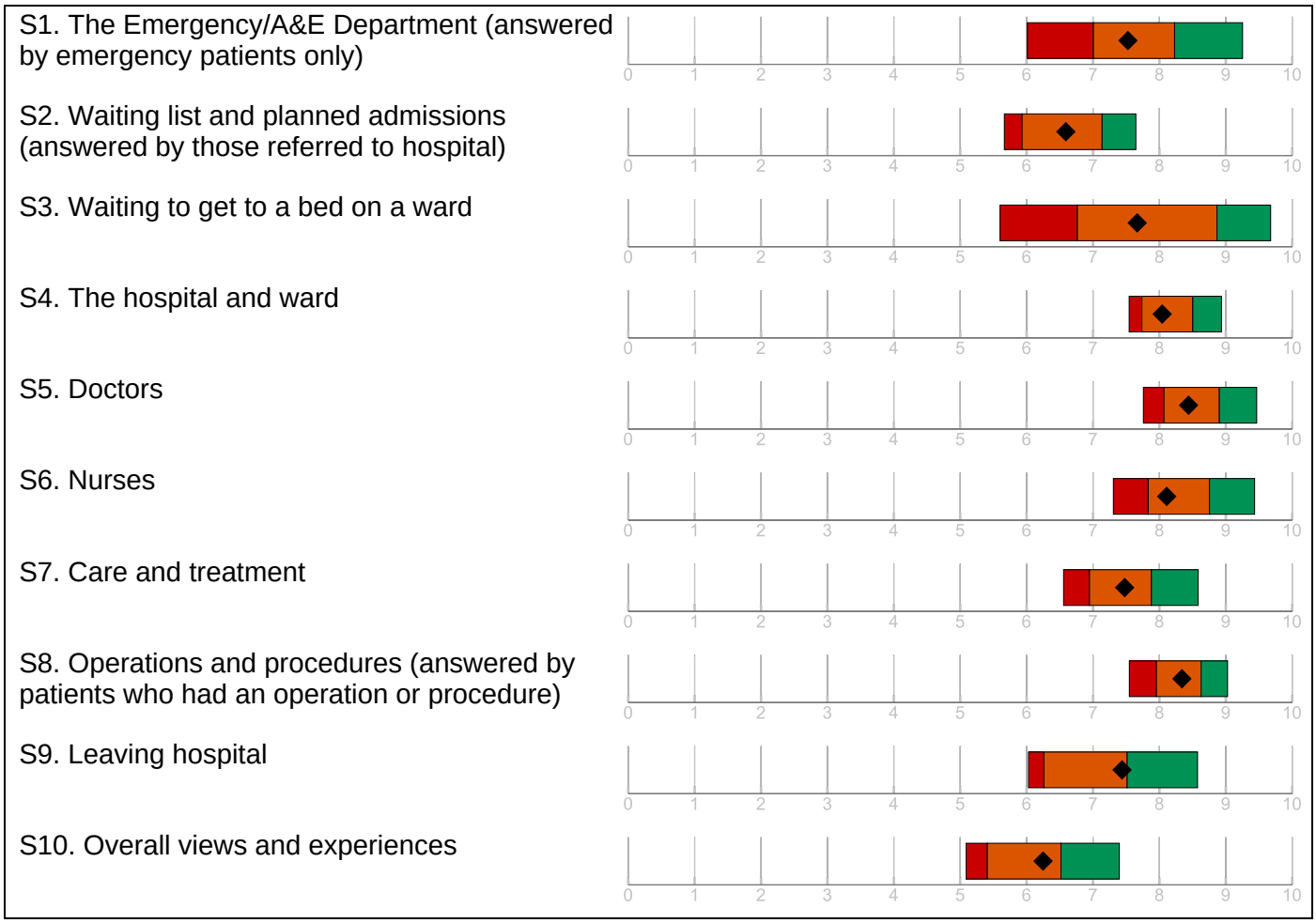
More information on the programme of NHS patient surveys is available at:
www.cqc.org.uk/public/reports-surveys-and-reviews/surveys

More information on Quality and Risk Profiles (QRP) can be found at:
www.cqc.org.uk/organisations-we-regulate/registered-services/quality-and-risk-profiles-qrps

Survey of adult inpatients 2011

Sandwell and West Birmingham Hospitals NHS Trust

Section scores

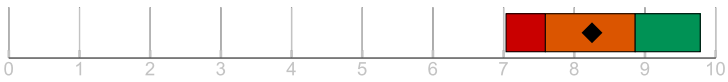


Survey of adult inpatients 2011

Sandwell and West Birmingham Hospitals NHS Trust

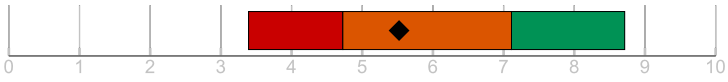
The Emergency/A&E Department (answered by emergency patients only)

Q3. While you were in the A&E Department, how much information about your condition or treatment was given to you?



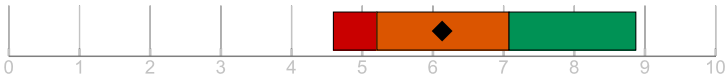
Q4. Were you given enough privacy when being examined or treated in the A&E Department?

Q5. Following arrival at the hospital, how long did you wait before being admitted to a bed on a ward?



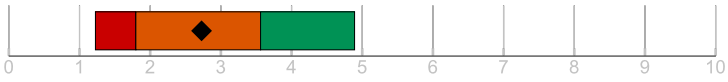
Waiting list and planned admissions (answered by those referred to hospital)

Q8. Overall, from the time you first talked to a health professional about being referred to hospital, how long did you wait to be admitted to hospital?



Q9. How do you feel about the length of time you were on the waiting list?

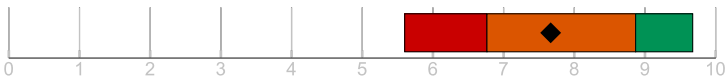
Q10. Were you given a choice of admission dates?



Q11. Was your admission date changed by the hospital?

Waiting to get to a bed on a ward

Q12. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?



Best performing trusts

About the same

Worst performing trusts

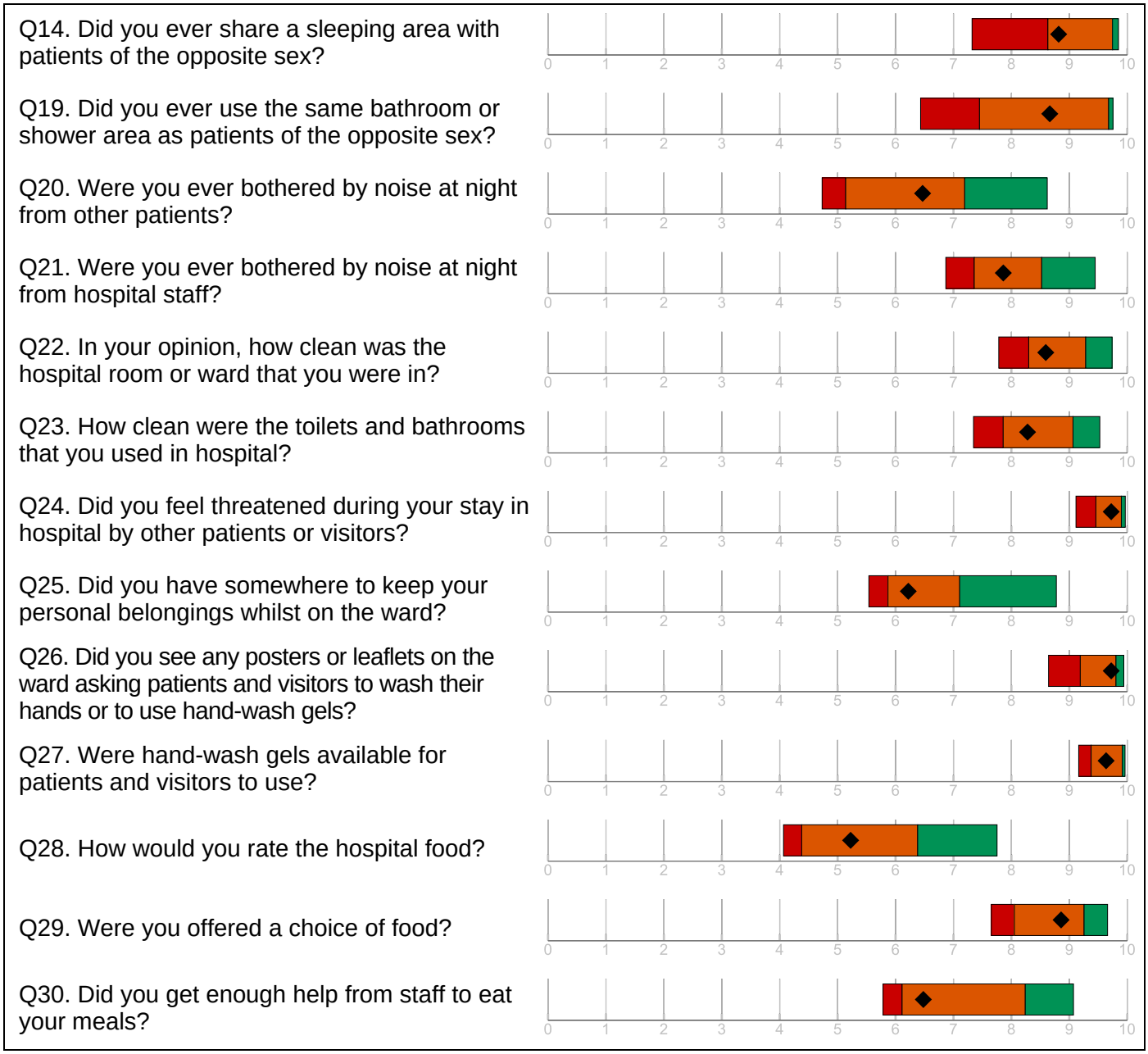
This trust

This trust's results are not shown if there were fewer than 30 respondents.

Survey of adult inpatients 2011

Sandwell and West Birmingham Hospitals NHS Trust

The hospital and ward



Best performing trusts

About the same

Worst performing trusts

This trust

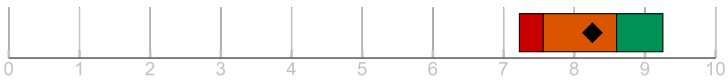
This trust's results are not shown if there were fewer than 30 respondents.

Survey of adult inpatients 2011

Sandwell and West Birmingham Hospitals NHS Trust

Doctors

Q31. When you had important questions to ask a doctor, did you get answers that you could understand?



Q32. Did you have confidence and trust in the doctors treating you?

Q33. Did doctors talk in front of you as if you weren't there?

Q34. As far as you know, did doctors wash or clean their hands between touching patients?

Nurses

Q35. When you had important questions to ask a nurse, did you get answers that you could understand?

Q36. Did you have confidence and trust in the nurses treating you?

Q37. Did nurses talk in front of you as if you weren't there?

Q38. In your opinion, were there enough nurses on duty to care for you in hospital?

Q39. As far as you know, did nurses wash or clean their hands between touching patients?

Best performing trusts

About the same

Worst performing trusts

This trust

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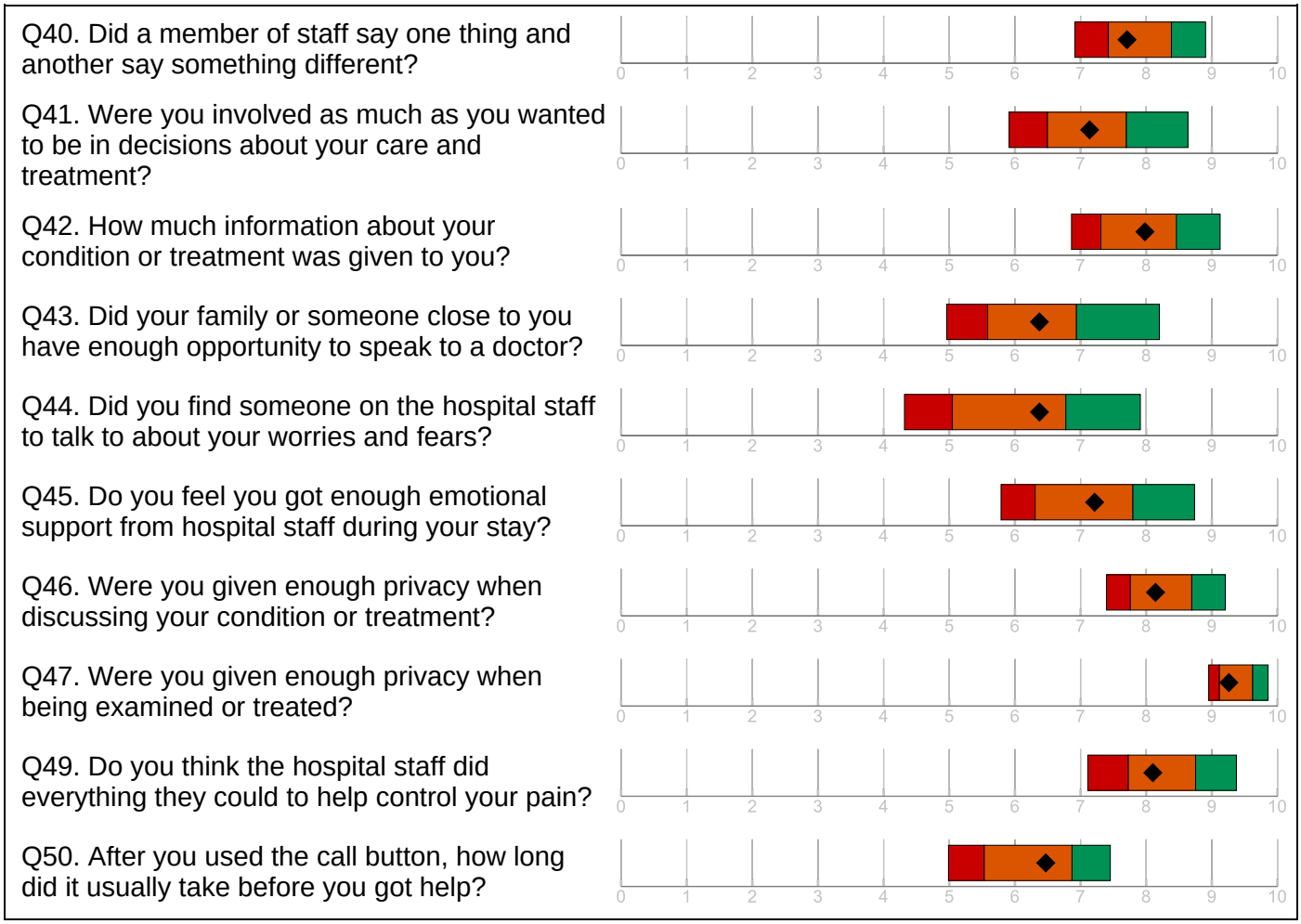
Survey of adult inpatients 2011

Sandwell and West Birmingham Hospitals NHS Trust

Care and treatment



Best performing trusts

About the same

Worst performing trusts

This trust

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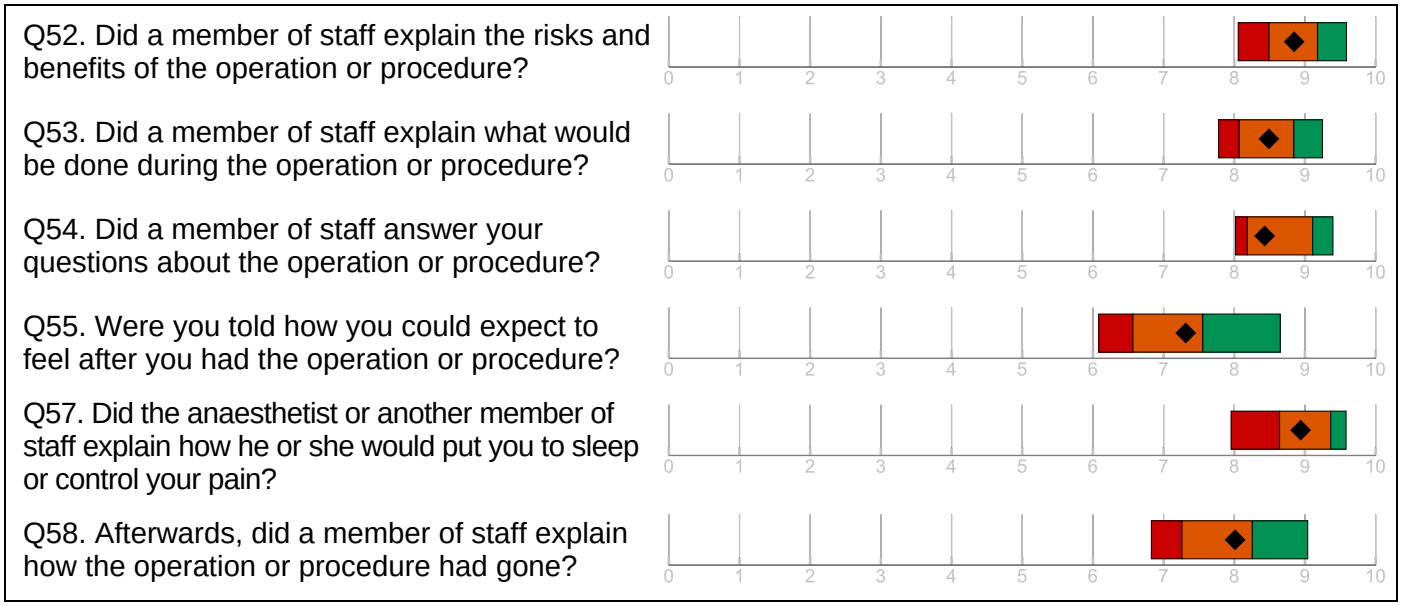
Survey of adult inpatients 2011

Sandwell and West Birmingham Hospitals NHS Trust

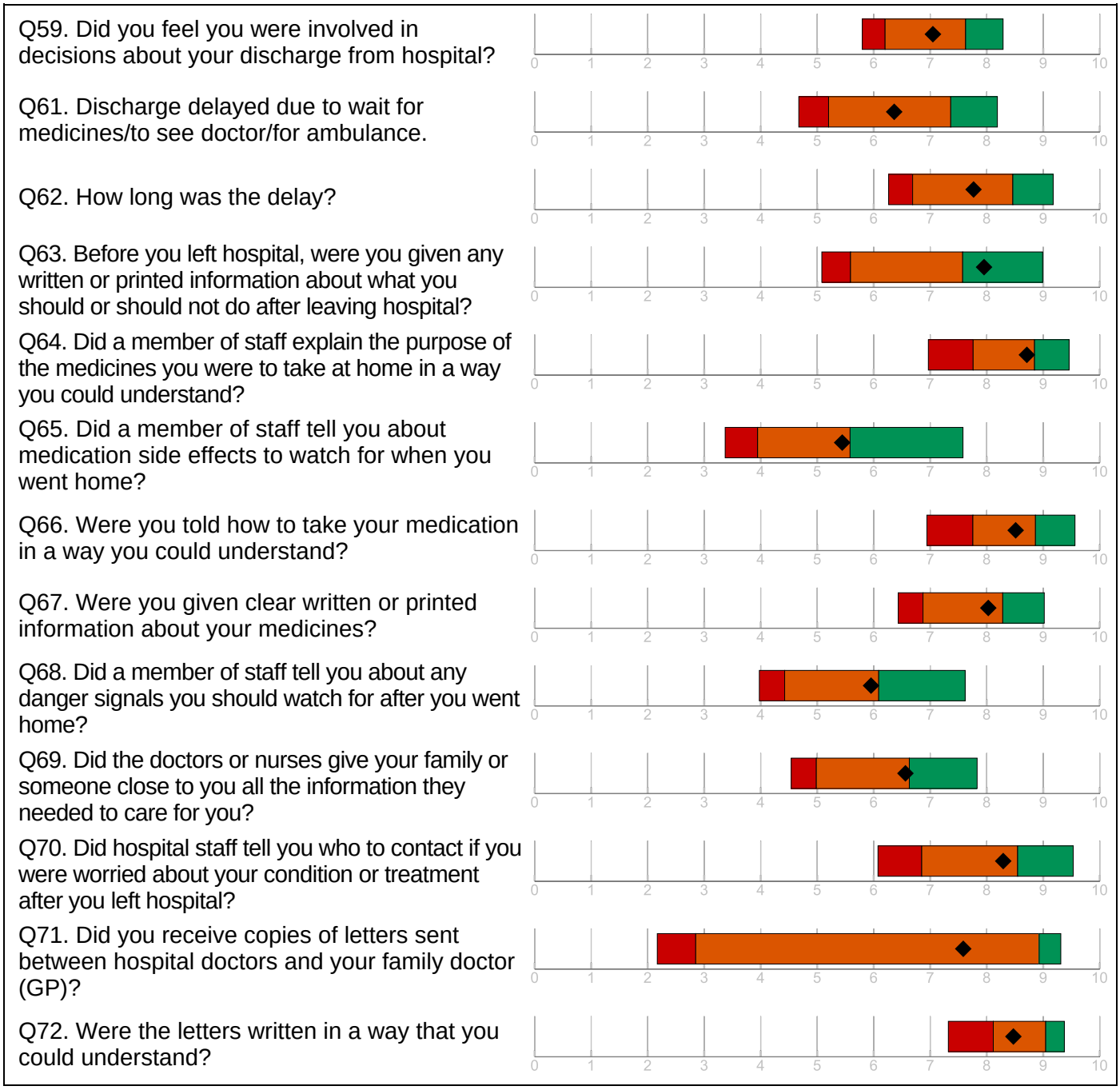
Operations and procedures (answered by patients who had an operation or procedure)



Survey of adult inpatients 2011

Sandwell and West Birmingham Hospitals NHS Trust

Leaving hospital



Best performing trusts

About the same

Worst performing trusts

This trust

This trust's results are not shown if there were fewer than 30 respondents.

Survey of adult inpatients 2011

Sandwell and West Birmingham Hospitals NHS Trust

Overall views and experiences

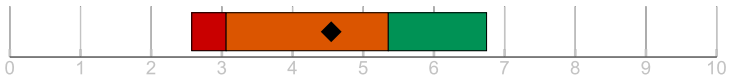
Q73. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Q74. How would you rate how well the doctors and nurses worked together?

Q75. Overall, how would you rate the care you received?

Q76. During your hospital stay, were you ever asked to give your views on the quality of your care?

Q77. While in hospital, did you ever see any posters or leaflets explaining how to complain about the care you received?



Best performing trusts

About the same

Worst performing trusts

◆ This trust

This trust's results are not shown if there were fewer than 30 respondents.

Survey of adult inpatients 2011

Sandwell and West Birmingham Hospitals NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)
The Emergency/A&E Department (answered by emergency patients only)					
S1	Section score	7.5	6.0	9.3	
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	8.3	7.0	9.8	157
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	8.8	7.6	9.8	178
Q5	Following arrival at the hospital, how long did you wait before being admitted to a bed on a ward?	5.5	3.4	8.7	172
Waiting list and planned admissions (answered by those referred to hospital)					
S2	Section score	6.6	5.7	7.6	
Q8	Overall, from the time you first talked to a health professional about being referred to hospital, how long did you wait to be admitted to hospital?	6.1	4.6	8.9	188
Q9	How do you feel about the length of time you were on the waiting list?	8.4	6.6	9.4	207
Q10	Were you given a choice of admission dates?	2.7	1.2	4.9	205
Q11	Was your admission date changed by the hospital?	9.1	8.4	9.8	209
Waiting to get to a bed on a ward					
S3	Section score	7.7	5.6	9.7	
Q12	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	7.7	5.6	9.7	392

Survey of adult inpatients 2011

Sandwell and West Birmingham Hospitals NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)
The hospital and ward					
S4	Section score	8.0	7.5	8.9	
Q14	Did you ever share a sleeping area with patients of the opposite sex?	8.8	7.3	9.9	312
Q19	Did you ever use the same bathroom or shower area as patients of the opposite sex?	8.7	6.4	9.8	354
Q20	Were you ever bothered by noise at night from other patients?	6.5	4.7	8.6	387
Q21	Were you ever bothered by noise at night from hospital staff?	7.9	6.9	9.4	387
Q22	In your opinion, how clean was the hospital room or ward that you were in?	8.6	7.8	9.7	391
Q23	How clean were the toilets and bathrooms that you used in hospital?	8.3	7.3	9.5	379
Q24	Did you feel threatened during your stay in hospital by other patients or visitors?	9.7	9.1	10.0	390
Q25	Did you have somewhere to keep your personal belongings whilst on the ward?	6.2	5.5	8.8	354
Q26	Did you see any posters or leaflets on the ward asking patients and visitors to wash their hands or to use hand-wash gels?	9.7	8.6	9.9	374
Q27	Were hand-wash gels available for patients and visitors to use?	9.6	9.2	10.0	377
Q28	How would you rate the hospital food?	5.2	4.1	7.8	377
Q29	Were you offered a choice of food?	8.9	7.7	9.7	387
Q30	Did you get enough help from staff to eat your meals?	6.5	5.8	9.1	121
Doctors					
S5	Section score	8.4	7.8	9.5	
Q31	When you had important questions to ask a doctor, did you get answers that you could understand?	8.3	7.2	9.3	363
Q32	Did you have confidence and trust in the doctors treating you?	9.0	8.1	9.7	392
Q33	Did doctors talk in front of you as if you weren't there?	7.9	7.1	9.5	391
Q34	As far as you know, did doctors wash or clean their hands between touching patients?	8.6	7.9	9.7	249

Survey of adult inpatients 2011

Sandwell and West Birmingham Hospitals NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)
Nurses					
S6	Section score	8.1	7.3	9.4	
Q35	When you had important questions to ask a nurse, did you get answers that you could understand?	8.0	6.9	9.2	370
Q36	Did you have confidence and trust in the nurses treating you?	8.6	7.5	9.5	396
Q37	Did nurses talk in front of you as if you weren't there?	8.0	7.2	9.7	395
Q38	In your opinion, were there enough nurses on duty to care for you in hospital?	7.4	6.0	9.1	396
Q39	As far as you know, did nurses wash or clean their hands between touching patients?	8.5	7.8	9.7	279
Care and treatment					
S7	Section score	7.5	6.6	8.6	
Q40	Did a member of staff say one thing and another say something different?	7.7	6.9	8.9	398
Q41	Were you involved as much as you wanted to be in decisions about your care and treatment?	7.1	5.9	8.6	394
Q42	How much information about your condition or treatment was given to you?	8.0	6.9	9.1	397
Q43	Did your family or someone close to you have enough opportunity to speak to a doctor?	6.4	5.0	8.2	290
Q44	Did you find someone on the hospital staff to talk to about your worries and fears?	6.4	4.3	7.9	247
Q45	Do you feel you got enough emotional support from hospital staff during your stay?	7.2	5.8	8.7	266
Q46	Were you given enough privacy when discussing your condition or treatment?	8.1	7.4	9.2	396
Q47	Were you given enough privacy when being examined or treated?	9.3	9.0	9.9	397
Q49	Do you think the hospital staff did everything they could to help control your pain?	8.1	7.1	9.4	286
Q50	After you used the call button, how long did it usually take before you got help?	6.5	5.0	7.5	225

Survey of adult inpatients 2011

Sandwell and West Birmingham Hospitals NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)
Operations and procedures (answered by patients who had an operation or procedure)					
S8	Section score	8.3	7.5	9.0	
Q52	Did a member of staff explain the risks and benefits of the operation or procedure?	8.8	8.1	9.6	313
Q53	Did a member of staff explain what would be done during the operation or procedure?	8.5	7.8	9.2	309
Q54	Did a member of staff answer your questions about the operation or procedure?	8.4	8.0	9.4	276
Q55	Were you told how you could expect to feel after you had the operation or procedure?	7.3	6.1	8.7	314
Q57	Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?	8.9	8.0	9.6	284
Q58	Afterwards, did a member of staff explain how the operation or procedure had gone?	8.0	6.8	9.0	316
Leaving hospital					
S9	Section score	7.4	6.0	8.6	
Q59	Did you feel you were involved in decisions about your discharge from hospital?	7.0	5.8	8.3	351
Q61	Discharge delayed due to wait for medicines/to see doctor/for ambulance.	6.4	4.7	8.2	371
Q62	How long was the delay?	7.8	6.3	9.2	368
Q63	Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	8.0	5.1	9.0	386
Q64	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	8.7	7.0	9.5	324
Q65	Did a member of staff tell you about medication side effects to watch for when you went home?	5.4	3.4	7.6	267
Q66	Were you told how to take your medication in a way you could understand?	8.5	6.9	9.6	284
Q67	Were you given clear written or printed information about your medicines?	8.0	6.4	9.0	335
Q68	Did a member of staff tell you about any danger signals you should watch for after you went home?	6.0	4.0	7.6	311
Q69	Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	6.6	4.5	7.8	282
Q70	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	8.3	6.1	9.5	364
Q71	Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?	7.6	2.2	9.3	358
Q72	Were the letters written in a way that you could understand?	8.5	7.3	9.4	270

Survey of adult inpatients 2011

Sandwell and West Birmingham Hospitals NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)
Overall views and experiences					
S10	Section score	6.2	5.1	7.4	
Q73	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	8.7	7.9	9.7	390
Q74	How would you rate how well the doctors and nurses worked together?	7.7	6.6	9.2	387
Q75	Overall, how would you rate the care you received?	7.7	6.6	9.2	389
Q76	During your hospital stay, were you ever asked to give your views on the quality of your care?	2.5	0.4	4.1	353
Q77	While in hospital, did you ever see any posters or leaflets explaining how to complain about the care you received?	4.5	2.6	6.7	287

Survey of adult inpatients 2011
Sandwell and West Birmingham Hospitals NHS Trust

Background information

The sample	This trust	All trusts
Number of respondents	403	70863
Response Rate (percentage)	49	53

Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	45	46
Female	55	54
Age group (percentage)	(%)	(%)
Aged 35 and younger	9	8
Aged 36-50	16	13
Aged 51-65	27	25
Aged 66 and older	48	53
Ethnic group (percentage)	(%)	(%)
White	75	90
Multiple ethnic group	0	1
Asian or Asian British	12	3
Black or Black British	6	2
Arab or other ethnic group	0	0
Not known	5	5

SWBTB (5/12) 091 (b)

2011 National Inpatient Survey

Sandwell and West Birmingham Hospitals NHS Trust

Management Report

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Introduction

The National Inpatient Survey was undertaken by Quality Health for Sandwell and West Birmingham Hospitals NHS Trust between October 2011 and January 2012.

The survey required a sample of 850 inpatients to be drawn from those patients being discharged during June, July, or August 2011 who had had a stay of at least one night in hospital. There were a number of categories of patients excluded from the survey e.g. psychiatric patients and maternity patients.

Response Rate

The target response rate for the survey set nationally was to achieve at least 60% from the usable sample, and the number of usable responses should be at least 500.

403 completed questionnaires were returned from the sample of 850 from Sandwell and West Birmingham Hospitals NHS Trust. A group of 26 patients were excluded from the sample for the following reasons:

- Moved / not known at this address 17
- Ineligible 1
- Deceased 8

The final response rate for the Trust was 49% (403 usable responses from a final sample of 824**).**

Report Contents

This Report contains sections that describe the results from the survey, and sets out the full results in the same format as they appear in the questionnaire. It provides an analysis of issues where the Trust is achieving good results as well as areas where management action is required.

It also provides comparisons of both the Trust results against those of other Trusts in the Quality Health database who undertook the National Patients Survey (headed Trust and All), and the 2011 National Patients Survey results compared to those achieved in the 2010 Survey, where questions are comparable.

This Report also describes the CQUIN payment by improvement arrangements put in place by DH, which uses the results from the 2009 inpatient survey as the baseline and measures progress by reference to the 2011 survey results.

There is also an Executive Summary which pulls together all the Report's conclusions and action points.

The questionnaire provided space for patients to write their own comments about any aspect of the service. The comments received are and set out verbatim[1] in a separate document.

[1] All comments are anonymised and any inappropriate language or references to individuals are removed before submission.

Link to the National Operating Framework

The Department of Health's Operating Framework 2011-12 has continued to identify patient experience survey outcomes as a key factor in measuring the quality of service to patients.

In December 2007 the DH published the Operating Framework for the NHS 2008-9 (Gateway Ref 9120) and it is clear that "ensuring we improve the patient experience, staff satisfaction, and engagement" is now a core part of the ambition that the service has for the future. These specific commitments have been continued in later versions of the Operating Framework and the Outcomes White Papers have extended the commitment to further monitoring base on patient surveys and the extension of the PROMs programmes.

In his introduction to the NOF, the NHS Chief Executive David Nicholson stated: "this year improving patient experience is an explicit priority rather than an assumption and needs to underpin the decisions that local organisations make about where their priorities will lie".

Executive Summary

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

Admission

Actions:

Emergency Admissions:

- Review the provision of verbal information to patients in A&E and MAU.
- Ensure that patients are given as much privacy as possible when being examined or treated.
- Assess the need for further action on waits over 4 hours for admission from A&E and MAU.

Waiting List Admissions:

- Continue action to reduce waiting times to the 18 week envelope.
- Ensure that all patients being admitted through the list are given a choice of admission date to suit their circumstances.
- Review the reasons for changes of admission date by the hospital particularly where these occur twice or more.

All Types:

- Examine reasons why some patients have long waits to get a bed on a ward.

The Hospital and Ward

Actions:

- Review progress on eliminating mixed gender rooms, bays and bathroom facilities in the light of information contained in the survey.
- Review the reasons for the apparent levels of noise from other patients and from staff at night.
- Review the cleaning service/contract in the light of scores for cleanliness in both wards and bathroom facilities.
- Many patients rate the food as only fair or poor. Review food quality and the operation of the catering service/contract.
- Clarify the responsibility of Ward Managers / Nurse in Charge to ensure that feeding of patients takes place where required by suitable members of staff. Undertake spot checks to ensure compliance with supervisory requirements.

Doctors

Actions:

- Further address communication issues between doctors and patients identified by the survey through the training and induction of junior staff. Survey results typically show that about a quarter of the patients do not fully understand answers to questions given by doctors.
- Reinforce policies on hand washing / use of alcohol gel to all clinicians and initiate spot checks for compliance.

Nurses

Actions:

- As with doctors, some patients found information from Nurses hard to understand, or limited in extent. Review communication skills and competences, e.g talking in front of patients as if they weren't there, amongst all nursing staff and especially on induction to the Trust.
- Review staffing levels and skill mix in the light of patient perceptions of nurse staffing levels.
- Reinforce policies on hand washing / use of alcohol gel to all nursing staff and initiate spot checks for compliance.

Care and Treatment

Actions:

- Some patients said that one member of staff would say one thing and another would say something quite different. Discuss with nurses and doctors methods by which reduction in the amount of conflicting information given to patients can be achieved.
- Many patients would like to be more involved in decisions made about their care. This view is probably linked to the feeling that some patients have that doctors and nurses talk in front of them as if they were not there. Review methods by which staff can involve patients in decisions about their care and treatment.
- Improve the quality and simplicity of written information available to patients on the ward. Consider appointing an information lead on each ward from existing staff.
- Some patients' families were said not to have had the opportunity to talk to a doctor. Ensure that appropriate signs are placed on all wards indicating that family can speak to a relevant clinician. Review the admission process to ensure that all patients are aware that their family can have such conversations with clinicians.
- Ensure that patients know there is a member of staff to talk to if they have any worries or fears, or need emotional support.
- There was some criticism of privacy particularly when discussing condition or treatment. Examine ways of improving privacy around the patient's bed, where most such discussions take place.
- Examine the location and reasons for poor pain control on wards, giving due weight to concentrations of concern in particular specialties and locations.
- Review reasons why some patients have waits of more than 5 minutes when using call buttons.

Operations and Procedures

Actions:

- Ensure that patients are given as much information as they want about what the operation would entail, including anaesthesia and its effects.
- Review methods by which patients are told about post-operative outcomes and how they might expect to feel after any operation or procedure.

Leaving Hospital

Actions:

- The main reason for delays in discharge was patients having to wait for medication to take home. Examine further the mechanisms and processes by which discharge prescriptions are ordered and delivered to the discharging ward.
- Review verbal and written information to patients on common and / or important side-effects of medication, with the aim of imparting information that is simple, clear, and memorable.
- Some patients did not think that they were told adequately what danger signals to look for regarding their condition or illness after discharge. Review verbal and written information strategies for transmission of information on danger signals to the patient.
- Ensure all patients are told who to contact if they are worried about their condition or treatment after returning home.
- Continue to increase the visibility and transparency of communications passing from clinical teams to GPs, and ensure that there are robust arrangements in place to copy such letters to patients in every clinical team.

Overall

Actions:

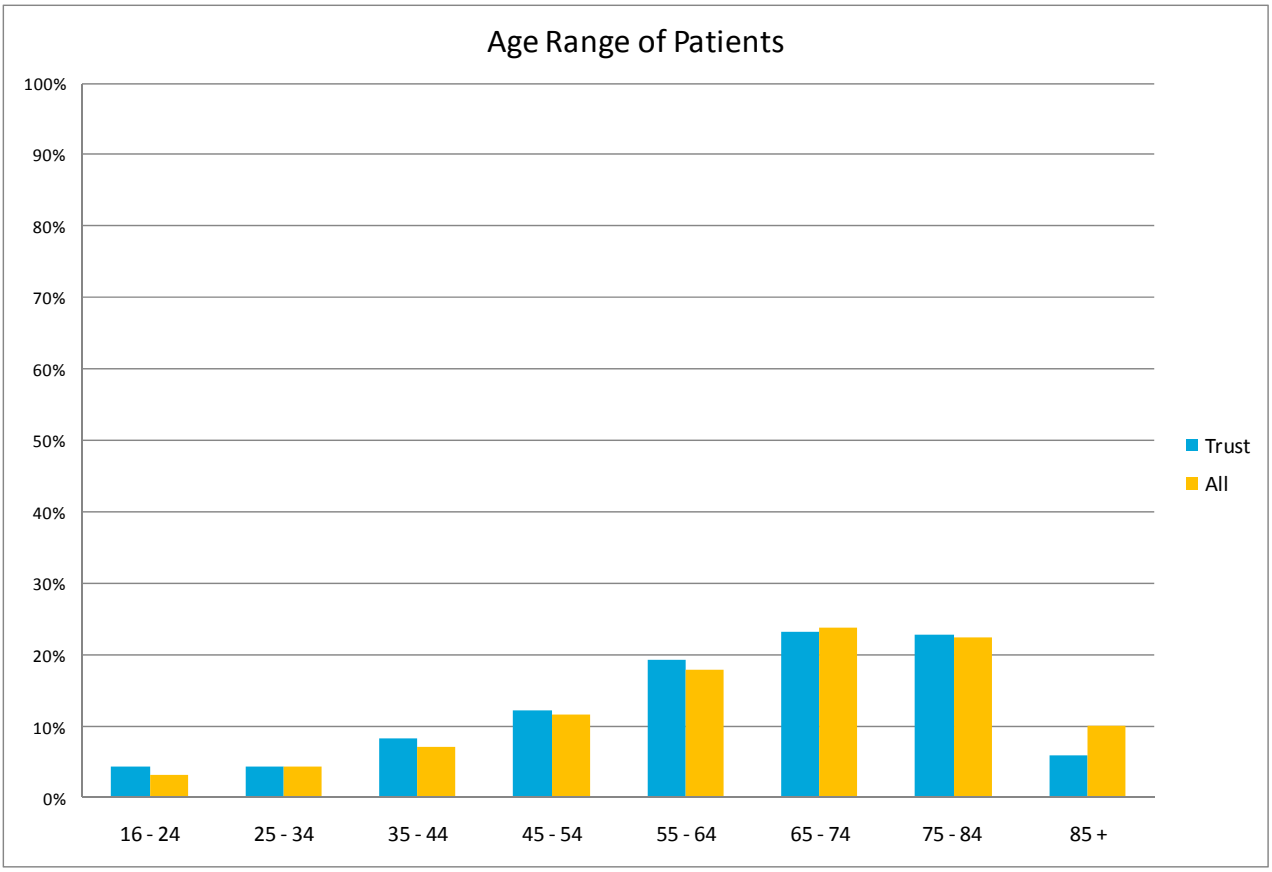
- Ensure that all patients feel they are treated with respect and dignity whilst in hospital.
- Review scores on overall rating of care and address any particular areas od concern.
- Ensure that information about how to complain (such as leaflets and posters) is available for patients in hospital.

Respondents' Characteristics

Details of the characteristics of the patients who responded are set out below. Gender, age, and ethnic background breakdown is crucial, as it is clear from Quality Health's research into patient attitudes over many years that there are significant variations in the views of patients because of demographic differences. There are also differences between patients depending on their route of entry to hospital and the specialty of treatment because of the nature of the patient's medical problems. The Trust can analyse the survey data by these variables using Quality Health's extranet facility.

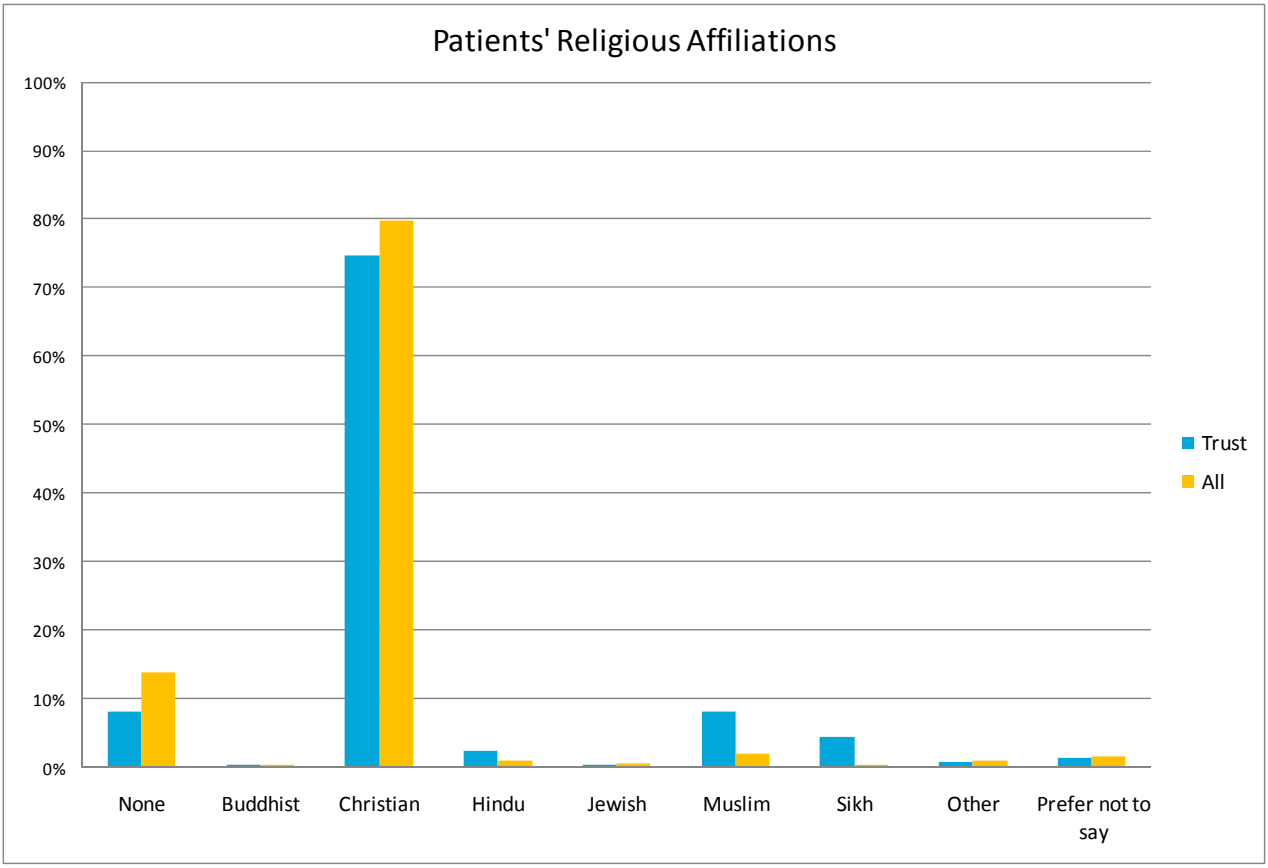
1. GENDER AND AGE PROFILE

45% of patients were men, 55% were women. The survey asked patients to stipulate their year of birth. This information has been amalgamated into age groups. The chart shows the proportion of patients in each age group compared to the national average.



2. RELIGION

Patients were asked about their religion. The chart below shows how patients responded to this question.

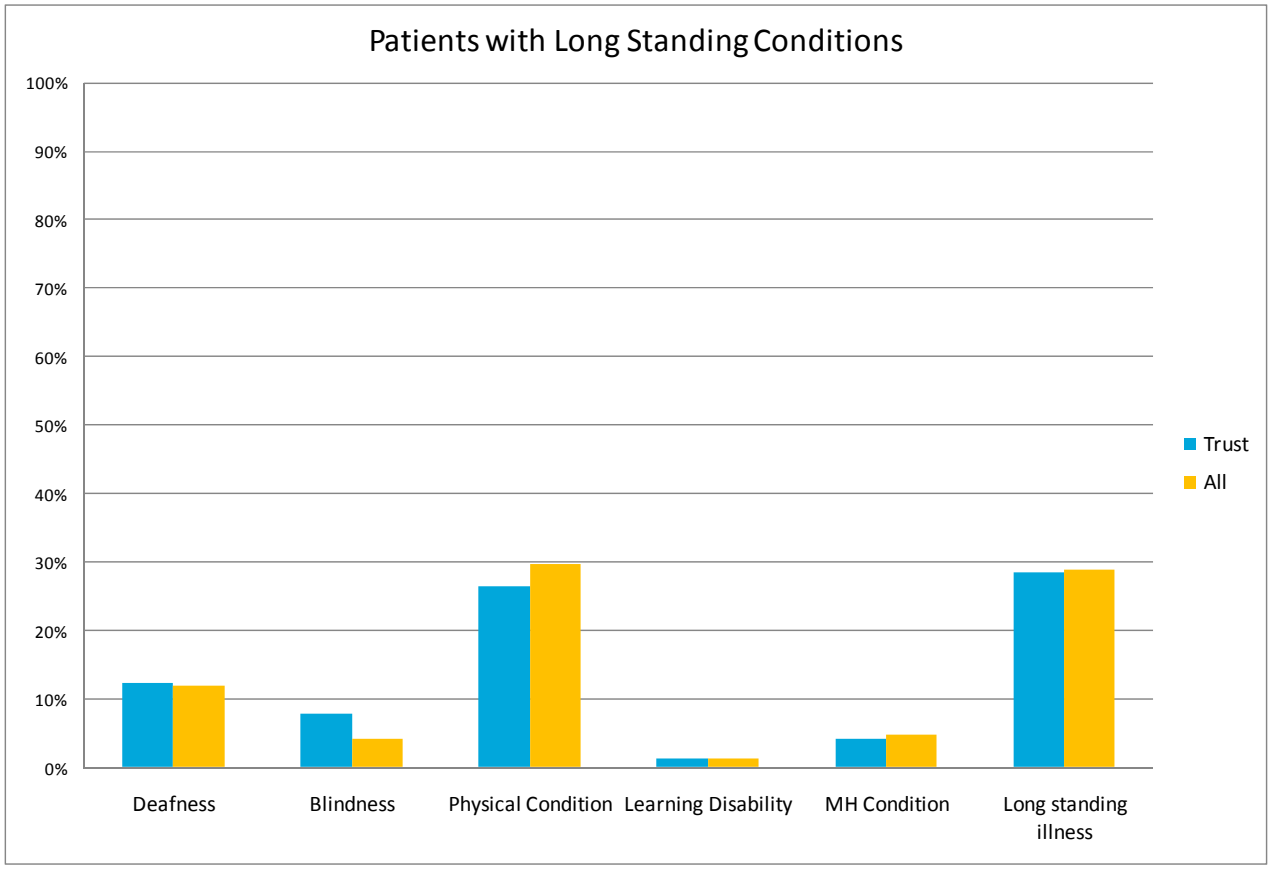


3. SEXUALITY

Patients were also asked about their sexuality. 93% identified themselves as heterosexual; 1% said that they were a gay man or lesbian. No patients were bisexual and 2 patients identified their sexuality as "other". 5% of patients preferred not to say what their sexuality was.

4. LONG-STANDING CONDITIONS

Patients were then asked if they had any of six long-standing conditions. 36% of patients said they did **not** have a long standing condition; the chart below shows the proportion of patients who said they did have each of the conditions listed.



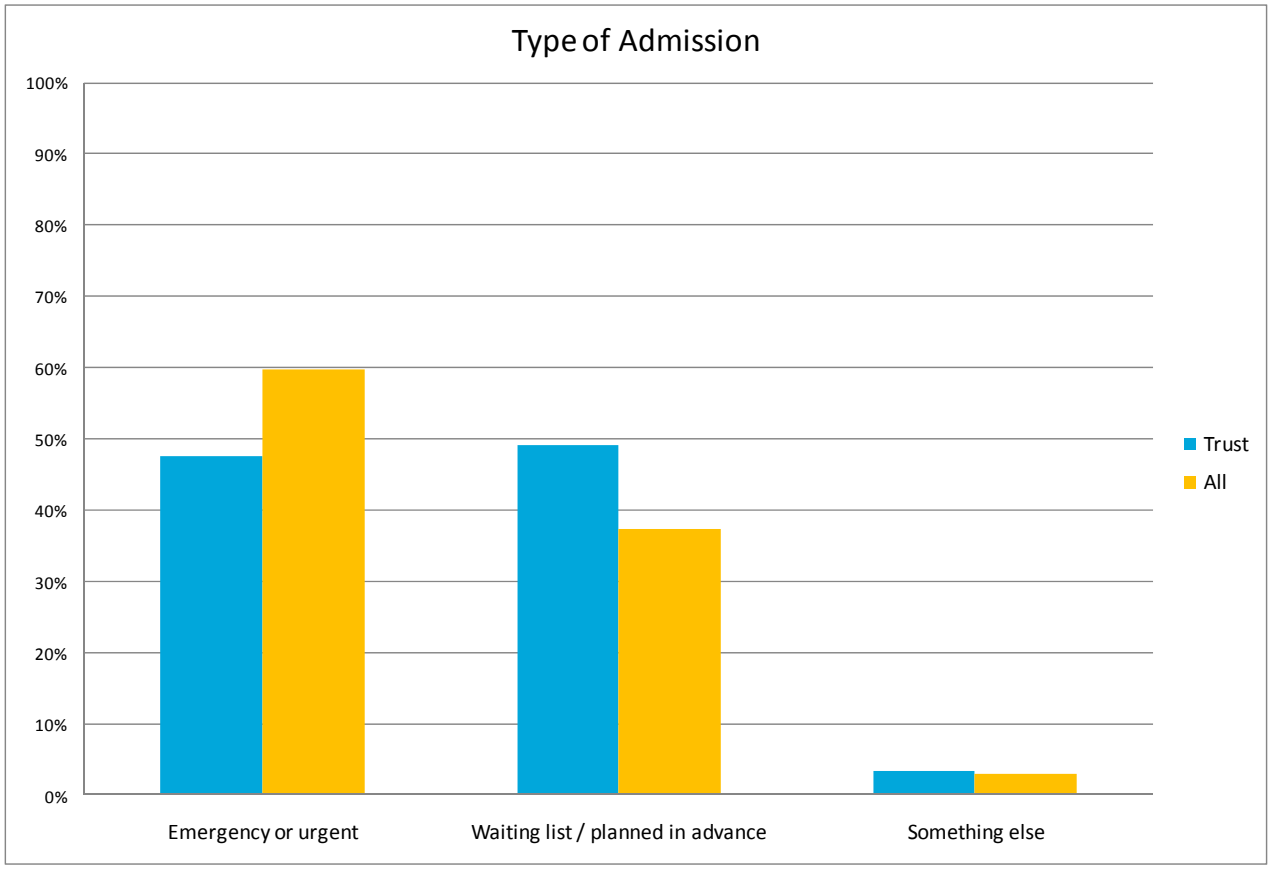
56% of patients with a long-standing illness or condition said their condition caused them difficulty with everyday activities people of their age could usually do; smaller numbers said they had difficulty in a range of other areas including work, access and communication.

4. ETHNICITY

77% of patients classified themselves as "White English / Welsh / Scottish / Northern Irish / British"; 7% described themselves as Black or Black British (African, Caribbean or other Black background) and 13% described themselves as Asian or Asian British (Indian, Pakistani, Bangladeshi or other Asian background).

5. ROUTE OF ADMISSION

48% of patients said their admission to hospital was an emergency or urgent and 49% said it was a waiting list admission or planned in advance. 3% of patients said they had some other form of admission, which could possibly include transfers from other hospitals or self-admission for a condition previously treated at the hospital.



91% of non-waiting list patients said they went to the A&E department (the Emergency Department, Casualty, Medical or Surgical Admissions Unit) when they arrived at hospital.

Survey Results

This section of the report describes the results for each part of the questionnaire in the order in which it was read by patients.

The results from each question in the survey are described in the following sections. A chart shows the Trust score as well as the national score[2], for the purpose of comparison. For most questions, a second chart shows the progress over time on both the Trust and national score. The national score is displayed from 2005 onwards, or since the question was first asked. The Trust score is displayed from when Quality Health first holds data for the Trust.

At the end of most sections, a scored and standardised dataset has been used to produce benchmark bar charts for key questions within that section. The scoring applied uses the CQC methodology, which scores responses based on how positive they are. To produce a "score" the CQC takes the most positive answer line and combines it in most cases with 50% of the next most positive answer line. When this process has been undertaken, and the data has been standardised by age, gender and route of entry, it means that the CQC scores in this section will usually be different from the results set out in the Survey Results Manual (frequency tables) at the end of this report. The purpose of displaying the CQC scored data, and giving the Trust its real unscored data, is to enable the Trust to understand how their results are changed by the scoring system, and to build Quality Improvement Plans based on accurate data. Each bar represents the range of results across all Trusts that took part in the survey for one question. The bar is divided into:

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

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

The table below each benchmarking chart shows the Trust score for the 2010 survey, where available, in the first column (not displayed on the benchmarking chart). The second column shows the Trust score for this year (represented by a black circle on the benchmarking chart). The third and fourth columns represent the upper threshold for the lowest scoring 20% and the lower threshold for the highest scoring 20% (i.e. the end of the red section and the beginning of the green section on the chart). The fifth column displays a "+" alongside any question where the Trust's score falls within the lowest 20% of Trust scores for that question.

Finally, there are a number of management recommendations at the end of each section for consideration when action planning.

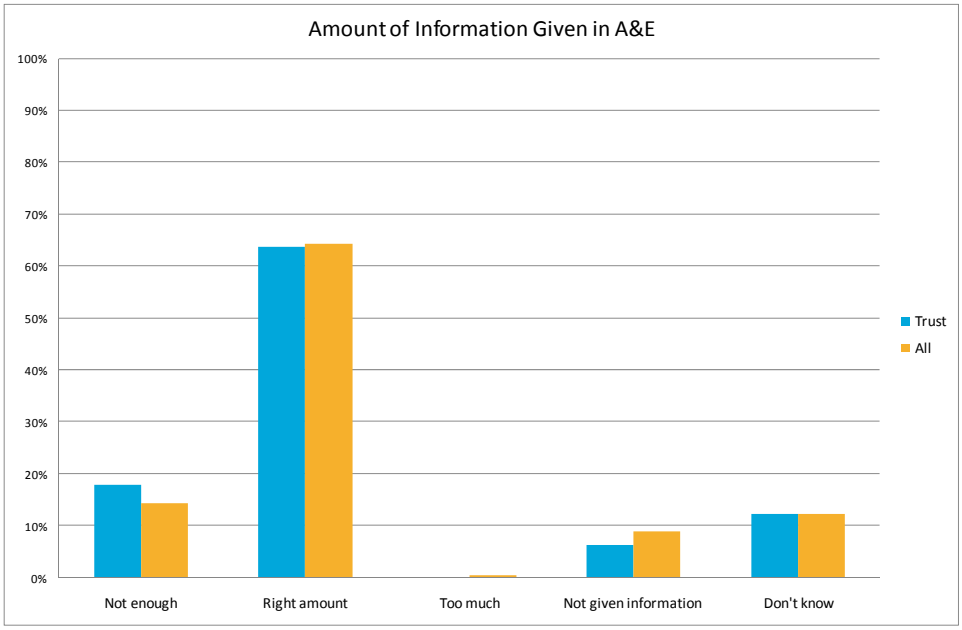
[2] Scores displayed use raw data (data has not been scored or standardised).

Admission to Hospital

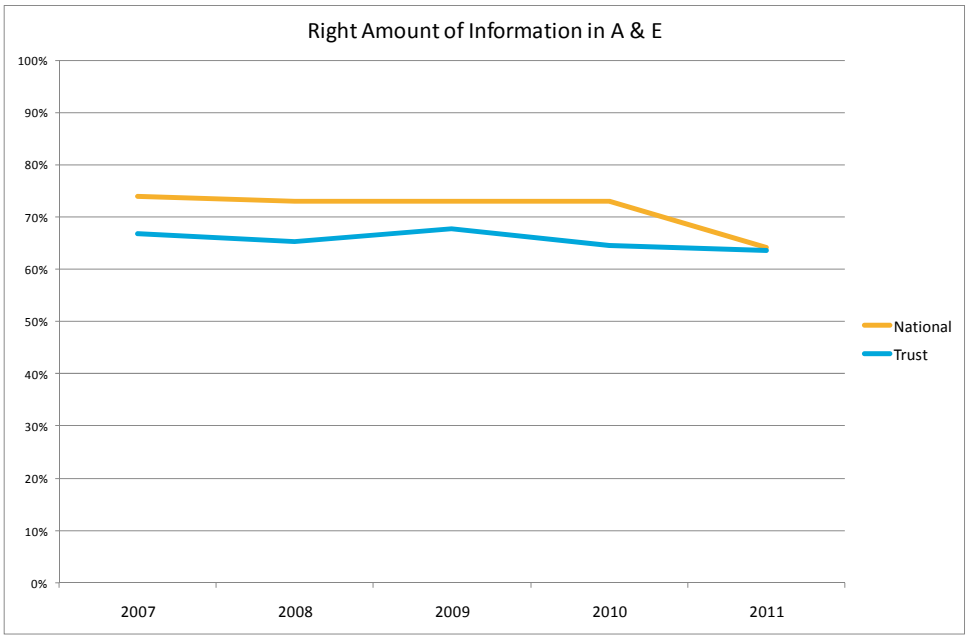
EMERGENCY CARE - INFORMATION

While you were in the A&E Department, how much information about your condition or treatment was given to you?

Patients were asked how much information was given to them while they were in the Emergency Department about their condition or treatment; 64% said the right amount, 18% said they were not given enough.



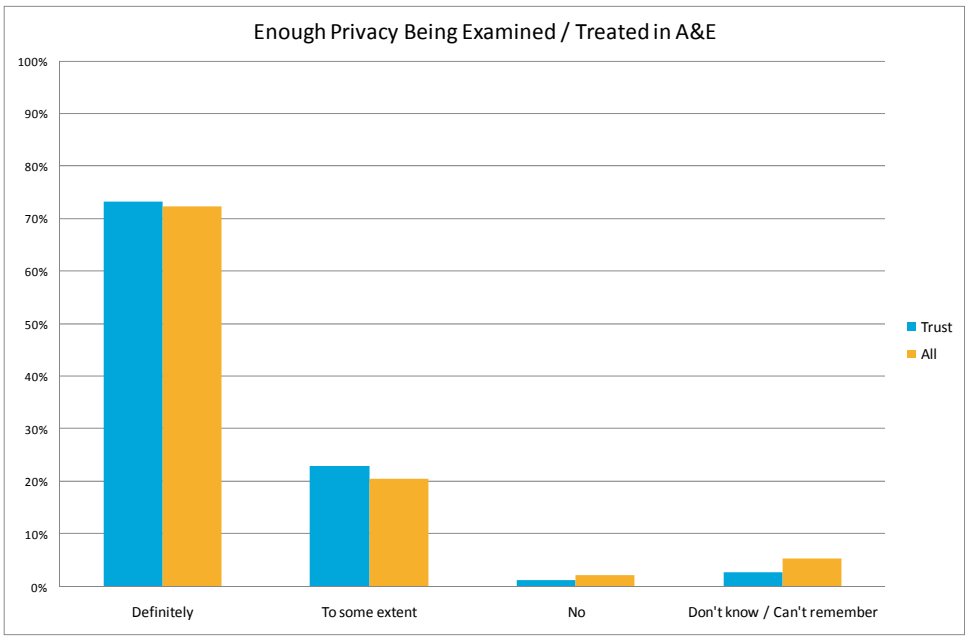
Comparison over time for this question:



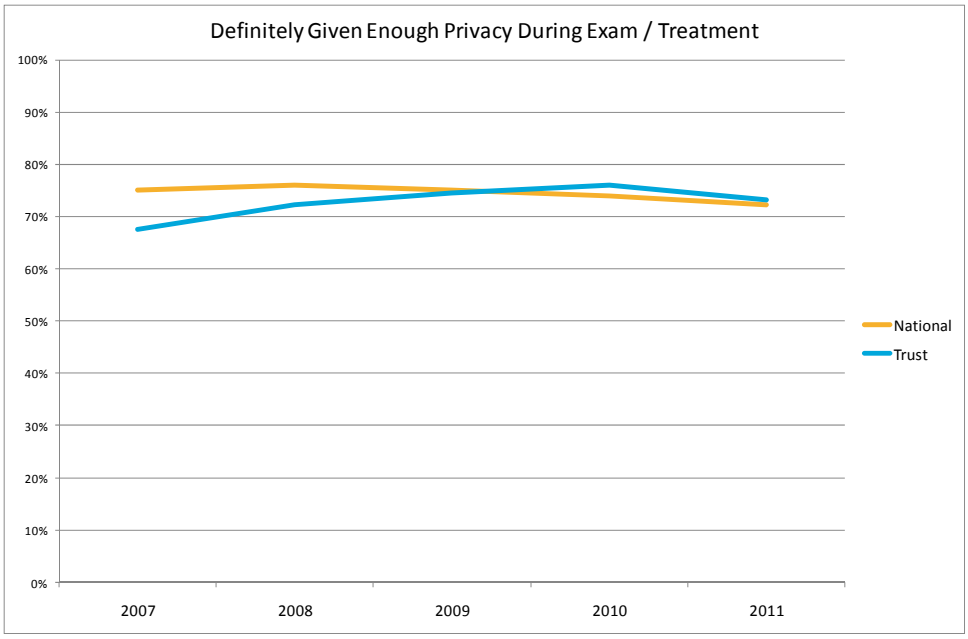
EMERGENCY CARE - PRIVACY

Were you given enough privacy when being examined or treated in the A&E Department?

73% of patients said they were definitely given enough privacy when being examined or treated in the Emergency Department; 1% said they were not.



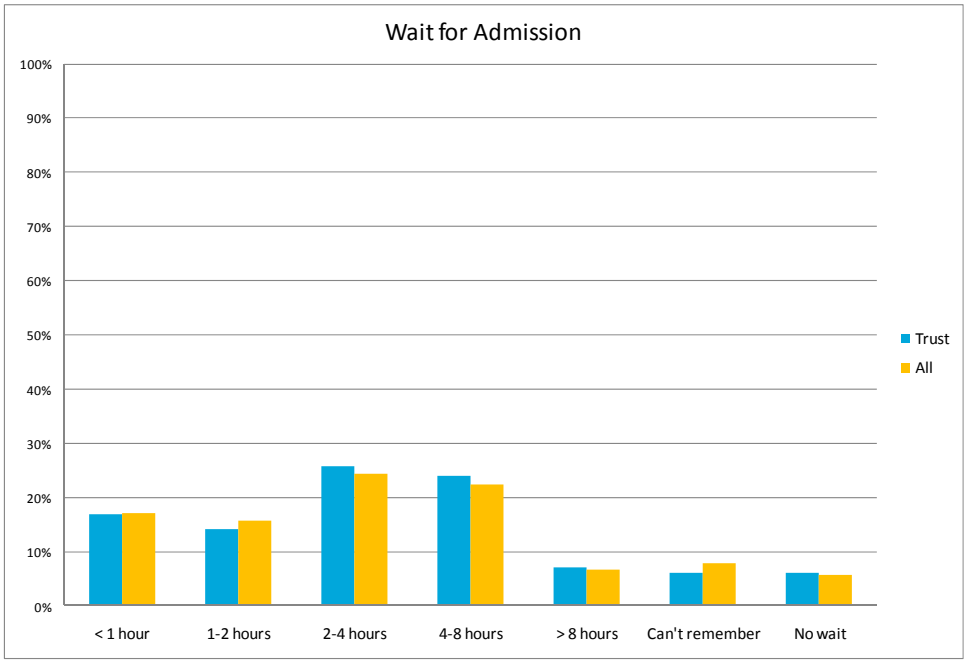
Comparison over time for this question:



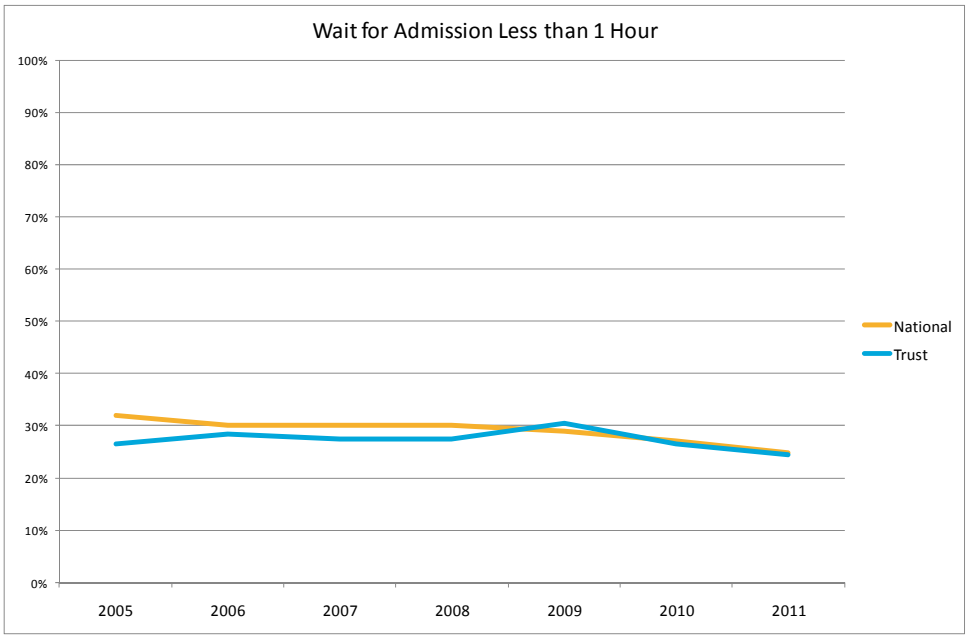
EMERGENCY CARE - WAIT FOR ADMISSION

Following arrival at the hospital, how long did you wait before being admitted to a bed on a ward?

6% of emergency admission patients said they did not have to wait for admission to a bed on a ward; a further 17% said they waited less than an hour. 7% said they waited 8 hours or longer.



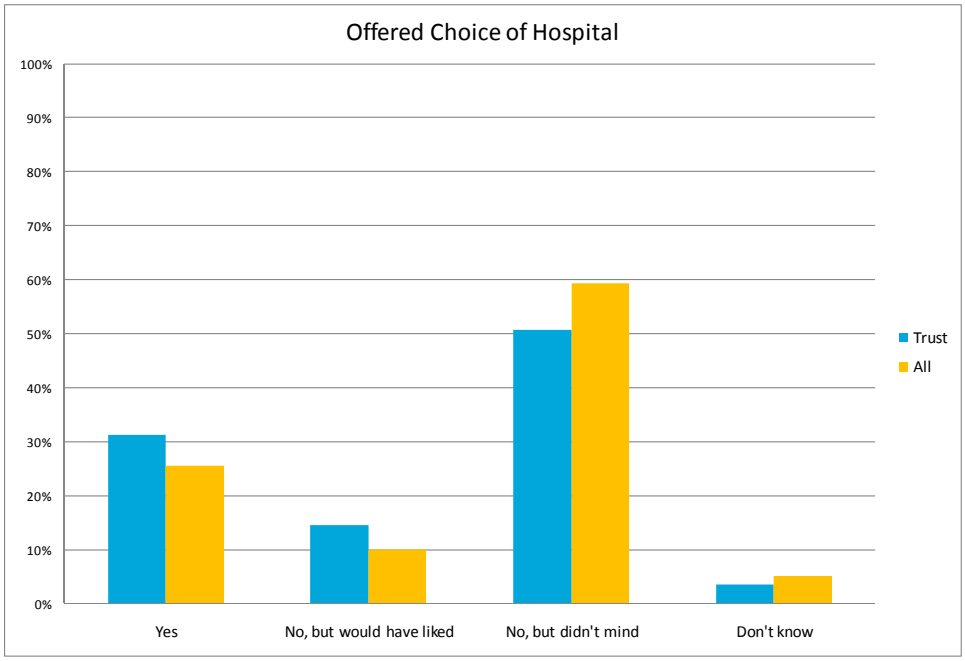
Comparison over time for this question:



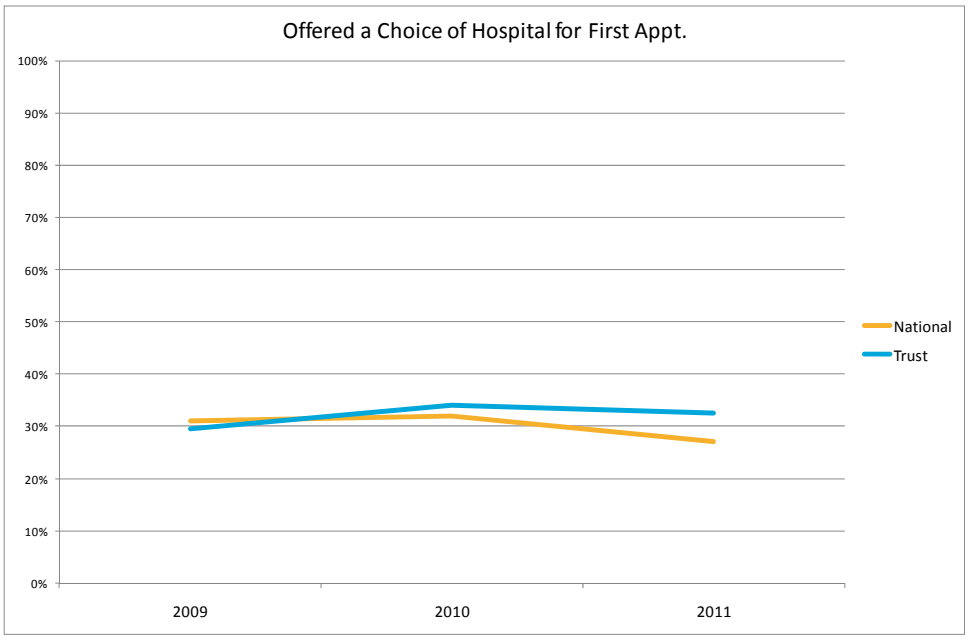
WAITING LIST OR PLANNED ADMISSION - CHOICE OF HOSPITAL

When you were referred to see a specialist, were you offered a choice of hospital for your first hospital appointment?

31% of waiting list patients said they were offered a choice about which hospital they went to for their first hospital appointment. 14% said they were not offered a choice but would have liked one.



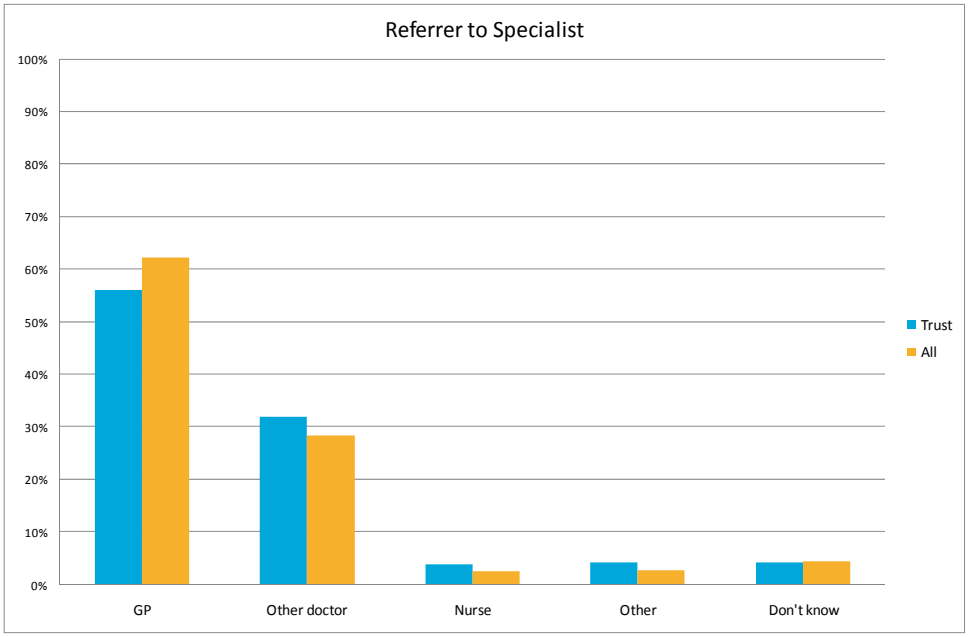
Comparison over time for this question:



WAITING LIST OR PLANNED ADMISSION - WHO REFERRED PATIENT

Who referred you to see a specialist?

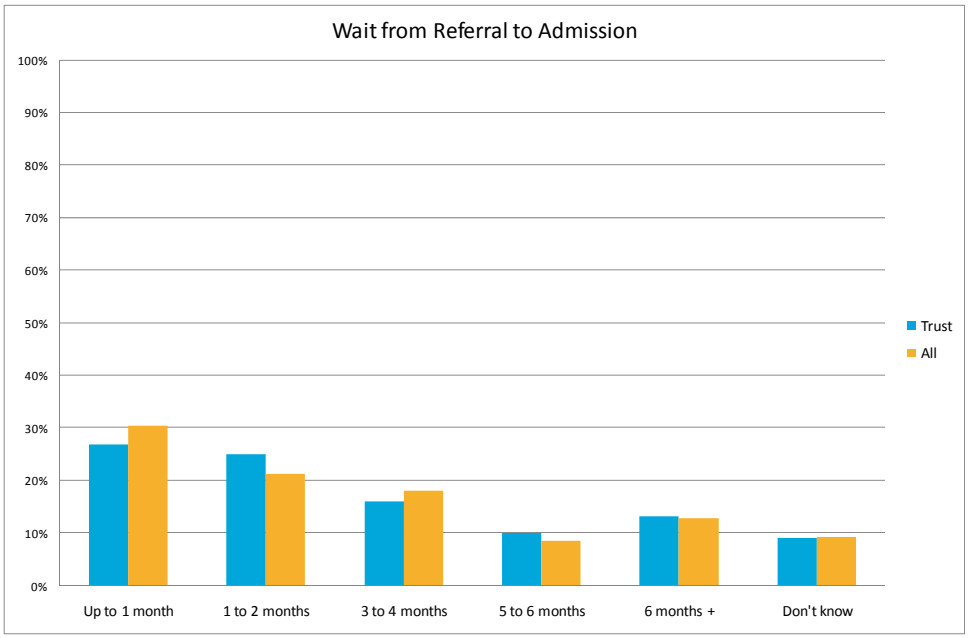
56% of waiting list patients said they were referred to see the specialist by a doctor from their local general practice; a further 32% were referred by another doctor or specialist.



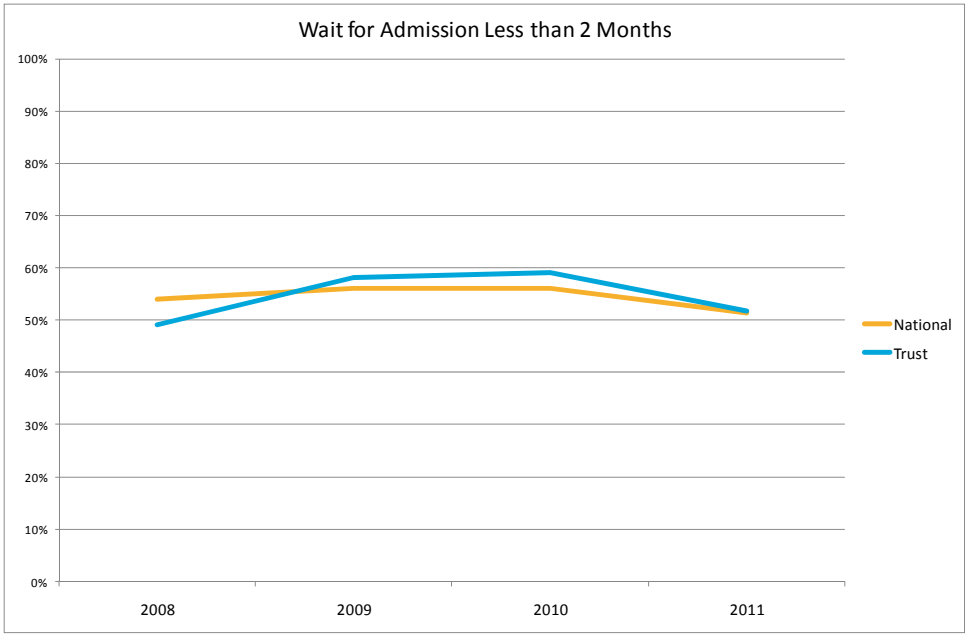
WAITING LIST OR PLANNED ADMISSION - WAIT BEFORE ADMISSION

Overall, from the time you first talked to this health professional about being referred to a hospital, how long did you wait to be admitted to hospital?

52% of waiting list patients said they waited 2 months or less for admission after being referred; 13% waited more than 6 months.

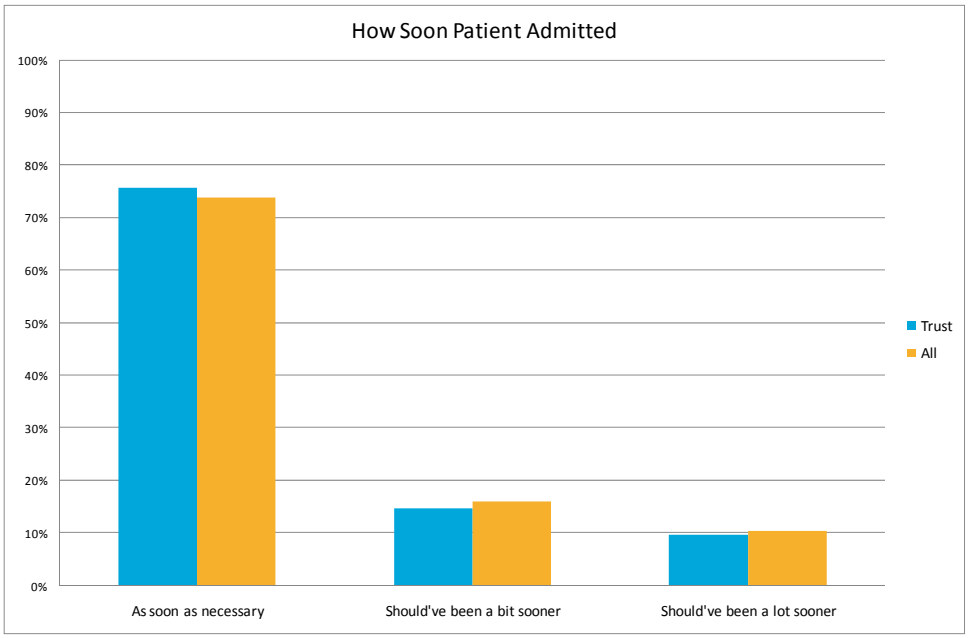


Comparison over time for this question:

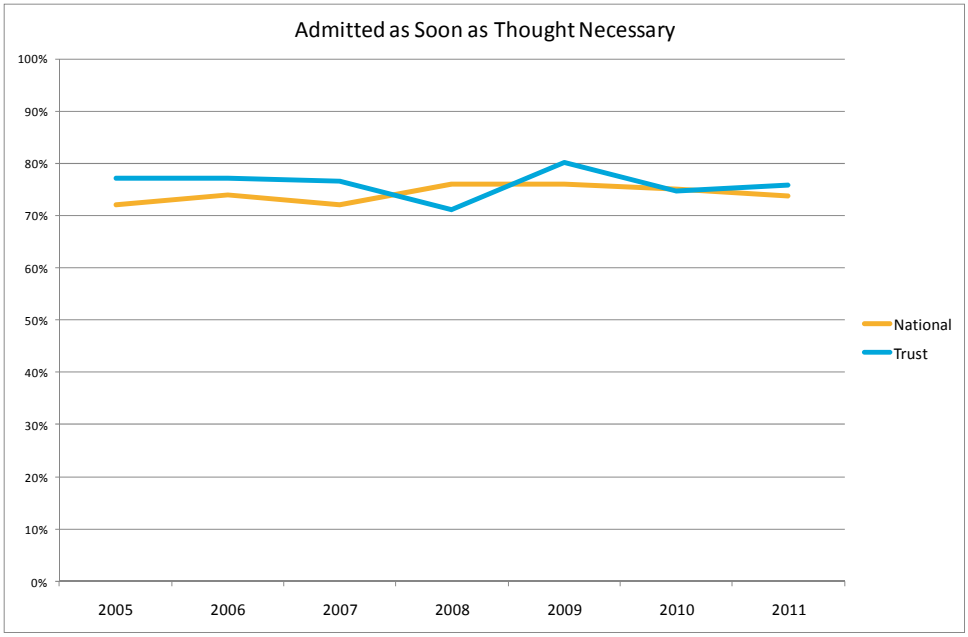


How do you feel about the length of time you were on the waiting list before your admission to hospital?

10% of waiting list patients thought they should have been admitted a lot sooner than they were; a further 15% thought they should have been admitted a bit sooner.



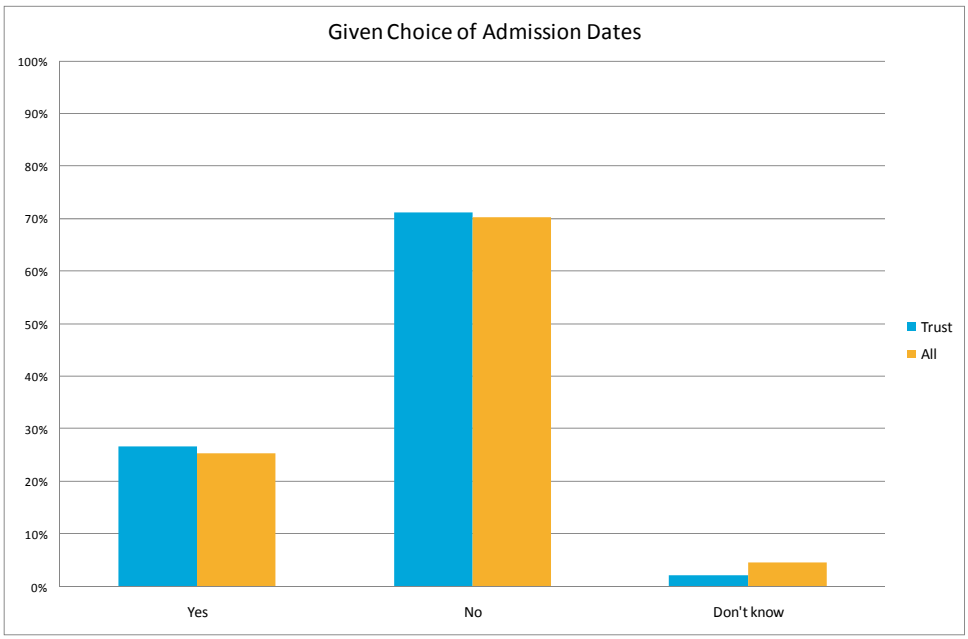
Comparison over time for this question:



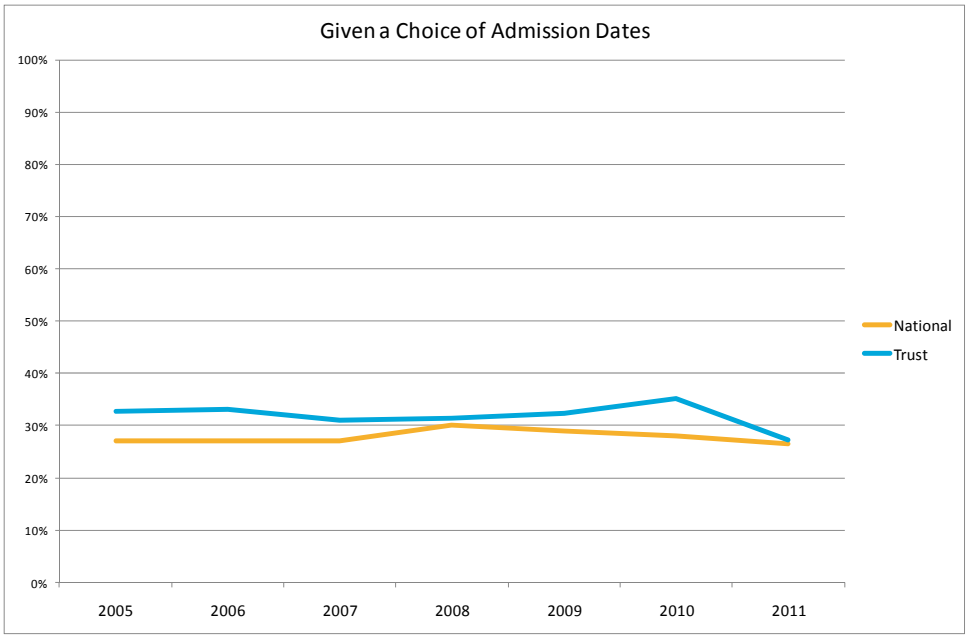
WAITING LIST OR PLANNED ADMISSION - CHOICE OF ADMISSION DATE

Were you given a choice of admission dates?

27% of waiting list patients said they were given a choice of admission dates; 71% were not given a choice.



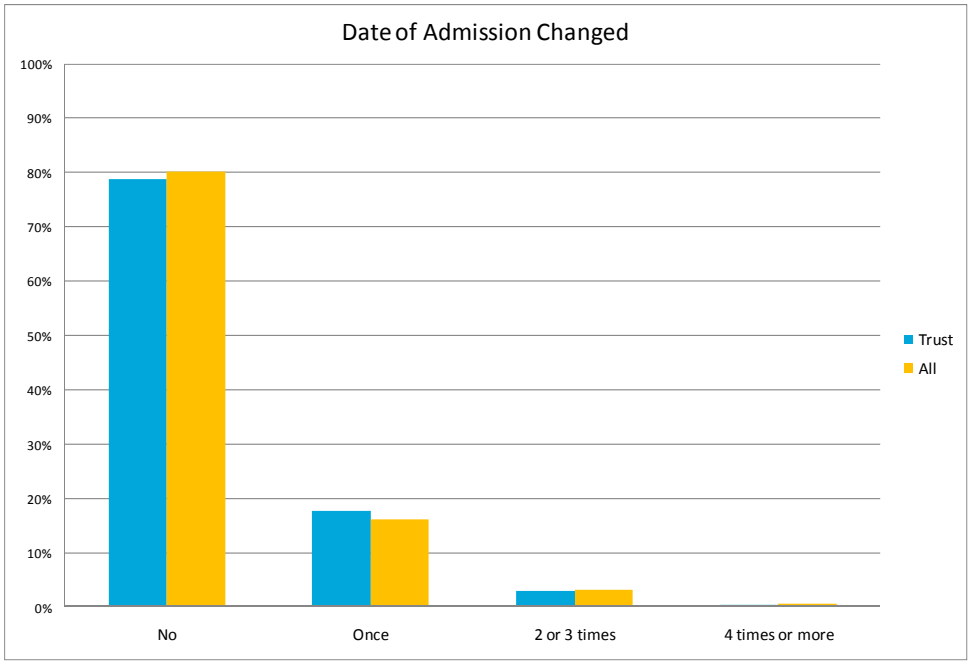
Comparison over time for this question:



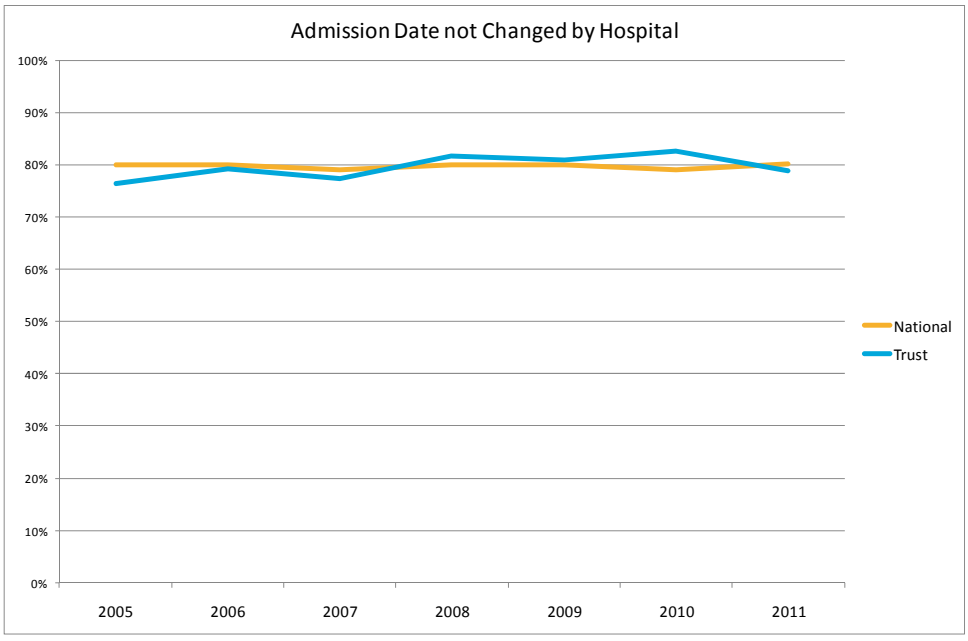
WAITING LIST OR PLANNED ADMISSION - CHANGE OF ADMISSION DATE

Was your admission date changed by the hospital?

79% of waiting list patients said their admission date was **not** changed by the hospital. However, 18% said it was changed once, and a further 3% said it was changed twice or more.



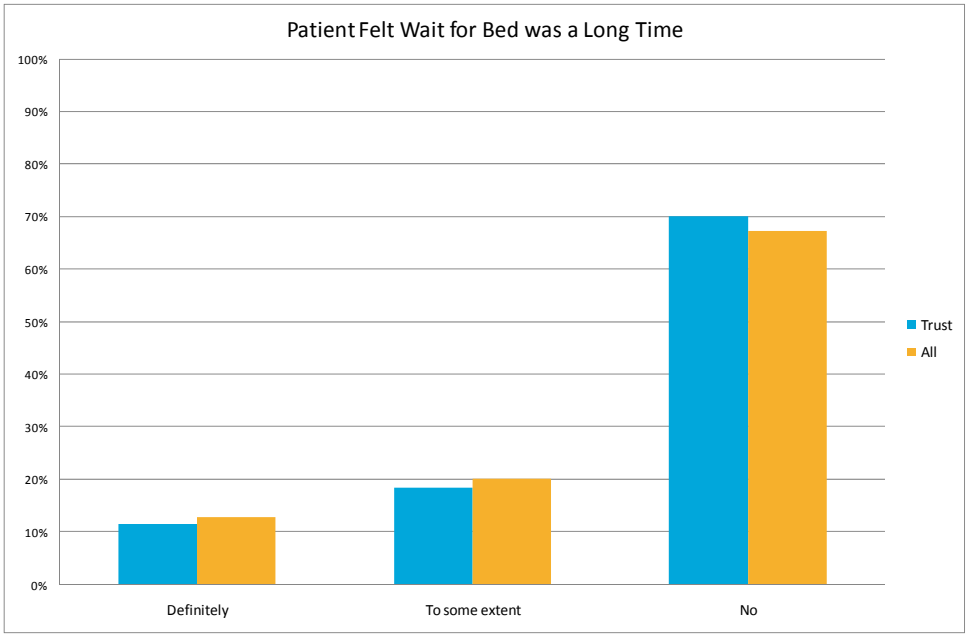
Comparison over time for this question:



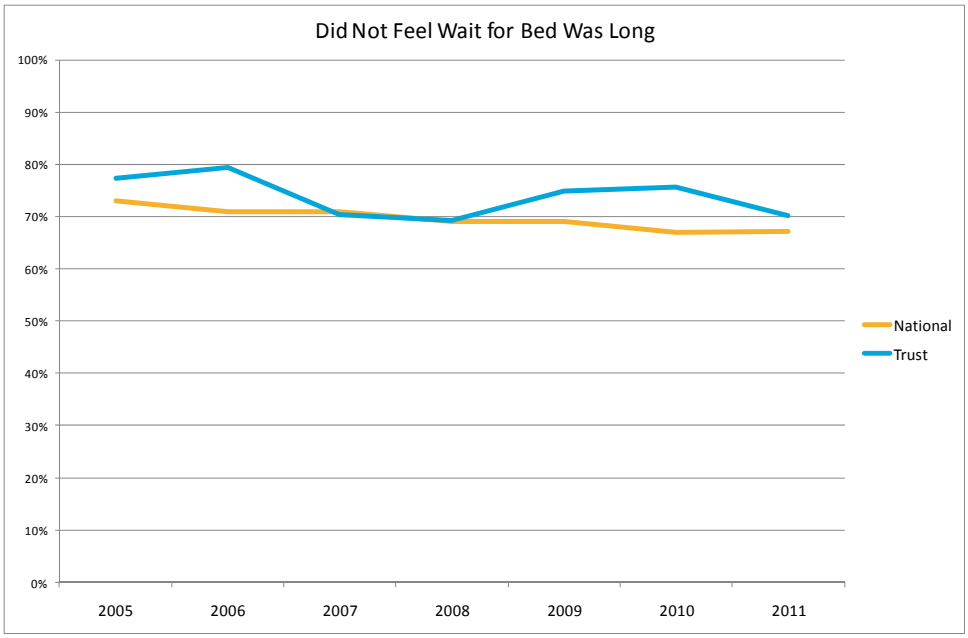
ALL TYPES OF ADMISSION - WAIT FOR A BED

From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?

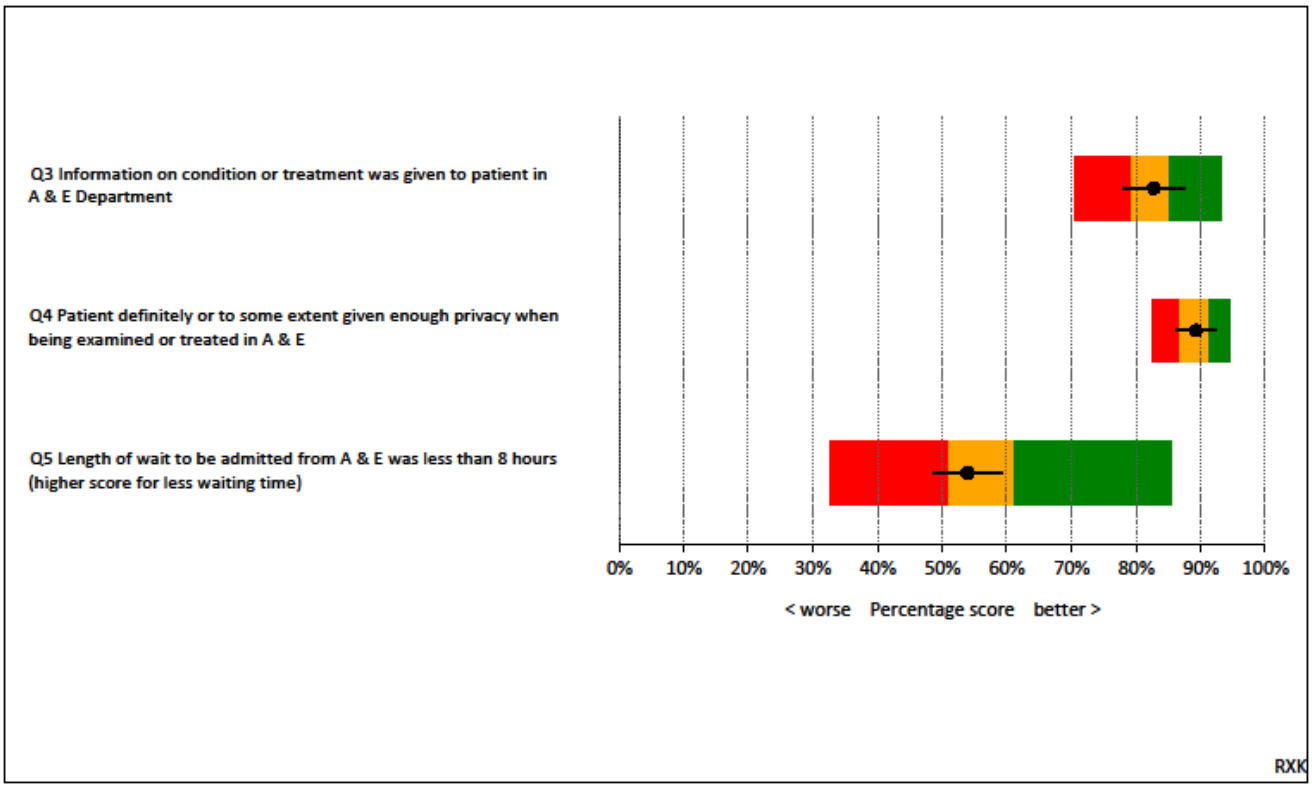
11% of all patients thought they definitely had a long wait before getting to a bed on a ward; a further 18% thought the wait was long 'to some extent'.



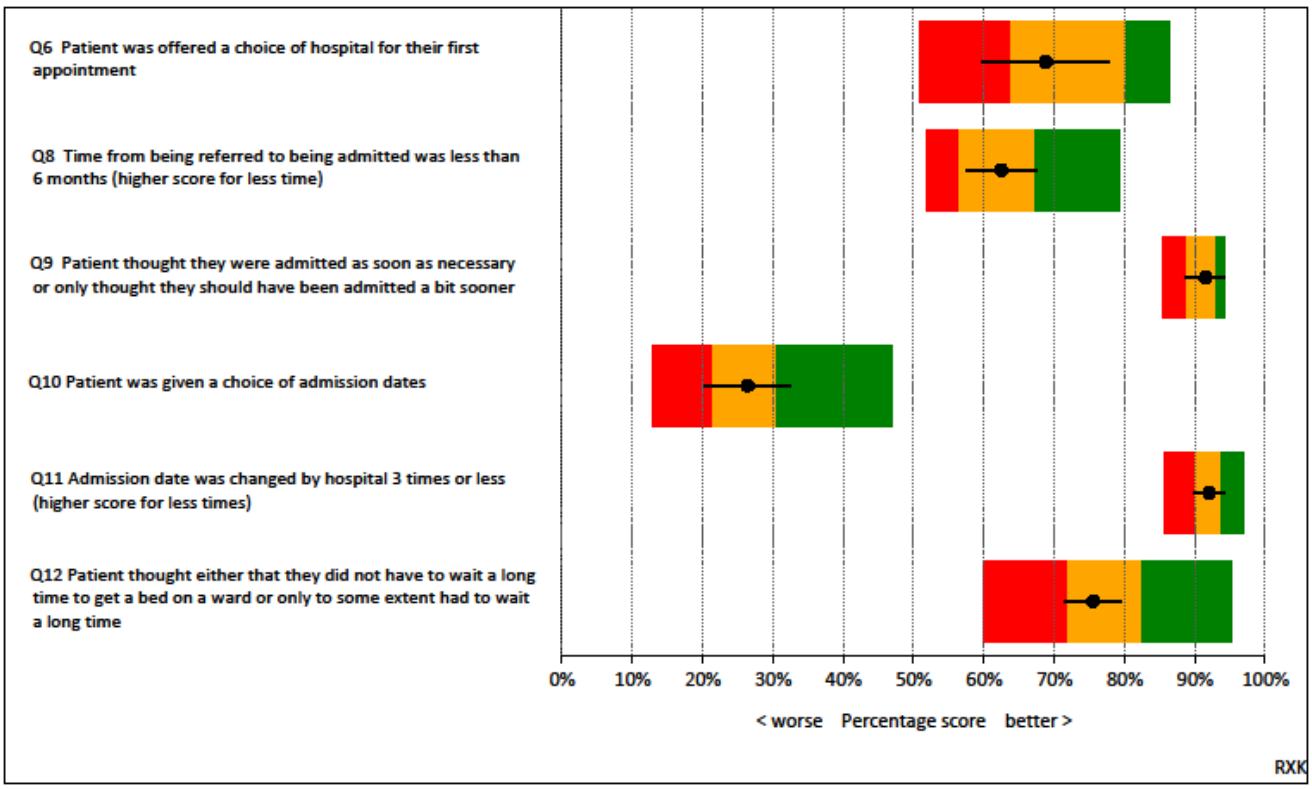
Comparison over time for this question:



SUMMARY AND ACTIONS



Question	2010 percentage for this Trust	2011 percentage for this Trust	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Scored % in lowest 20% of Trusts
Q3 Information on condition or treatment was given to patient in A & E Department	83%	83%	79%	85%	
Q4 Patient given enough privacy when being examined or treated in A & E	92%	89%	87%	91%	
Q5 Length of wait to be admitted from A & E was less than 8 hours (higher score for less waiting time)	58%	54%	51%	61%	



Question	2010 percentage for this Trust	2011 percentage for this Trust	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Scored % in lowest 20% of Trusts
Q6 Patient was offered a choice of hospital for their first appointment	67%	69%	64%	80%	
Q8 Time from being referred to being admitted was less than 6 months (higher score for less time)	68%	62%	56%	67%	
Q9 Patient thought they were admitted as soon as necessary or only thought they should have been admitted a bit sooner	92%	92%	89%	93%	
Q10 Patient was given a choice of admission dates	34%	26%	21%	30%	
Q11 Admission date was changed by hospital 3 times or less (higher score for less times)	93%	92%	90%	94%	
Q12 Patient thought either that they did not have to wait a long time to get a bed on a ward or only to some extent had to wait a long time	82%	76%	72%	83%	

ACTIONS:

Emergency Admissions:

- Review the provision of verbal information to patients in A&E and MAU.
- Ensure that patients are given as much privacy as possible when being examined or treated.
- Assess the need for further action on waits over 4 hours for admission from A&E and MAU.

Waiting List Admissions:

- Continue action to reduce waiting times to the 18 week envelope.
- Ensure that all patients being admitted through the list are given a choice of admission date to suit their circumstances.
- Review the reasons for changes of admission date by the hospital particularly where these occur twice or more.

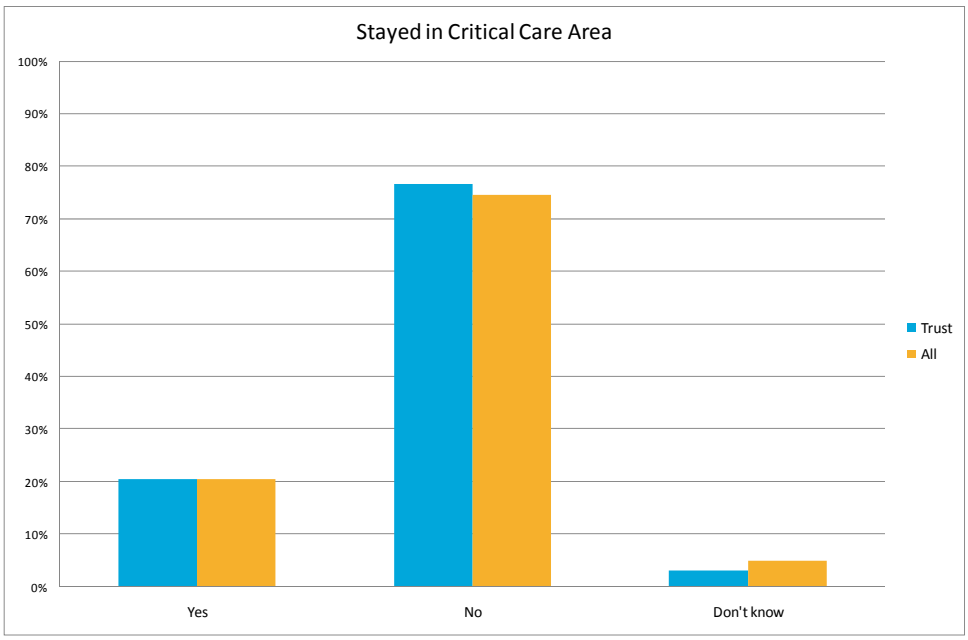
All Types:

- Examine reasons why some patients have long waits to get a bed on a ward.

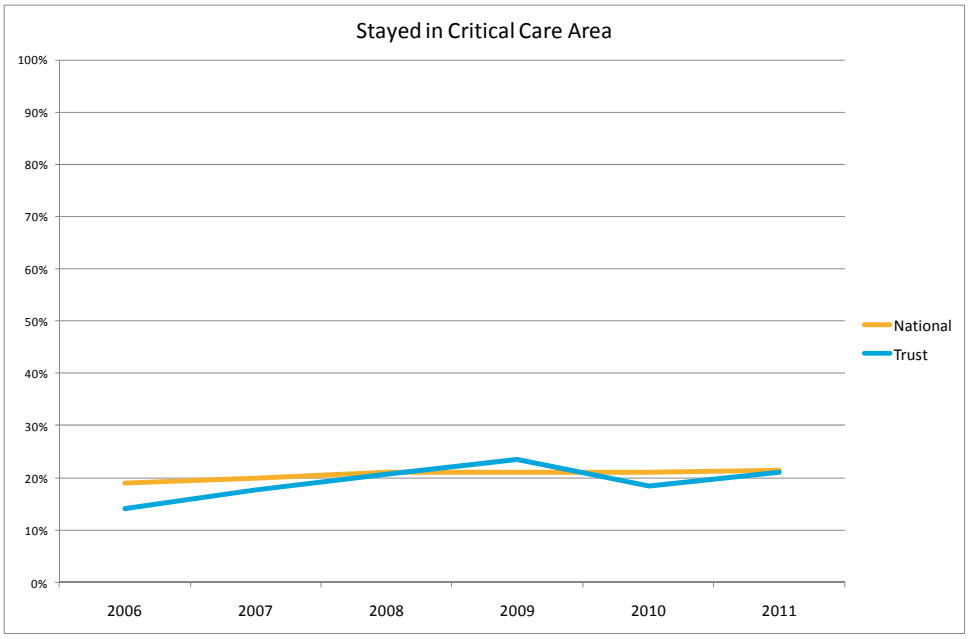
The Hospital and Ward

While in hospital, did you ever stay in a critical care area (Intensive Care Unit, High Dependency Unit or Coronary Care Unit)?

Patients were asked if they ever stayed in a critical care area (Intensive Care Unit, High Dependency Unit, Coronary Care Unit) while in hospital, 20% said that they did.



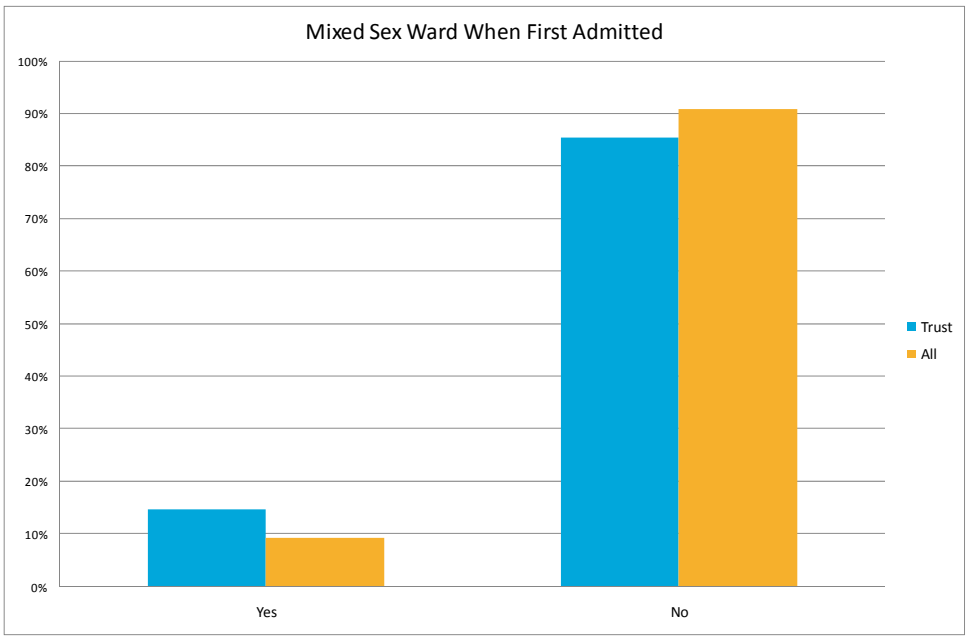
Comparison over time for this question:



MIXED GENDER FACILITIES

When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?

Patients were asked when they were first admitted to a bed on a ward, whether they had to share a sleeping area (e.g. room or bay) with patients of the opposite sex, 15% said that they did have to share.



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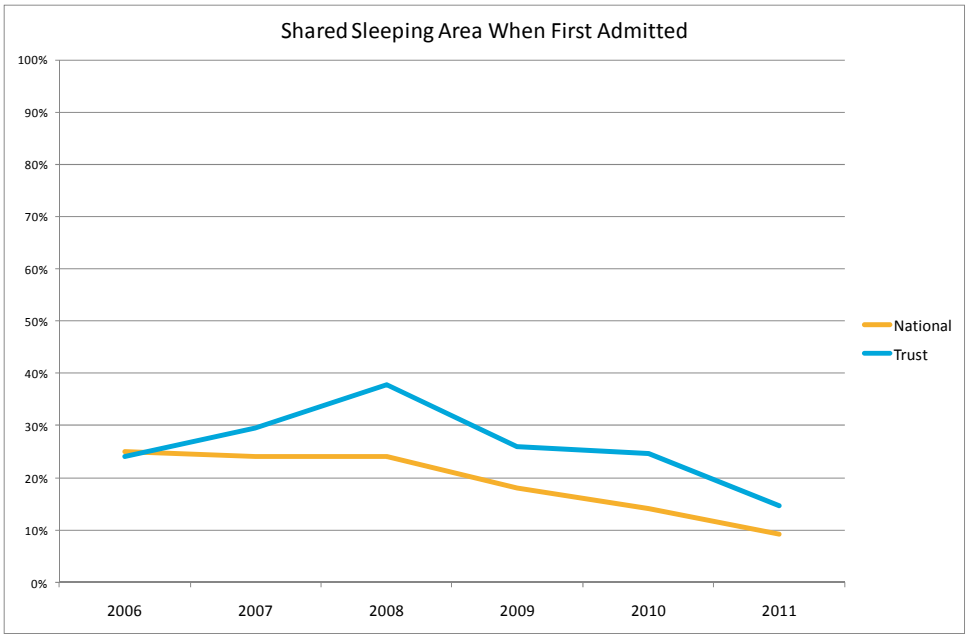
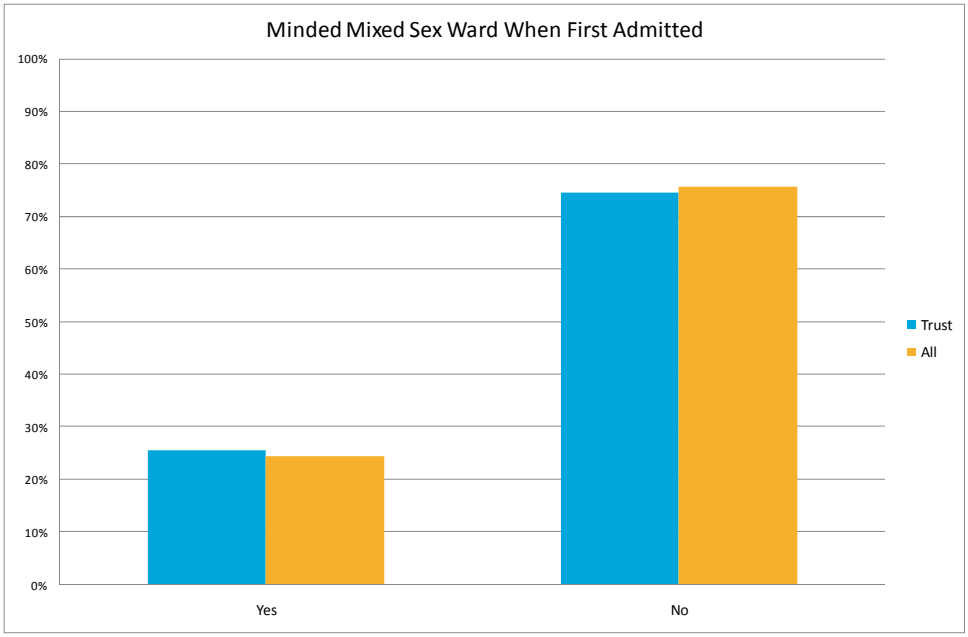
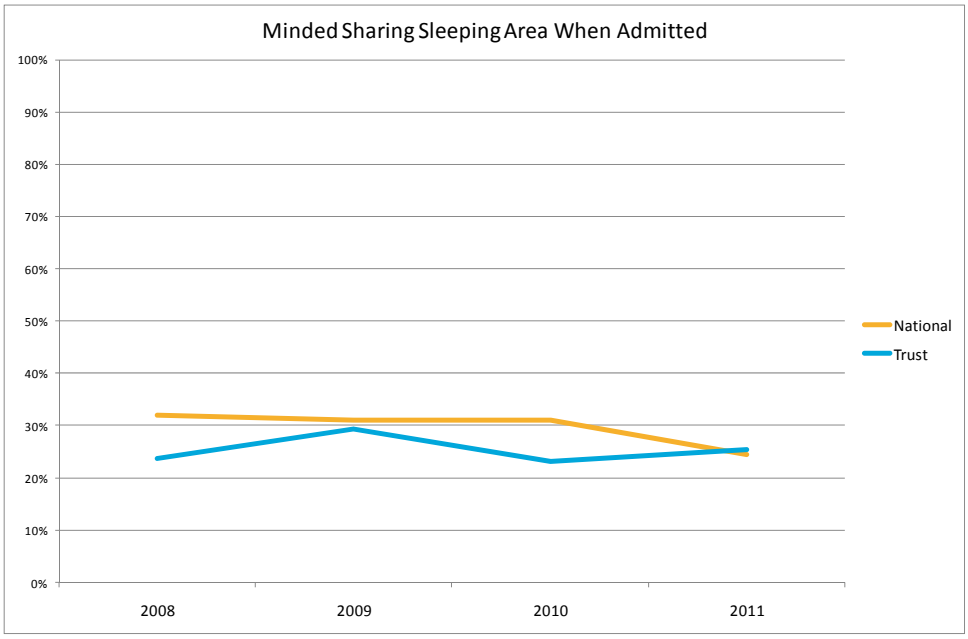


When you were first admitted, did you mind sharing a sleeping area, for example a room or bay, with patients of the opposite sex?

25% of patients who did have to share a sleeping area with patients of the opposite sex when first admitted said they did mind sharing.

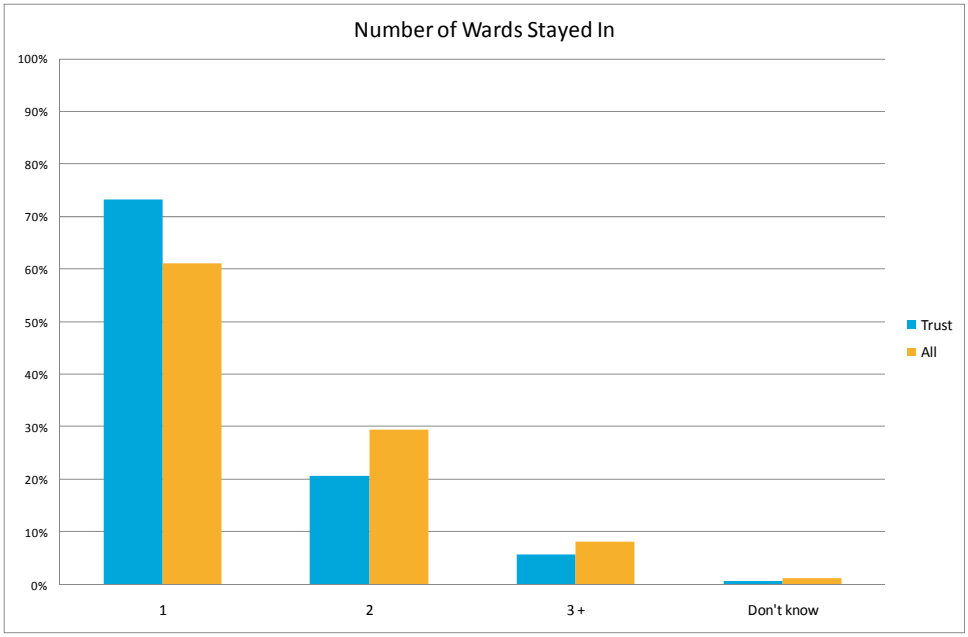


Comparison over time for this question:



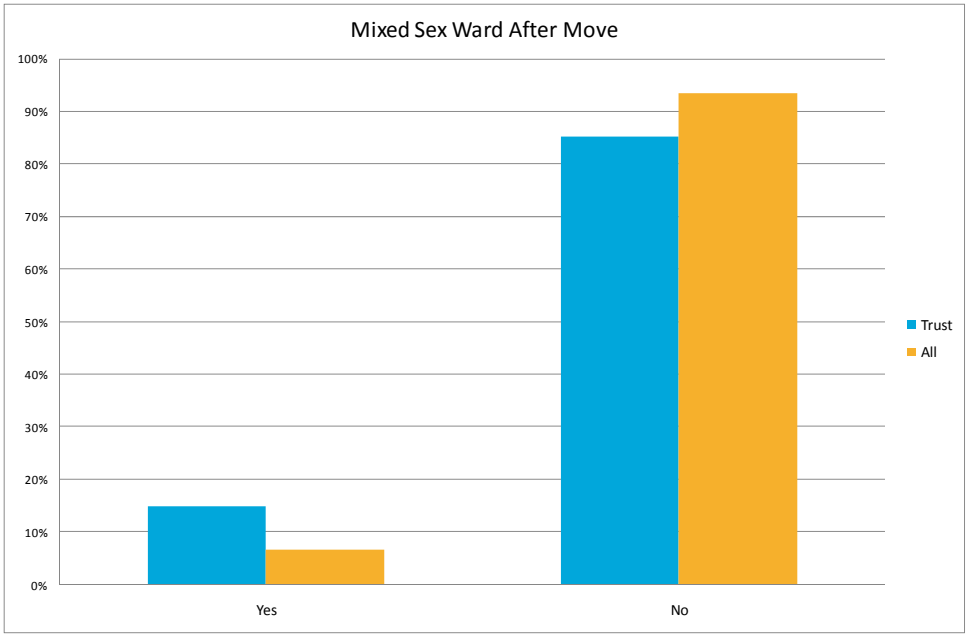
During your stay in hospital, how many wards did you stay in?

The chart below shows the number of wards patients stayed in during their stay. 6% stayed on 3 or more wards.

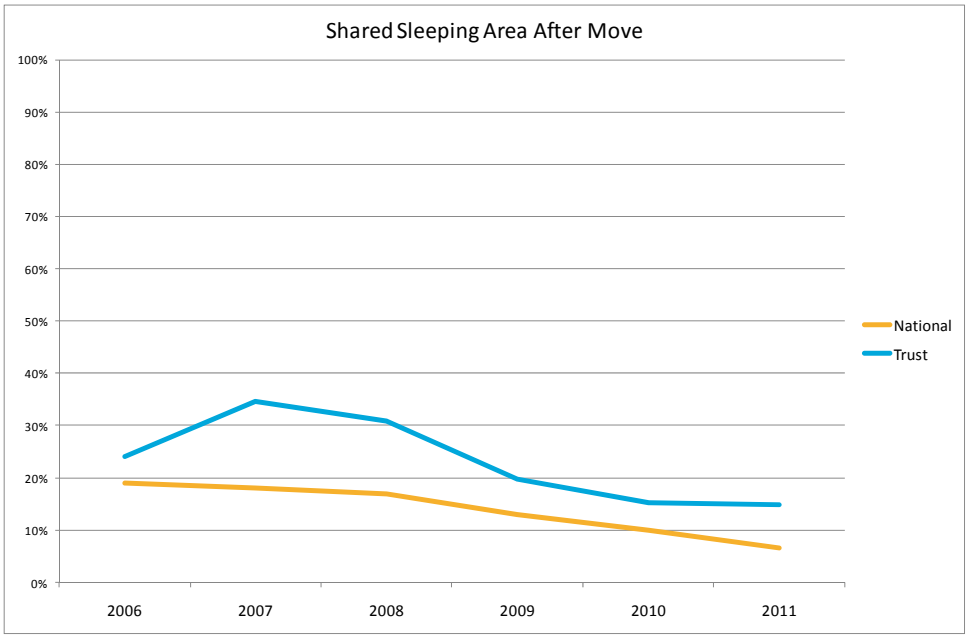


After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?

Patients who moved to other wards were then asked if they ever shared a sleeping area with patients of the opposite sex and 15% said that they did.

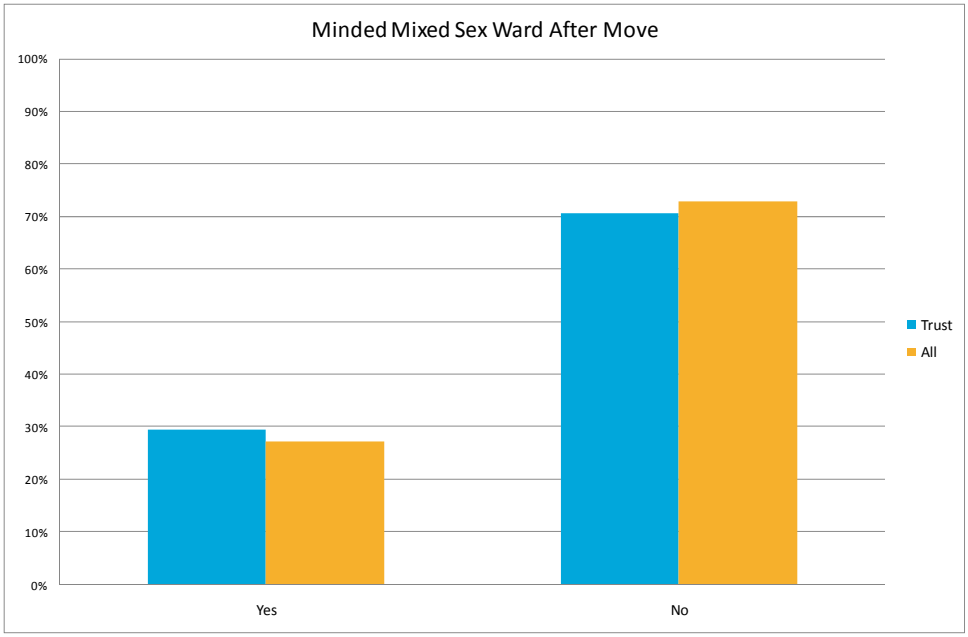


Comparison over time for this question:

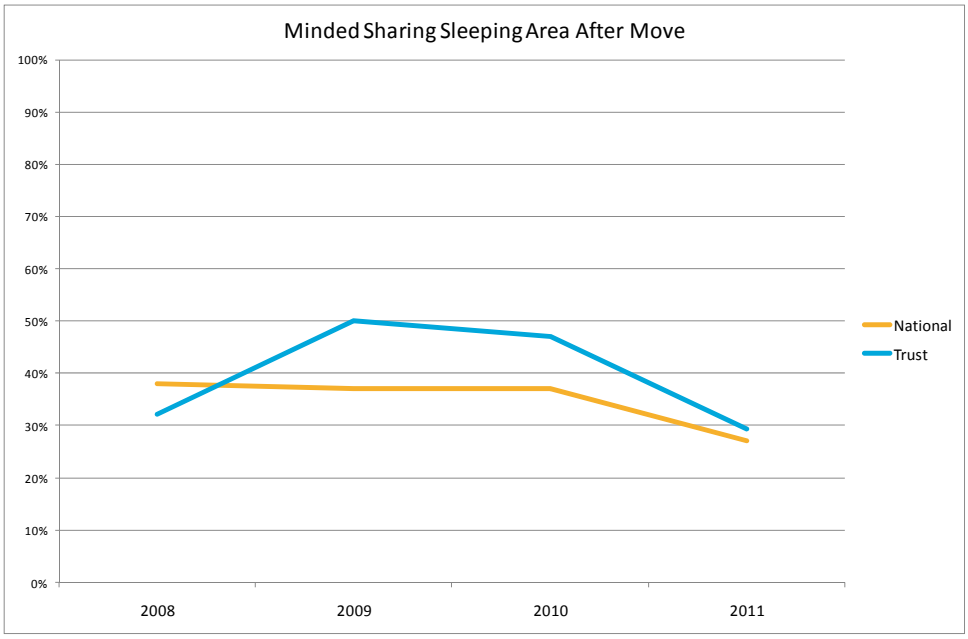


After you moved, did you mind sharing a sleeping area, for example a room or bay, with patients of the opposite sex?

29% of patients who did have to share said they did mind sharing after their move, as the chart shows.

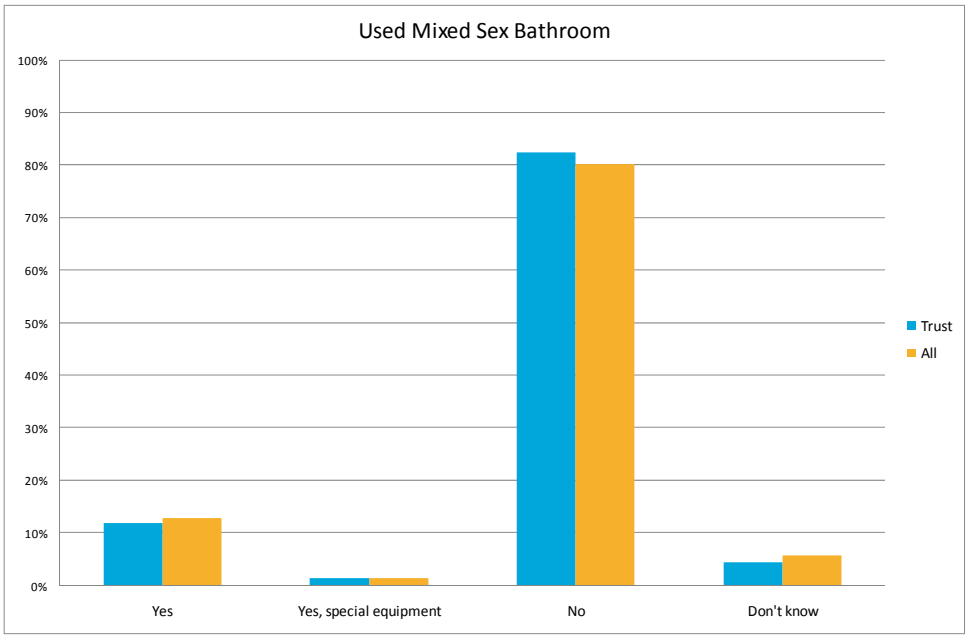


Comparison over time for this question:

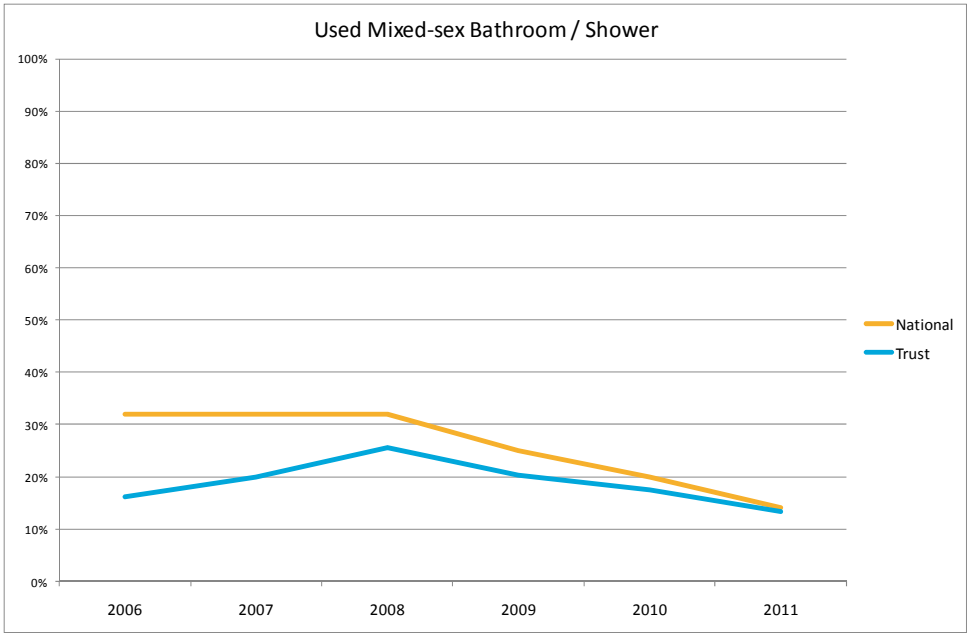


While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?

Patients were also asked about shared bathroom or shower areas. 12% of patients who used these areas said they did use the same facilities as patients of the opposite sex; 1% said they did because there were special bathing facilities they needed.



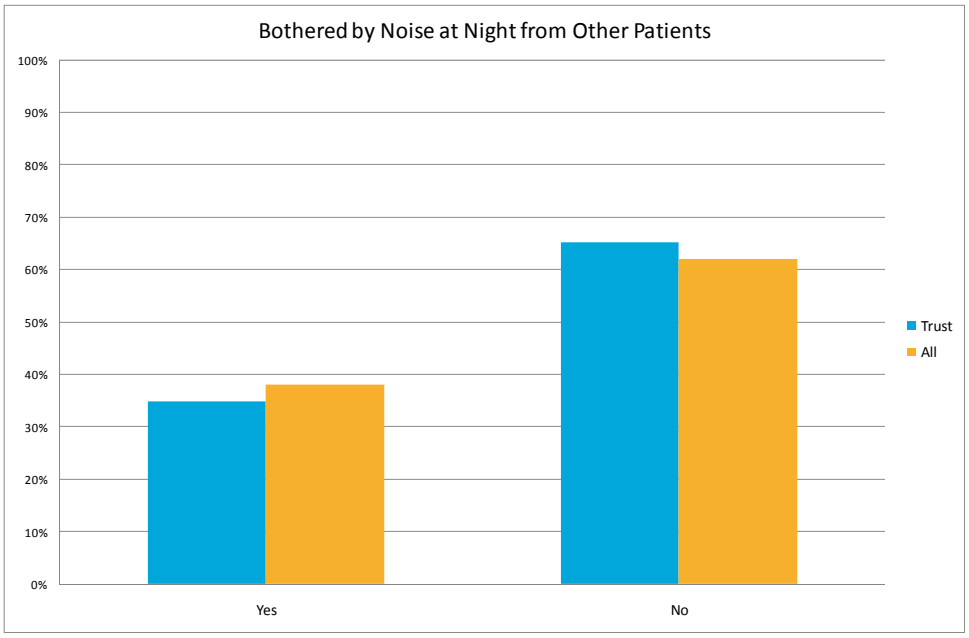
Comparison over time for this question:



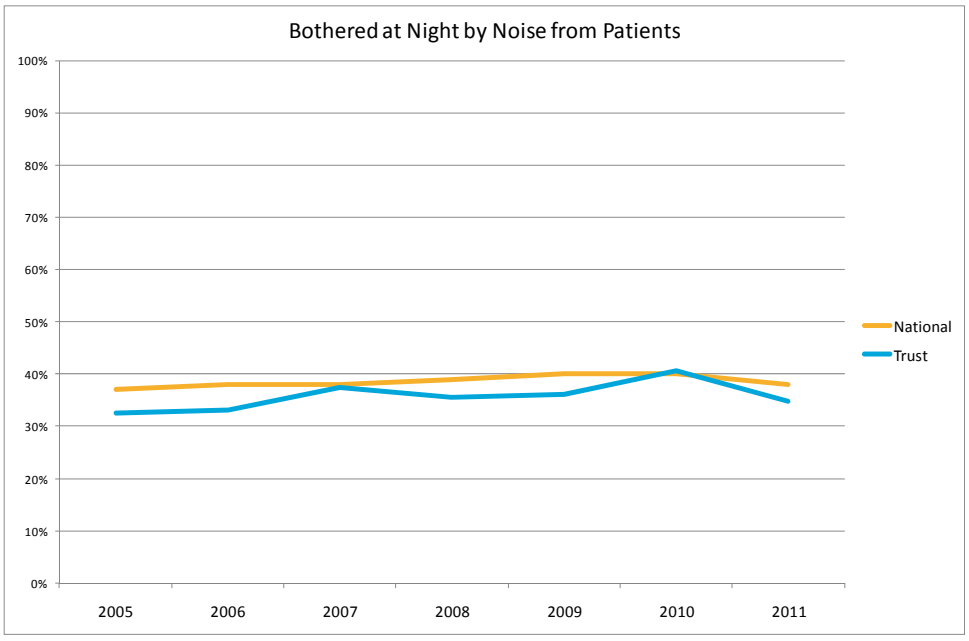
NOISE

Were you ever bothered by noise at night from other patients?

35% of patients were bothered by noise at night from other patients, as the chart shows.

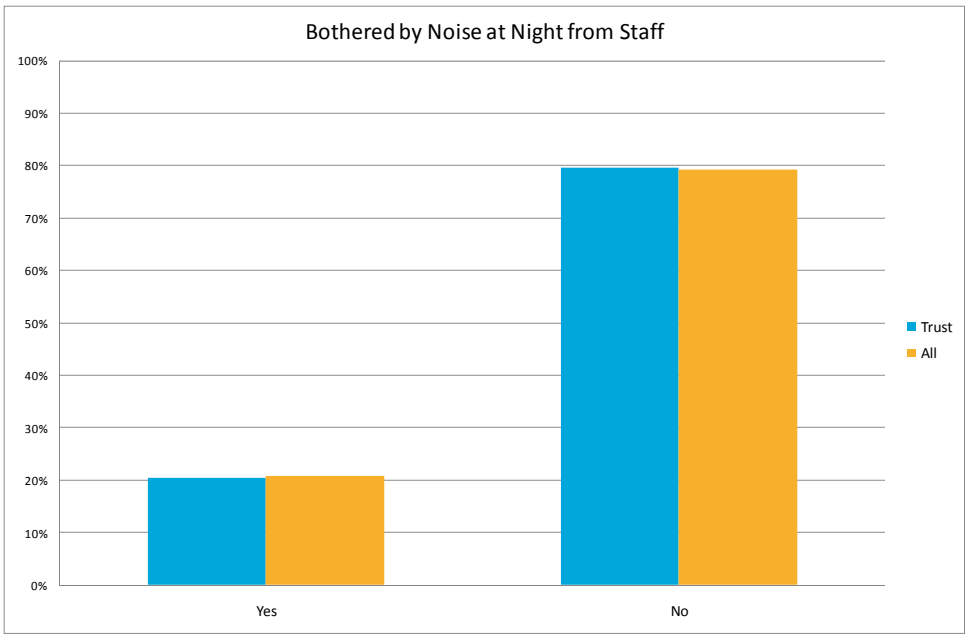


Comparison over time for this question:

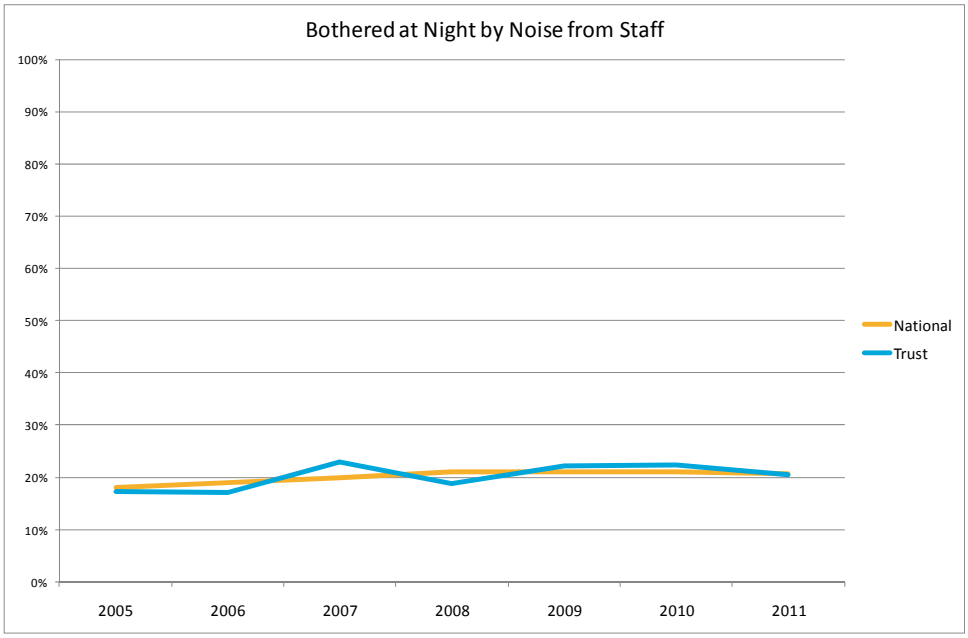


Were you ever bothered by noise at night from hospital staff?

Noise at night from hospital staff bothered 20% of patients.



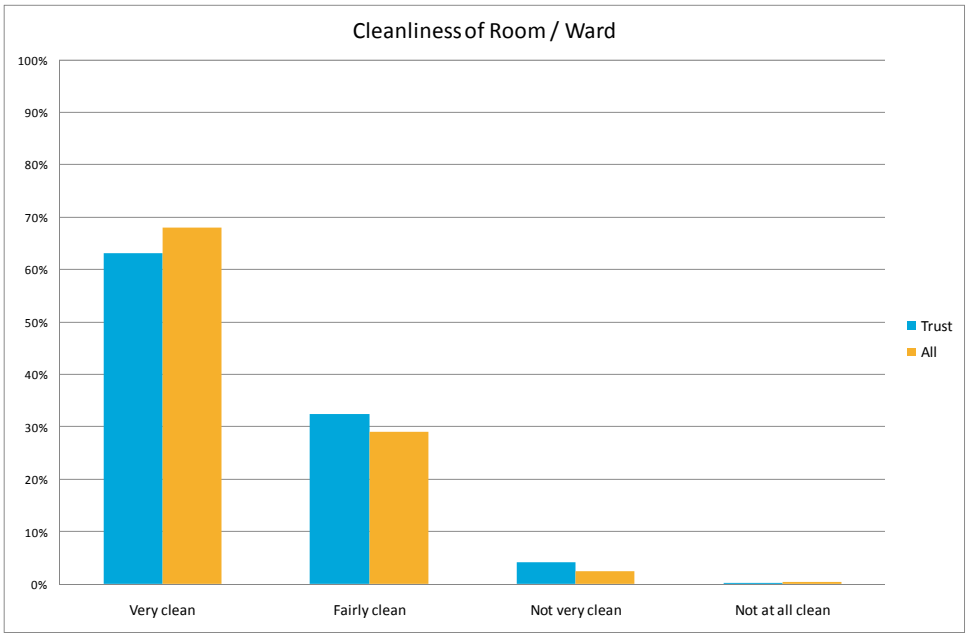
Comparison over time for this question:



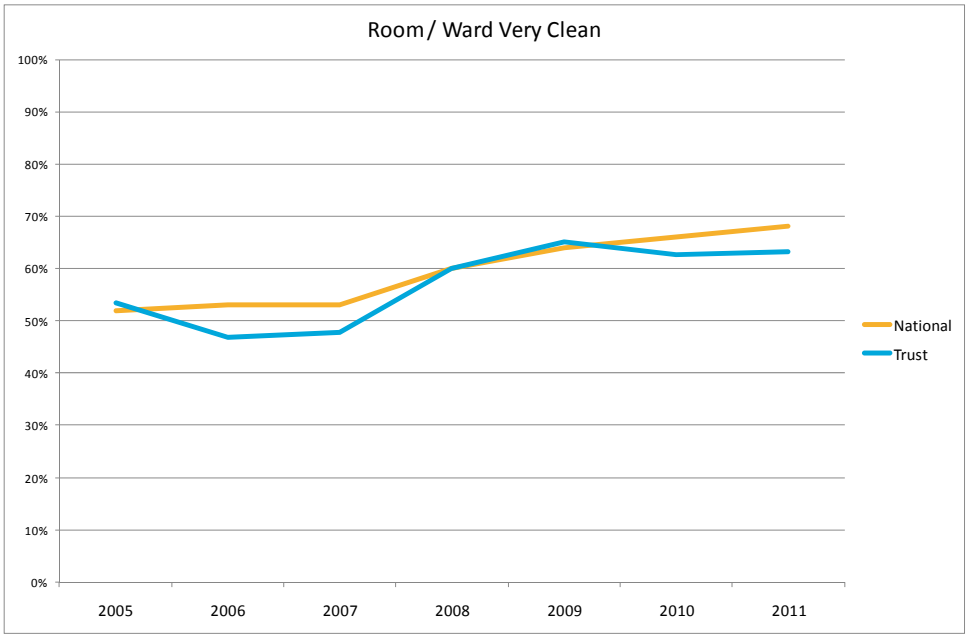
CLEANLINESS

In your opinion, how clean was the hospital room or ward that you were in?

63% of patients thought the room or ward they were in was very clean; 17 patients (4%) said the ward was not very clean or not at all clean.

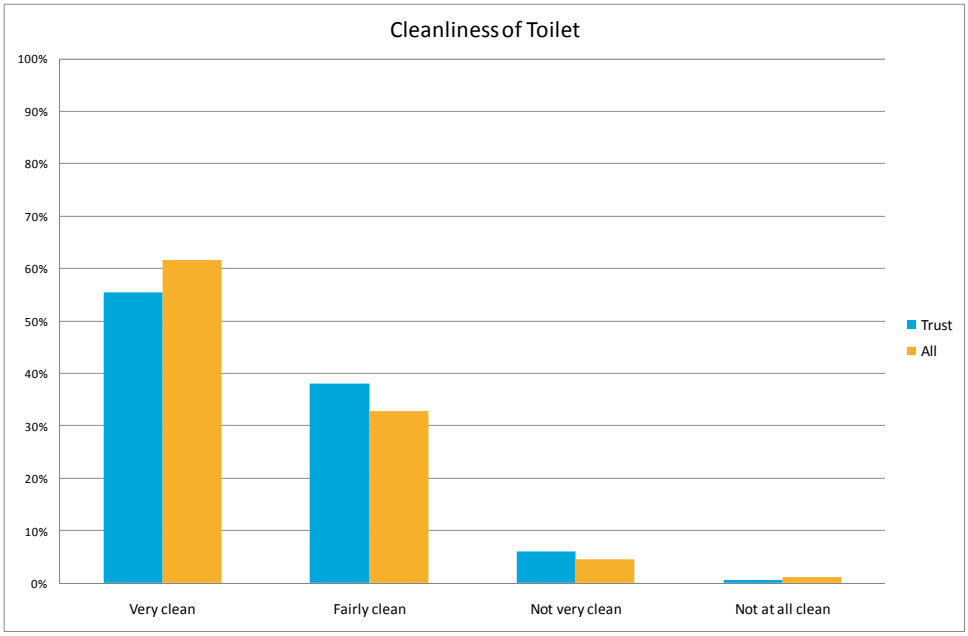


Comparison over time for this question:

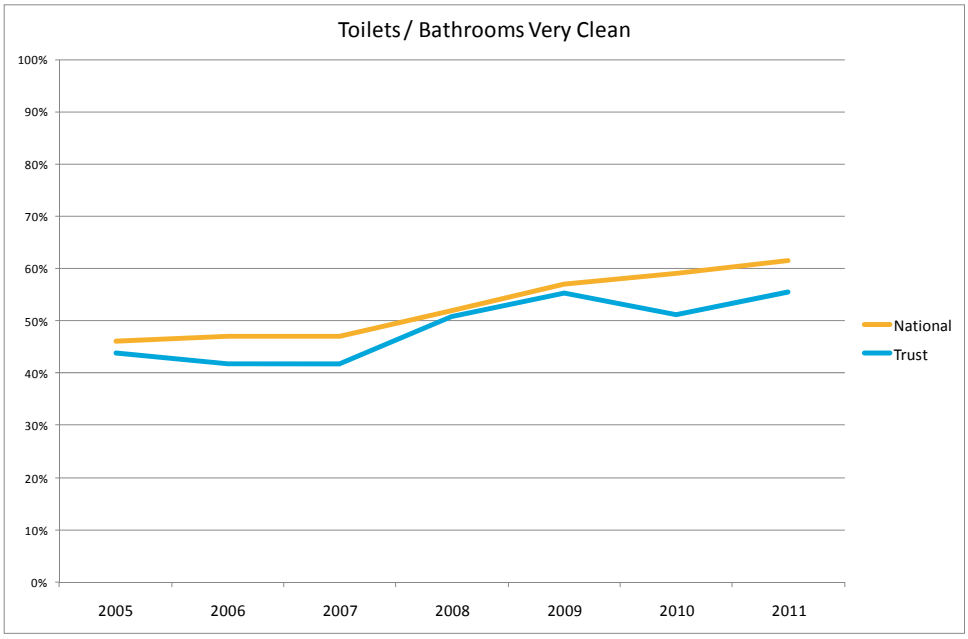


How clean were the toilets and bathrooms that you used in hospital?

55% of those patients that used bathrooms and toilets said they were very clean. 25 patients (7%of those using them) said they were not very clean or not at all clean.



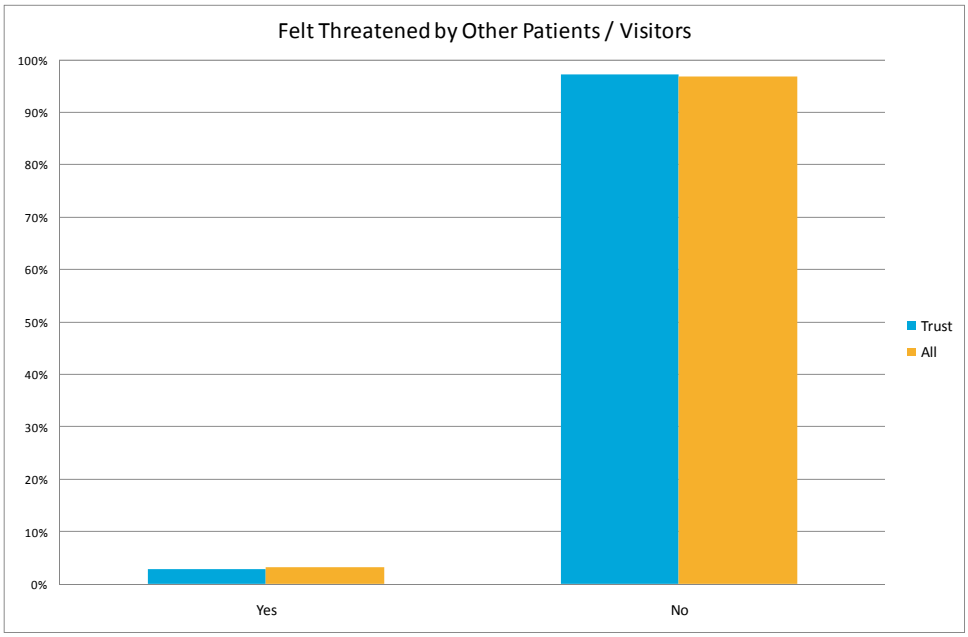
Comparison over time for this question:



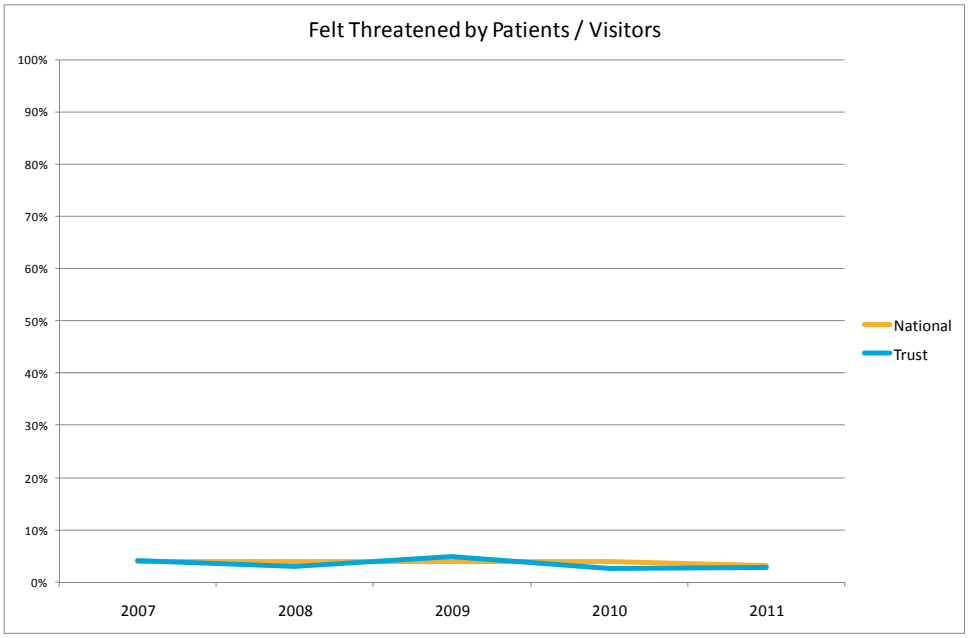
SECURITY ON THE WARD

Did you feel threatened during your stay in hospital by other patients or visitors?

Patients were asked if they felt threatened during their stay in hospital by other patients or visitors: 97% said they did not.

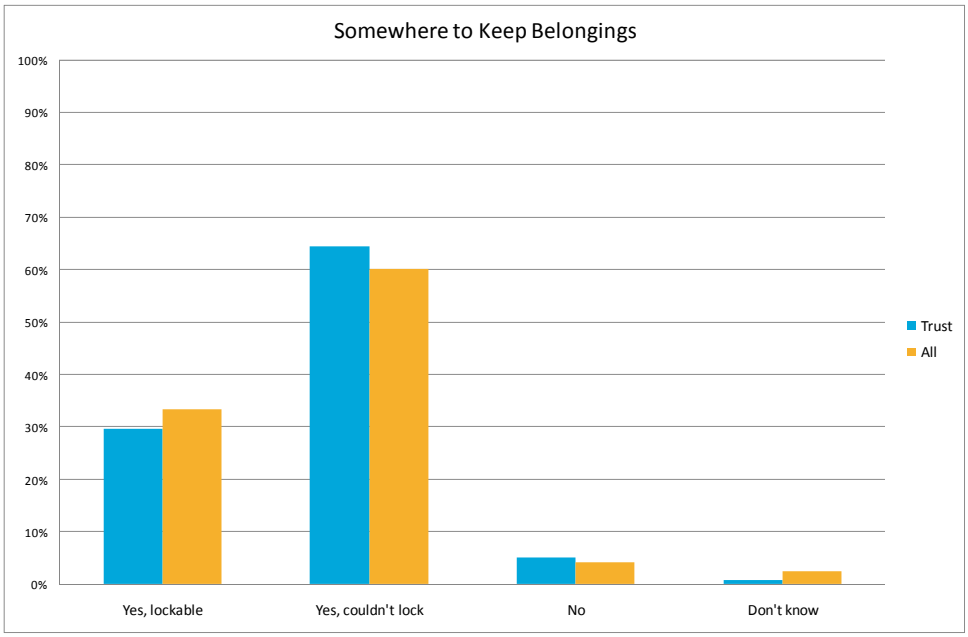


Comparison over time for this question:

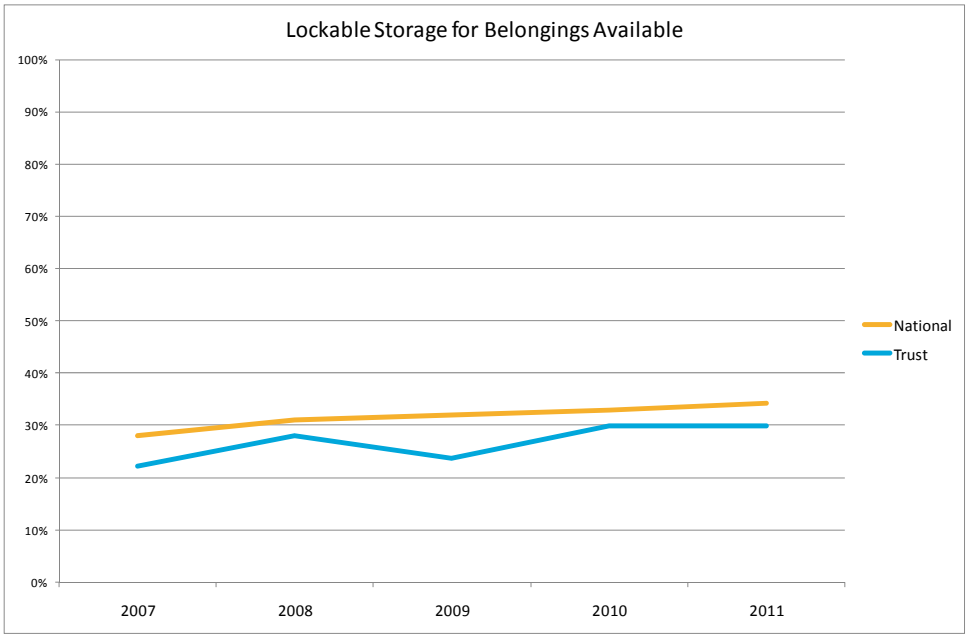


Did you have somewhere to keep your personal belongings whilst on the ward?

Patients were also asked if they had somewhere to keep their personal belongings whilst on the ward. 64% said that they did have somewhere but that they could not lock it as the chart shows.



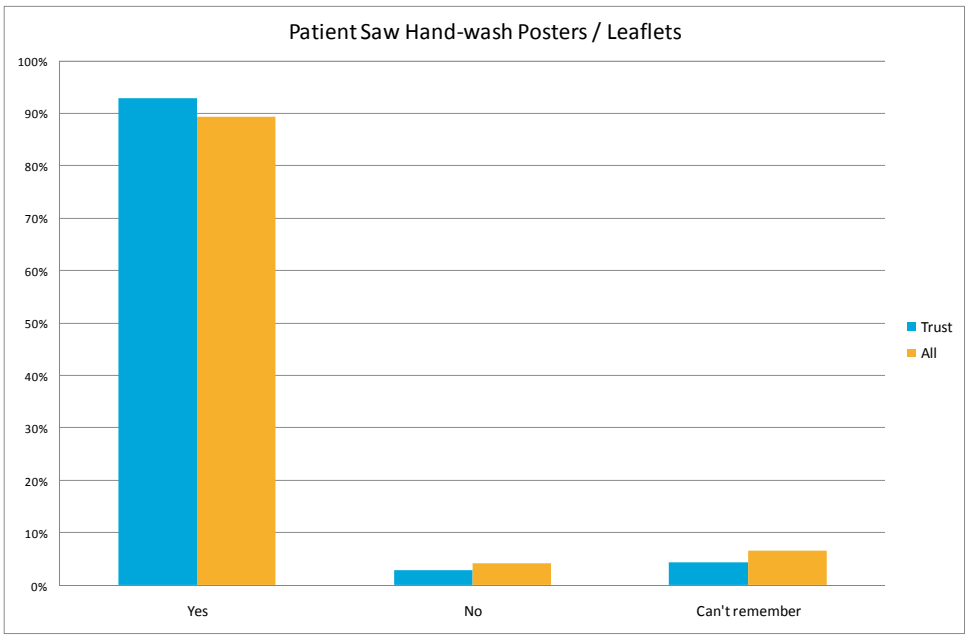
Comparison over time for this question:



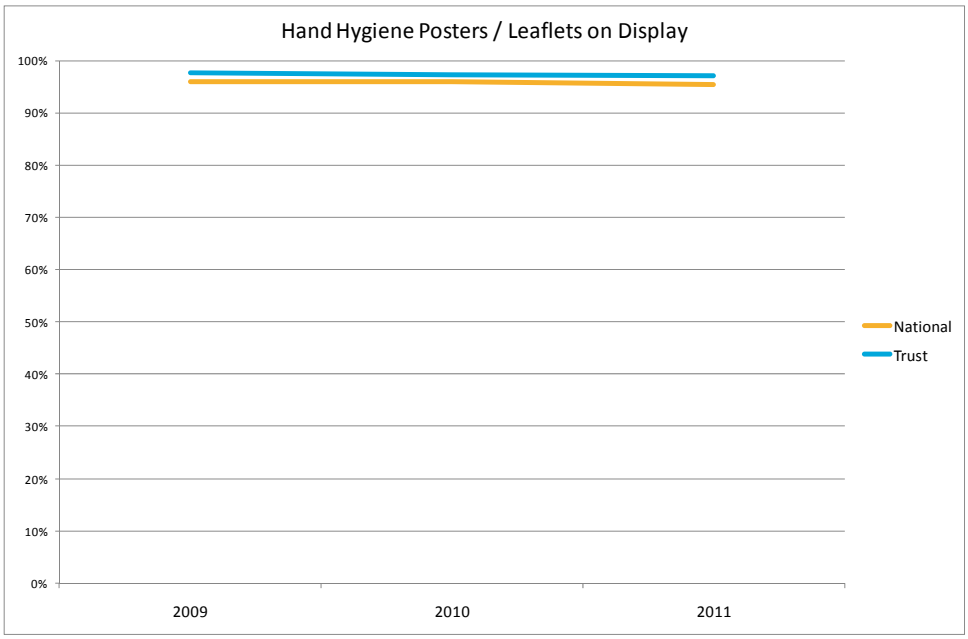
HYGIENE ON THE WARD

Did you see any posters or leaflets on the ward asking patients and visitors to wash their hands or to use hand-wash gels?

Patients were asked if they saw any posters or leaflets on the ward asking patients and visitors to wash their hands or to use hand-wash gels; 93% said that they did see such information.

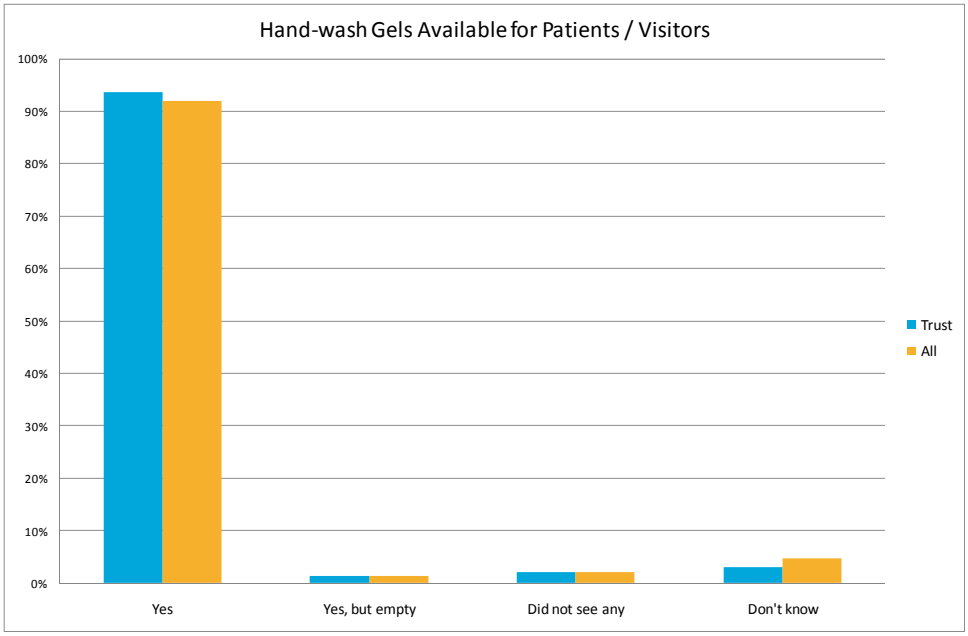


Comparison over time for this question:

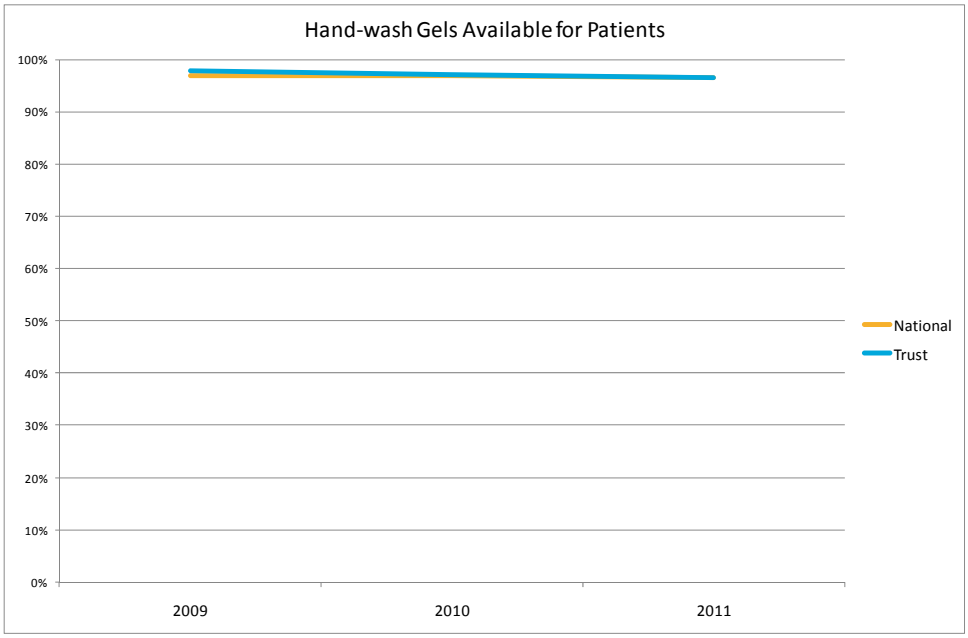


Were hand-wash gels available for patients and visitors to use?

94% of patients said hand-wash gels were available for patients and visitors to use; 1% saw dispensers but said they were empty. 2% did not see any hand-wash gels.



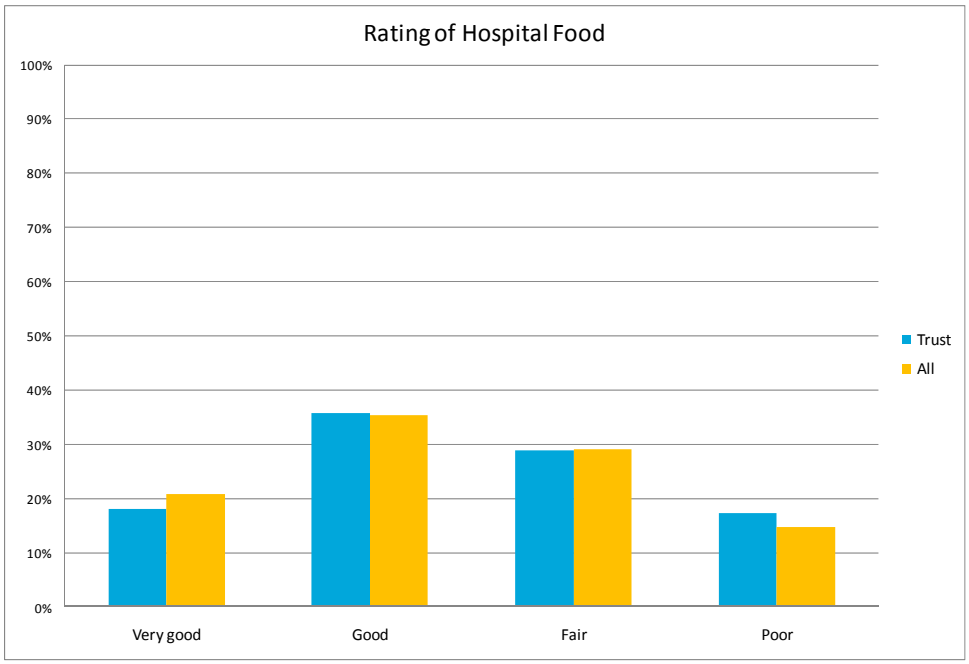
Comparison over time for this question:



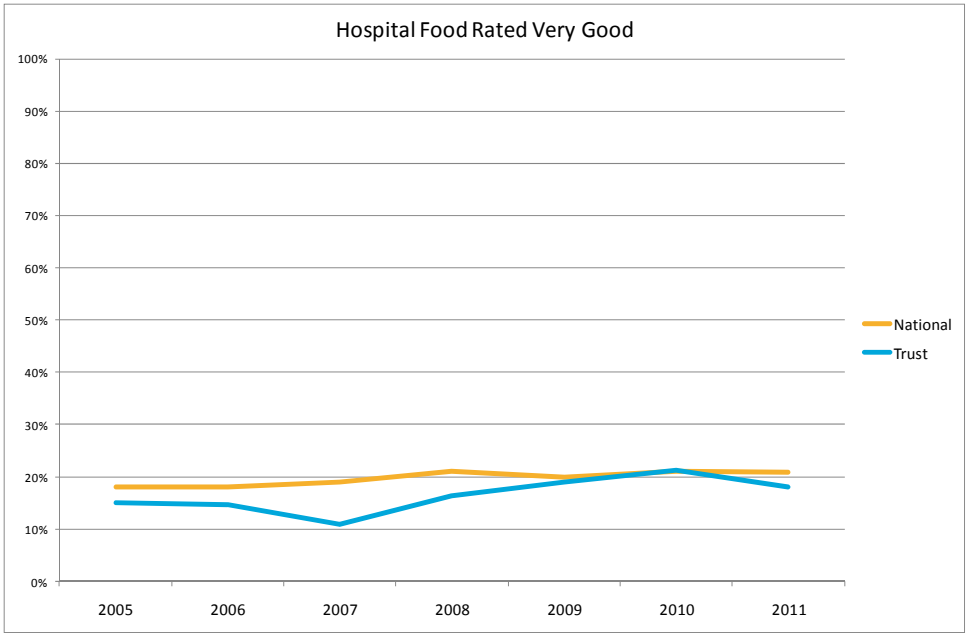
HOSPITAL FOOD

How would you rate the hospital food?

18% of the patients who had food in hospital thought that it was very good and a further 36% thought it was good; 17% said that it was poor.

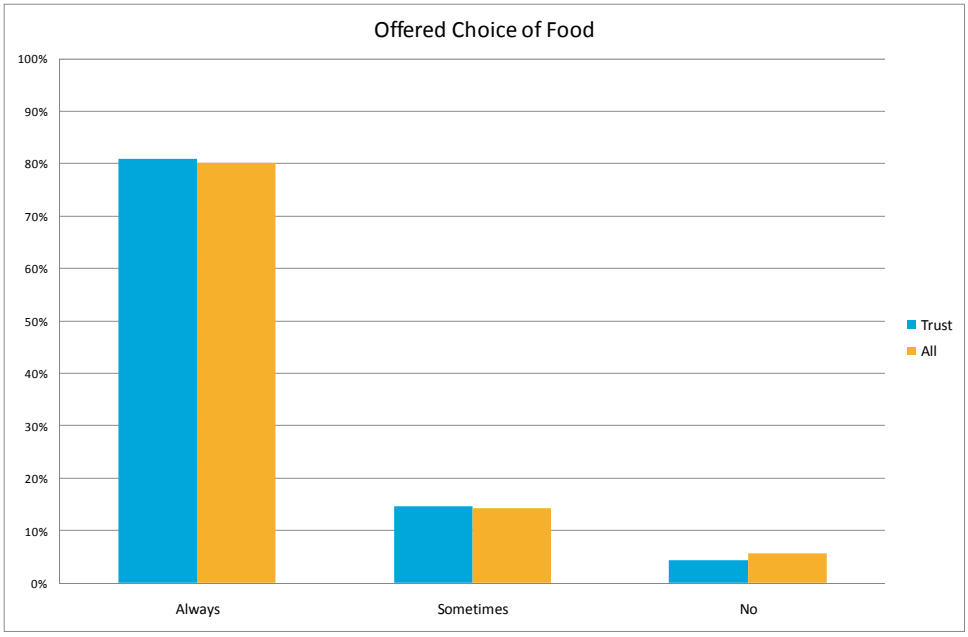


Comparison over time for this question:

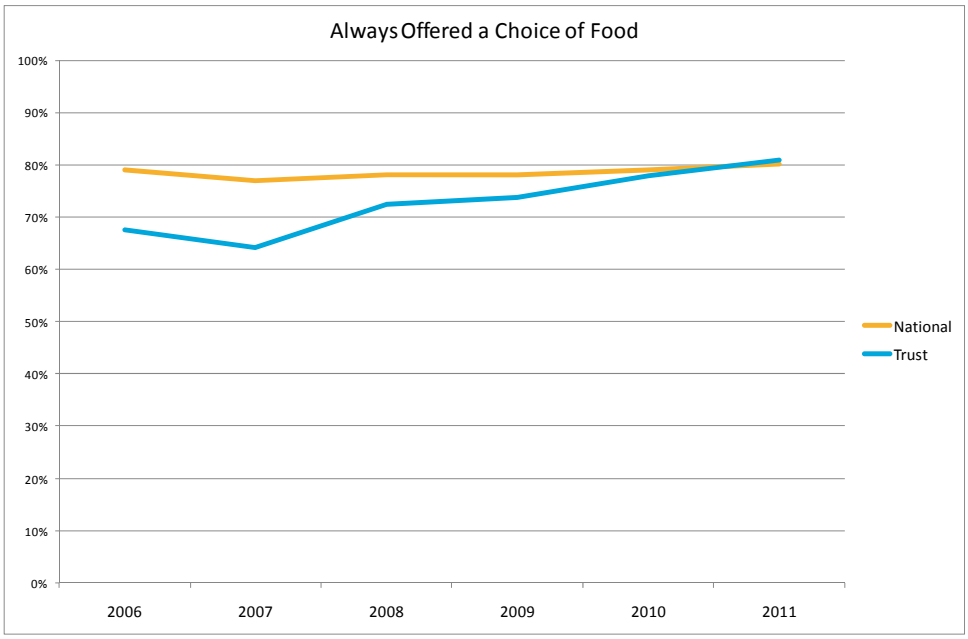


Were you offered a choice of food?

81% of patients said they were always offered a choice of food; 4% said they were not offered a choice.



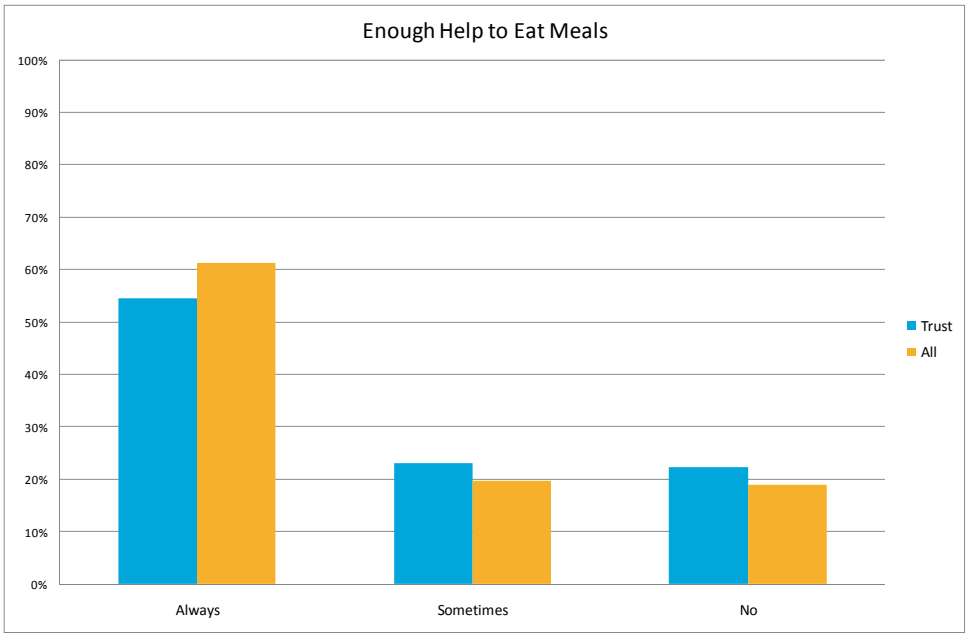
Comparison over time for this question:



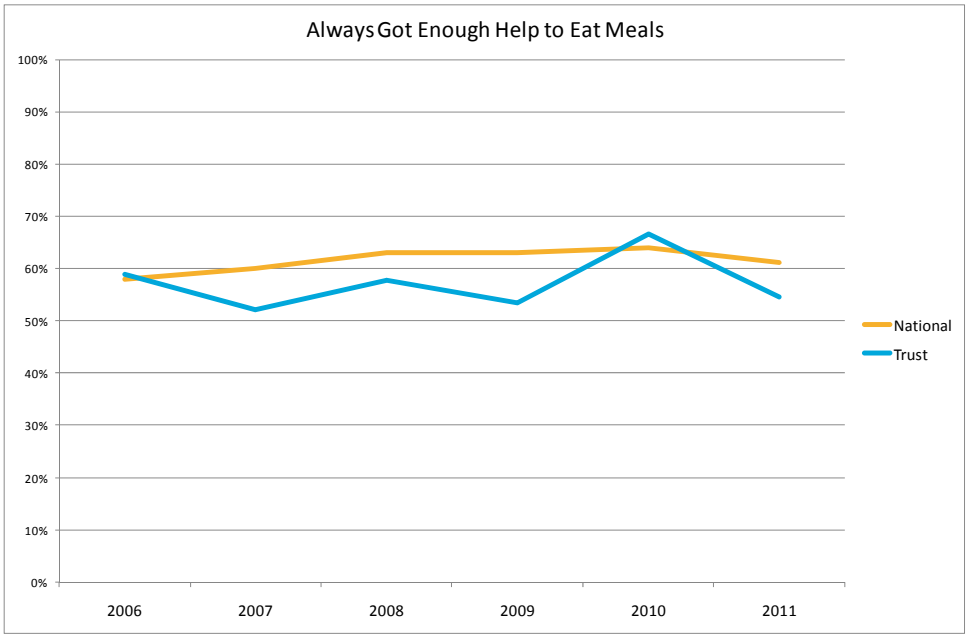
HELP WITH EATING

Did you get enough help from staff to eat your meals?

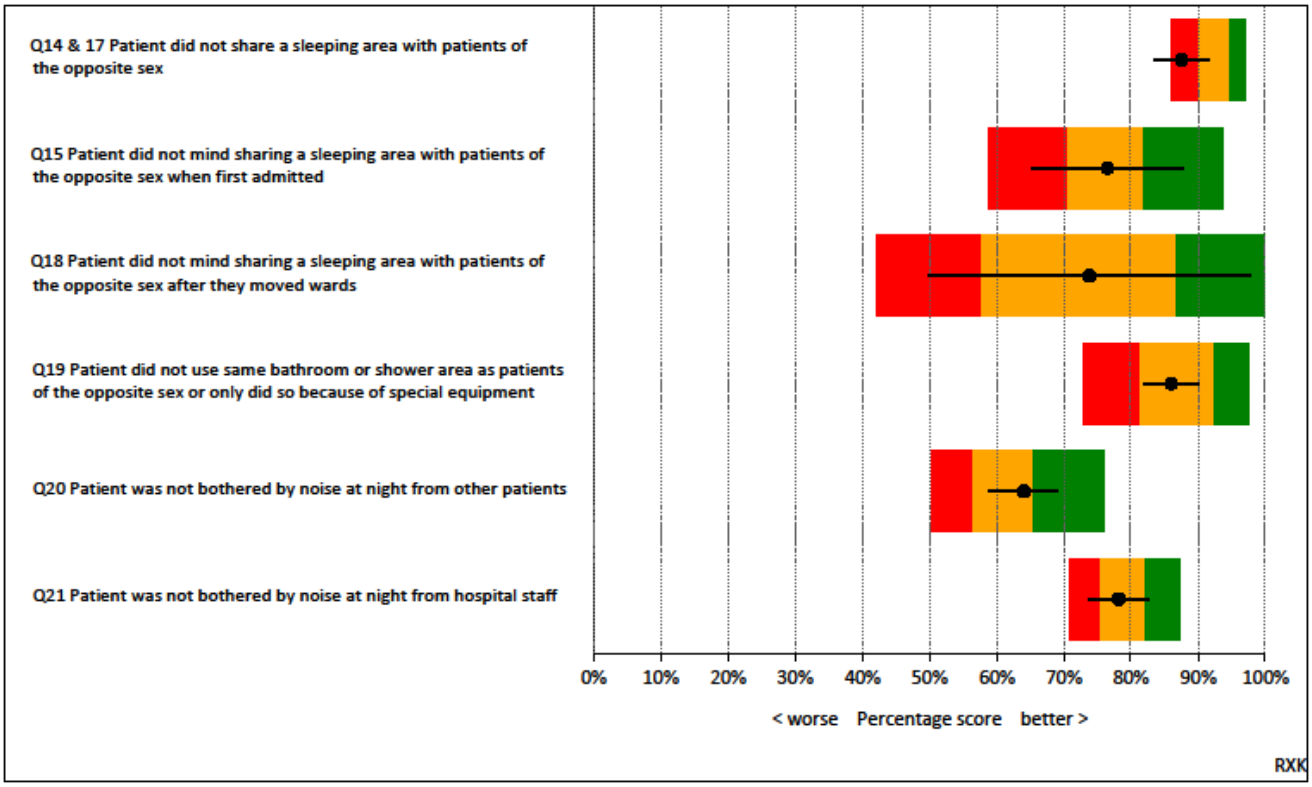
Of those patients needing help from staff to eat their meals, 55% said they always got enough help; 22% said they did not get enough help.



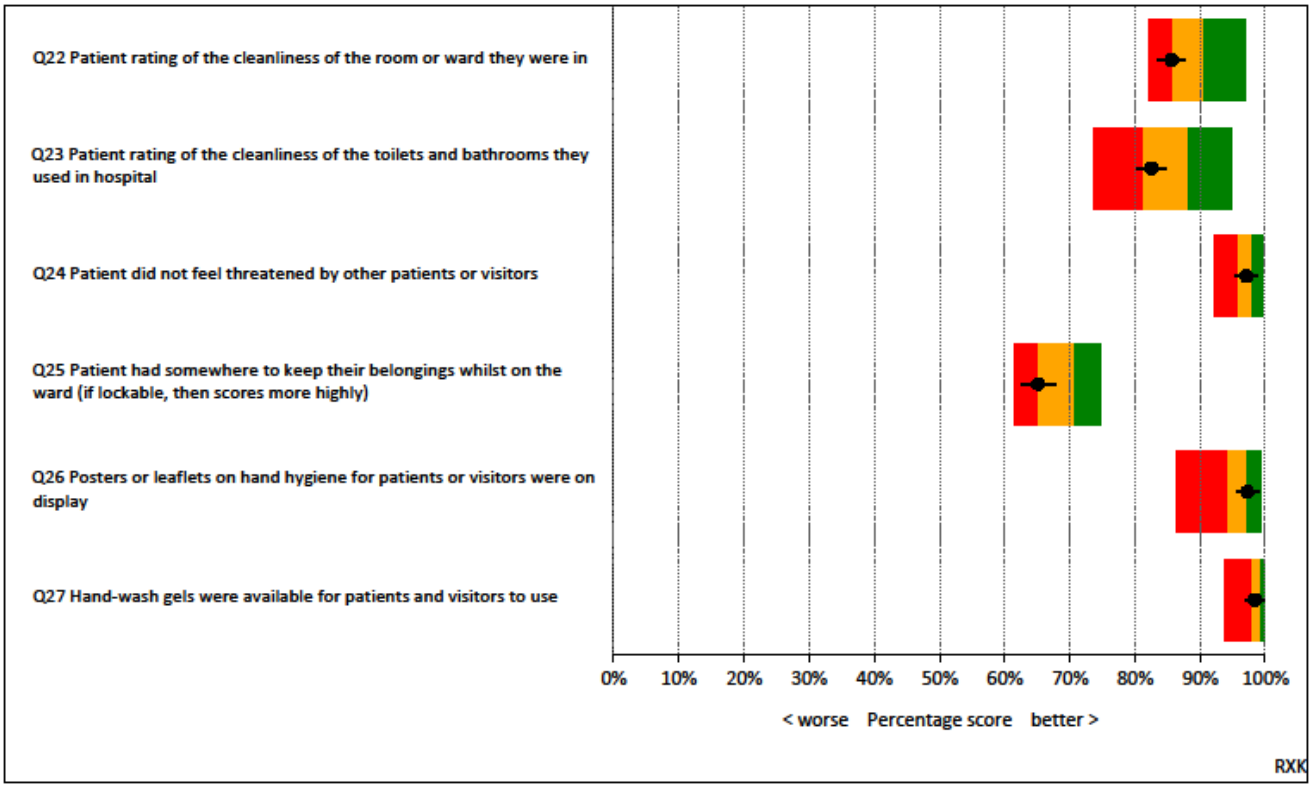
Comparison over time for this question:



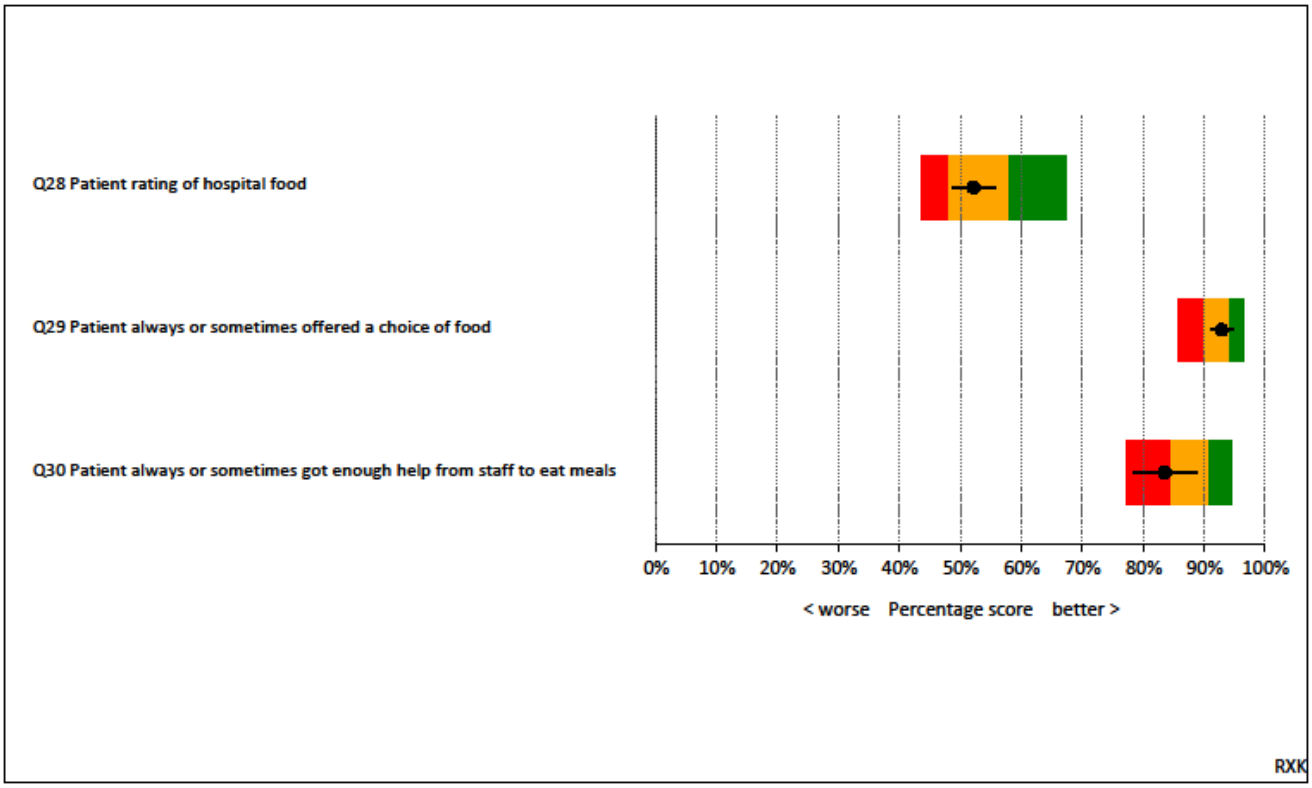
SUMMARY AND ACTIONS



Question	2010 percentage for this Trust	2011 percentage for this Trust	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Scored % in lowest 20% of Trusts
Q14 & 17 Patient did not share a sleeping area with patients of the opposite sex	79%	88%	90%	95%	+
Q15 Patient did not mind sharing a sleeping area with patients of the opposite sex when first admitted	73%	77%	71%	82%	
Q18 Patient did not mind sharing a sleeping area with patients of the opposite sex after they moved wards	52%	74%	58%	87%	
Q19 Patient did not use same bathroom or shower area as patients of the opposite sex or only did so because of special equipment	82%	86%	81%	92%	
Q20 Patient was not bothered by noise at night from other patients	58%	64%	56%	65%	
Q21 Patient was not bothered by noise at night from hospital staff	77%	78%	75%	82%	



Question	2010 percentage for this Trust	2011 percentage for this Trust	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Scored % in lowest 20% of Trusts
Q22 Patient rating of the cleanliness of the room or ward they were in	86%	86%	86%	91%	+
Q23 Patient rating of the cleanliness of the toilets and bathrooms they used in hospital	80%	83%	81%	88%	
Q24 Patient did not feel threatened by other patients or visitors	97%	97%	96%	98%	
Q25 Patient had somewhere to keep their belongings whilst on the ward (if lockable, then scores more highly)	66%	65%	65%	71%	+
Q26 Posters or leaflets on hand hygiene for patients or visitors were on display	98%	97%	94%	97%	
Q27 Hand-wash gels were available for patients and visitors to use	98%	98%	98%	99%	



Question	2010 percentage for this Trust	2011 percentage for this Trust	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Scored % in lowest 20% of Trusts
Q28 Patient rating of hospital food	54%	52%	48%	58%	
Q29 Patient always or sometimes offered a choice of food	92%	93%	90%	94%	
Q30 Patient always or sometimes got enough help from staff to eat meals	90%	83%	85%	91%	+

ACTIONS:

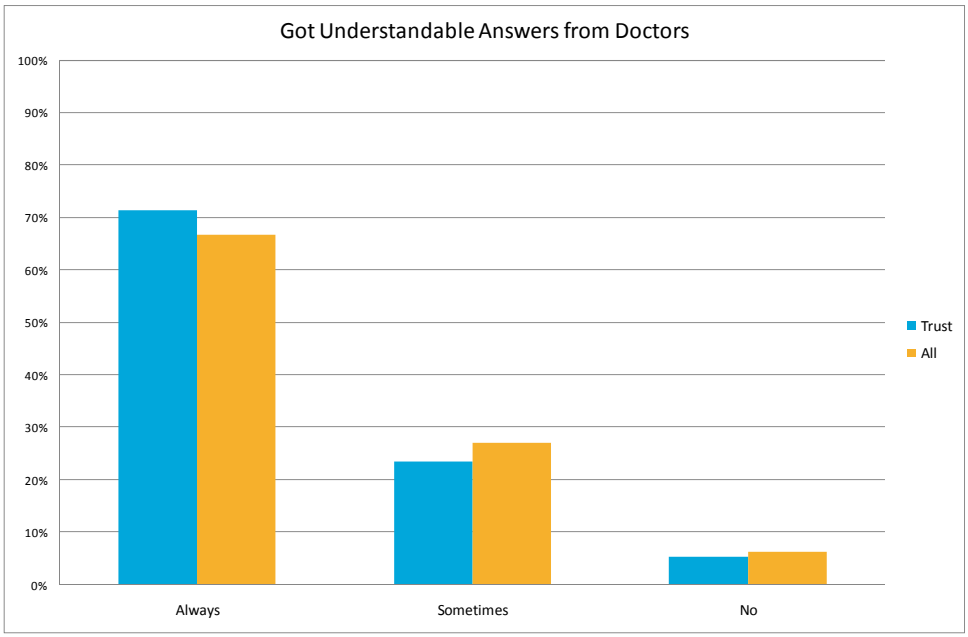
- Review progress on eliminating mixed gender rooms, bays and bathroom facilities in the light of information contained in the survey.
- Review the reasons for the apparent levels of noise from other patients and from staff at night.
- Review the cleaning service/contract in the light of scores for cleanliness in both wards and bathroom facilities.
- Many patients rate the food as only fair or poor. Review food quality and the operation of the catering service/contract.
- Clarify the responsibility of Ward Managers / Nurse in Charge to ensure that feeding of patients takes place where required by suitable members of staff. Undertake spot checks to ensure compliance with supervisory requirements.

Doctors

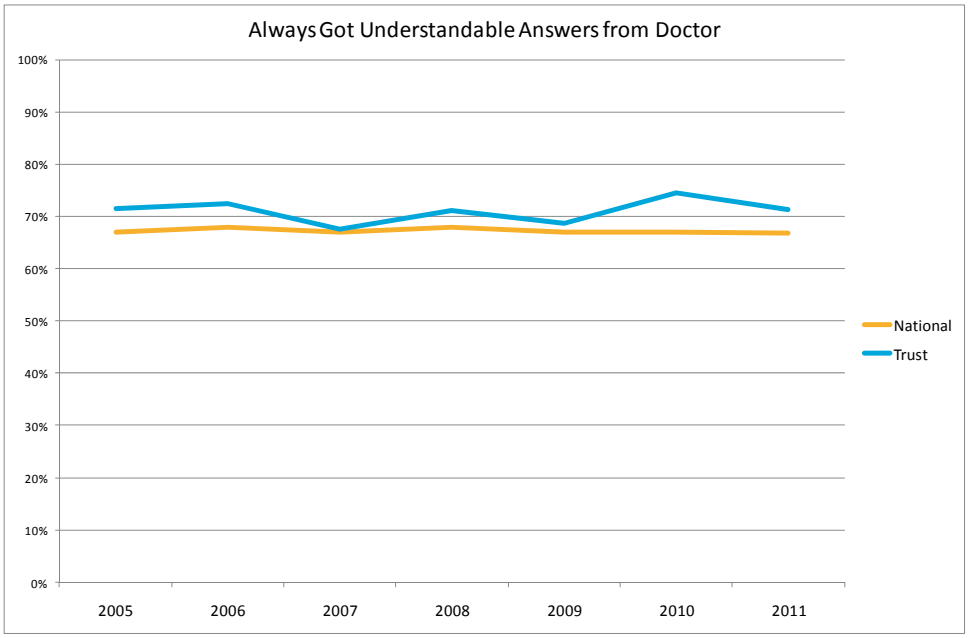
TALKING TO DOCTORS

When you had important questions to ask a doctor, did you get answers that you could understand?

71% of patients who had important questions to ask a doctor said they always understood the answers they were given. 5% said they did not understand, and a further 23% said they only sometimes did.



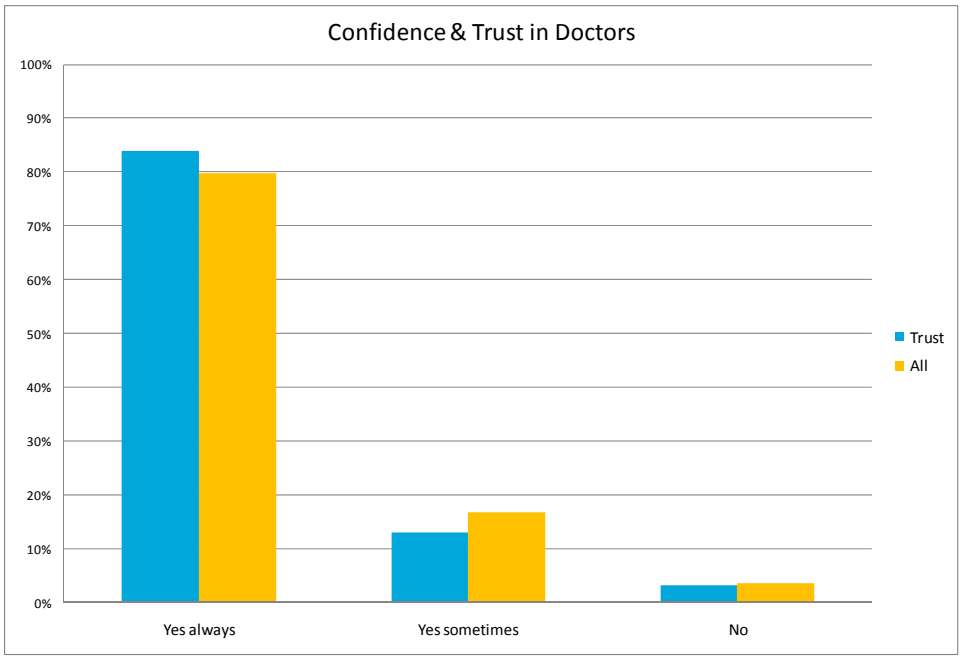
Comparison over time for this question:



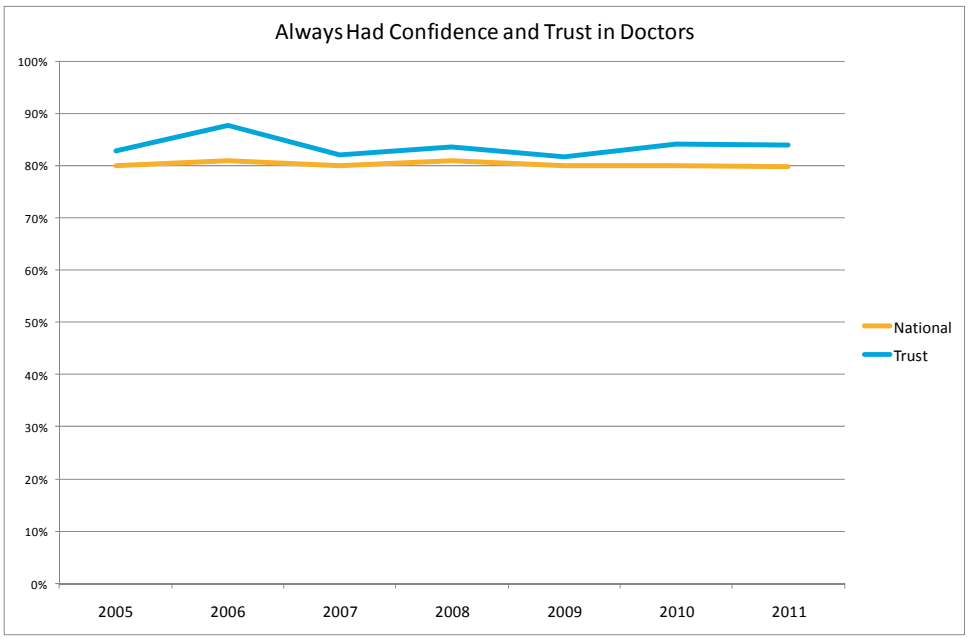
CONFIDENCE AND TRUST

Did you have confidence and trust in the doctors treating you?

84% of the patients said they always had confidence and trust in the doctors treating them; 3% said they did not.



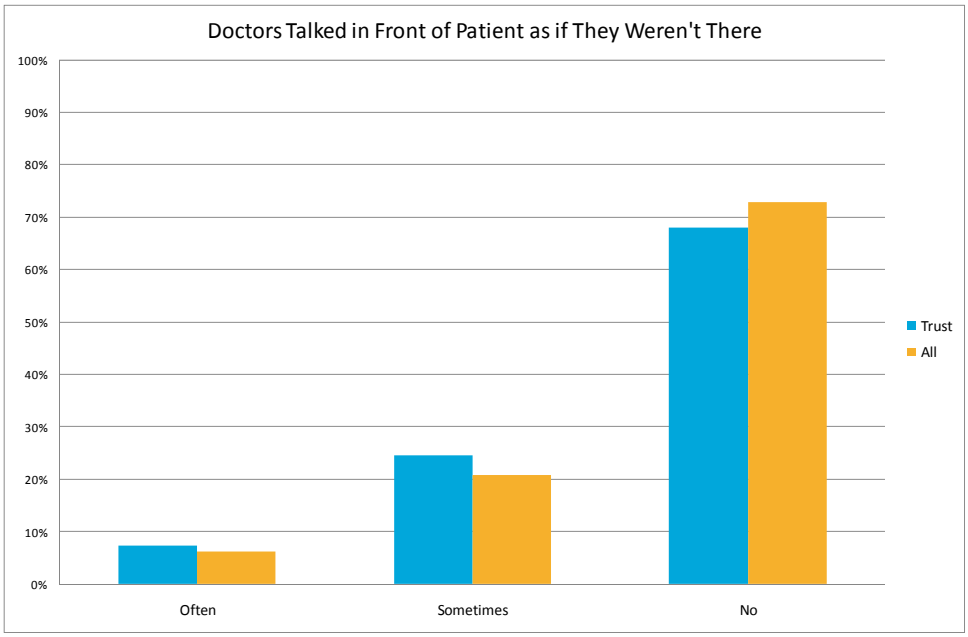
Comparison over time for this question:



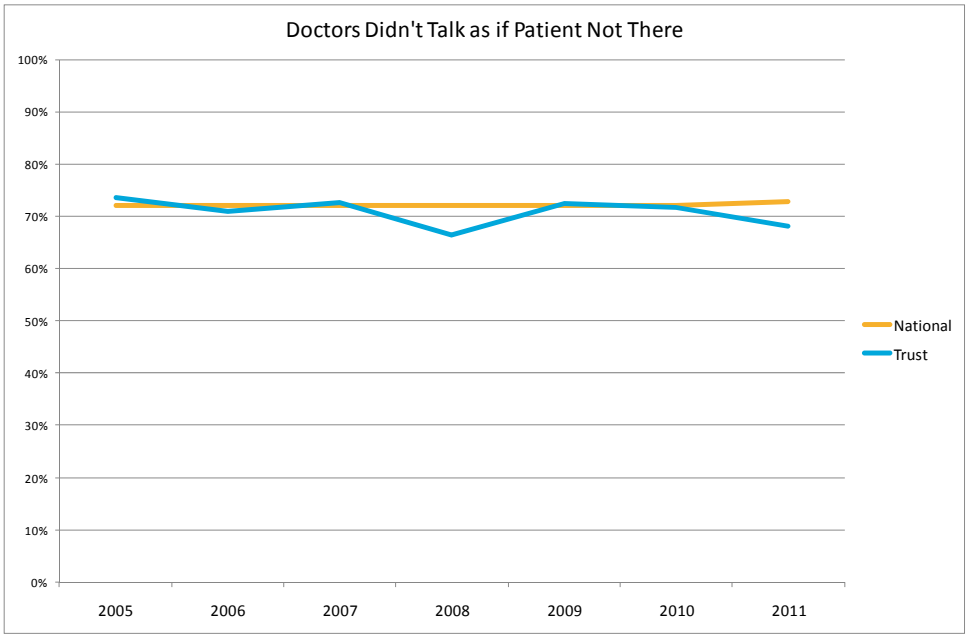
DOCTORS' ATTITUDE TO PATIENTS

Did doctors talk in front of you as if you weren't there?

7% of patients said that doctors often talked in front of them as if they were not there; 68% said that they did not.



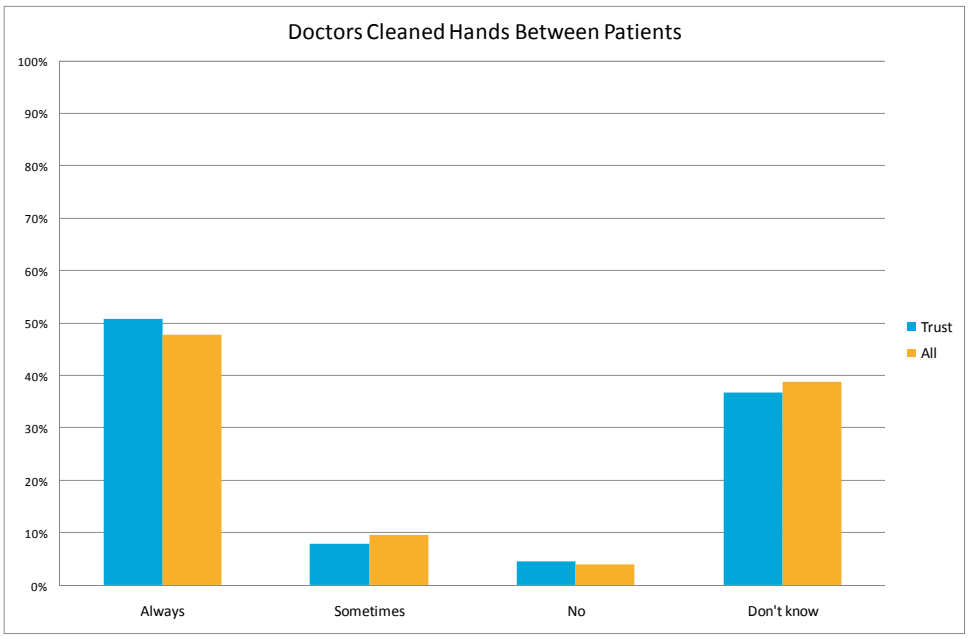
Comparison over time for this question:



HYGIENE

As far as you know, did doctors wash or clean their hands between touching patients?

51% of patients said that, as far as they knew, doctors always washed or cleaned their hands between touching patients; 5% said they did not wash or clean them. 37% did not know if they did or not.



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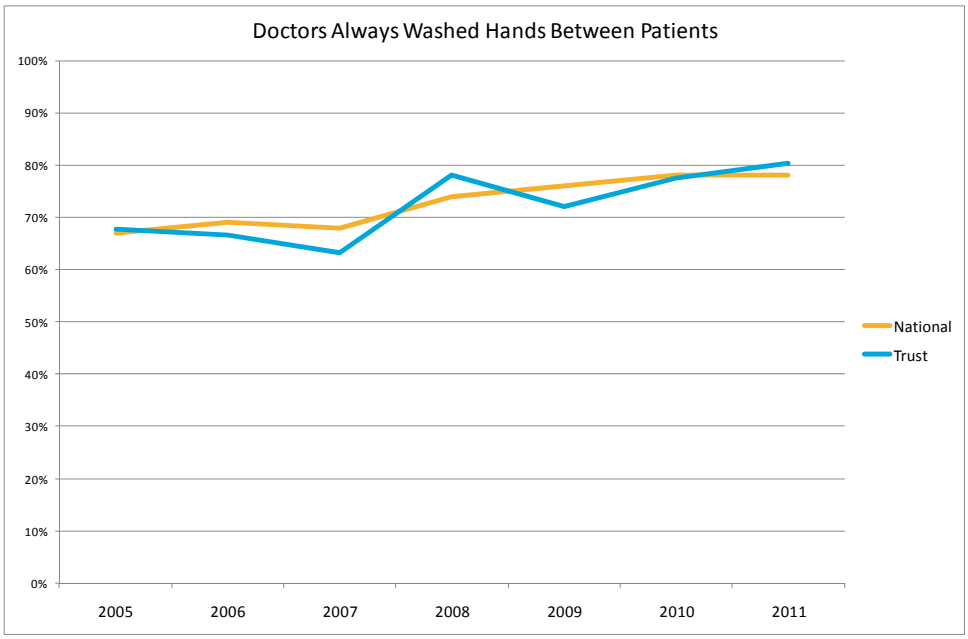
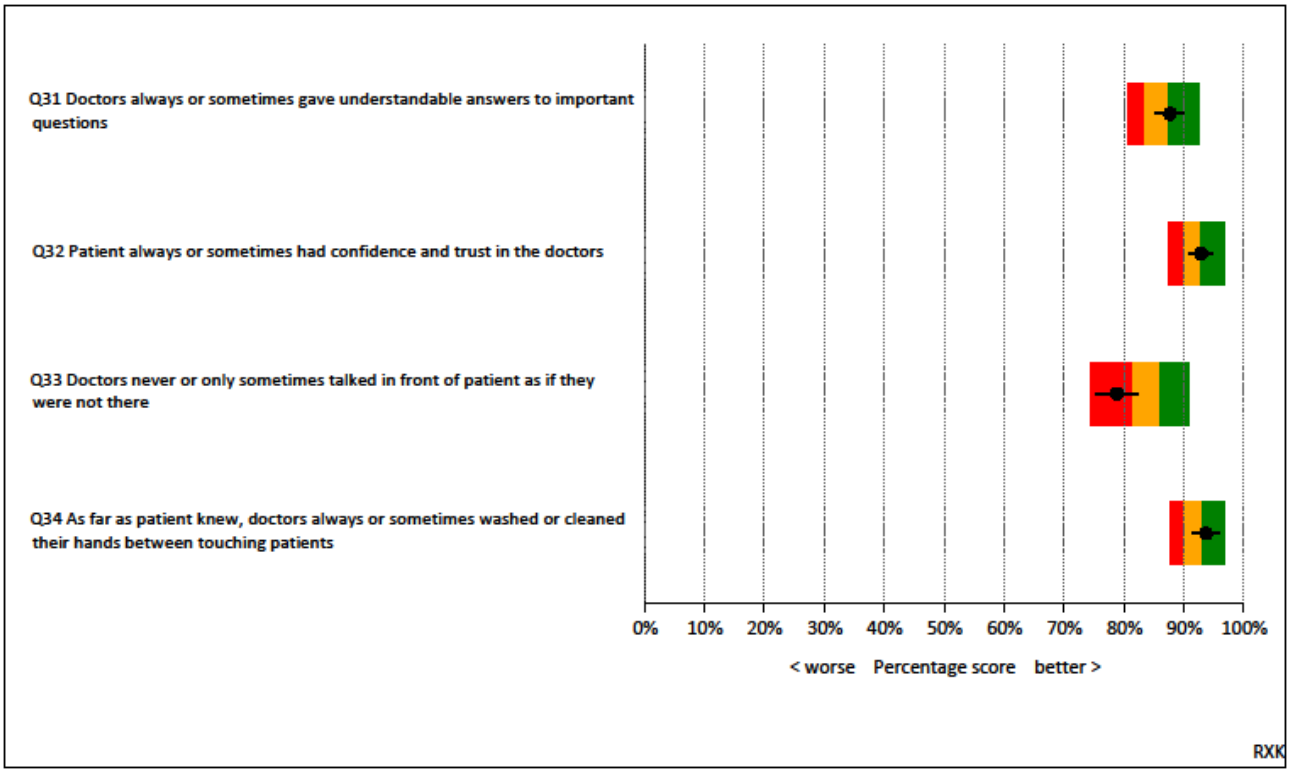


SUMMARY AND ACTIONS



Question	2010 percentage for this Trust	2011 percentage for this Trust	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Scored % in lowest 20% of Trusts
Q31 Doctors always or sometimes gave understandable answers to important questions	88%	88%	84%	87%	
Q32 Patient always or sometimes had confidence and trust in the doctors	94%	93%	90%	93%	
Q33 Doctors never or only sometimes talked in front of patient as if they were not there	83%	79%	81%	86%	+
Q34 As far as patient knew, doctors always or sometimes washed or cleaned their hands between touching patients	92%	94%	90%	93%	

ACTIONS:

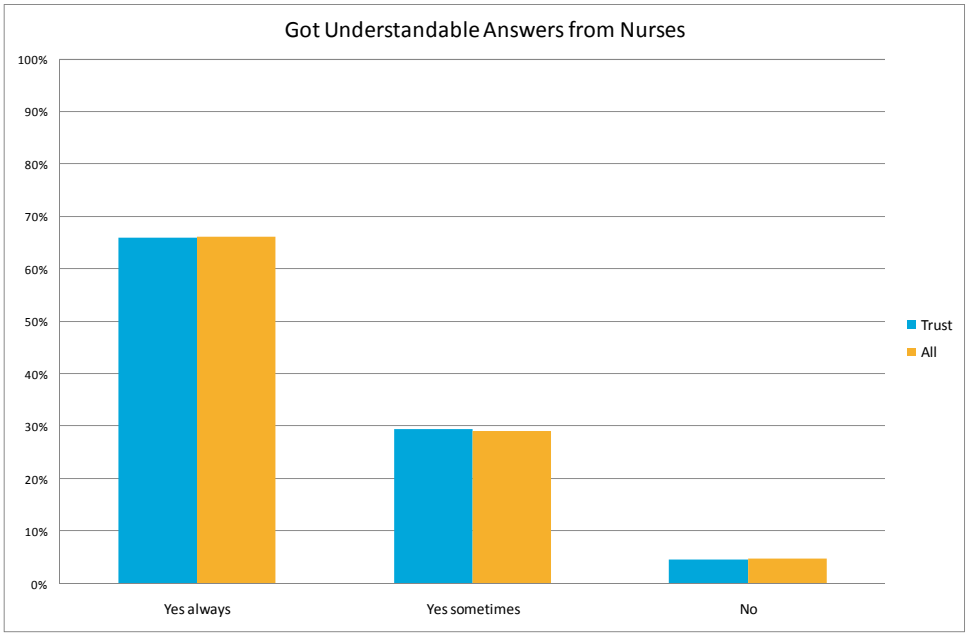
- Further address communication issues between doctors and patients identified by the survey through the training and induction of junior staff. Survey results typically show that about a quarter of the patients do not fully understand answers to questions given by doctors.
- Reinforce policies on hand washing / use of alcohol gel to all clinicians and initiate spot checks for compliance.

Nurses

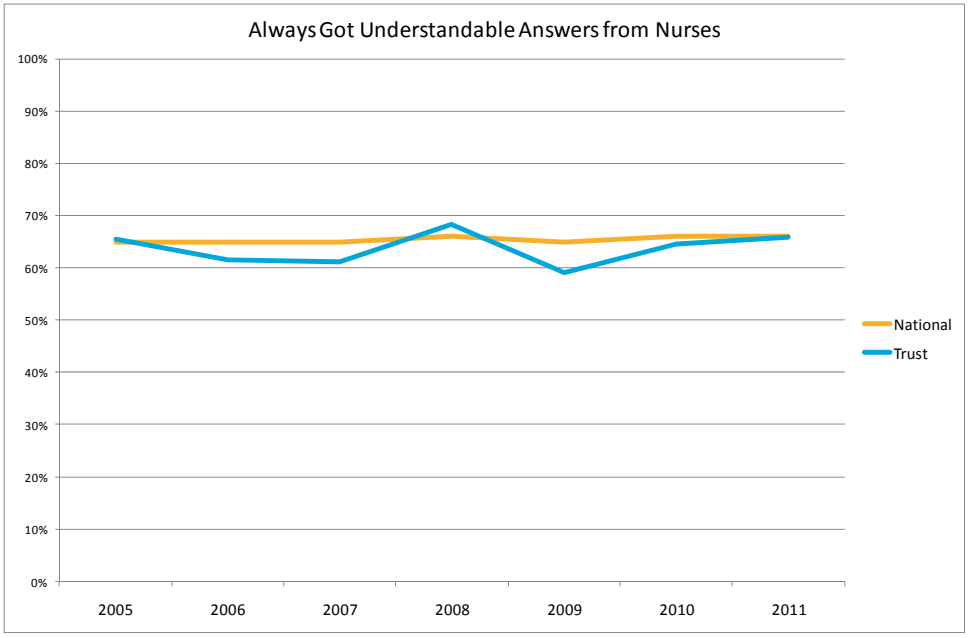
When you had important questions to ask a nurse, did you get answers that you could understand?

TALKING TO NURSES

66% of patients who had important questions to ask a nurse said they always understood the answers they were given. 5% said they did not understand answers from nurses, and a further 29% said they only sometimes did.



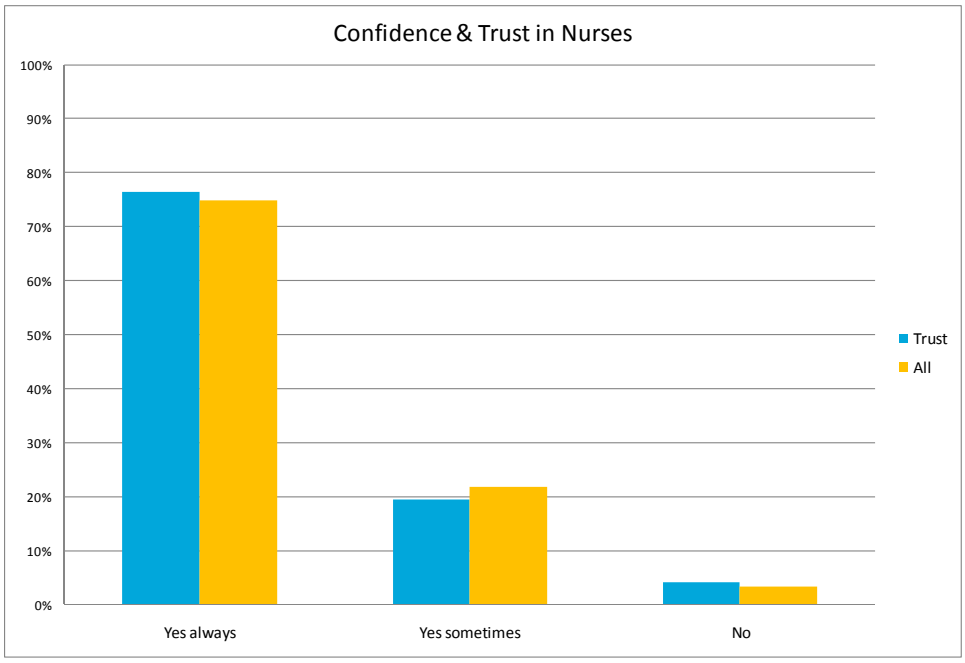
Comparison over time for this question:



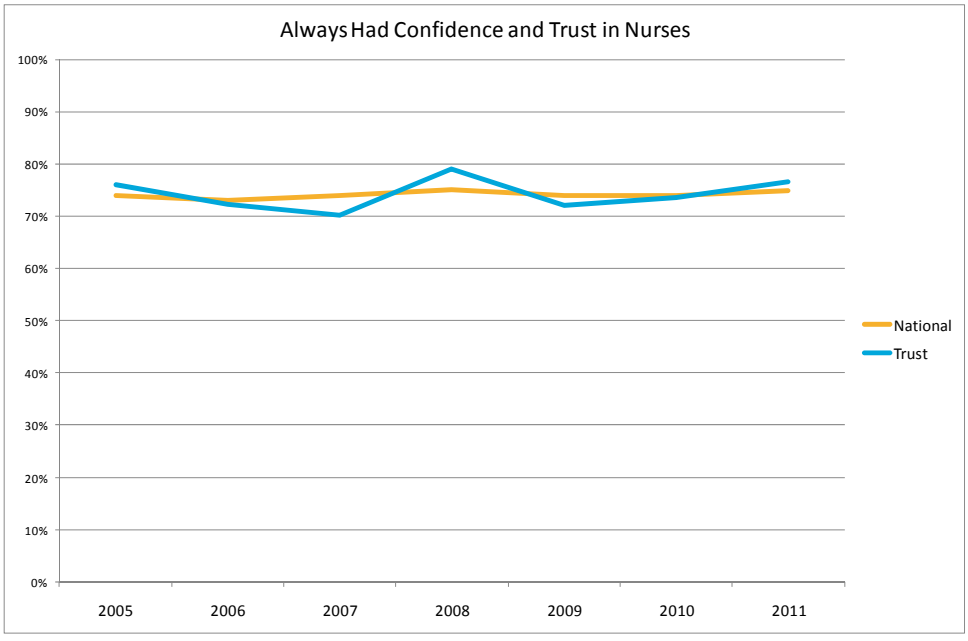
CONFIDENCE AND TRUST

Did you have confidence and trust in the nurses treating you?

77% of the patients said they always had confidence and trust in the nurses treating them; 4% said they did not.



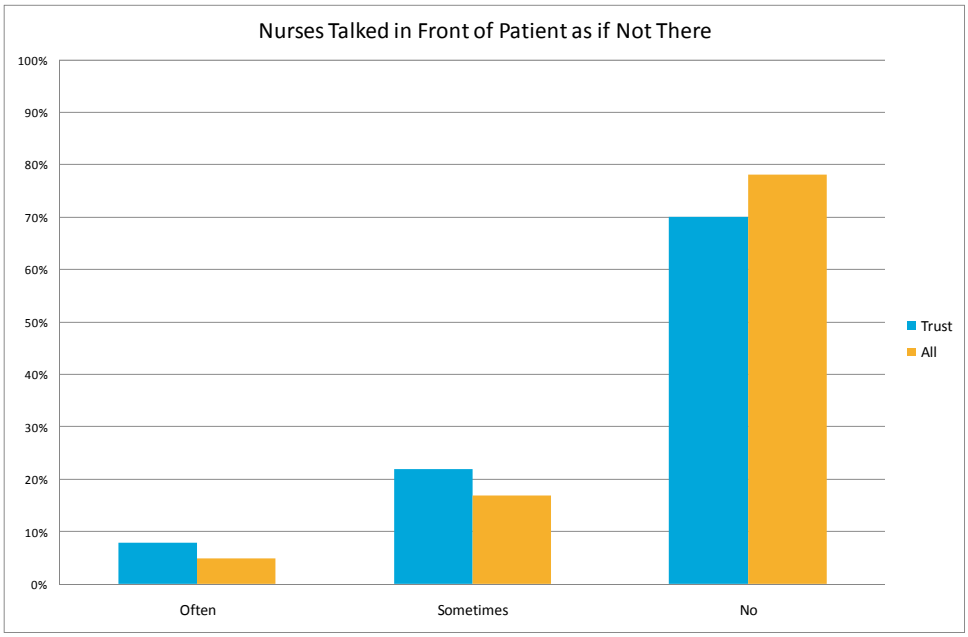
Comparison over time for this question:



NURSES' ATTITUDE TO PATIENTS

Did nurses talk in front of you as if you weren't there?

8% of patients said that nurses often talked in front of them as if they were not there; 70% said they did not.



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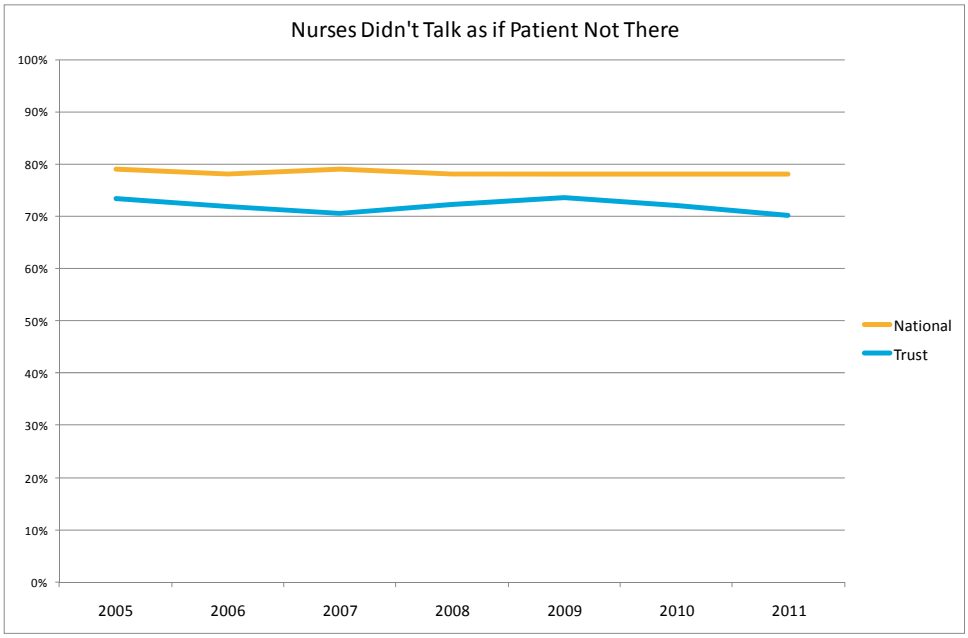
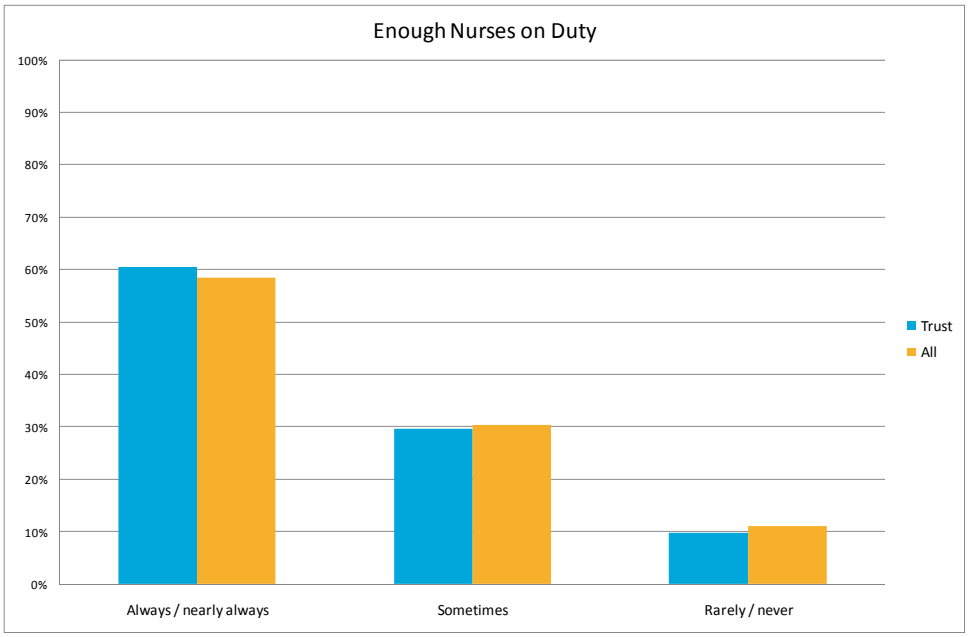


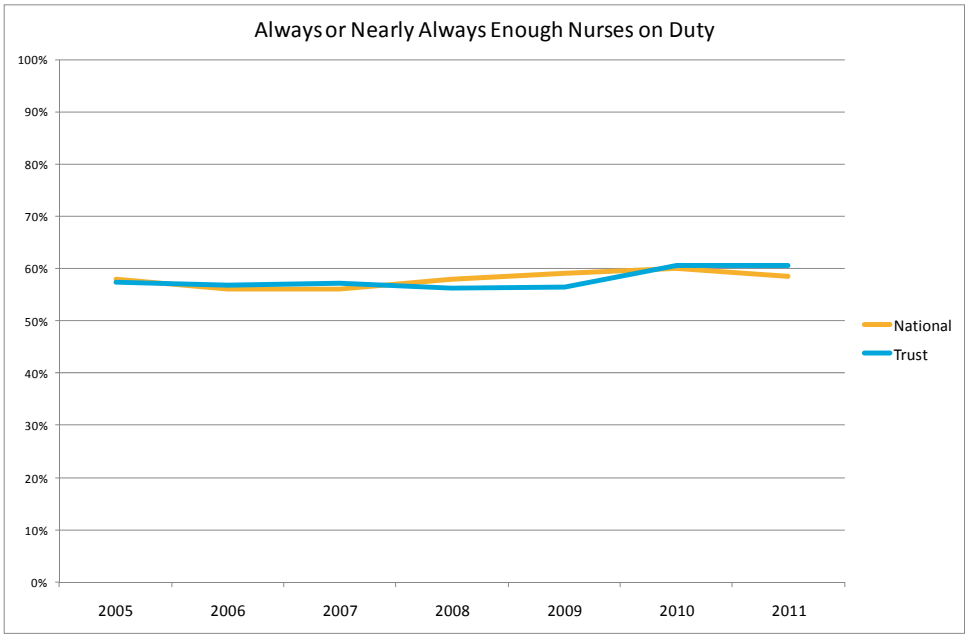
ENOUGH NURSES

In your opinion, were there enough nurses on duty to care for you in hospital?

61% of patients said there were always or nearly always enough nurses on duty to care for them; 10% said there rarely or never were enough.



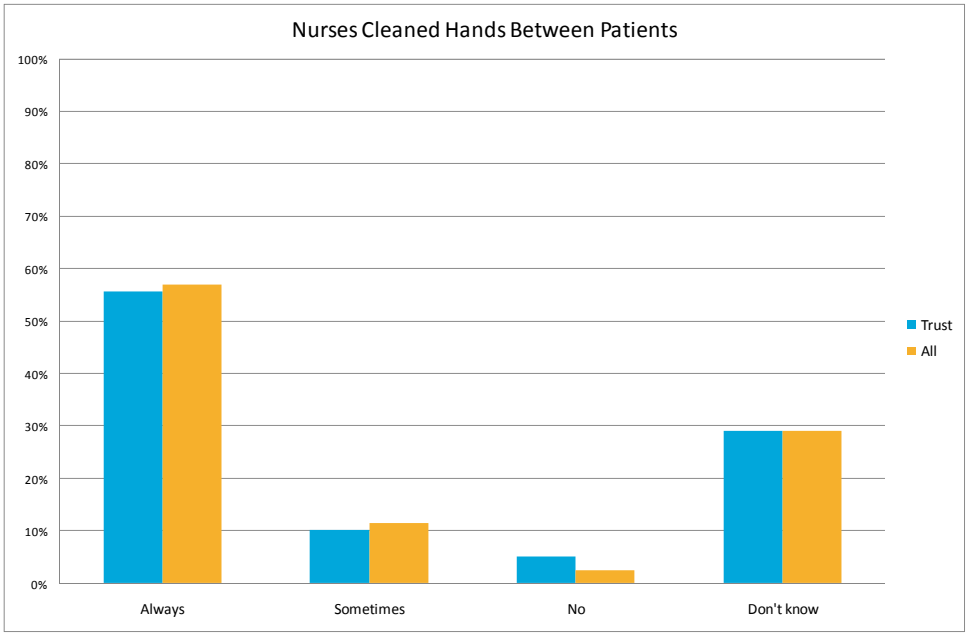
Comparison over time for this question:



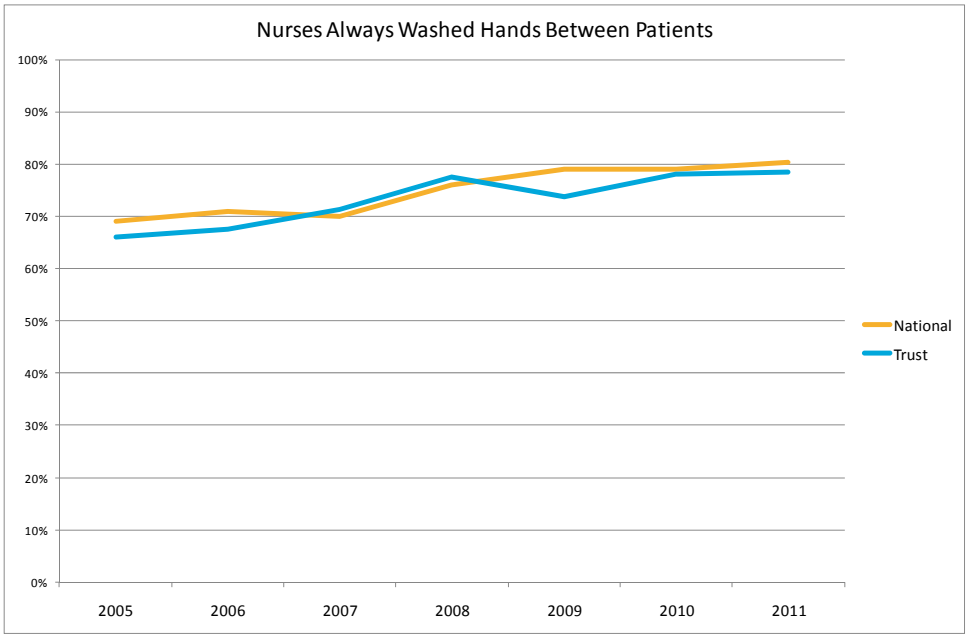
HYGEINE

As far as you know, did nurses wash or clean their hands between touching patients?

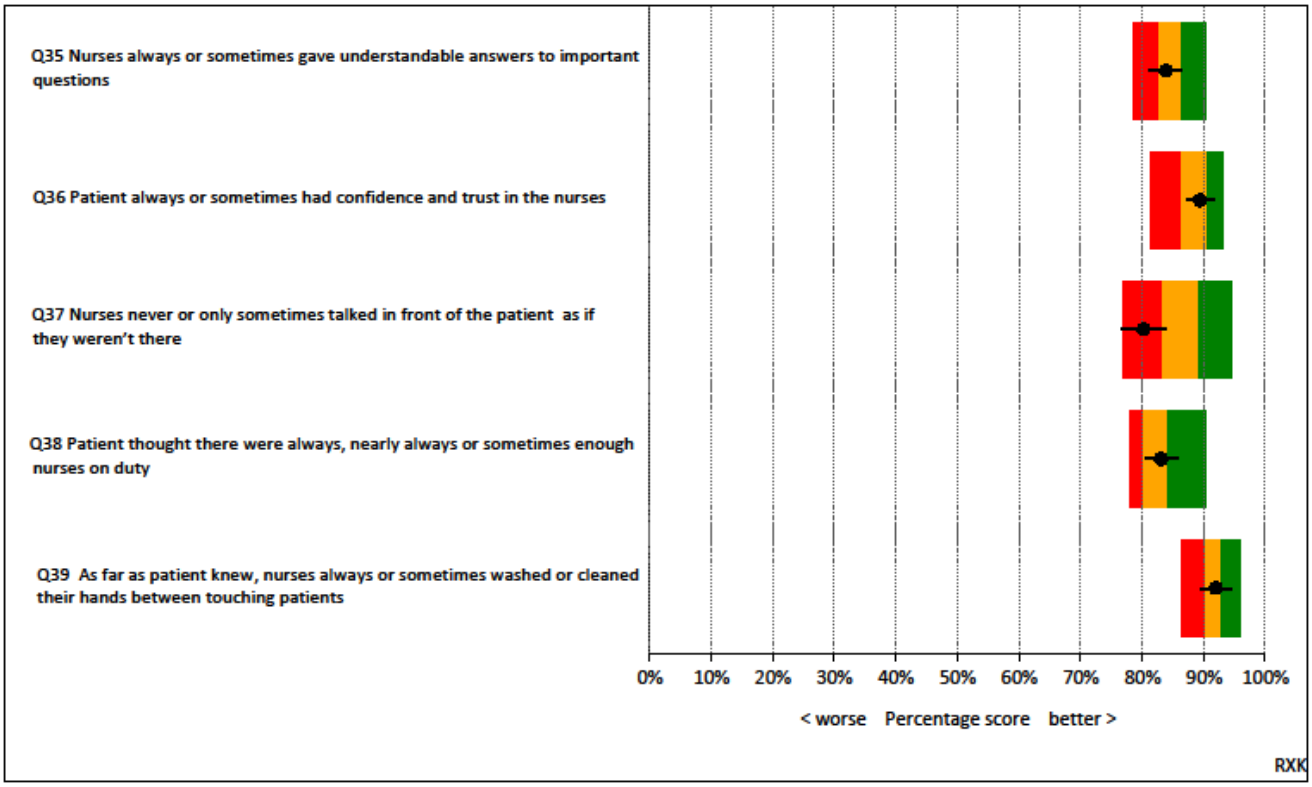
56% of patients said that, as far as they knew, nurses always washed or cleaned their hands between touching patients; 5% said they did not wash or clean them. 29% did not know if they did or not.



Comparison over time for this question:



SUMMARY AND ACTIONS



Question	2010 percentage for this Trust	2011 percentage for this Trust	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Scored % in lowest 20% of Trusts
Q35 Nurses always or sometimes gave understandable answers to important questions	84%	84%	83%	86%	
Q36 Patient always or sometimes had confidence and trust in the nurses	88%	89%	86%	91%	
Q37 Nurses never or only sometimes talked in front of the patient as if they weren't there	82%	80%	83%	89%	+
Q38 Patient thought there were always, nearly always or sometimes enough nurses on duty	83%	83%	80%	84%	
Q39 As far as patient knew, nurses always or sometimes washed or cleaned their hands between touching patients	90%	92%	90%	93%	

ACTIONS:

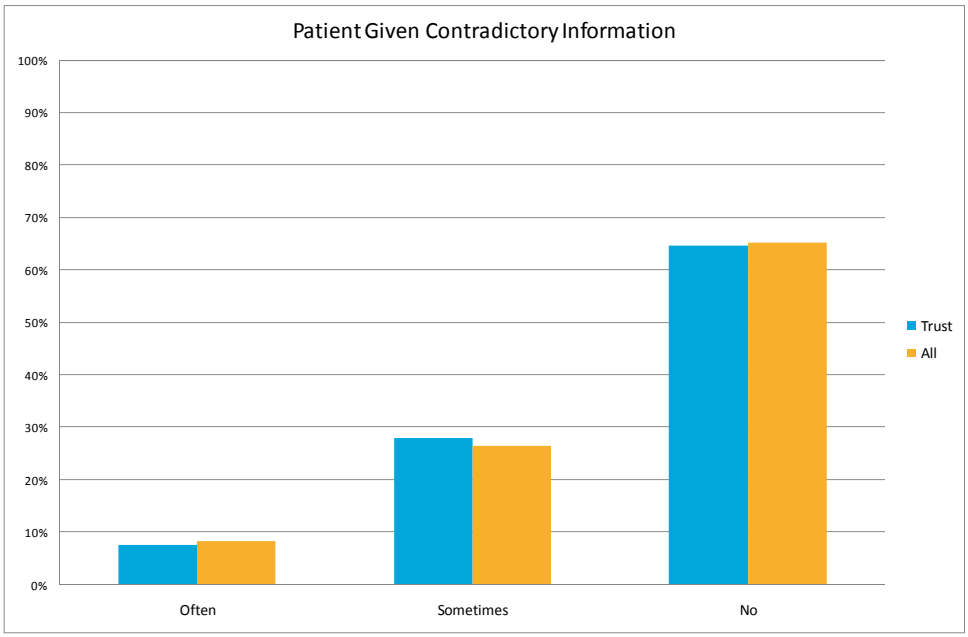
- As with doctors, some patients found information from Nurses hard to understand, or limited in extent. Review communication skills and competences, e.g talking in front of patients as if they weren't there, amongst all nursing staff and especially on induction to the Trust.
- Review staffing levels and skill mix in the light of patient perceptions of nurse staffing levels.
- Reinforce policies on hand washing / use of alcohol gel to all nursing staff and initiate spot checks for compliance.

Your Care and Treatment

Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?

CONTRADICTORY INFORMATION

8% of patients said they were often told one thing by one member of staff and something quite different by another; a further 28% said this sometimes was the case.



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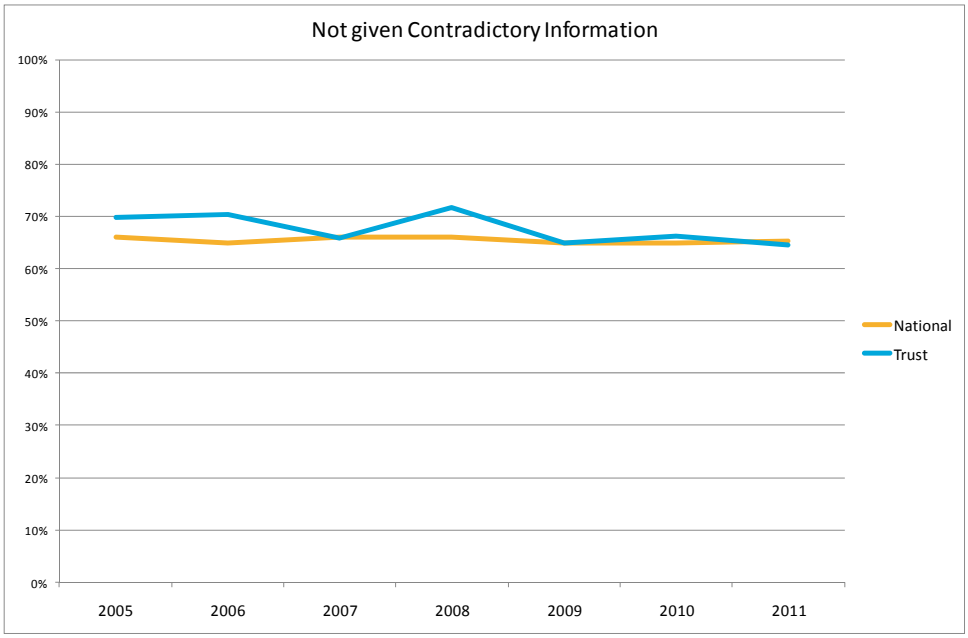
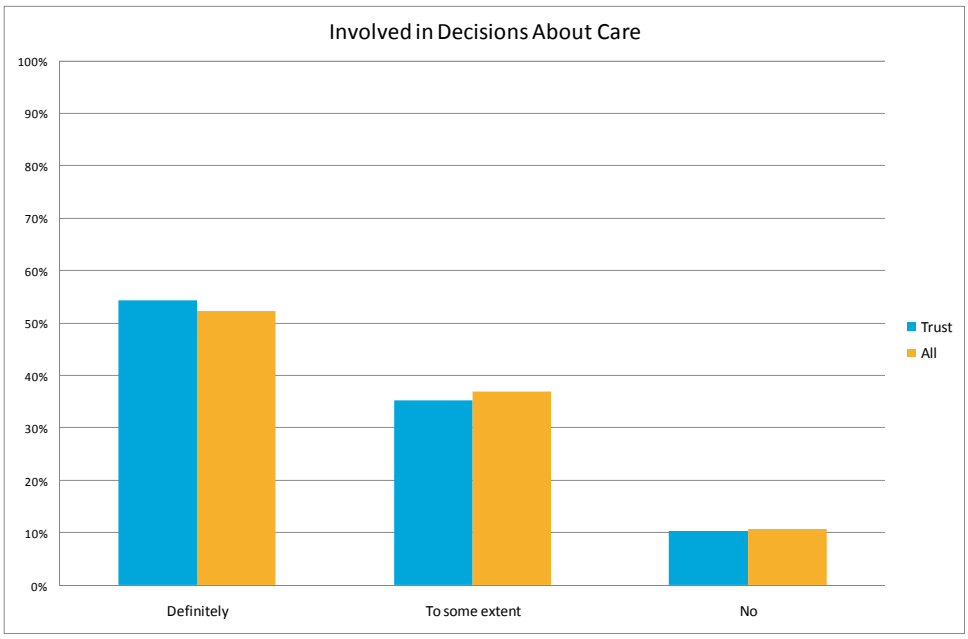


INVOLVED IN DECISION MAKING

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

54% of patients said they were definitely as involved as they wanted to be in decisions about their care and treatment; a further 35% said they were to some extent.



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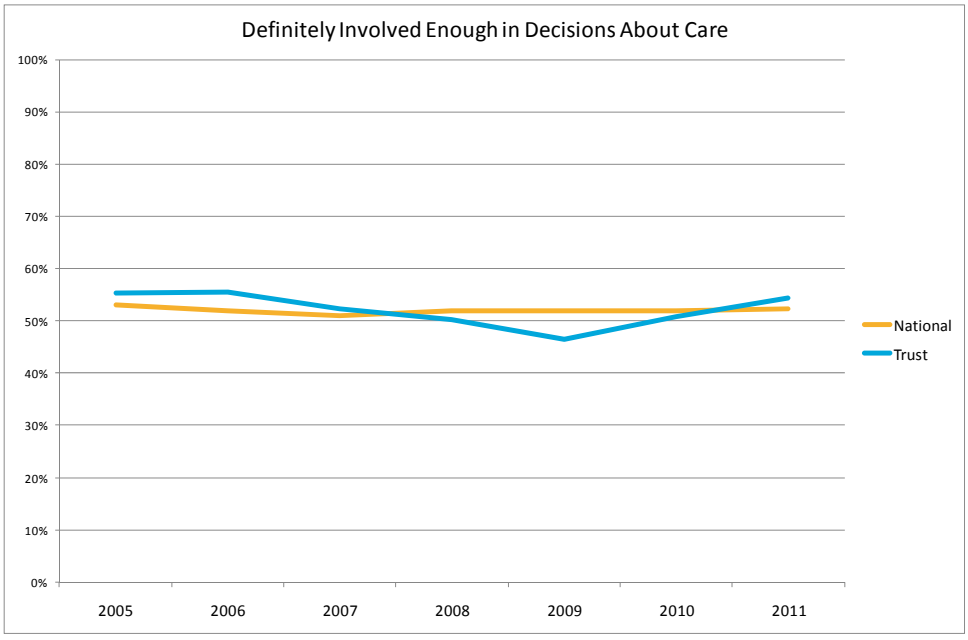
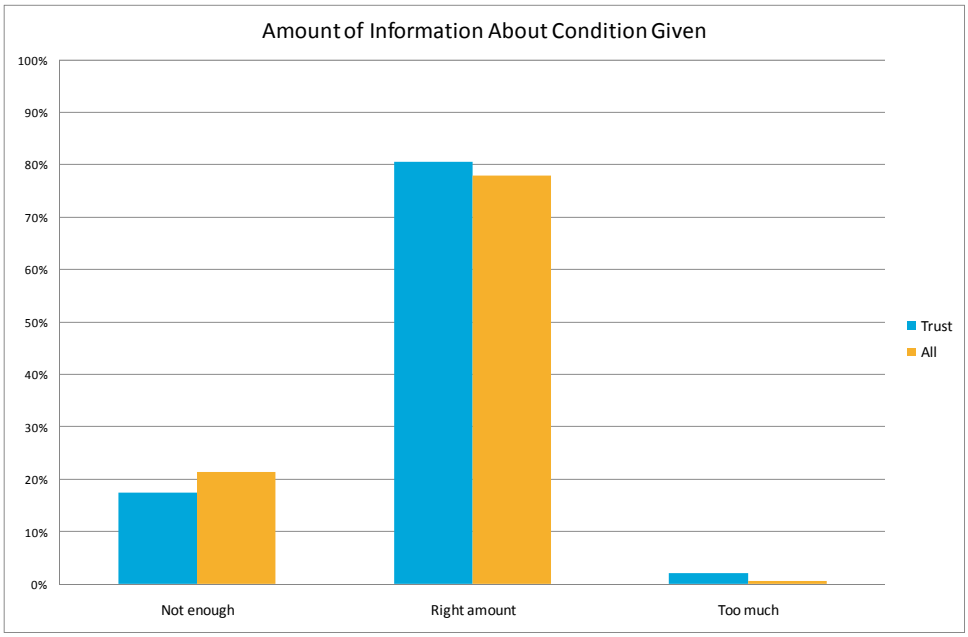


QUANTITY OF INFORMATION

How much information about your condition or treatment was given to you?

17% of patients said they were not given enough information about their condition or treatment; 81% said they were given the right amount.



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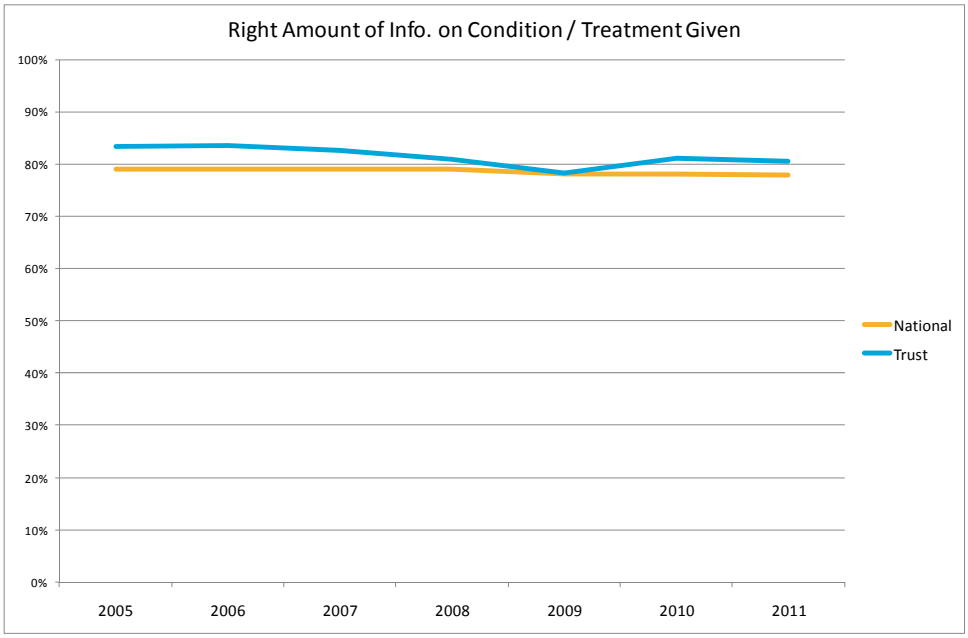
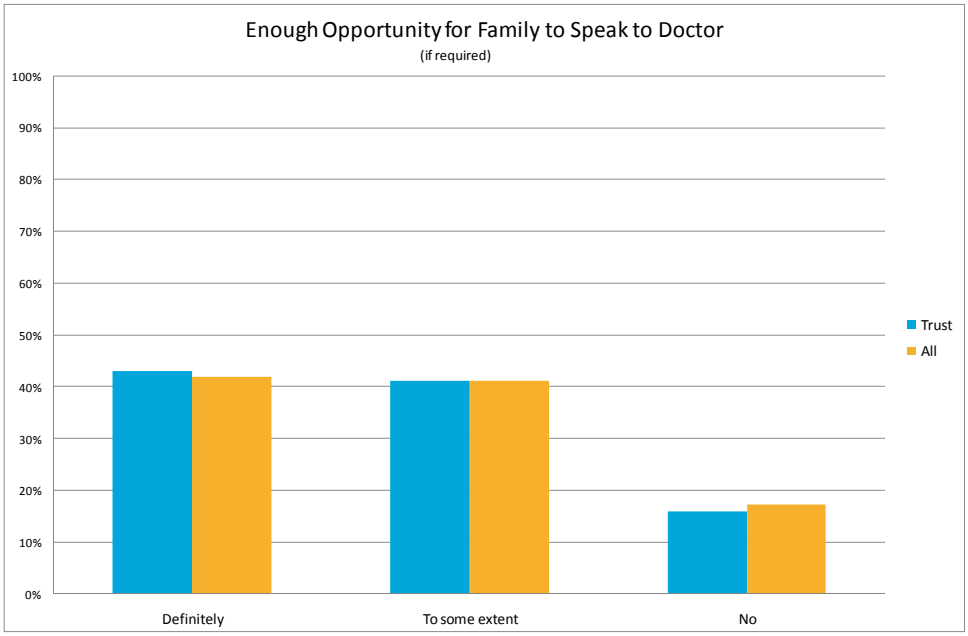


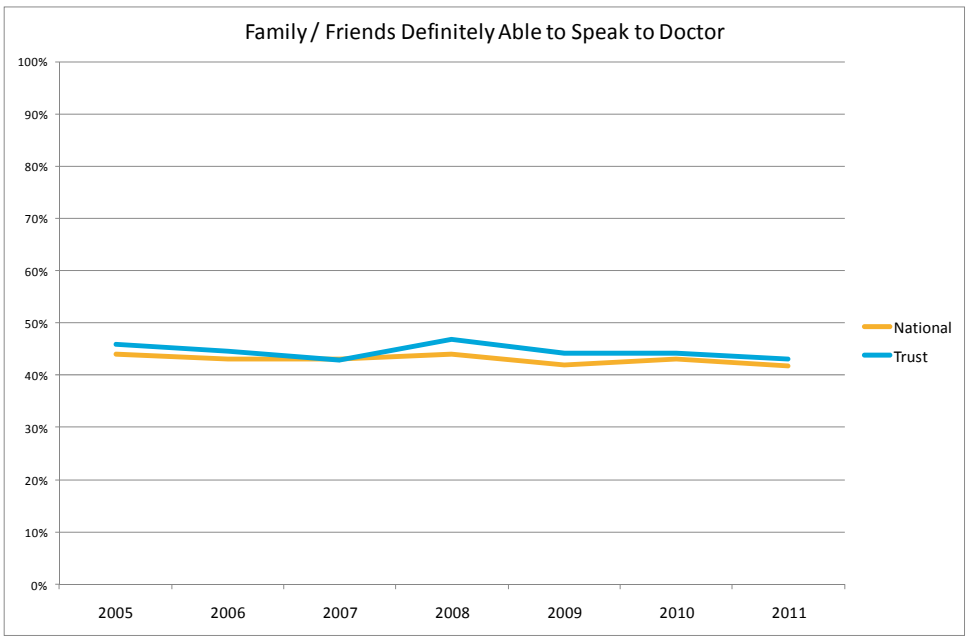
INFORMATION TO FAMILIES

If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?

16% of those patients whose families wanted to talk to a doctor said their family did not have enough opportunity to do so. 43% said they definitely did have enough opportunity and a further 41% said they did to some extent.



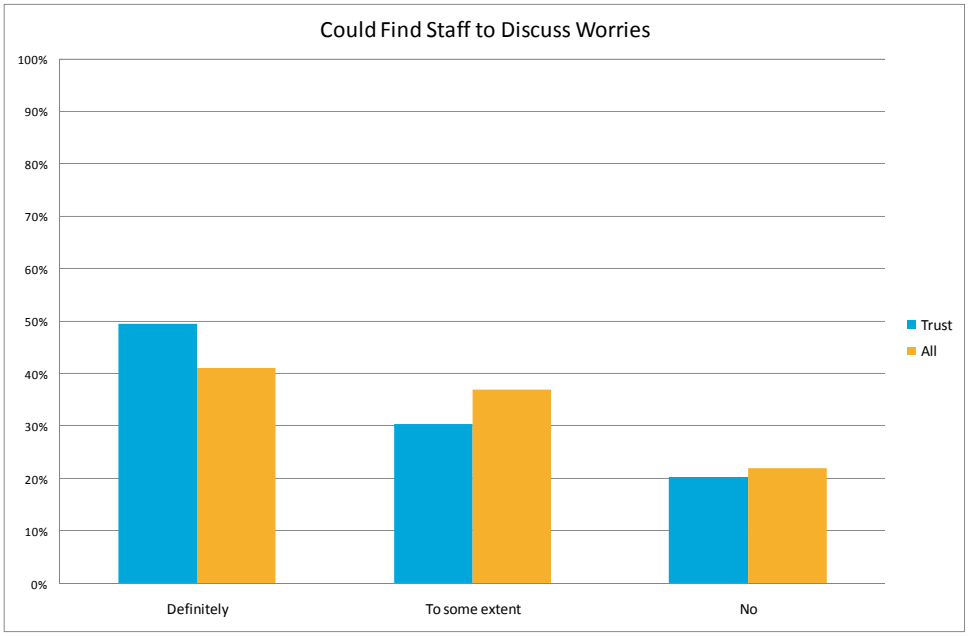
Comparison over time for this question:



DISCUSSING WORRIES AND FEARS

Did you find someone on the hospital staff to talk to about your worries and fears?

Of those patients who had worries or fears, 49% said they definitely found someone on the hospital staff to talk to about them; a further 30% said they did to some extent. 20% of patients said they did not find anyone to talk to.

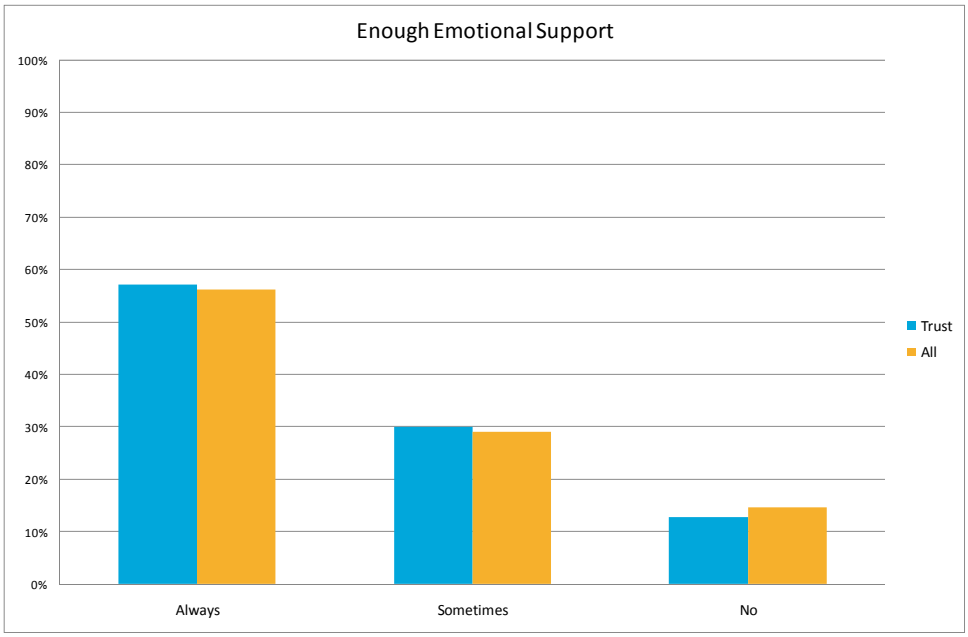


Comparison over time for this question:

EMOTIONAL SUPPORT

Do you feel you got enough emotional support from hospital staff during your stay?

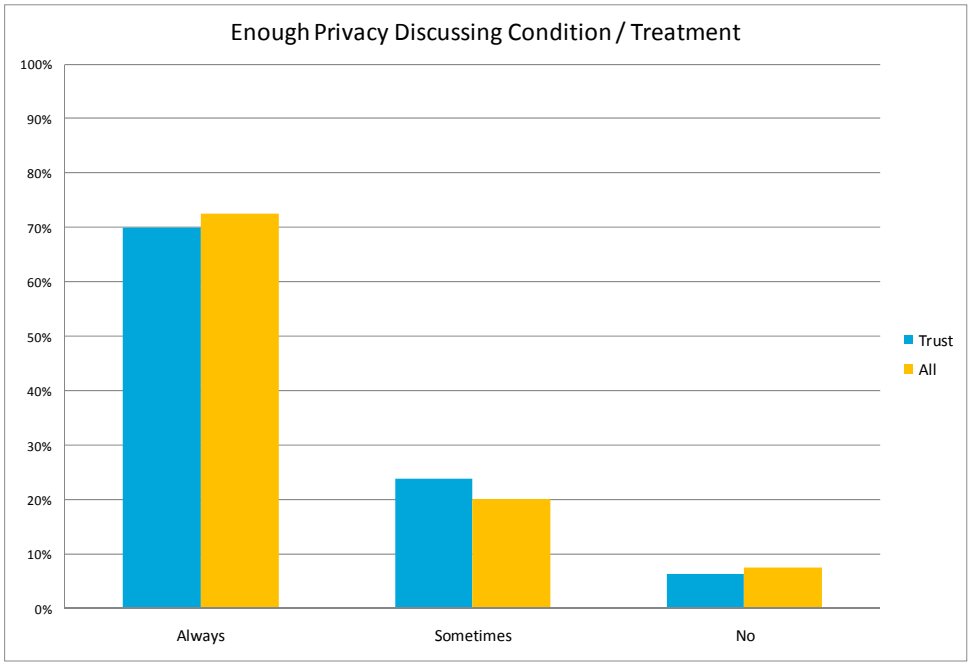
57% of patients felt that they always got enough emotional support from hospital staff during their stay. 13% said that they did not get this support.



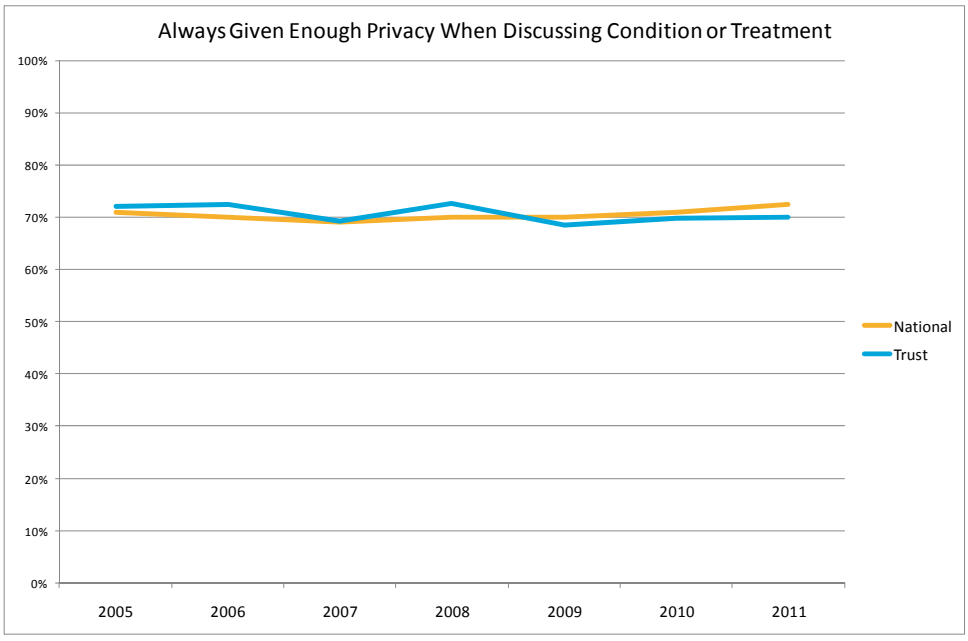
PRIVACY

Were you given enough privacy when discussing your condition or treatment?

70% of patients said they always were given enough privacy when discussing their condition or treatment. 6% said they were not given enough privacy, and a further 24% said they only sometimes were.

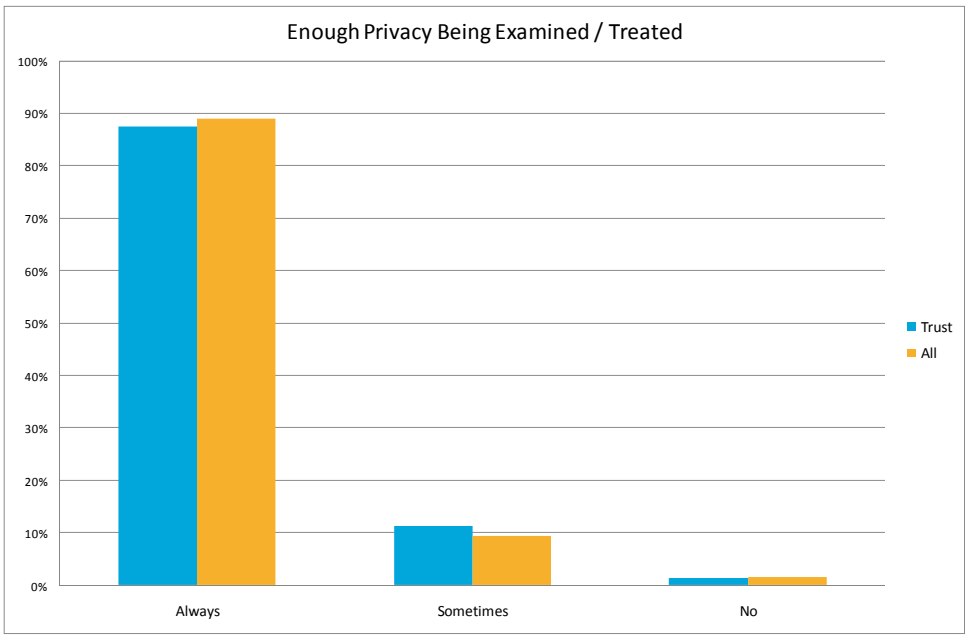


Comparison over time for this question:

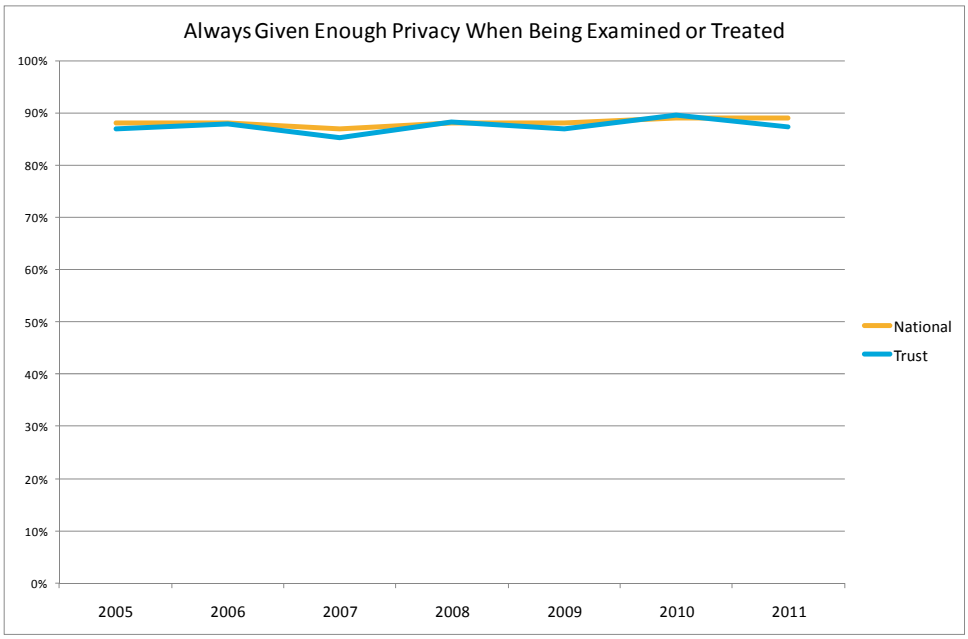


Were you given enough privacy when being examined or treated?

87% of patients felt they were always given enough privacy when being examined or treated. 11% said they sometimes were, and a further 1% said they were not given enough.



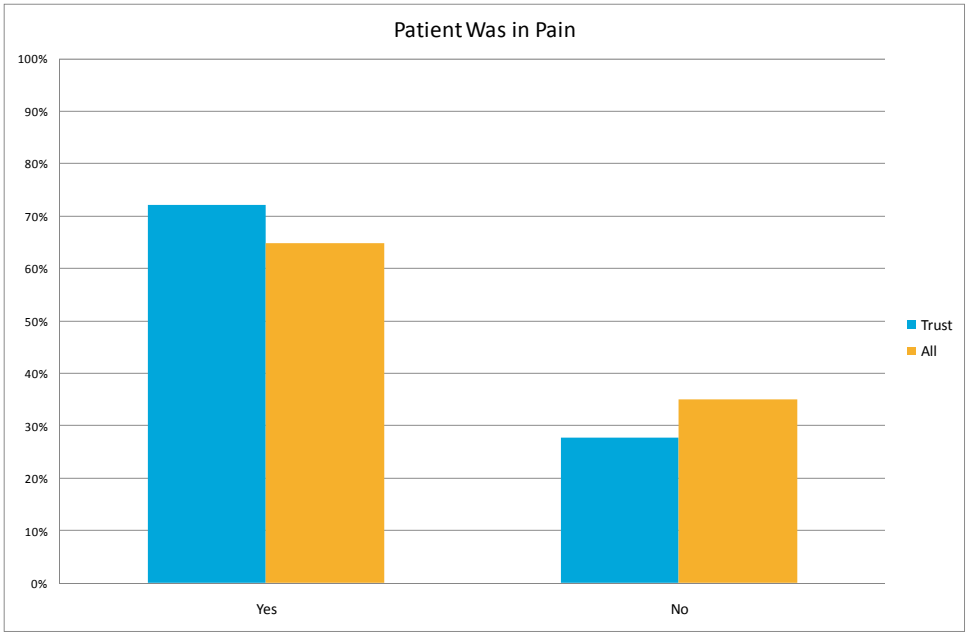
Comparison over time for this question:



PAIN

Were you ever in any pain?

72% of patients said they were in pain during their stay in hospital.



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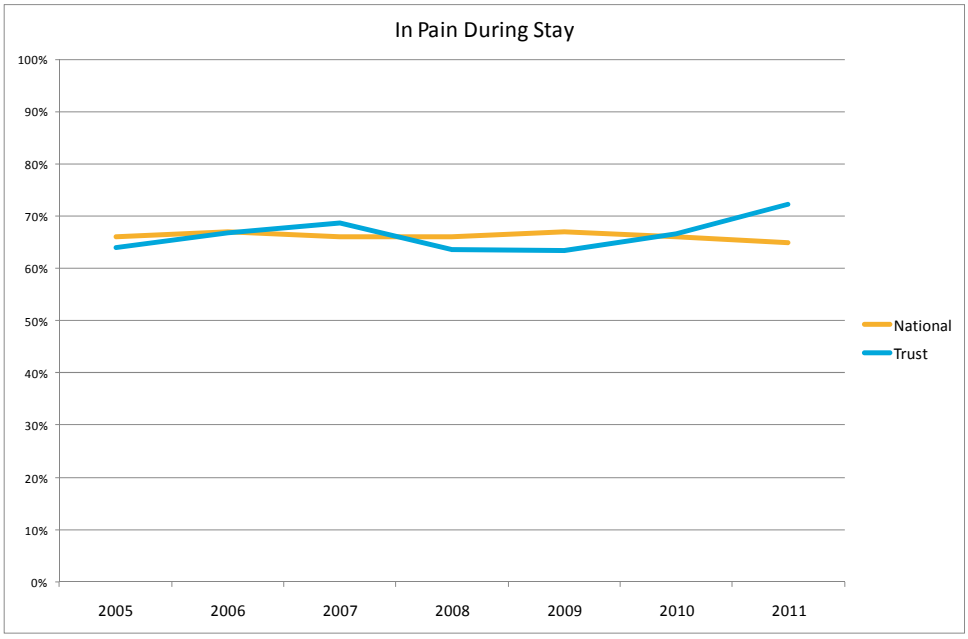
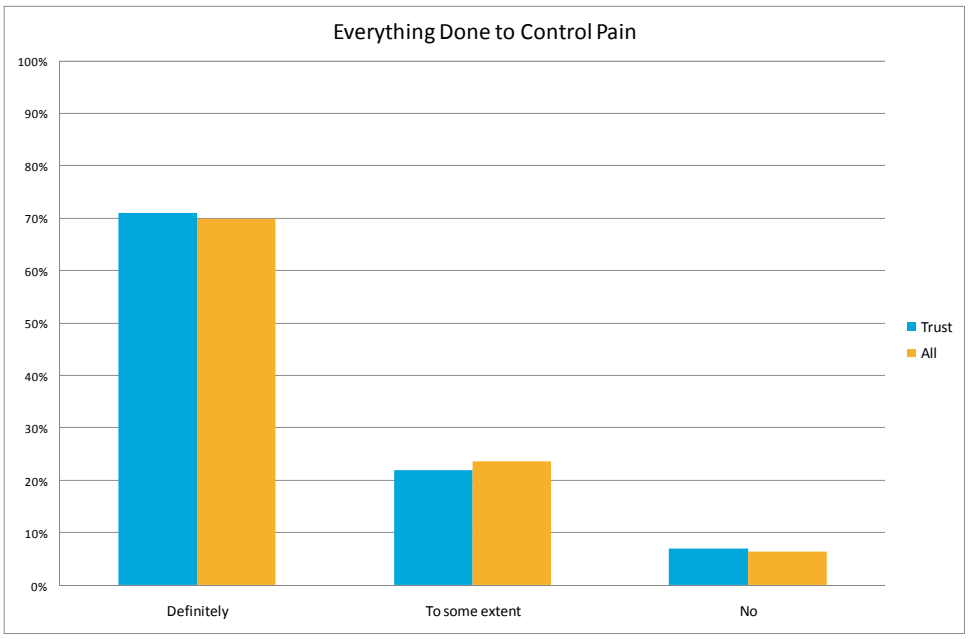
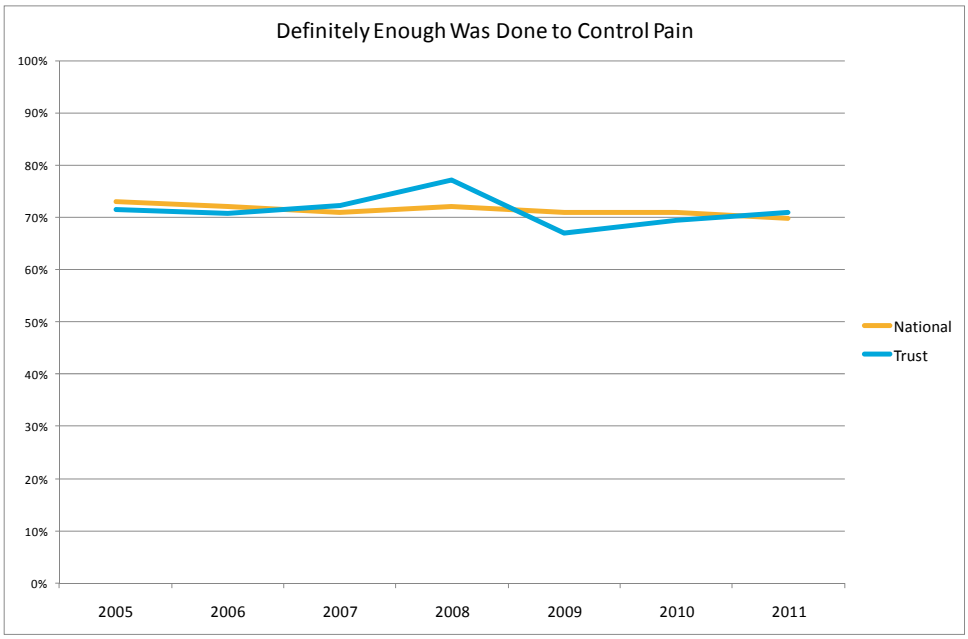


Do you think the hospital staff did everything they could to help control your pain?

71% of patients in pain said hospital staff definitely did everything they could to help control the pain; 7% said they did not do everything they could, and a further 22% said they only did to some extent.



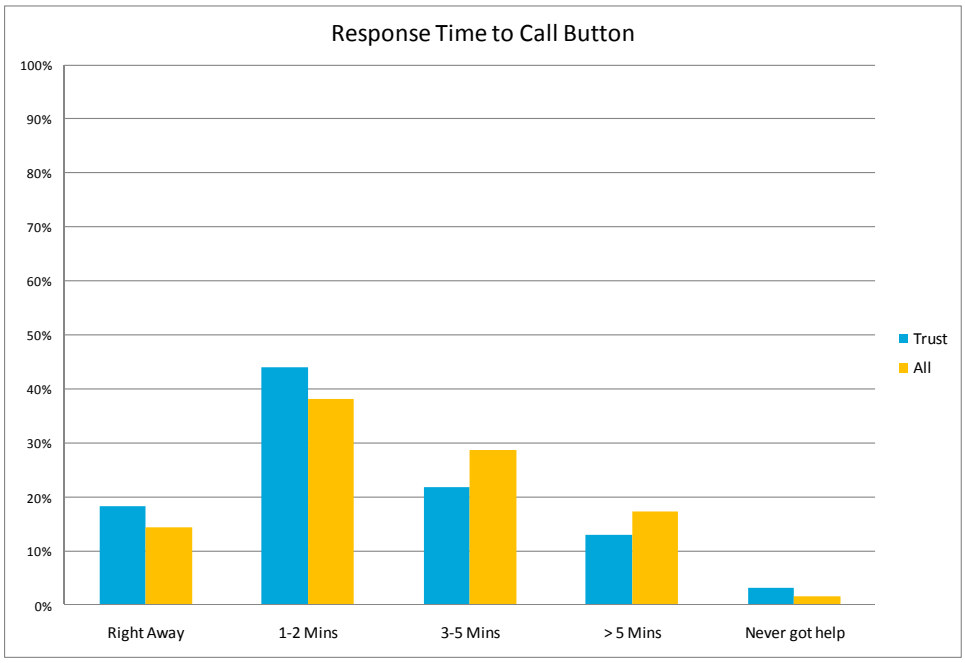
Comparison over time for this question:



USING CALL BUTTONS

How many minutes after you used the call button did it usually take before you got the help you needed?

Patients were asked how long it took after they used the call button for them to receive the help they needed. Of those patients using call buttons, 7 (3%) said they never received the help needed. 13% said they waited more than 5 minutes for help. 62% of patients said they received help either right away, or within 2 minutes; a further 22% received help within 3 to 5 minutes.



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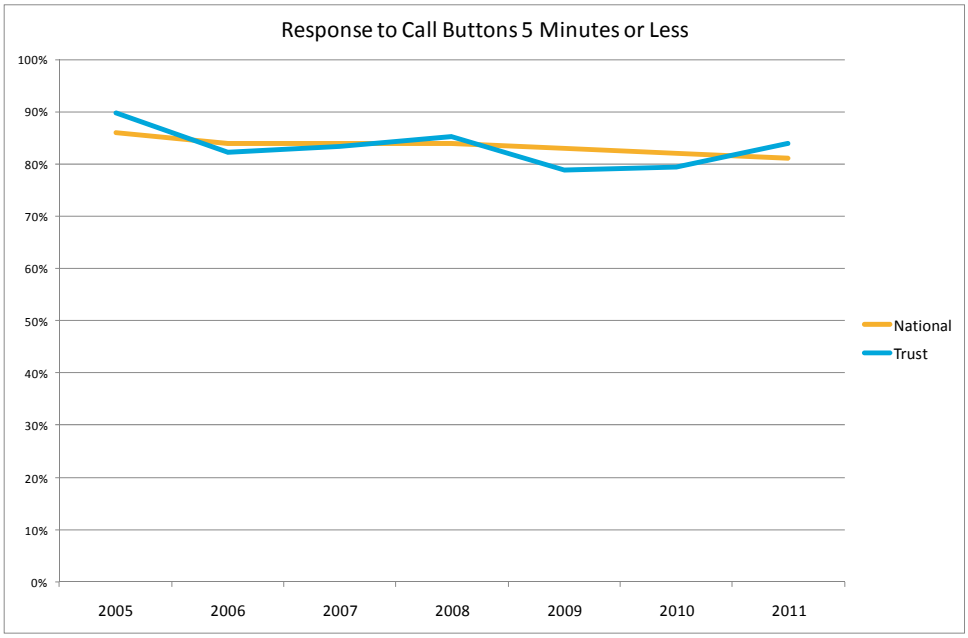
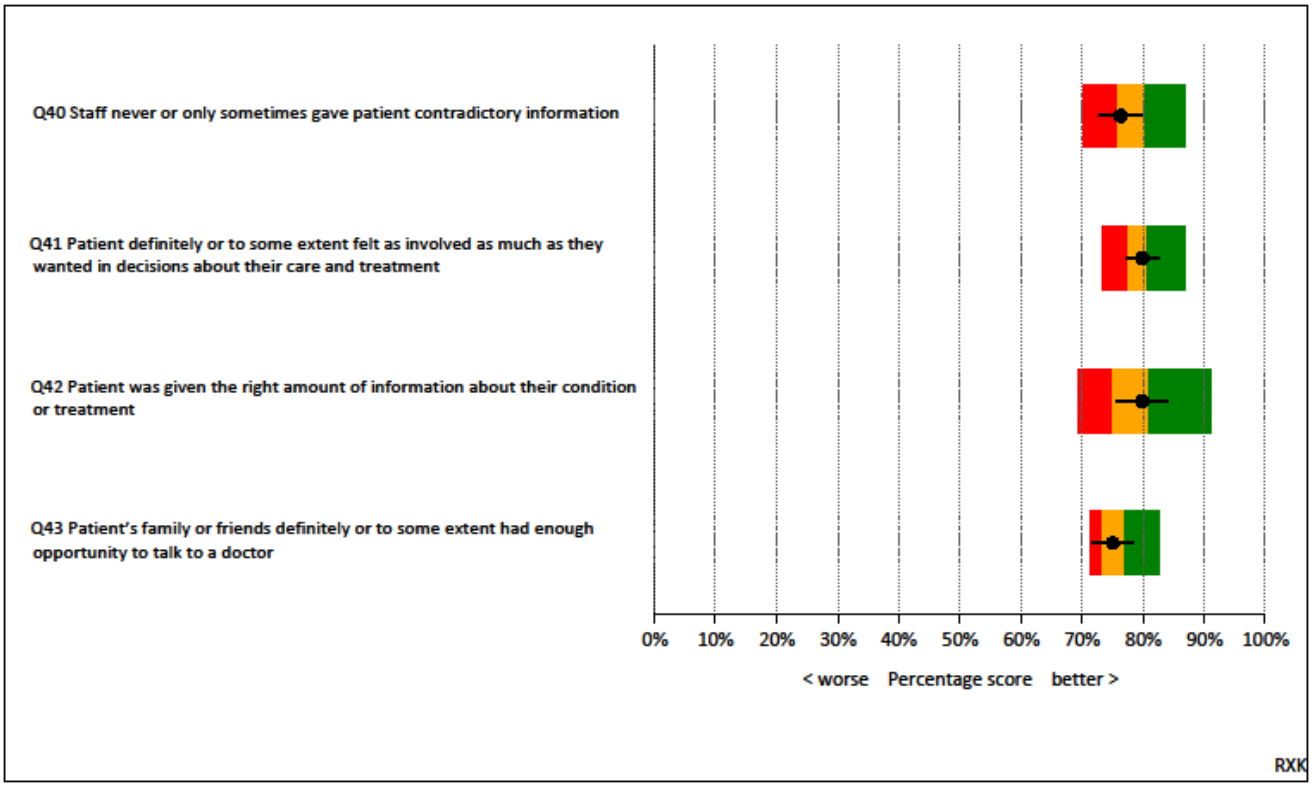
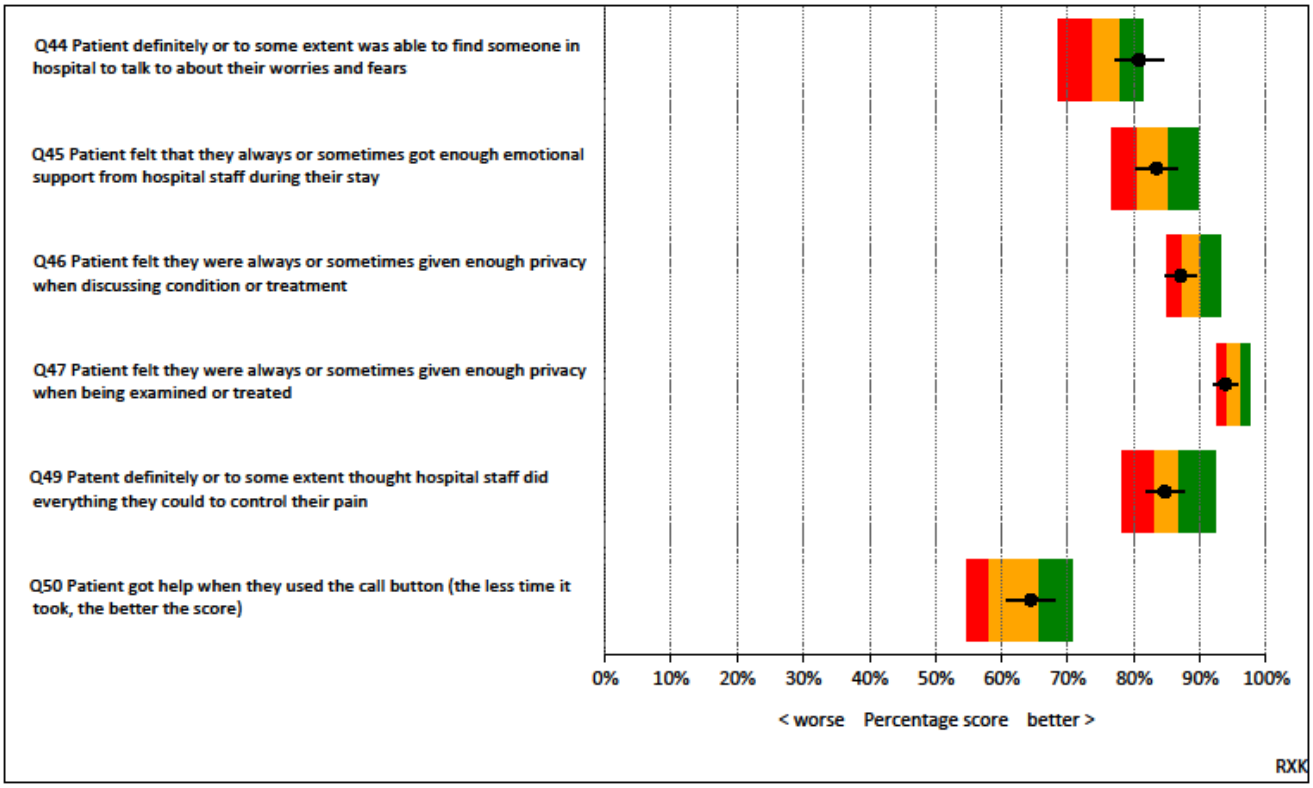


SUMMARY AND ACTIONS



Question	2010 percentage for this Trust	2011 percentage for this Trust	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Scored % in lowest 20% of Trusts
Q40 Staff never or only sometimes gave patient contradictory information	79%	76%	76%	80%	
Q41 Patient definitely or to some extent felt as involved as much as they wanted in decisions about their care and treatment	78%	80%	78%	81%	
Q42 Patient was given the right amount of information about their condition or treatment	81%	80%	75%	81%	
Q43 Patient's family or friends definitely or to some extent had enough opportunity to talk to a doctor	76%	75%	73%	77%	



Question	2010 percentage for this Trust	2011 percentage for this Trust	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Scored % in lowest 20% of Trusts
Q44 Patient definitely or to some extent was able to find someone in hospital to talk to about their worries and fears	75%	81%	74%	78%	
Q45 Patient felt that they always or sometimes got enough emotional support from hospital staff during their stay	-	83%	81%	85%	
Q46 Patient felt they were always or sometimes given enough privacy when discussing condition or treatment	87%	87%	87%	90%	+
Q47 Patient felt they were always or sometimes given enough privacy when being examined or treated	95%	94%	94%	96%	+
Q49 Patent definitely or to some extent thought hospital staff did everything they could to control their pain	87%	85%	83%	87%	
Q50 Patient got help when they used the call button (the less time it took, the better the score)	60%	64%	58%	66%	

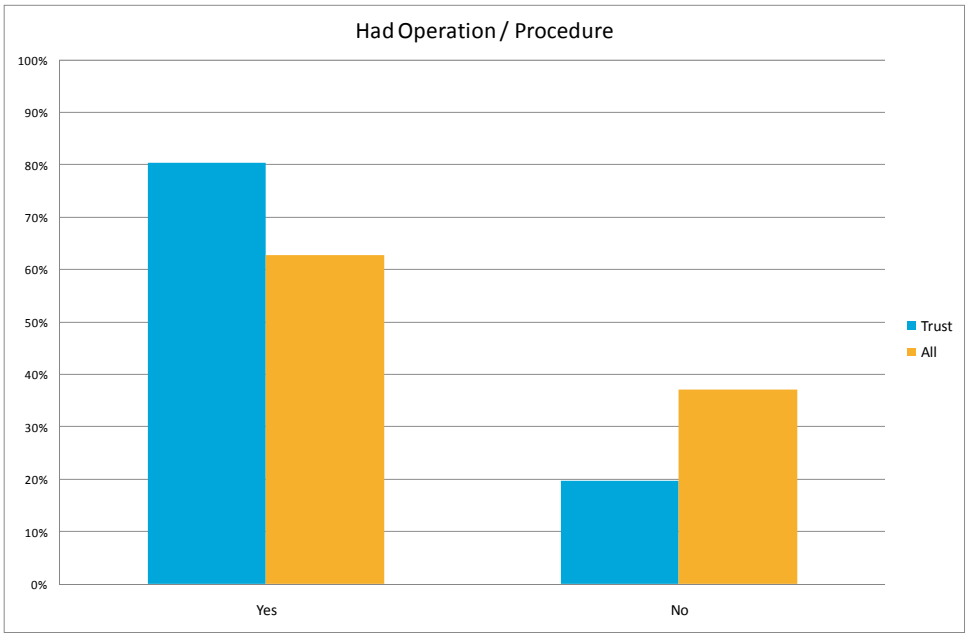
ACTIONS:

- Some patients said that one member of staff would say one thing and another would say something quite different. Discuss with nurses and doctors methods by which reduction in the amount of conflicting information given to patients can be achieved.
- Many patients would like to be more involved in decisions made about their care. This view is probably linked to the feeling that some patients have that doctors and nurses talk in front of them as if they were not there. Review methods by which staff can involve patients in decisions about their care and treatment.
- Improve the quality and simplicity of written information available to patients on the ward. Consider appointing an information lead on each ward from existing staff.
- Some patients' families were said not to have had the opportunity to talk to a doctor. Ensure that appropriate signs are placed on all wards indicating that family can speak to a relevant clinician. Review the admission process to ensure that all patients are aware that their family can have such conversations with clinicians.
- Ensure that patients know there is a member of staff to talk to if they have any worries or fears, or need emotional support.
- There was some criticism of privacy particularly when discussing condition or treatment. Examine ways of improving privacy around the patient's bed, where most such discussions take place.
- Examine the location and reasons for poor pain control on wards, giving due weight to concentrations of concern in particular specialties and locations.
- Review reasons why some patients have waits of more than 5 minutes when using call buttons.

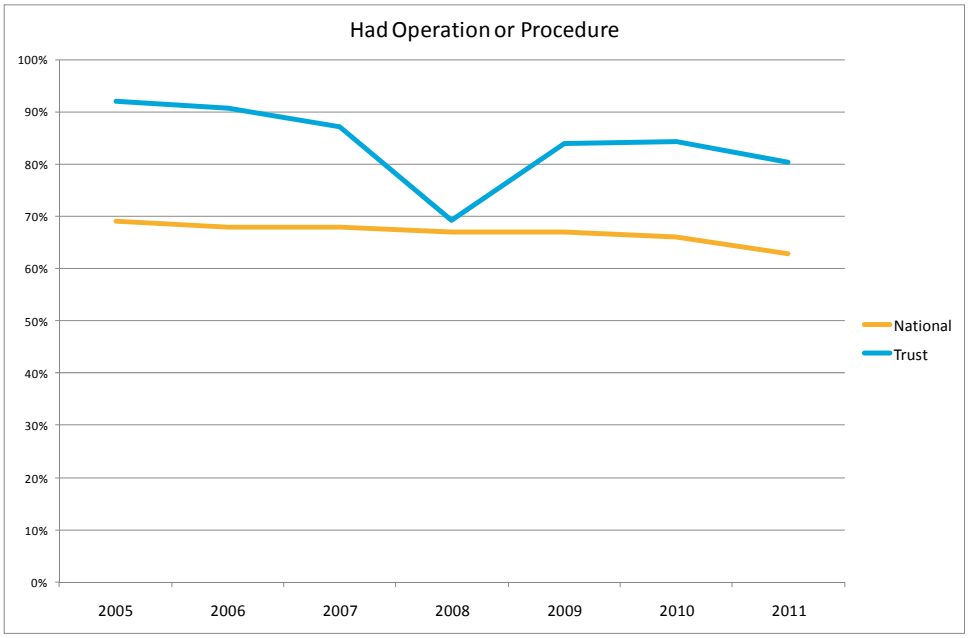
Operations and Procedures

During your stay in hospital, did you have an operation or procedure?

80% of patients said they had an operation or procedure during their stay in hospital.



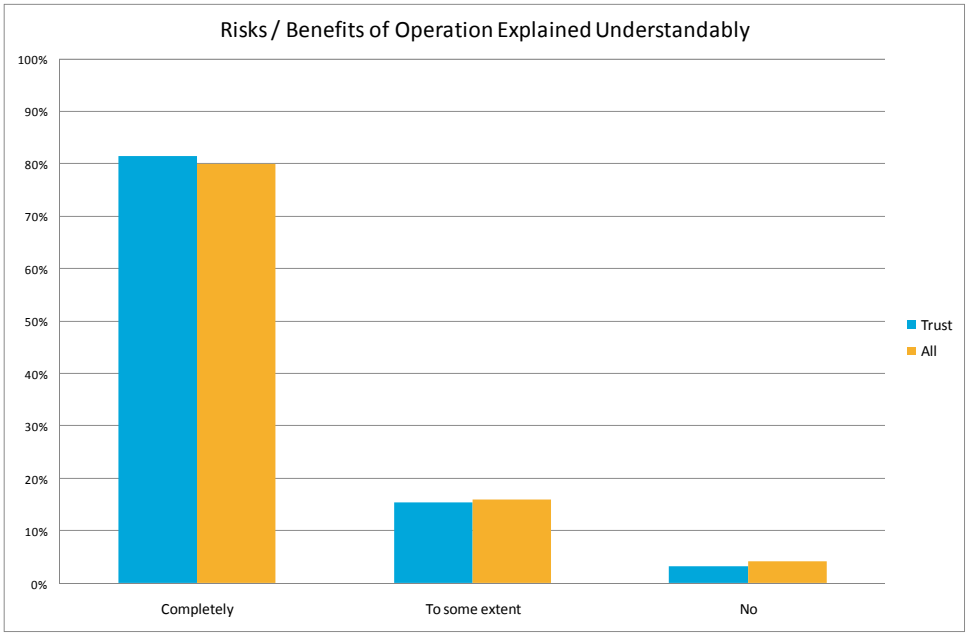
Comparison over time for this question:



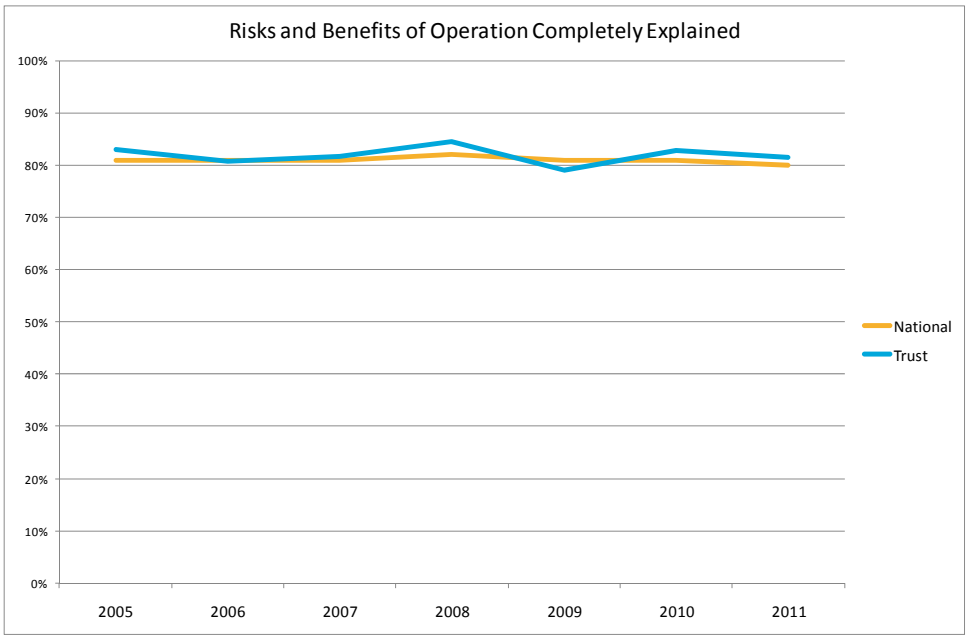
INFORMATION BEFOREHAND

Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?

Of those patients having operations or procedures who wanted explanations, 81% said staff explained the risks and benefits completely in a way they could understand; 3% said they were not explained.

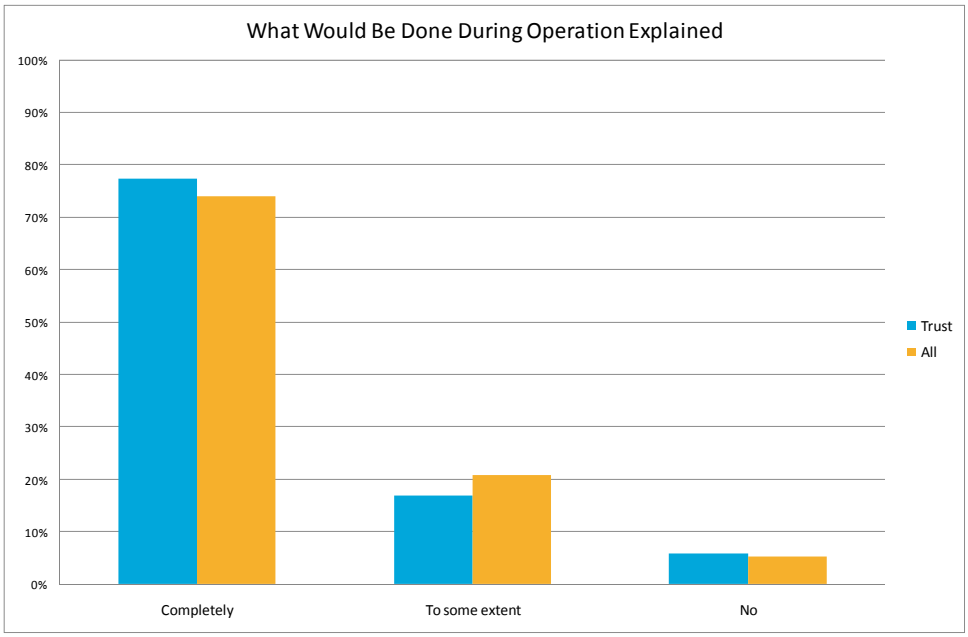


Comparison over time for this question:

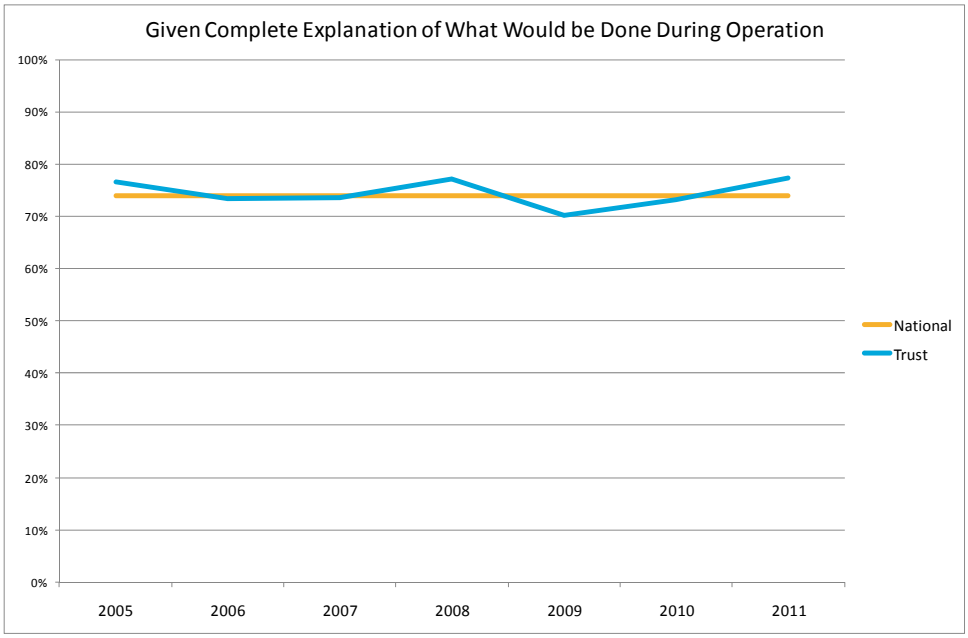


Beforehand, did a member of staff explain what would be done during the operation or procedure?

Patients were also asked if staff explained what would be done during the operation or procedure. 77% said staff explained what would be done completely in a way they could understand; 6% said this was not explained.

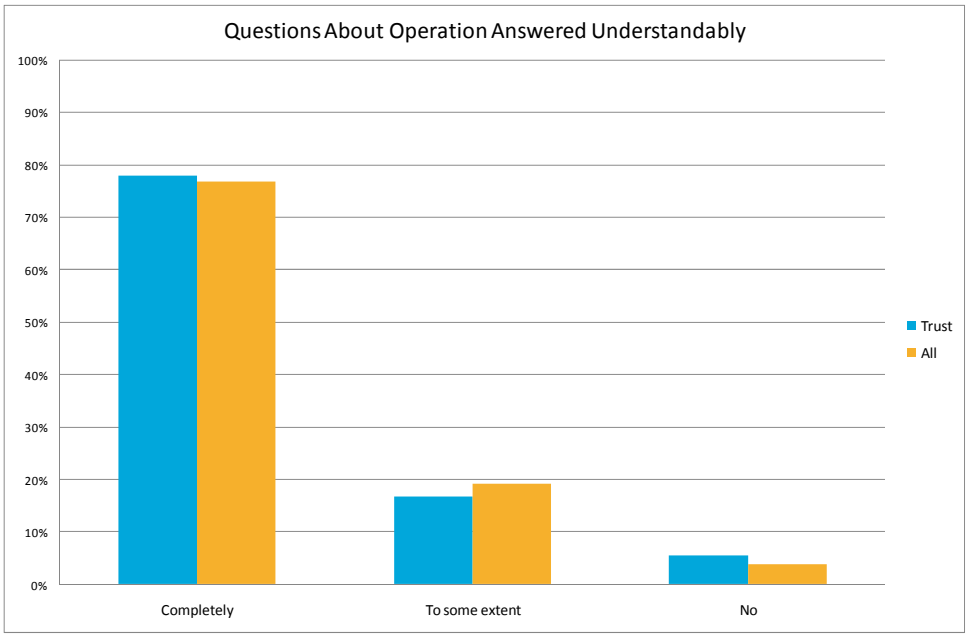


Comparison over time for this question:



Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?

78% of patients who had questions said a member of staff answered them completely in a way they could understand.



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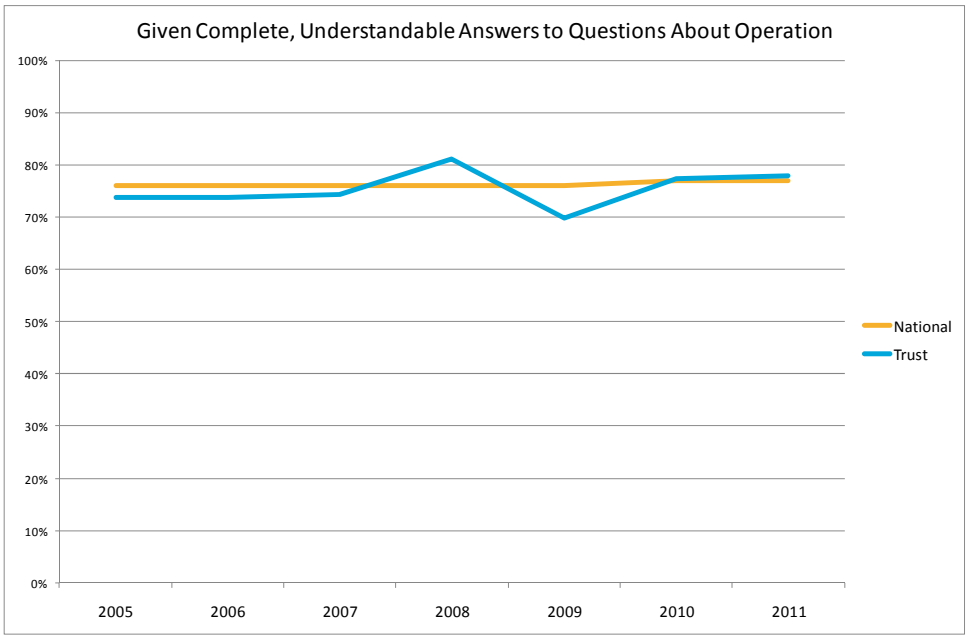
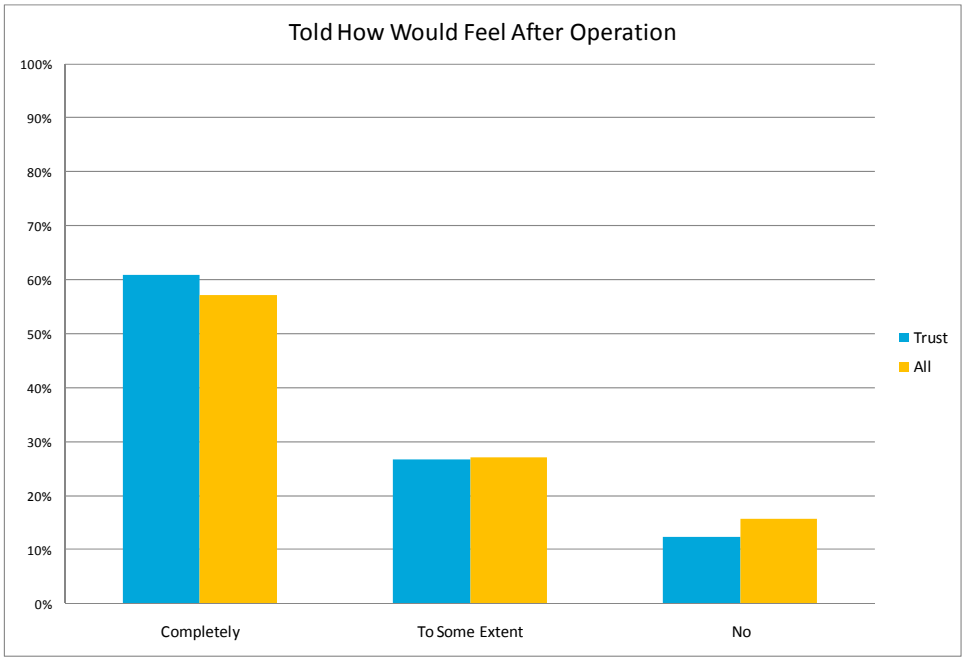


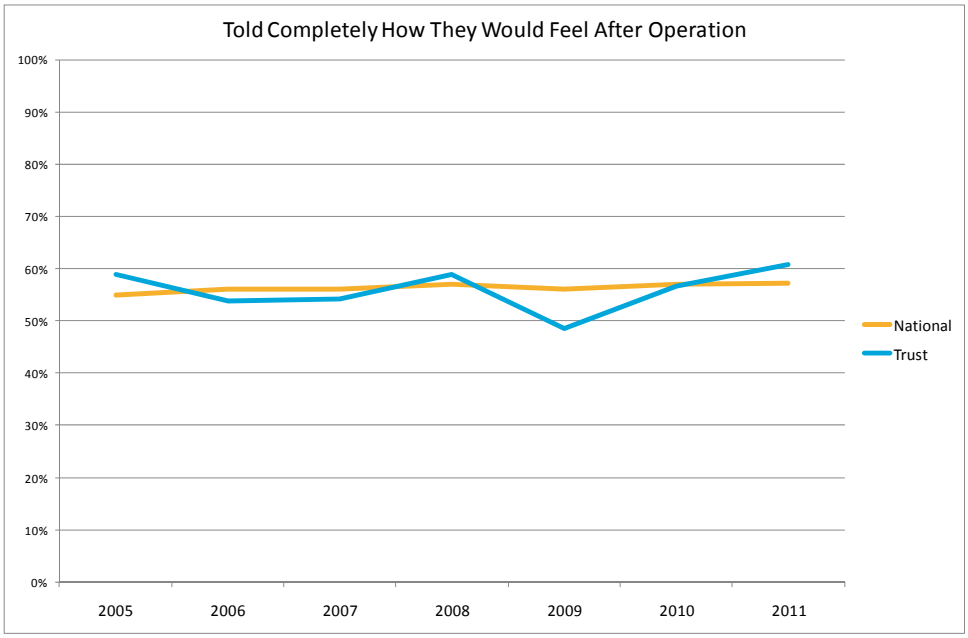
TOLD WHAT TO EXPECT POST OPERATION

Beforehand, were you told how you could expect to feel after you had the operation or procedure?

Patients were asked if they were told how they could expect to feel after they had their operation or procedure. 61% said they were told completely; 12% said they were not told.



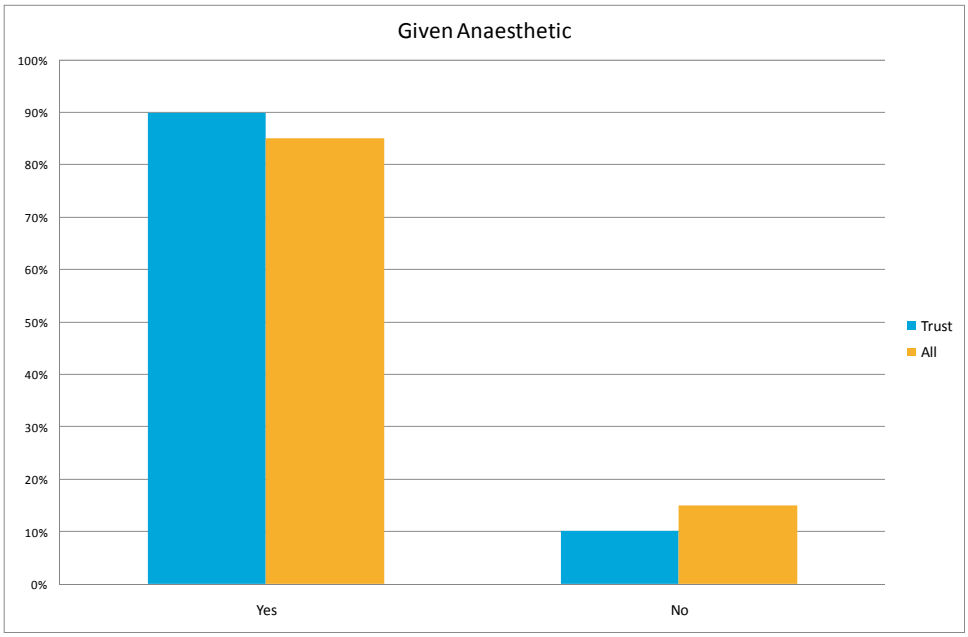
Comparison over time for this question:



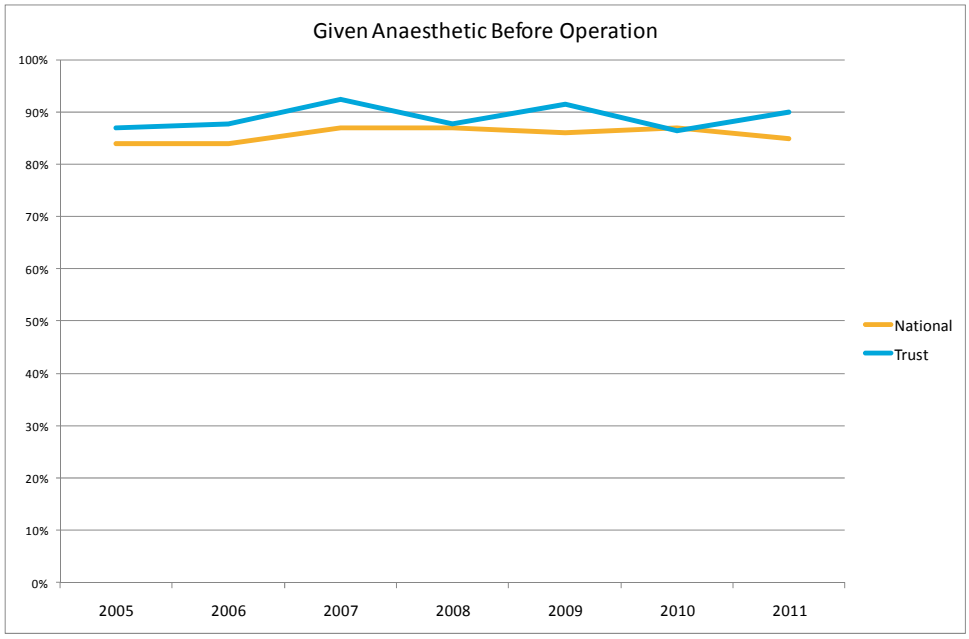
ANAESTHESIA

Before the operation or procedure, were you given an anaesthetic or medication to put you to sleep or control your pain?

90% of patients were given an anaesthetic before their operation or procedure.

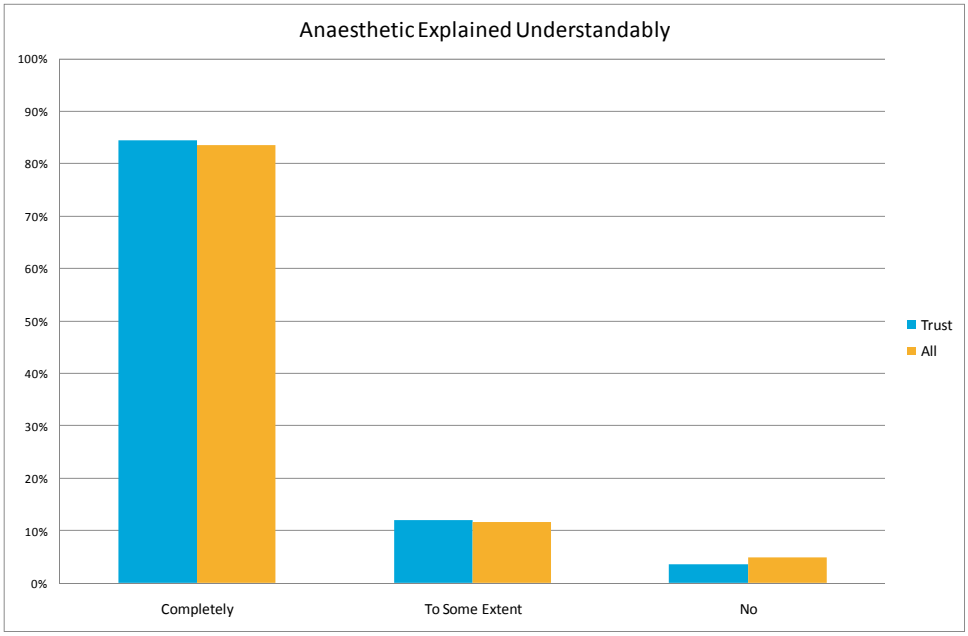


Comparison over time for this question:

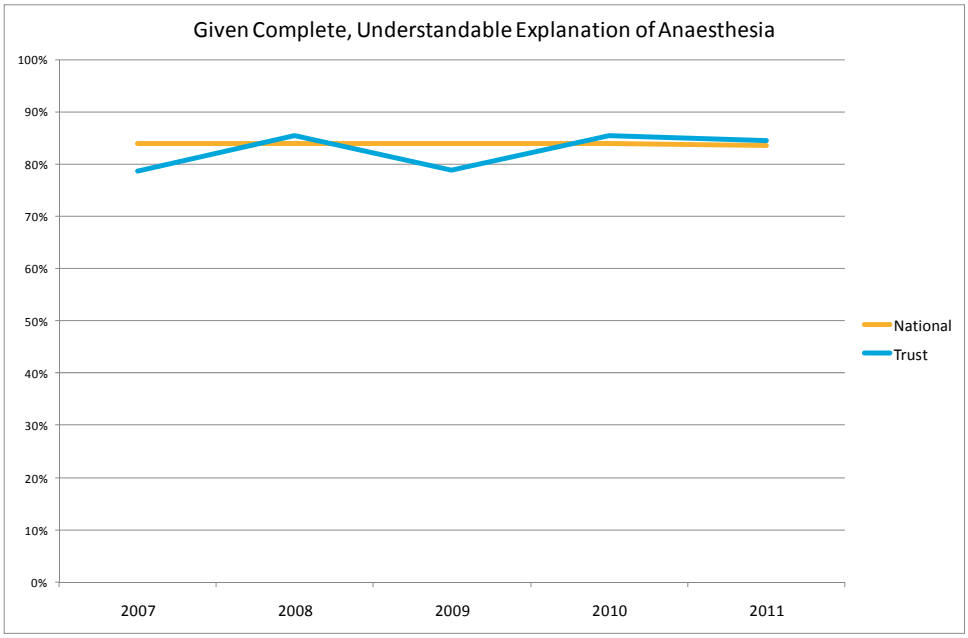


Before the operation or procedure, did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain in a way you could understand?

85% said the anaesthetist or another member of staff explained completely how the anaesthetic would work in a way they could understand.



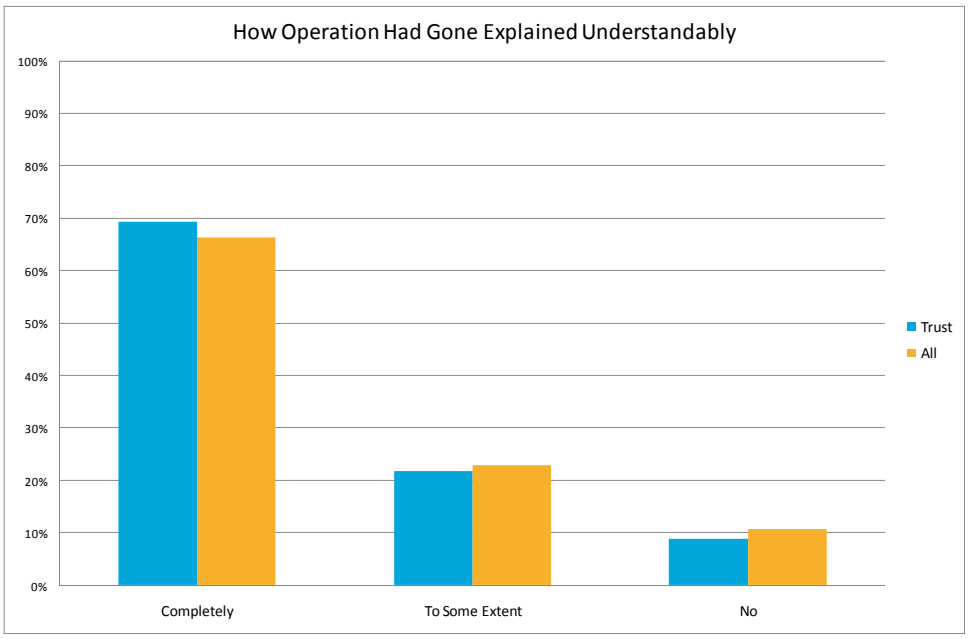
Comparison over time for this question:



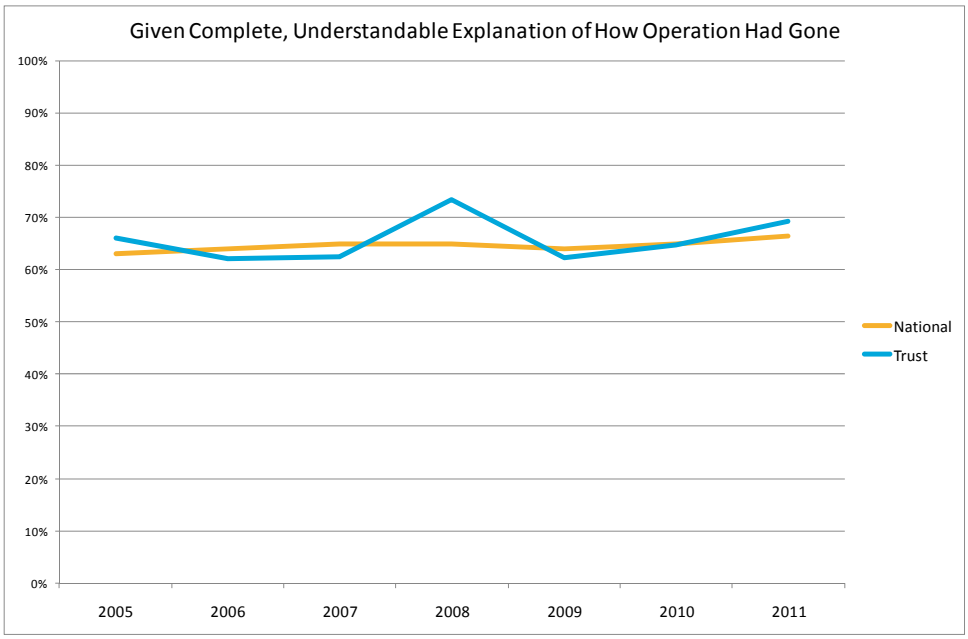
OUTCOME

After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?

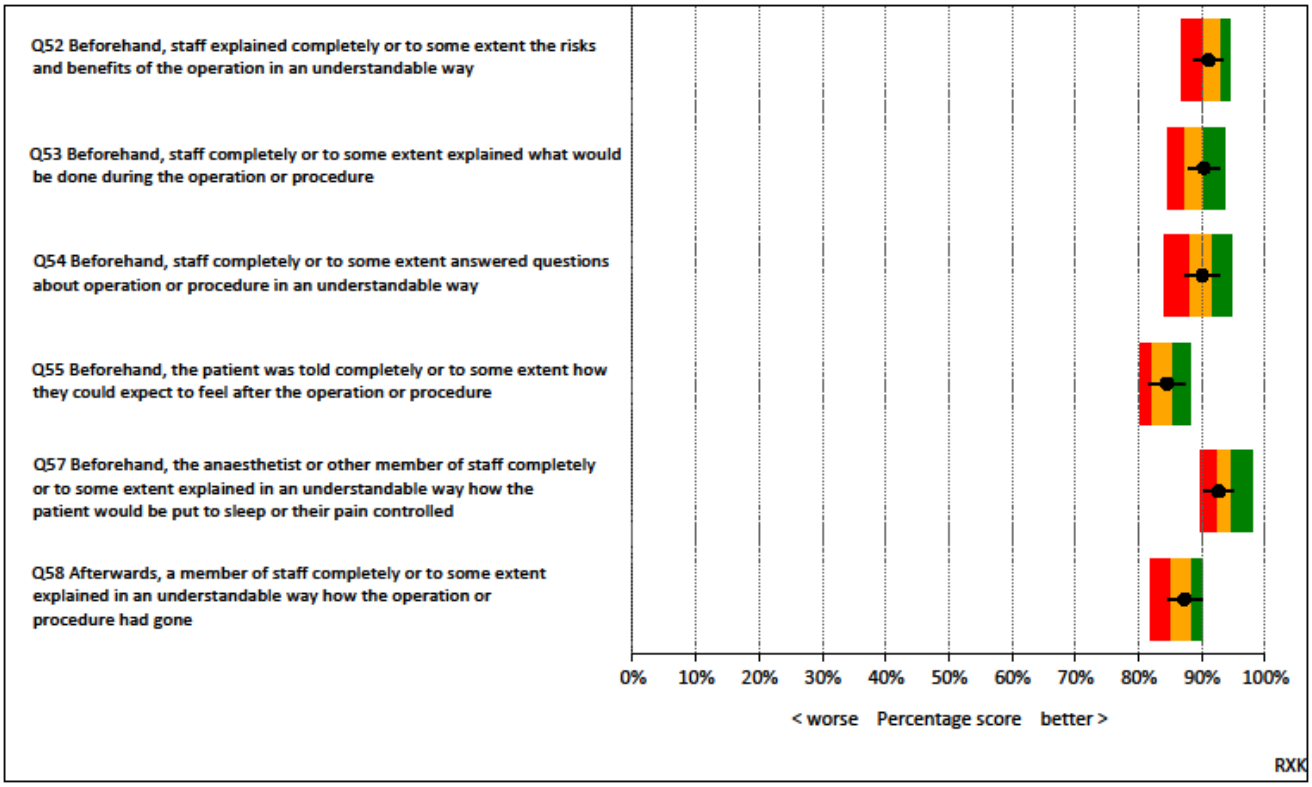
69% of patients said a member of staff had explained completely to them how the operation or procedure had gone in a way they could understand; 9% said it had not been explained.



Comparison over time for this question:



SUMMARY AND ACTIONS



Question	2010 percentage for this Trust	2011 percentage for this Trust	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Scored % in lowest 20% of Trusts
Q52 Beforehand, staff explained completely or to some extent the risks and benefits of the operation in an understandable way	92%	91%	90%	93%	
Q53 Beforehand, staff completely or to some extent explained what would be done during the operation or procedure	87%	90%	87%	90%	
Q54 Beforehand, staff completely or to some extent answered questions about operation or procedure in an understandable way	89%	90%	88%	92%	
Q55 Beforehand, the patient was told completely or to some extent how they could expect to feel after the operation or procedure	84%	84%	82%	85%	

Q57 Beforehand, the anaesthetist or other member of staff completely or to some extent explained in an understandable way how the patient would be put to sleep or their pain controlled	94%	93%	93%	95%	
Q58 Afterwards, a member of staff completely or to some extent explained in an understandable way how the operation or procedure had gone.	87%	87%	85%	88%	

ACTIONS:

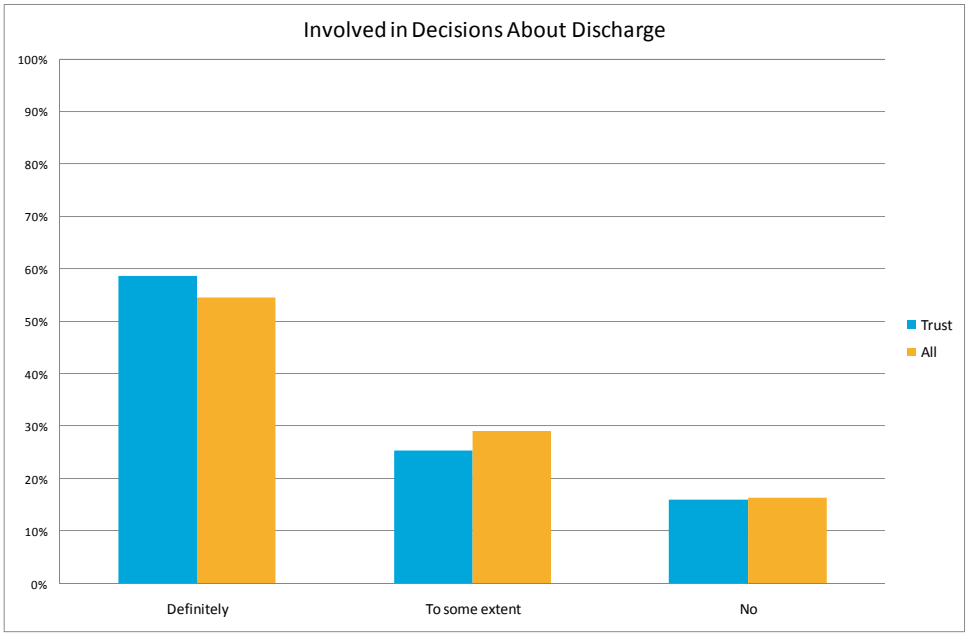
- Ensure that patients are given as much information as they want about what the operation would entail, including anaesthesia and its effects.
- Review methods by which patients are told about post-operative outcomes and how they might expect to feel after any operation or procedure.

Leaving Hospital

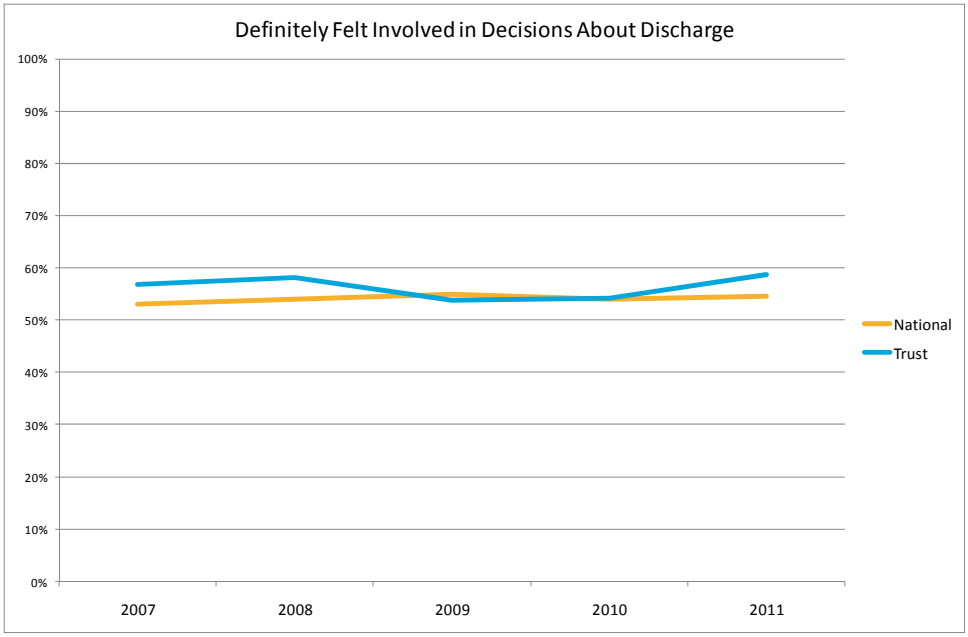
DISCHARGE AND DELAYS

Did you feel you were involved in decisions about your discharge from hospital?

Of those patients who needed to be, 59% felt that they were definitely involved in decisions about their discharge; 16% did not.

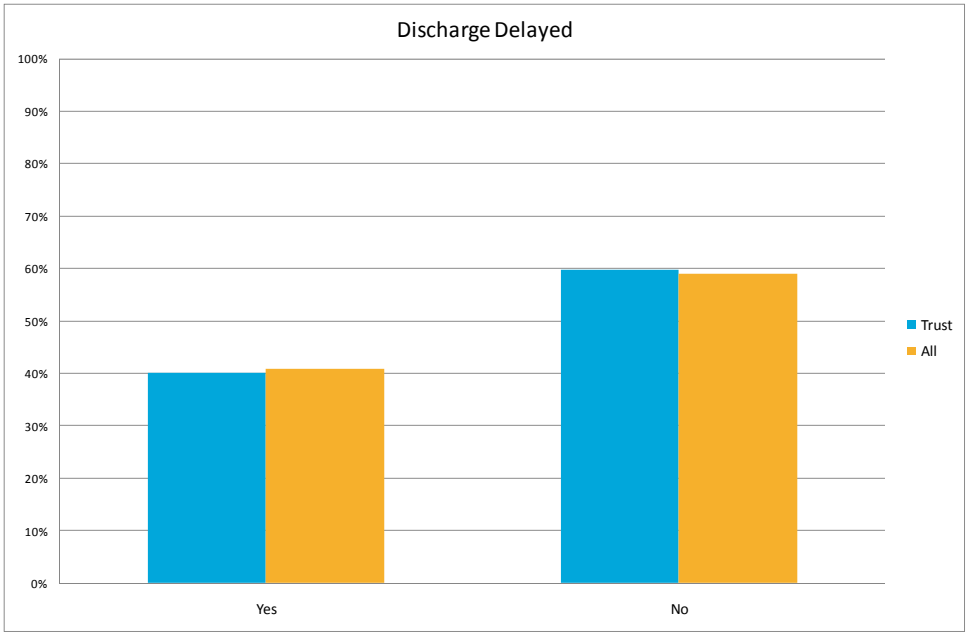


Comparison over time for this question:

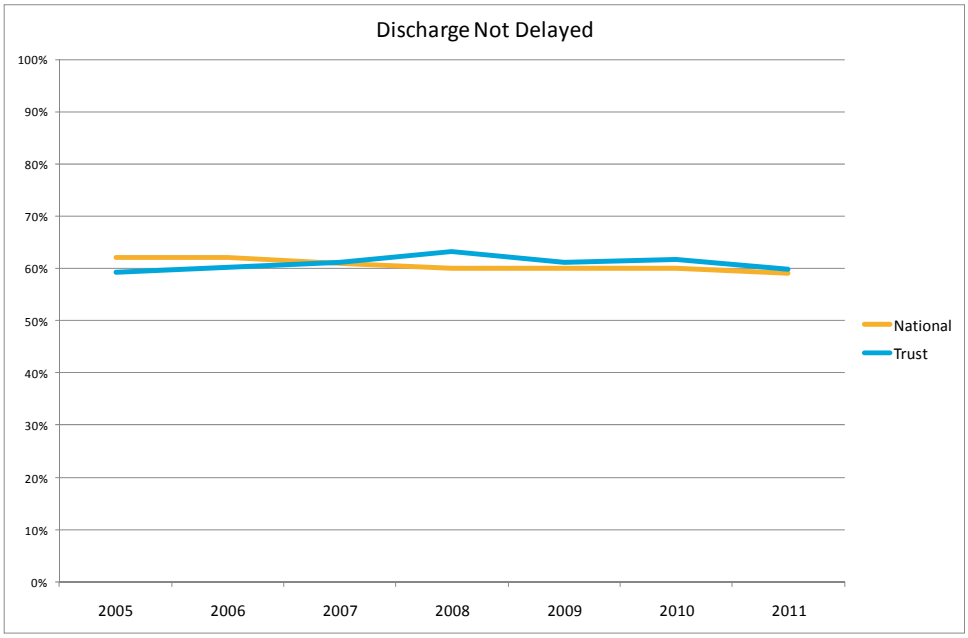


On the day you left hospital, was your discharge delayed for any reason?

40% of patients said that they experienced delays to their discharge from hospital, as the chart shows.

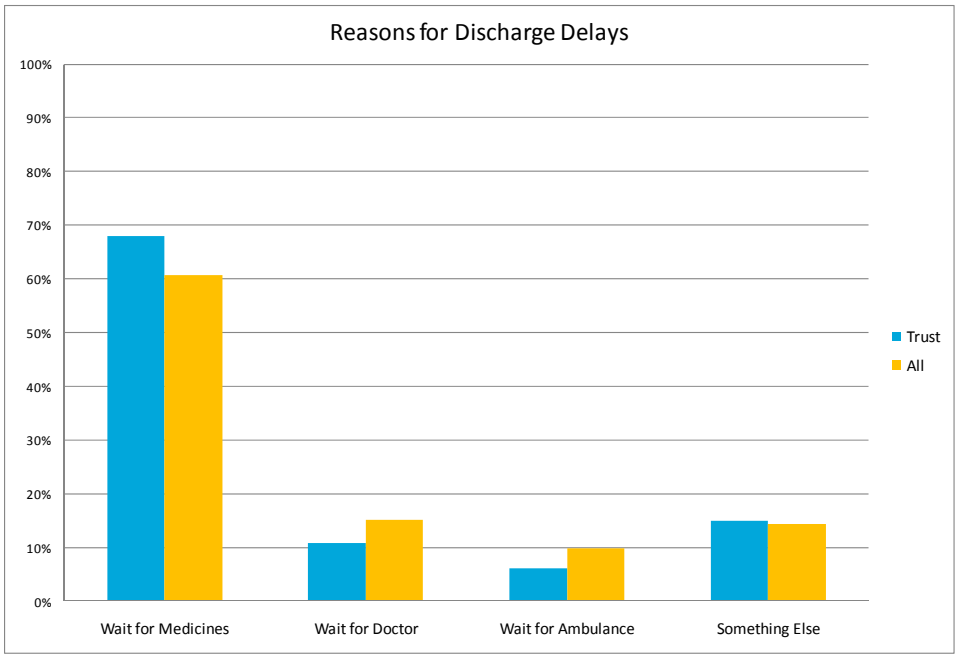


Comparison over time for this question:



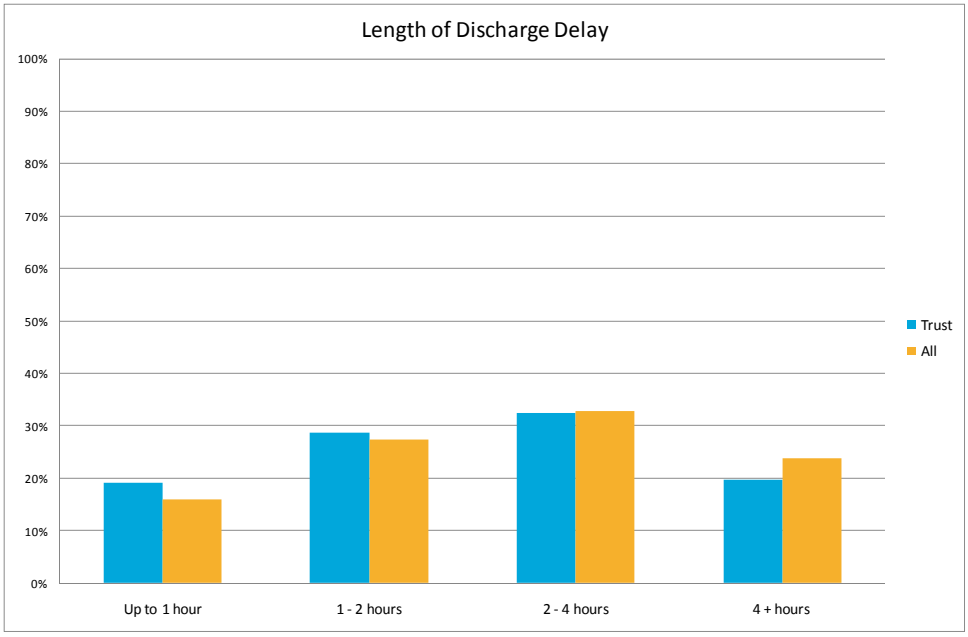
What was the MAIN reason for the delay?

The chart shows the main reasons for the delays in discharge that occurred.

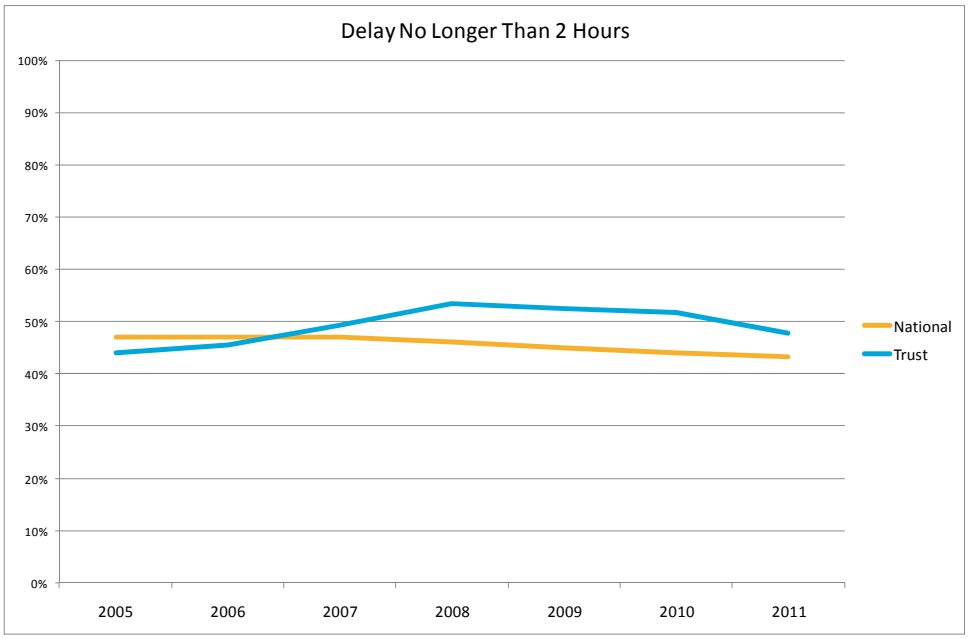


How long was the delay?

Patients were asked how long the delay to their discharge was. The chart below shows the responses to this question.



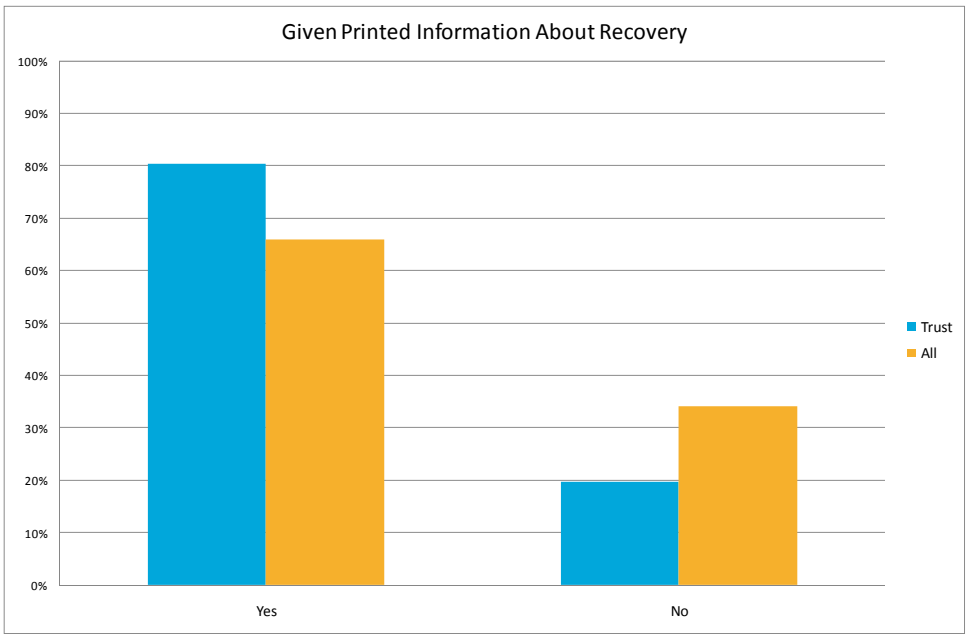
Comparison over time for this question:



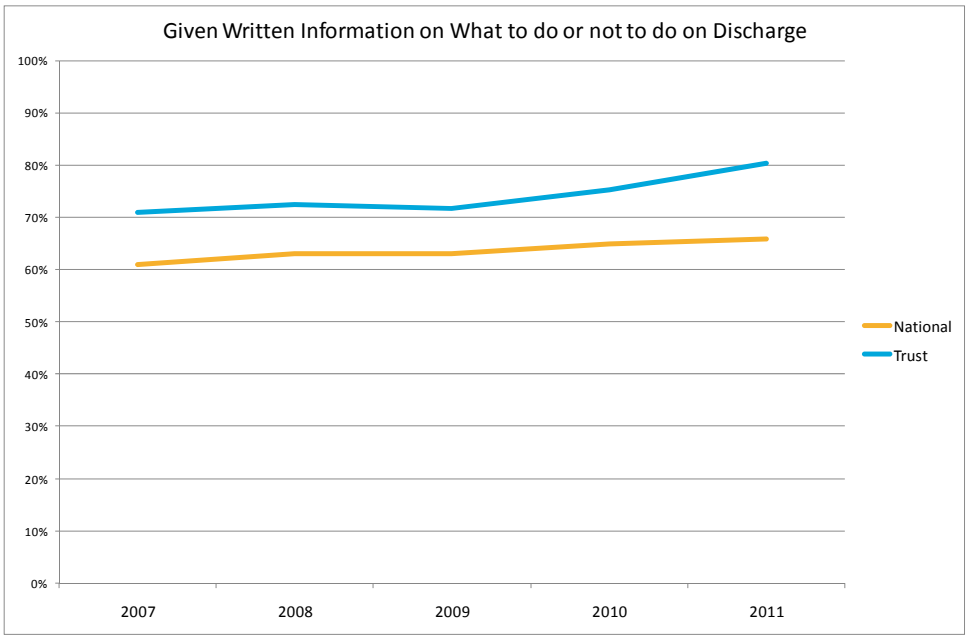
INFORMATION ON DISCHARGE

Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?

80% of patients were given written information on what to do or not to do during their recovery, after leaving hospital.



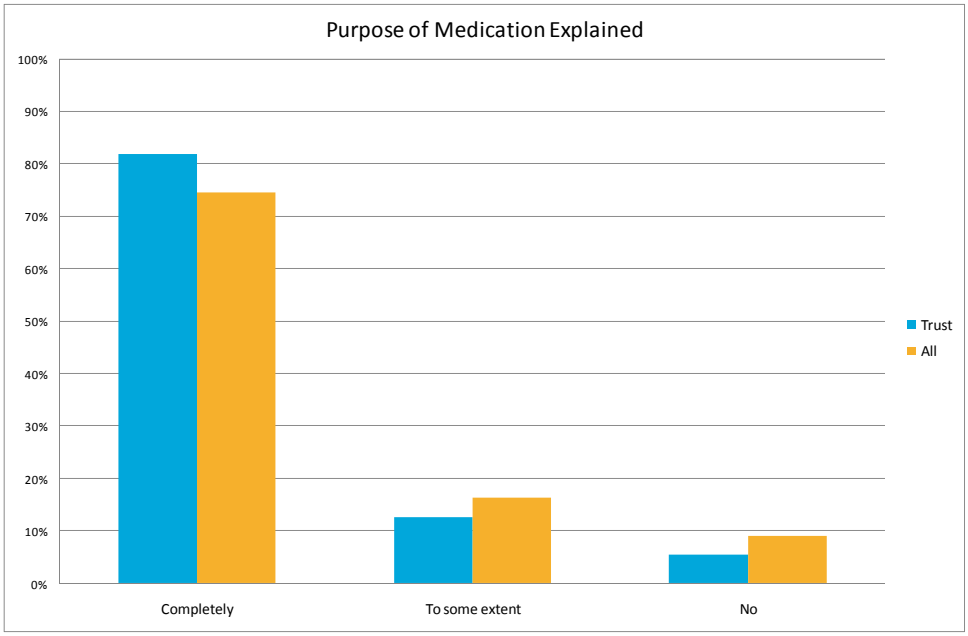
Comparison over time for this question:



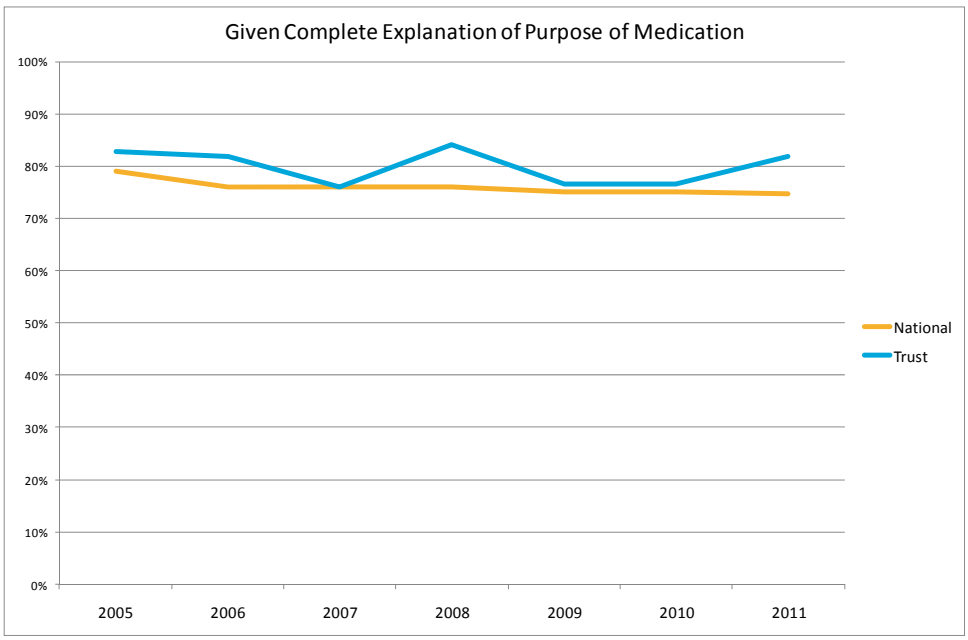
MEDICATION

Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?

82% of those patients taking medication home who needed an explanation said the purpose of the medicines was explained completely in a way they could understand. 6% said it was not explained, and a further 13% felt it was only explained to some extent.

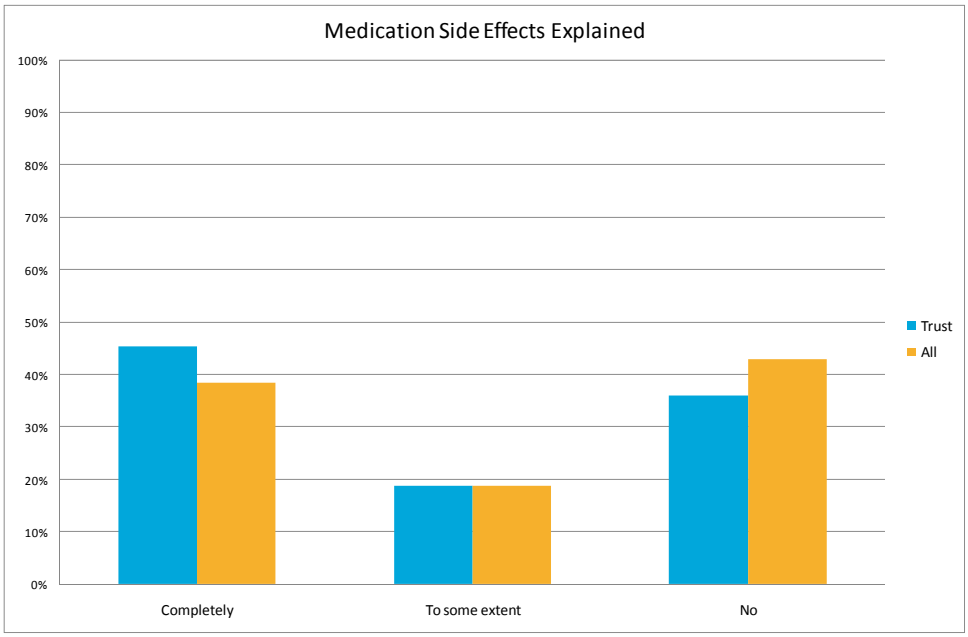


Comparison over time for this question:

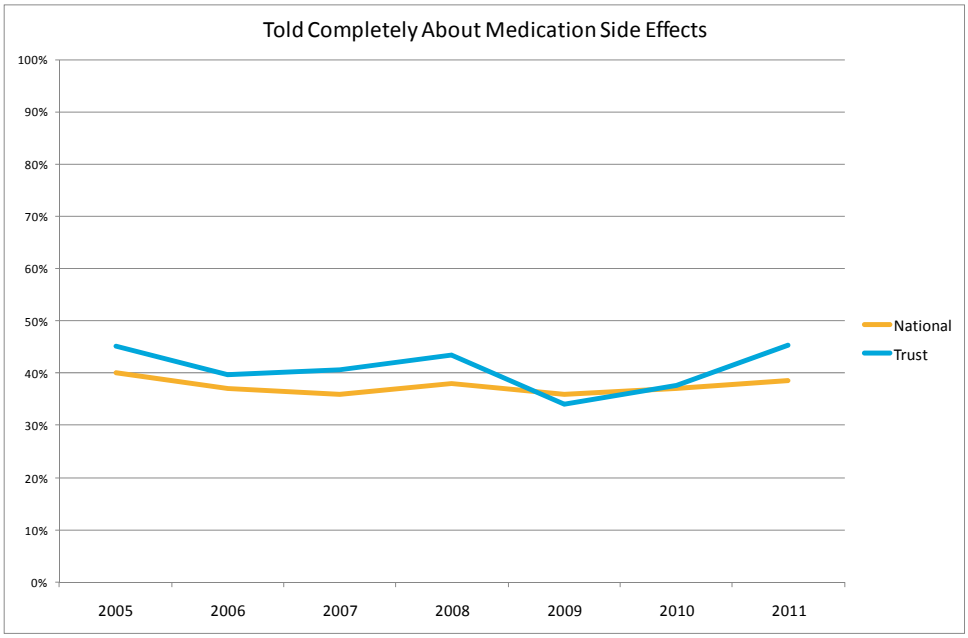


Did a member of staff tell you about medication side effects to watch for when you went home?

Of those patients who said they needed an explanation, 45% said a member of staff told them completely about side-effects of medication to watch for; 36% said they were not told and a further 19% said they were only told to some extent.

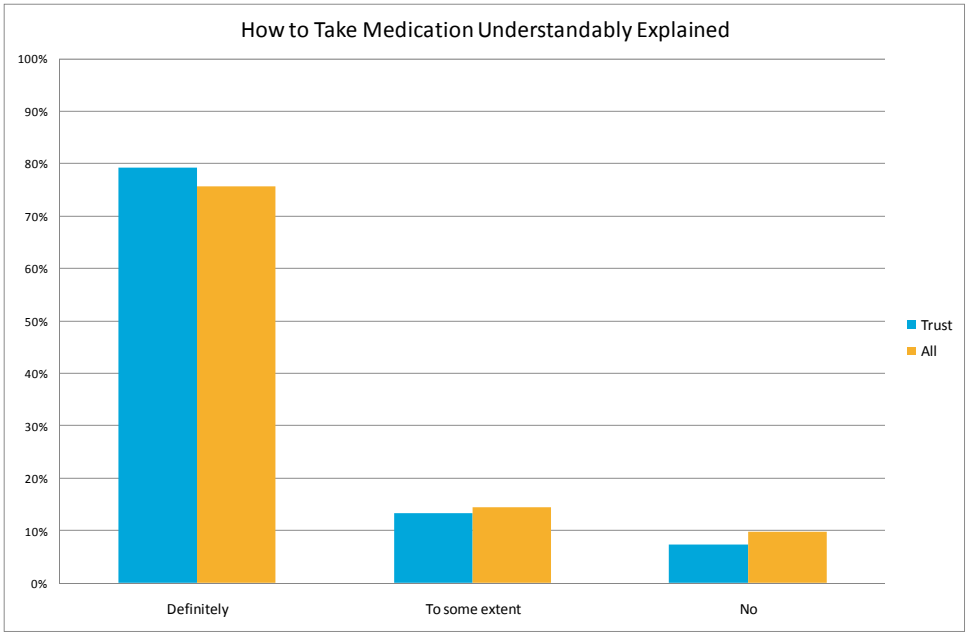


Comparison over time for this question:

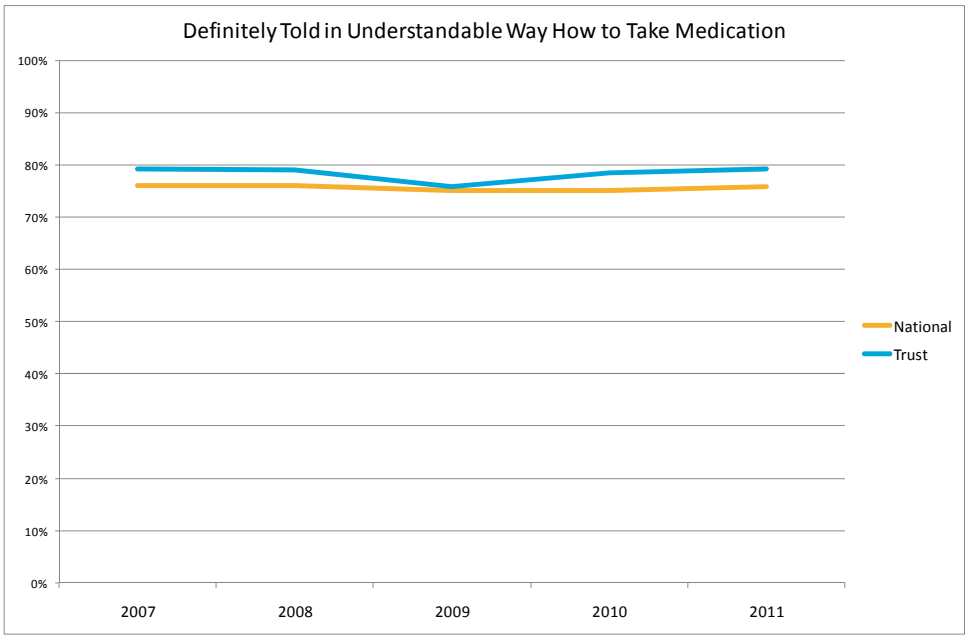


Were you told how to take your medication in a way you could understand?

79% of patients said they were definitely told how to take their medicines in a way they could understand.

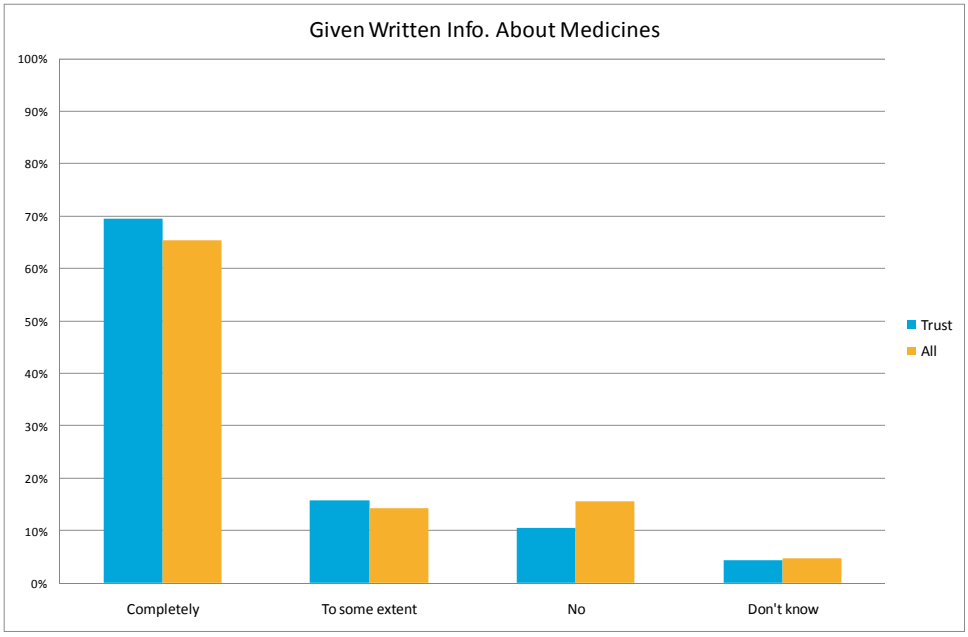


Comparison over time for this question:

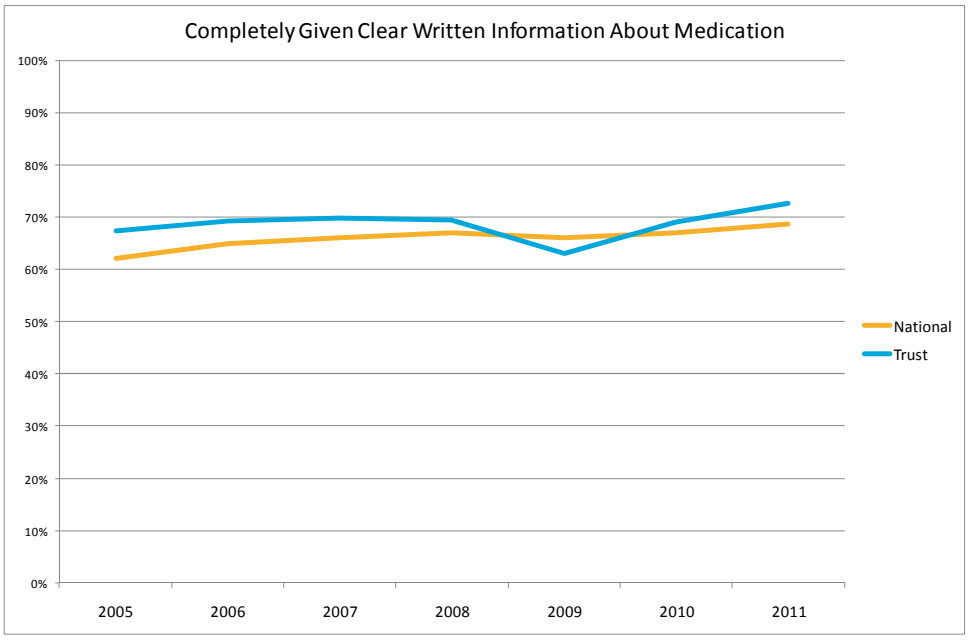


Were you given clear written or printed information about your medicines?

69% of patients said they were given clear written or printed information about their medicines. 11% said that they were not.



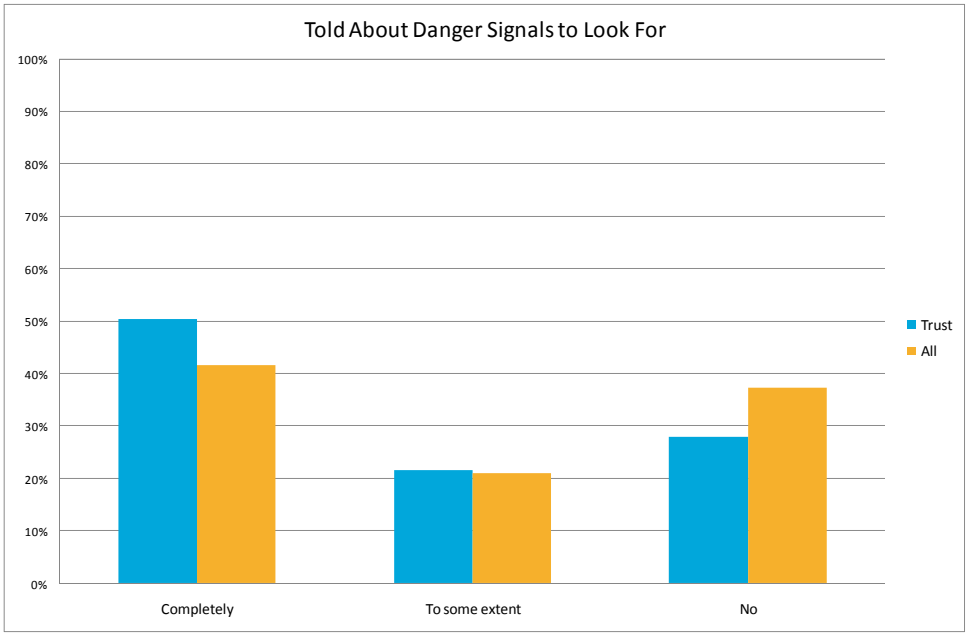
Comparison over time for this question:



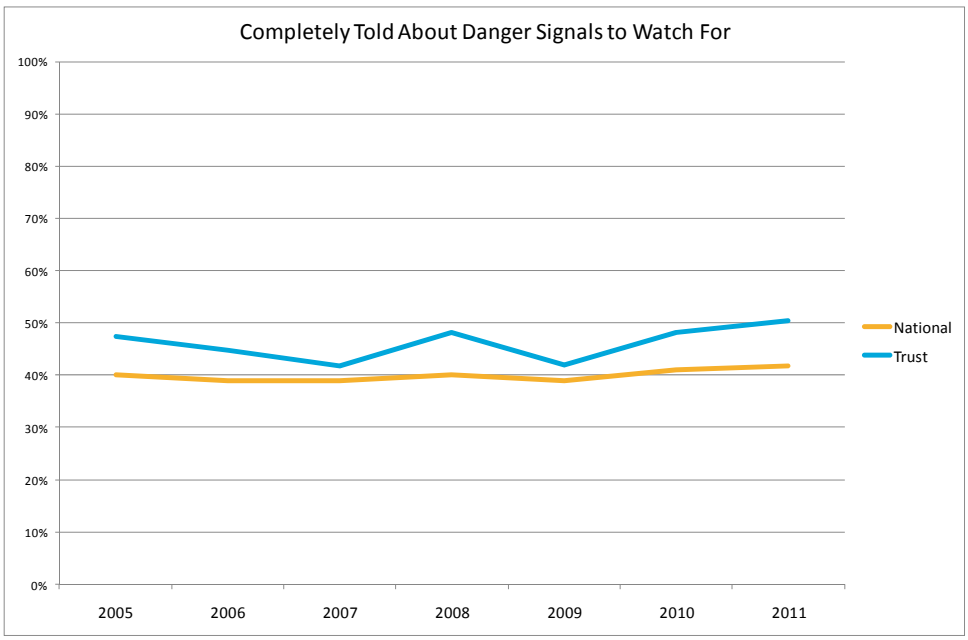
DANGER SIGNALS

Did a member of staff tell you about any danger signals you should watch for after you went home?

50% of patients who thought it was necessary said that they were told completely what danger signals to watch for regarding their illness or treatment after they went home; 28% said they were not told, and a further 22% said they were only told to some extent.



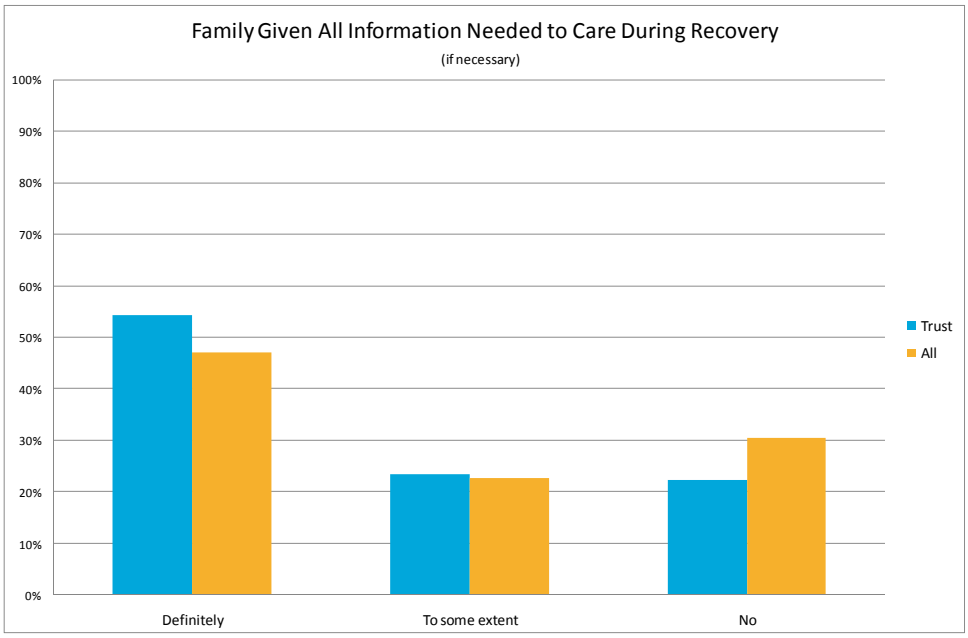
Comparison over time for this question:



INFORMATION TO FAMILIES

Did the doctors or nurses give your family or someone close to you all the information they needed to help care for you?

Of those patients whose families needed information, 54% said that their family had definitely been given all the information needed to help care for them; 22% said their family had not been given the information needed, and a further 23% said they had only been given such information to some extent.



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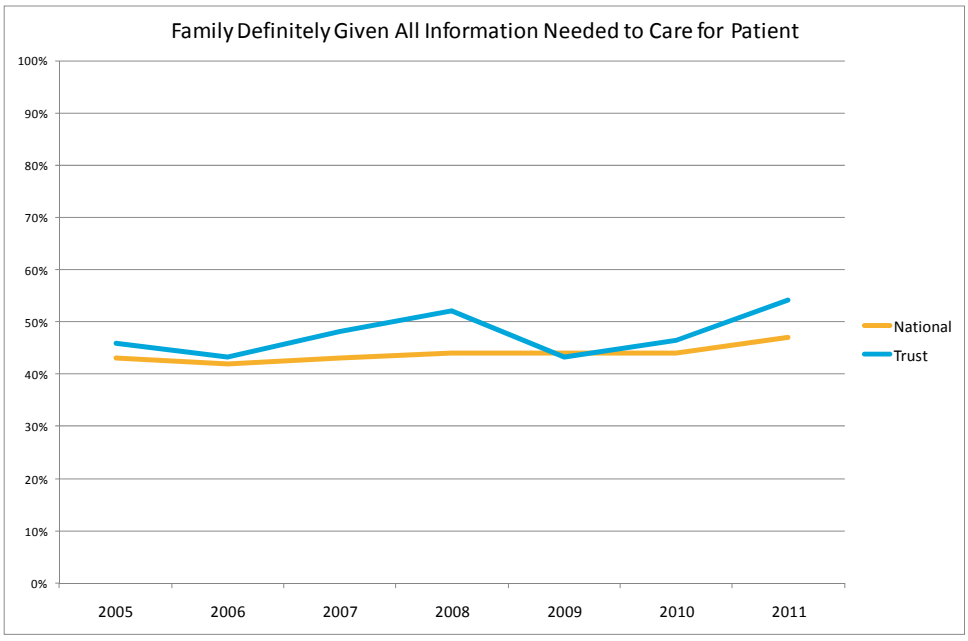
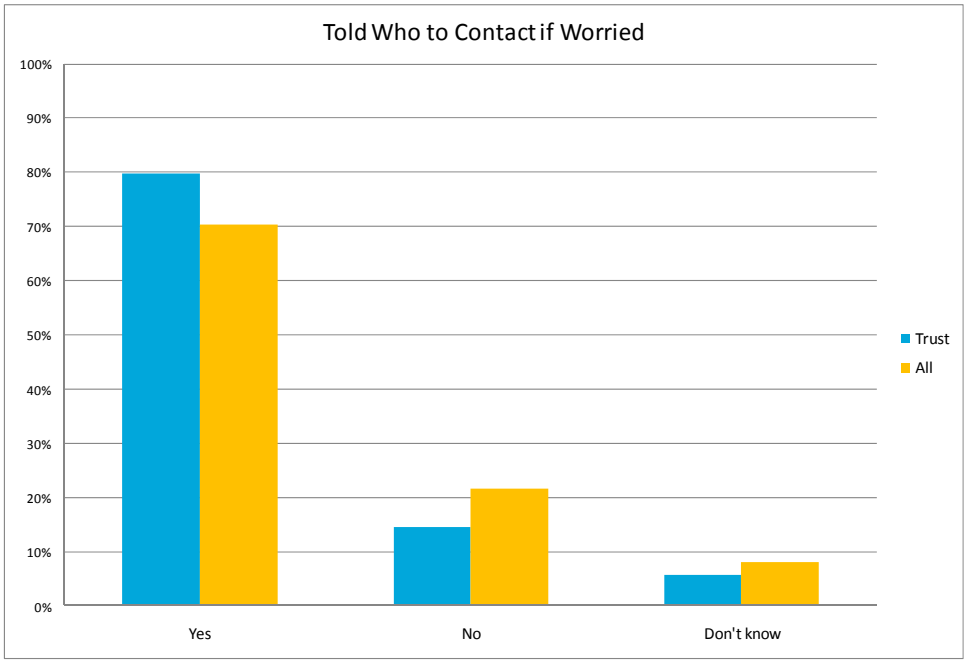


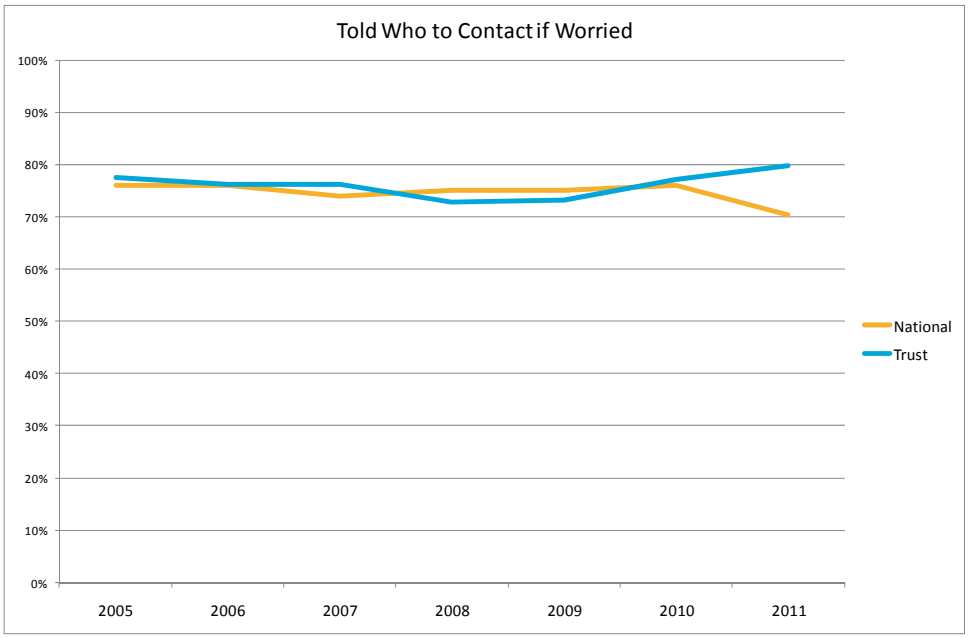
CONTACT AFTER LEAVING HOSPITAL

Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Patients were asked if they were told who to contact if they were worried about their condition or treatment after leaving hospital. 80% of patients said they were told; 15% said they were not told.



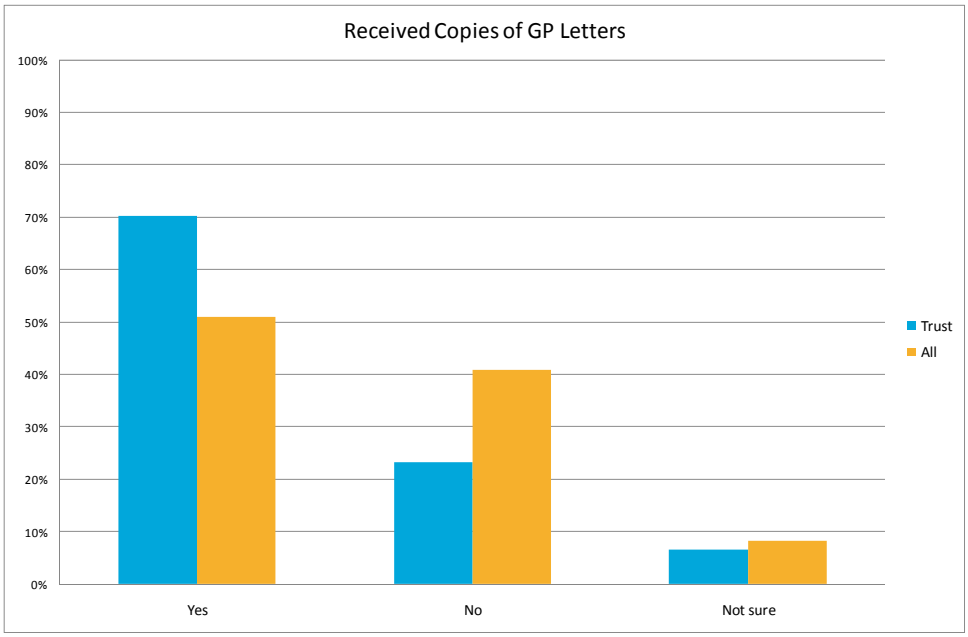
Comparison over time for this question:



GP LETTERS

Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?

70% of patients said they received copies of letters sent between hospital doctors and their GP; 23% said they had not received copies.



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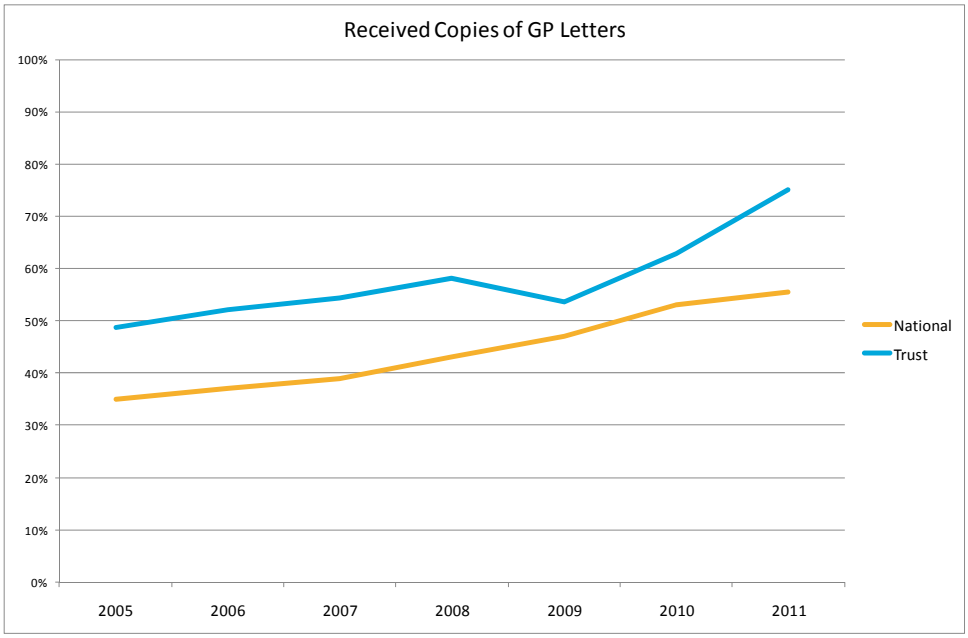
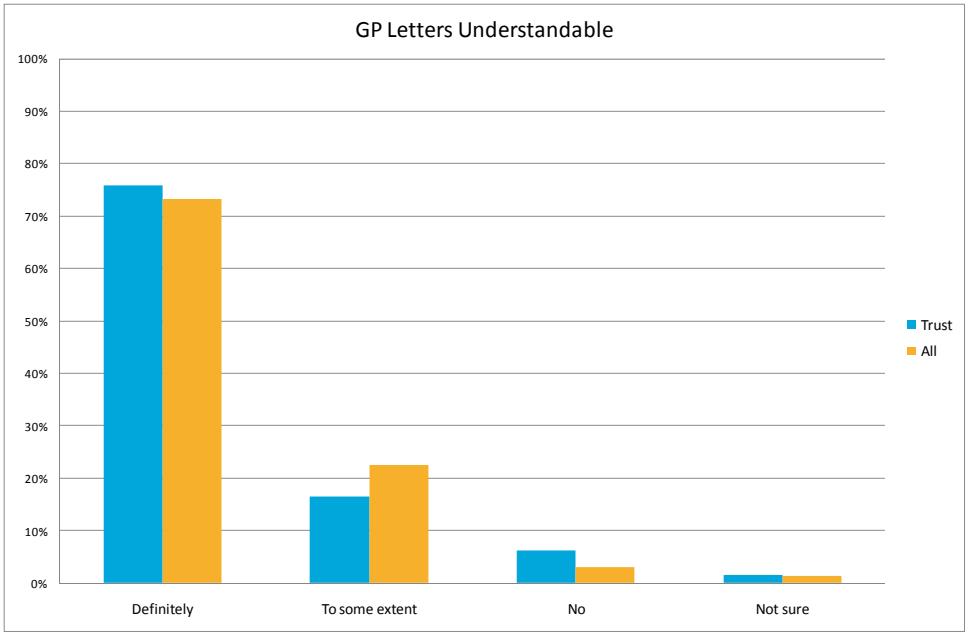
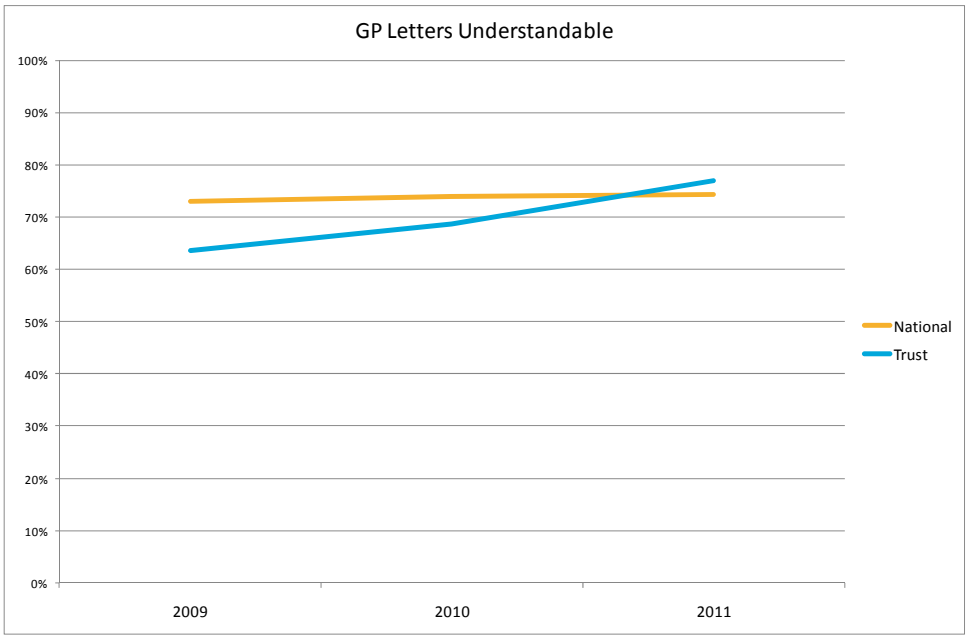


Were the letters written in a way that you could understand?

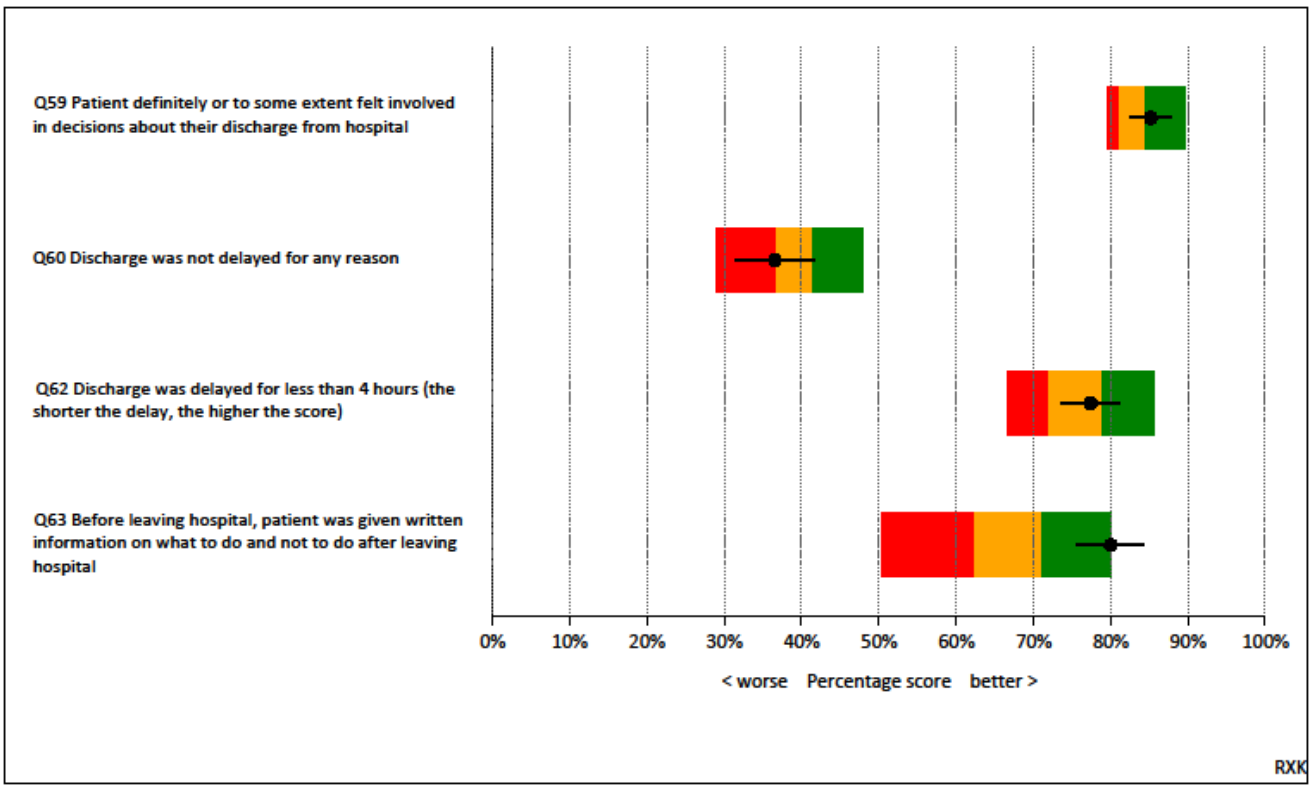
Of those that received letters, 76% said they were definitely written in a way that they could understand.



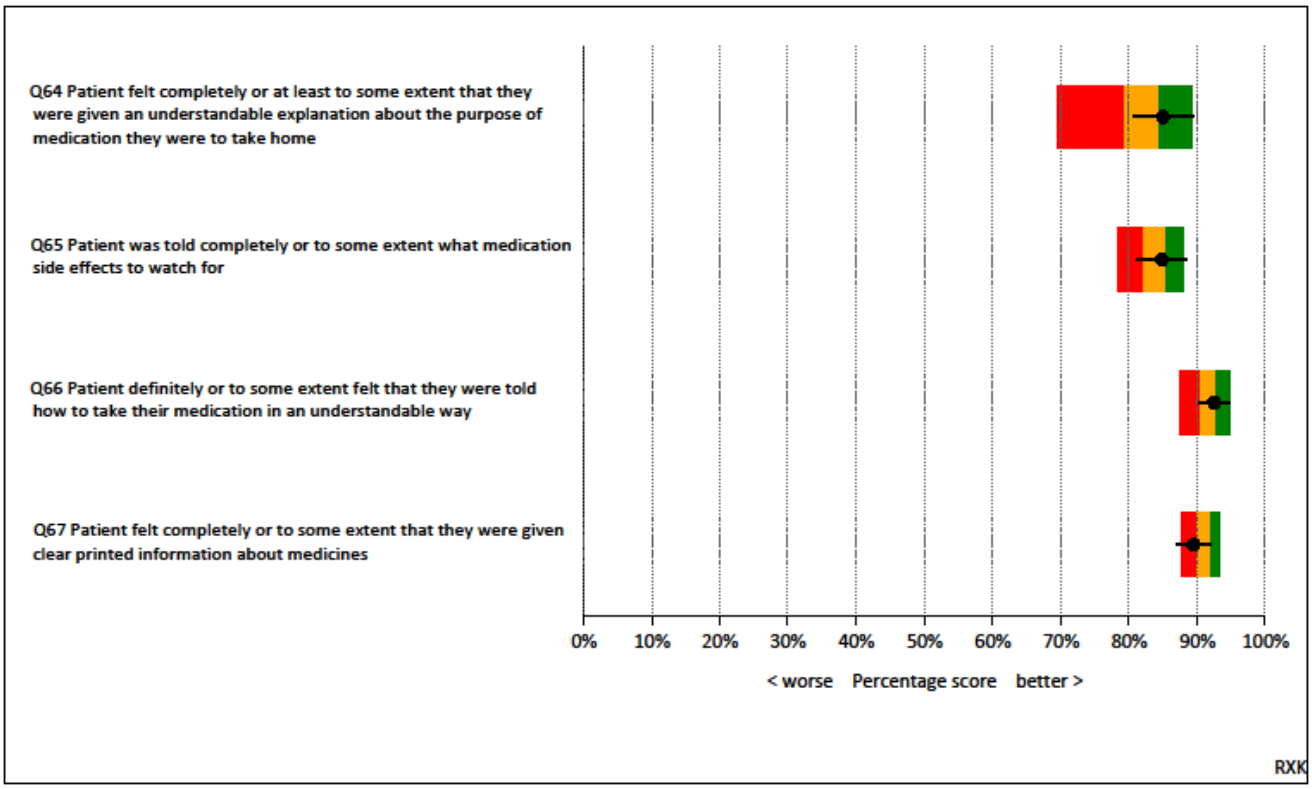
Comparison over time for this question:



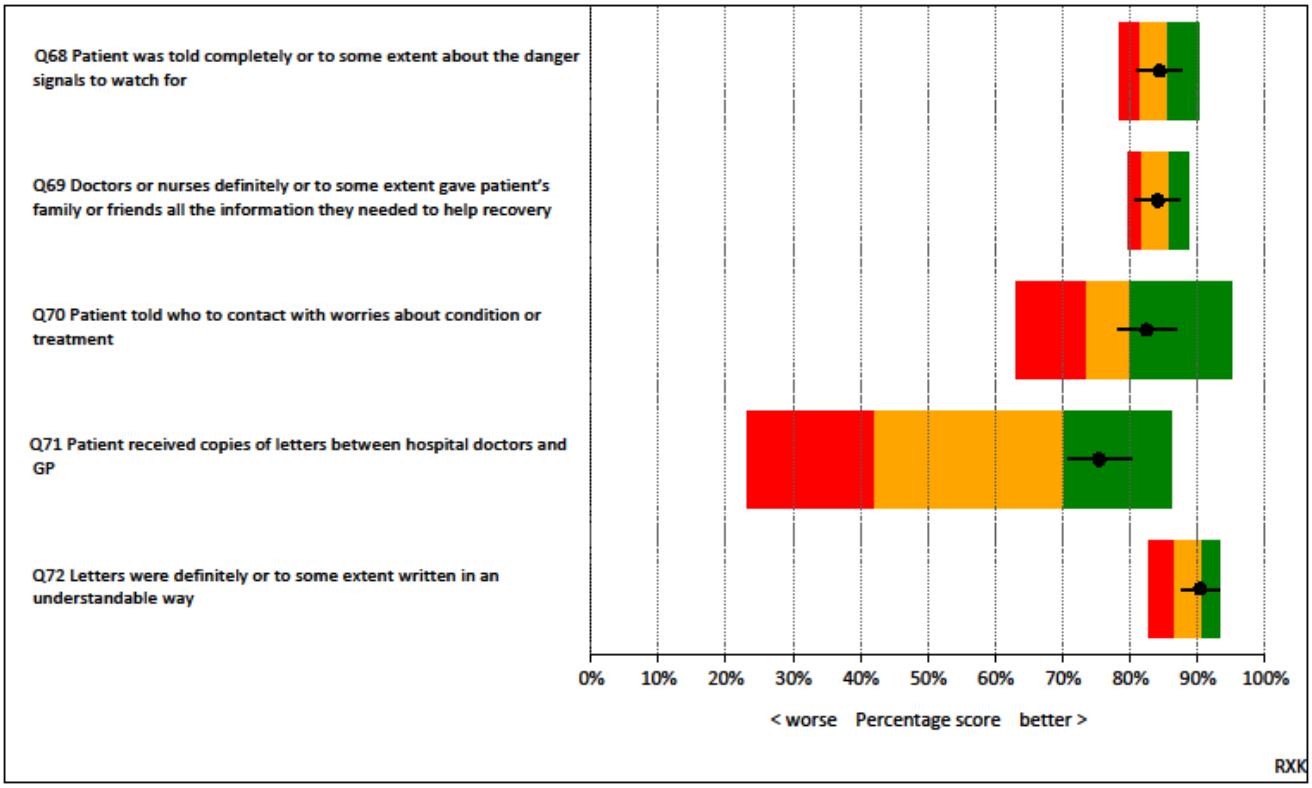
Summary and Actions



Question	2010 percentage for this Trust	2011 percentage for this Trust	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Scored % in lowest 20% of Trusts
Q59 Patient definitely or to some extent felt involved in decisions about their discharge from hospital	82%	85%	81%	84%	
Q60 Discharge was not delayed for any reason	63%	37%	37%	42%	+
Q62 Discharge was delayed for less than 4 hours (the shorter the delay, the higher the score)	79%	77%	72%	79%	
Q63 Before leaving hospital, patient was given written information on what to do and not to do after leaving hospital	74%	80%	62%	71%	



Question	2010 percentage for this Trust	2011 percentage for this Trust	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Scored % in lowest 20% of Trusts
Q64 Patient felt completely or at least to some extent that they were given an understandable explanation about the purpose of medication they were to take home	80%	85%	79%	85%	
Q65 Patient was told completely or to some extent what medication side effects to watch for	85%	85%	82%	85%	
Q66 Patient definitely or to some extent felt that they were told how to take their medication in an understandable way	92%	93%	90%	93%	
Q67 Patient felt completely or to some extent that they were given clear printed information about medicines	90%	89%	90%	92%	+



Question	2010 percentage for this Trust	2011 percentage for this Trust	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Scored % in lowest 20% of Trusts
Q68 Patient was told completely or to some extent about the danger signals to watch for	87%	84%	81%	85%	
Q69 Doctors or nurses definitely or to some extent gave patient's family or friends all the information they needed to help recovery	83%	84%	82%	86%	
Q70 Patient told who to contact with worries about condition or treatment	80%	82%	73%	80%	
Q71 Patient received copies of letters between hospital doctor and GP	62%	75%	42%	70%	
Q72 Letters were definitely or to some extent written in an understandable way	85%	90%	86%	91%	

ACTIONS:

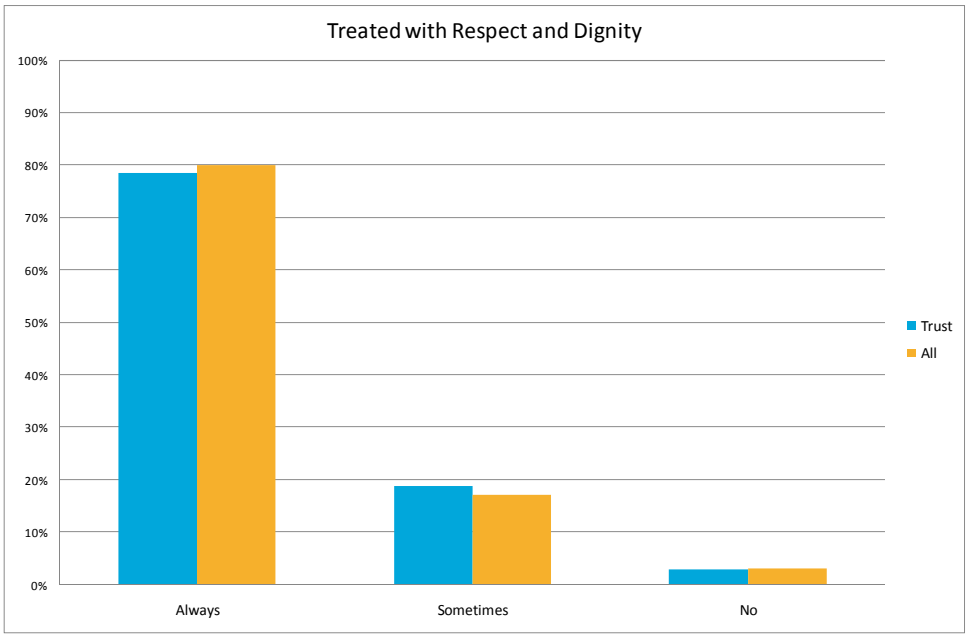
- The main reason for delays in discharge was patients having to wait for medication to take home. Examine further the mechanisms and processes by which discharge prescriptions are ordered and delivered to the discharging ward.
- Review verbal and written information to patients on common and / or important side-effects of medication, with the aim of imparting information that is simple, clear, and memorable.
- Some patients did not think that they were told adequately what danger signals to look for regarding their condition or illness after discharge. Review verbal and written information strategies for transmission of information on danger signals to the patient.
- Ensure all patients are told who to contact if they are worried about their condition or treatment after returning home.
- Continue to increase the visibility and transparency of communications passing from clinical teams to GPs, and ensure that there are robust arrangements in place to copy such letters to patients in every clinical team.

Overall

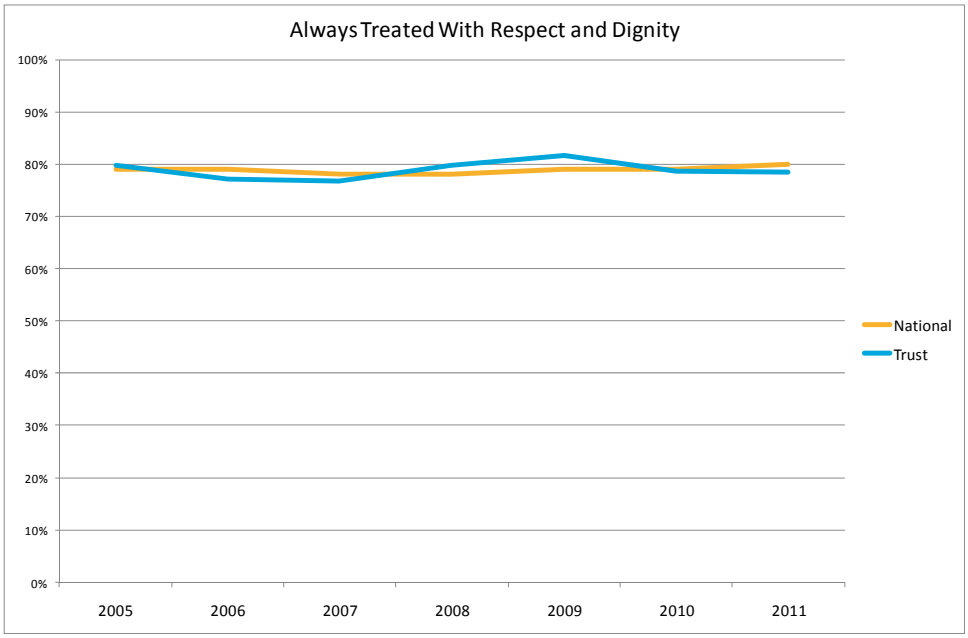
RESPECT AND DIGNITY

Overall, did you feel you were treated with respect and dignity while you were in the hospital?

78% of patients said they were always treated with respect and dignity while they were in hospital; 3% said they were not.



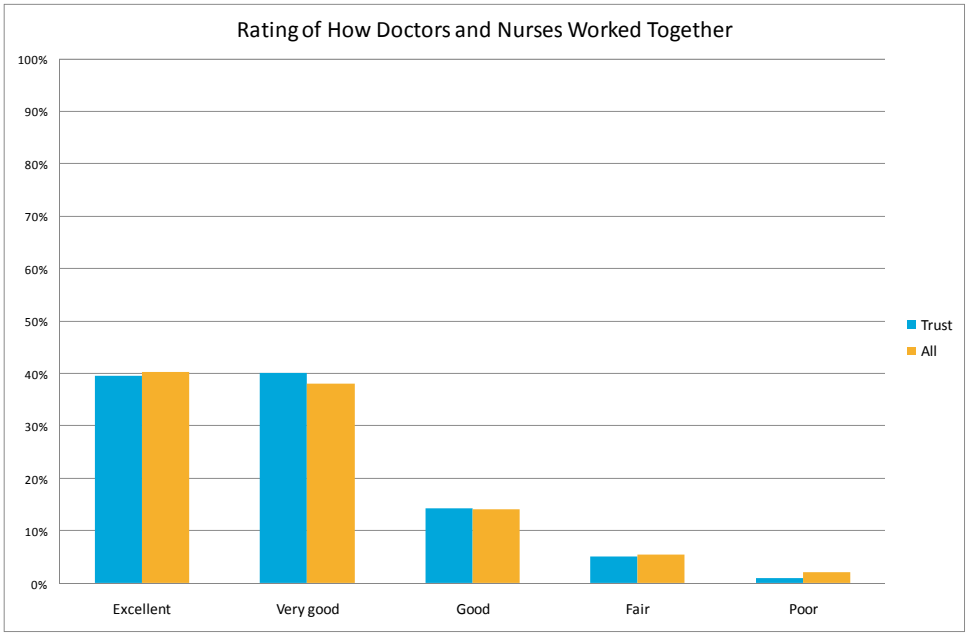
Comparison over time for this question:



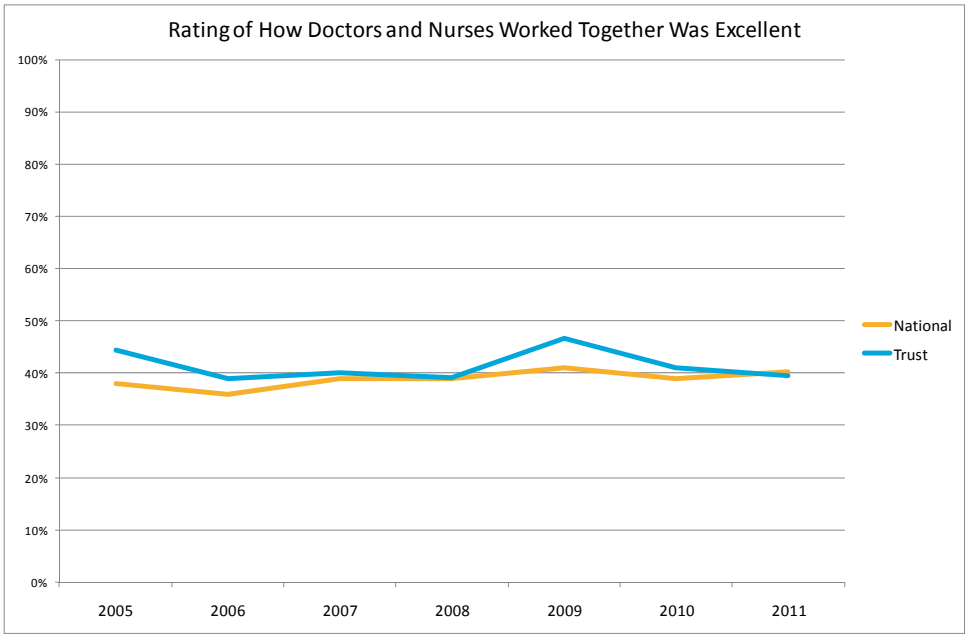
STAFF WORKING TOGETHER

How would you rate how well the doctors and nurses worked together?

Patients were asked to rate how well they thought doctors and nurses worked together. 80% rated working together as excellent or very good. 1% said working together was poor.



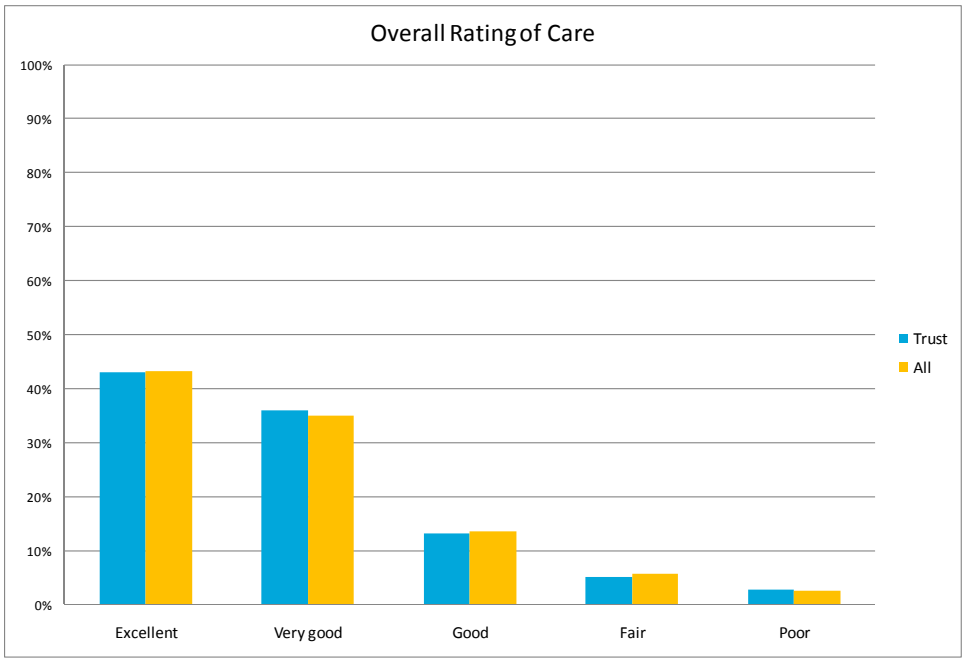
Comparison over time for this question:



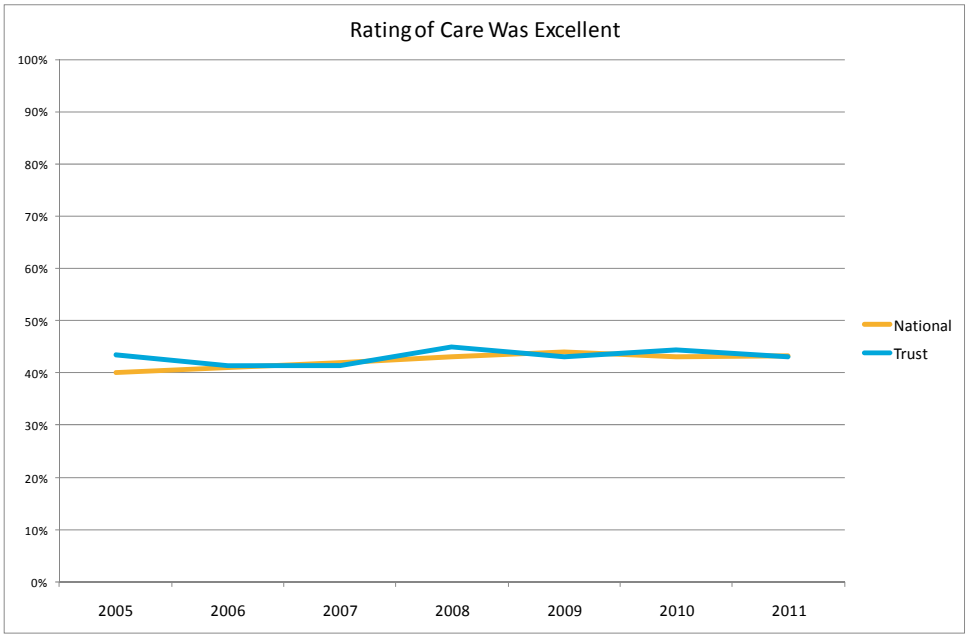
OVERALL RATING OF CARE

Overall, how would you rate the care you received?

79% of patients rated their care as excellent or very good; 3% said care was poor.



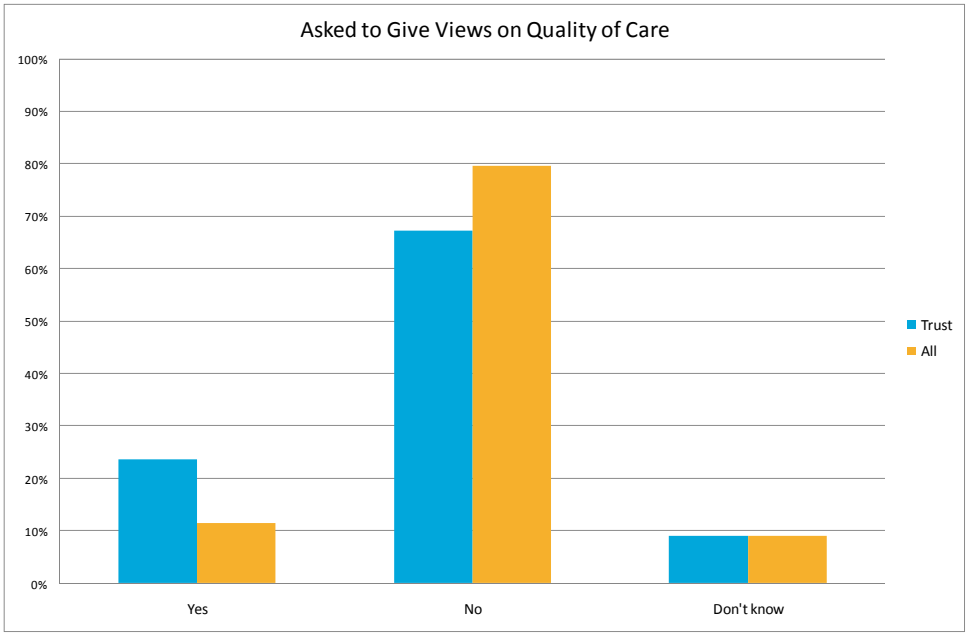
Comparison over time for this question:



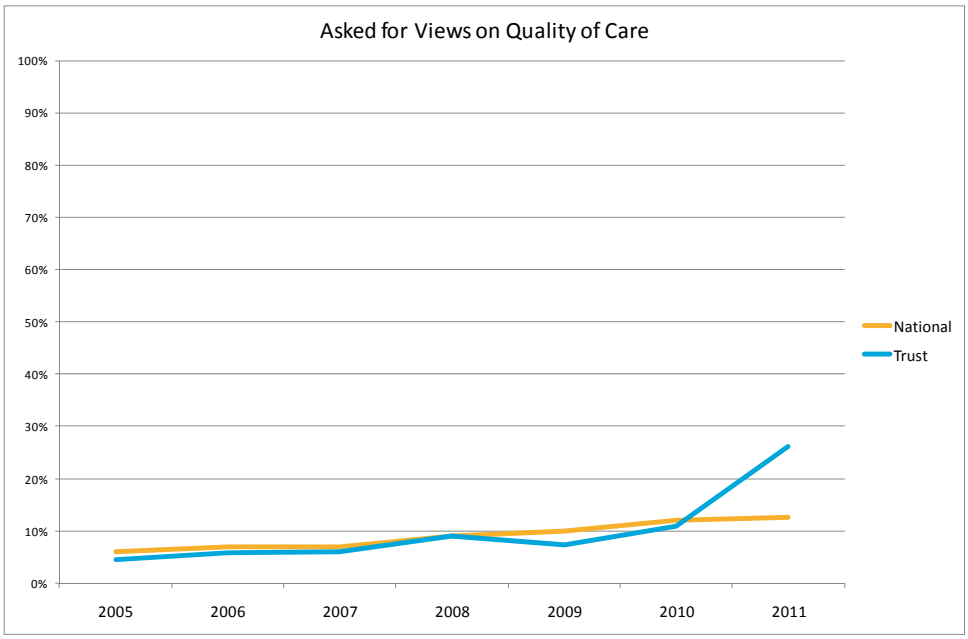
VIEWS ON CARE

During your hospital stay, were you ever asked to give your views on the quality of your care?

Patients were asked if, during their hospital stay, they were ever asked to give their views on the quality of the care they received. 24% of patients said they were asked.



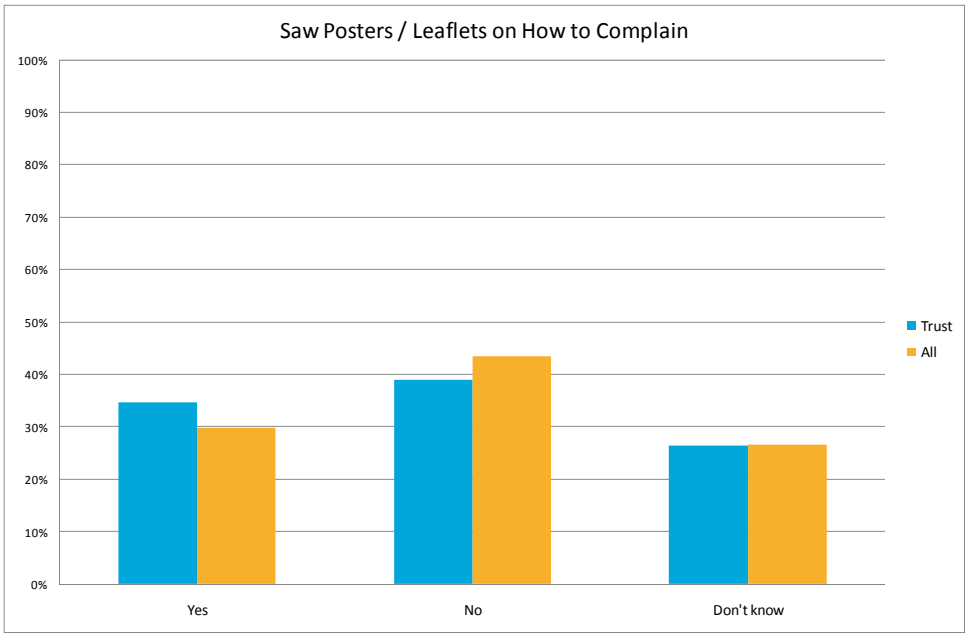
Comparison over time for this question:



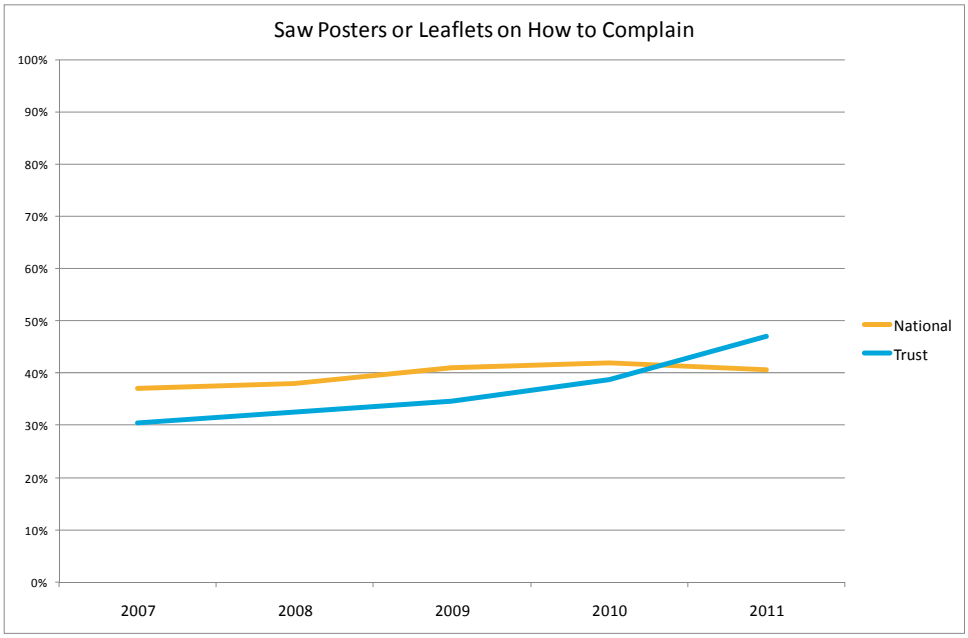
COMPLAINTS PROCEDURE

While in hospital, did you ever see any posters or leaflets explaining how to complain about the care you received?

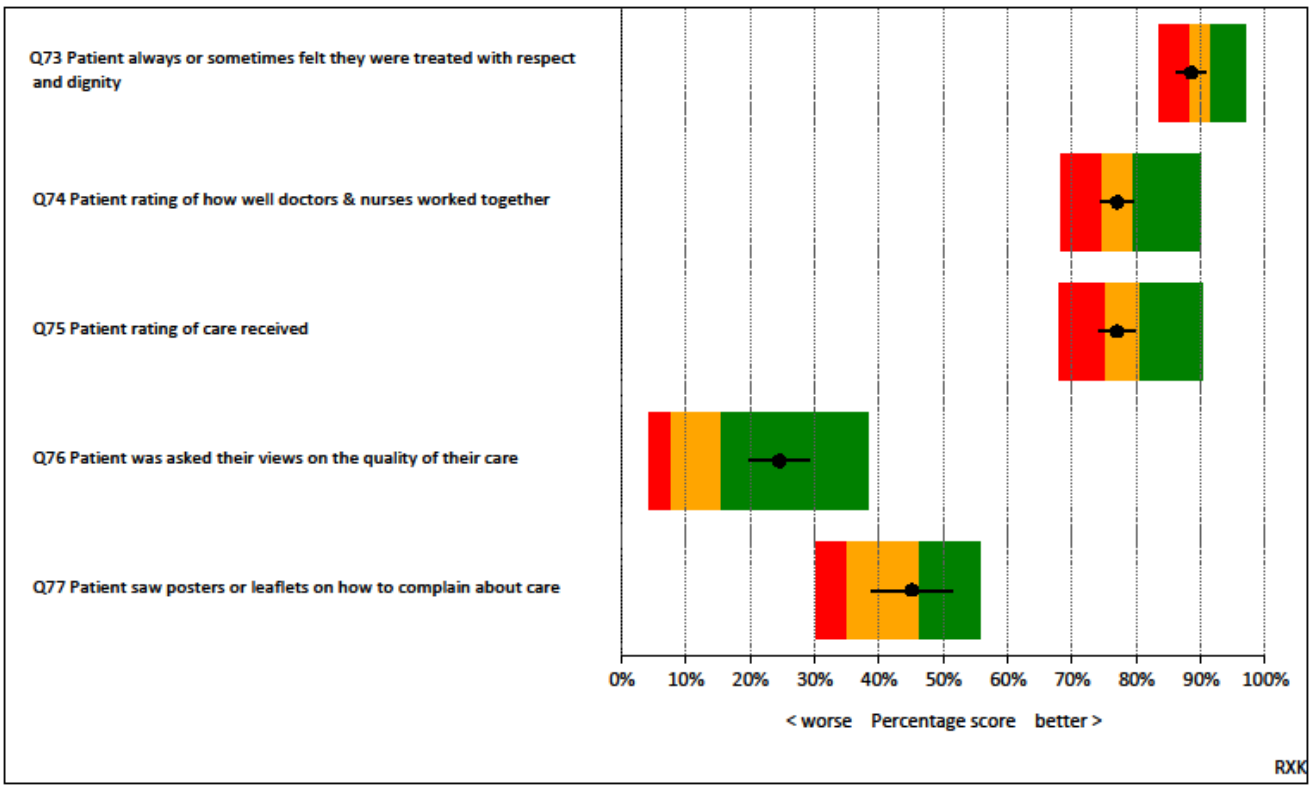
35% of patients said they saw posters or leaflets while they were in hospital about the complaints procedure; 39% said they did not.



Comparison over time for this question:



Summary and Actions



Question	2010 percentage for this Trust	2011 percentage for this Trust	Threshold for lowest scoring 20% of all Trusts	Threshold for highest scoring 20% of all Trusts	Scored % in lowest 20% of Trusts
Q73 Patient always or sometimes felt they were treated with respect and dignity	90%	89%	88%	92%	
Q74 Patient rating of how well doctors & nurses worked together	77%	77%	75%	79%	
Q75 Patient rating of care received	78%	77%	75%	80%	
Q76 Patient was asked their views on the quality of their care	11%	25%	8%	16%	
Q77 Patient saw posters or leaflets on how to complain about care	39%	45%	35%	46%	

ACTIONS:

- Ensure that all patients feel they are treated with respect and dignity whilst in hospital.
- Review scores on overall rating of care and address any particular areas od concern.
- Ensure that information about how to complain (such as leaflets and posters) is available for patients in hospital.

National Trends

The acute inpatients survey has been undertaken in all acute Trusts in England since 2002. The national data for each year has been analysed, and there are some clear conclusions that can be drawn from it.

The evidence on improvements in the national data sets related to the Inpatient survey is clear. Where there have been National Targets, or issues on which there has been strong national pressure, there have been serious improvements in perceived service quality by patients up to 2010.

In years prior to 2008, these improvements were related to waiting time in A&E, and length of time on the waiting list, in respect of inpatients.

However, the 2011 survey shows indications that progress previously made is in some cases being reversed. These have taken place in the following areas:

- Waiting time for admission to hospital in respect of elective patients. 74% said they waited 4 months or less in 2009, 72% in 2010, 69% in 2011. Fewer elective patients in 2011 said they were admitted as soon as they thought necessary, and fewer were given a choice of admission dates.
- Fewer patients in 2011 saw posters or leaflets asking them to wash their hands or use gels: this declined from 91% in 2010 to 89% in 2011.
- The proportion of patients who saw nurses wash or clean their hands between touching patients declined from 59% in 2010 to 57% in 2011.
- In 2011, more patients said the hospital food was Fair or Poor: 42% in 201, 44% in 2011.
- The proportion of patients who said that they needed help with eating their meals and who received it declined from 65% in 2010 to 61% in 2011
- Of those patients who used the call button to summon assistance, 17% said they waited over 5 minutes or never received help at all in 2010; 19% in 2011.

Some items where there has been continuing pressure to perform show continued improvement:

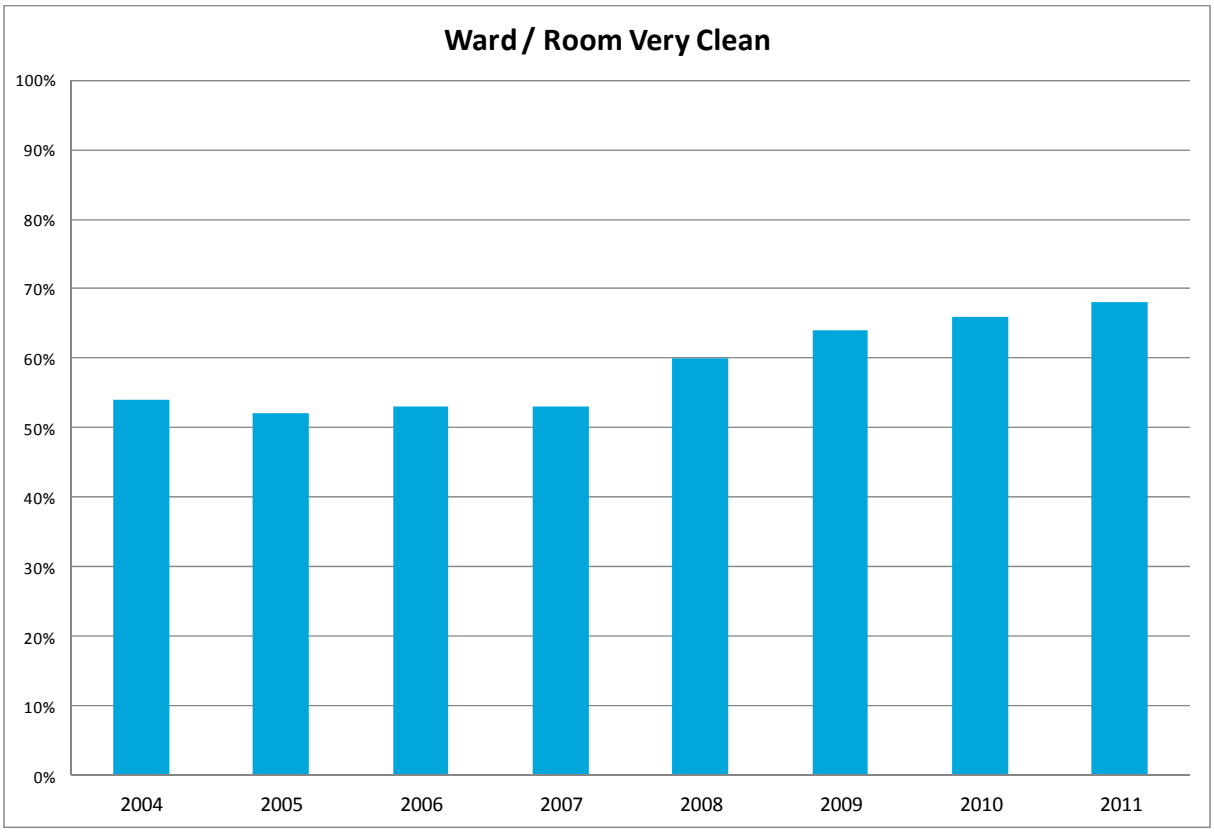
- Fewer patients in 2011 said they shared a sleeping area with patients of the opposite gender, both on first admission and subsequently after transfer. Some individual hospitals have made very significant progress on this issue. 7% said they shared such a sleeping area after transfer in 2010; 9% in 2010; and 11% in 2008. Also, fewer patients in 2011 said they shared bathroom or toilet facilities.
- Cleaning ratings have further improved following the significant rise in 2008 and 2009. In 2010, 67% said the room or ward they were on was very clean; 65% in 2009. In 2011 the rating rose to 68%. Cleaning ratings for toilets and bathrooms have also risen in 2010.

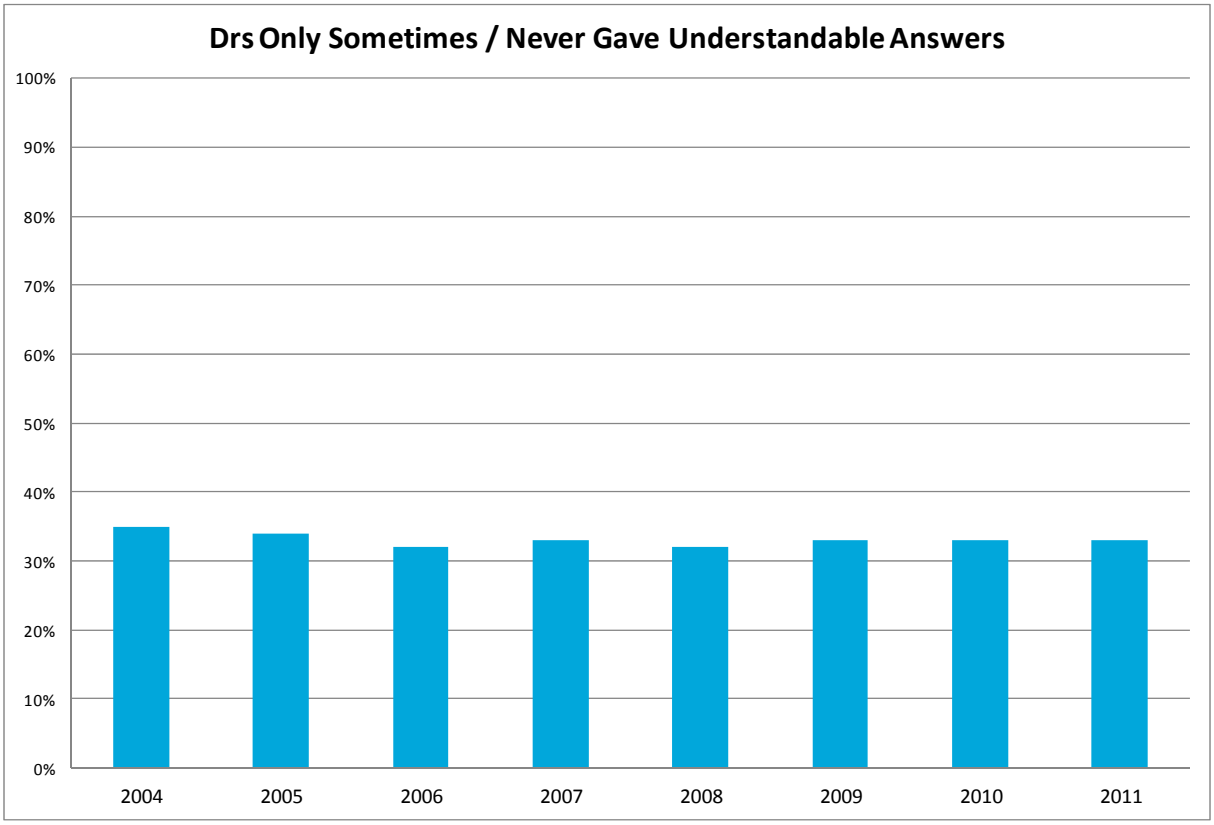
- The proportion of patients saying they were copied into letters passing from the hospital clinical team to their GP rose from 41% in 2009 to 46% in 2010 and 51% in 2011
- Discharge information improved: the proportion saying they received written information about what they should/should not do after leaving hospital rose from 64% in 2010 to 66% in 2011.

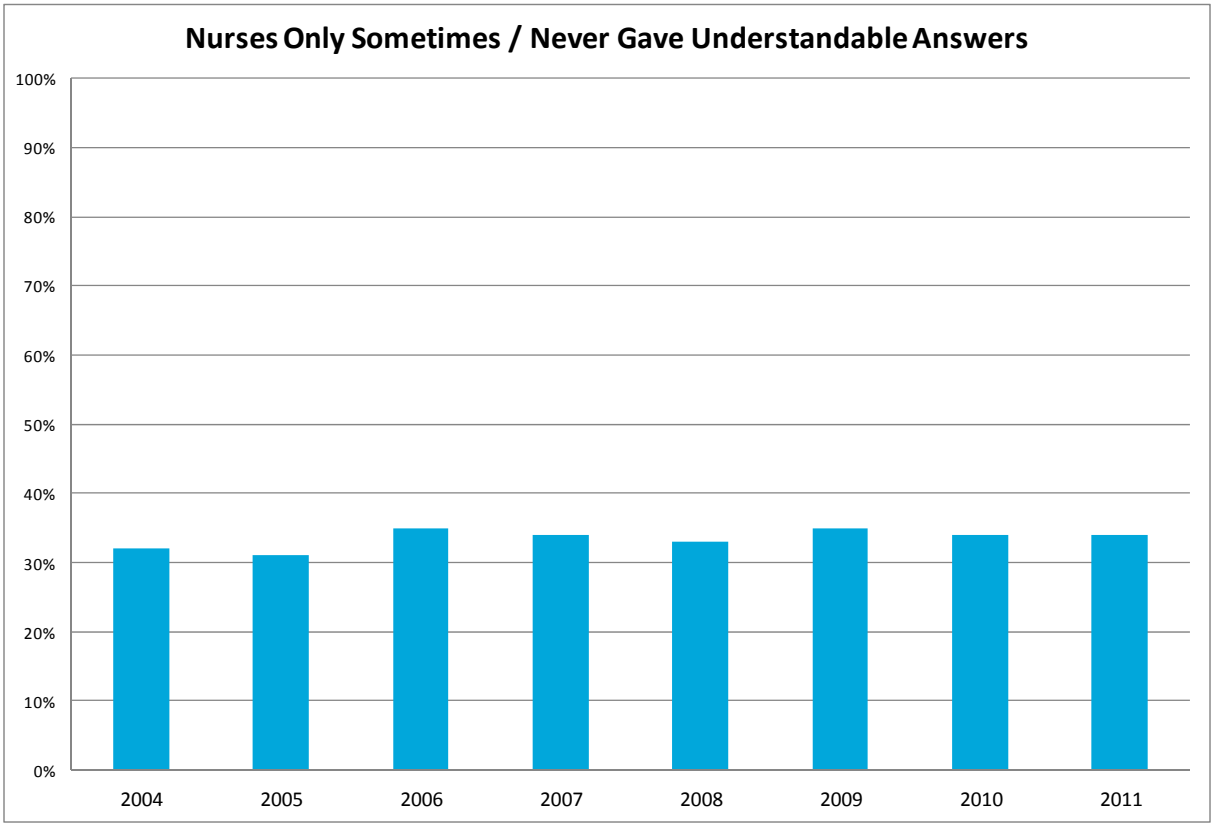
What is equally important however, are the areas on which there have been no significant positive movements in patient opinion. Some of these areas are:

- Overall ratings on quality of food.
- Information to patients on condition and treatment, including information on overall condition and treatment.
- Ratings for staff, both Doctors and Nurses.
- Perceived infection control by Drs hand washing between touching patients.
- Discharge delays.
- Overall ratings of care

The charts below provide examples of key areas that have improved and areas that have stayed the same. The data for the charts is drawn from the Healthcare Commission's published national data sets for England and the Quality Health national data set for 2011.




Drs Only Sometimes / Never Gave Understandable Answers
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2004
2005
2006
2007
2008
2009
2010
2011


Nurses Only Sometimes / Never Gave Understandable Answers
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2004
2005
2006
2007
2008
2009
2010
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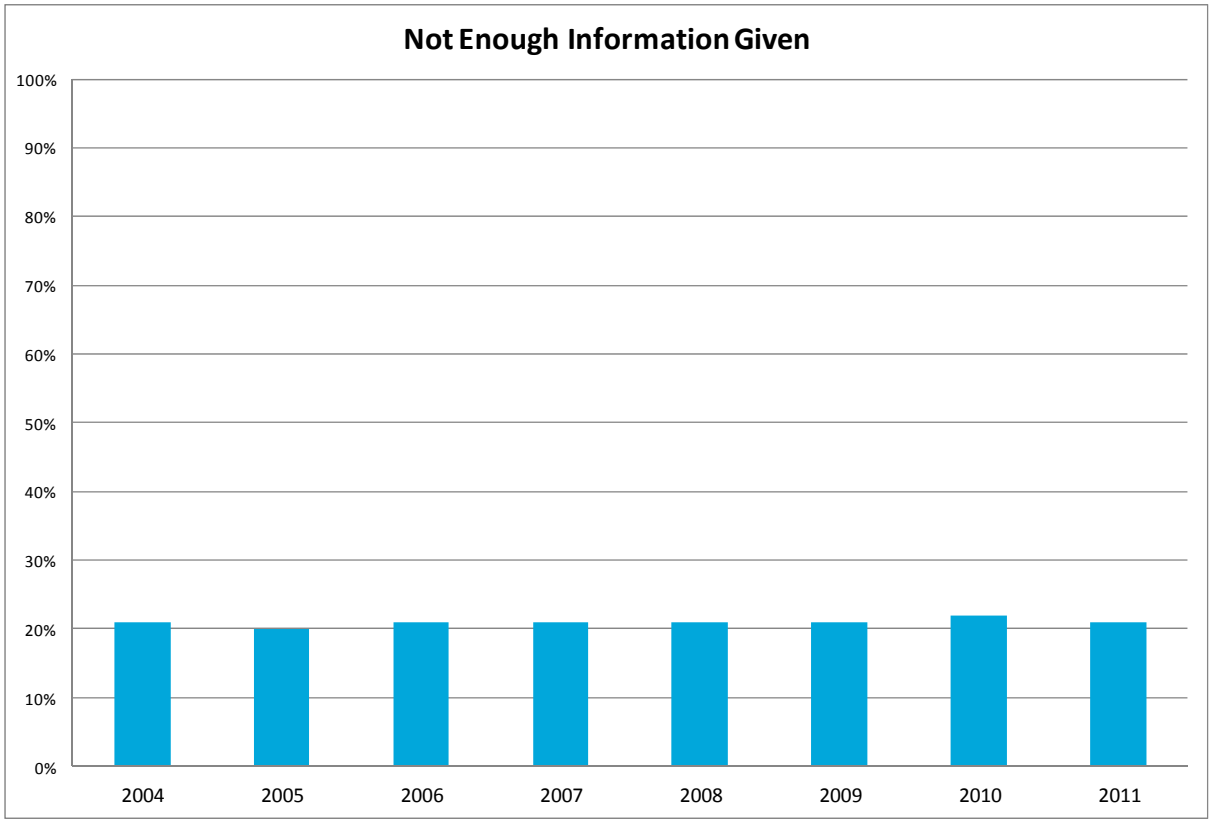
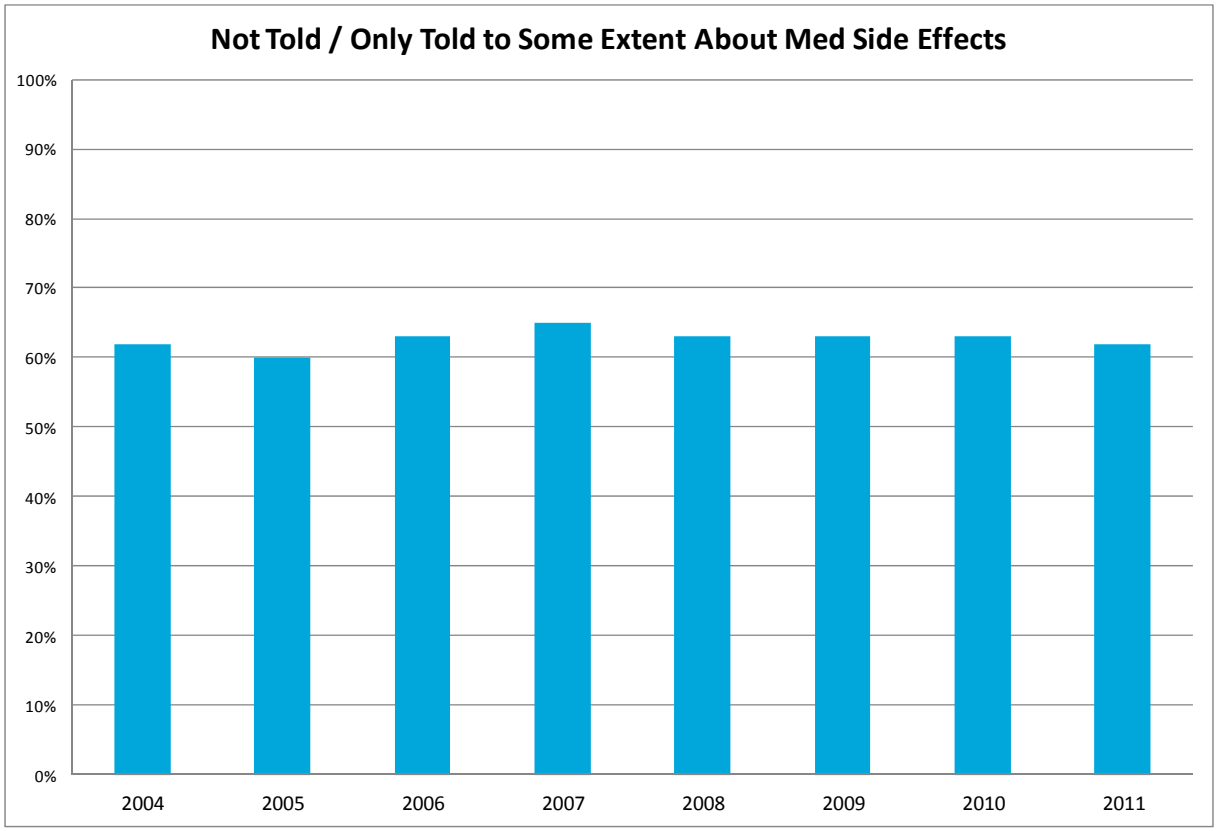
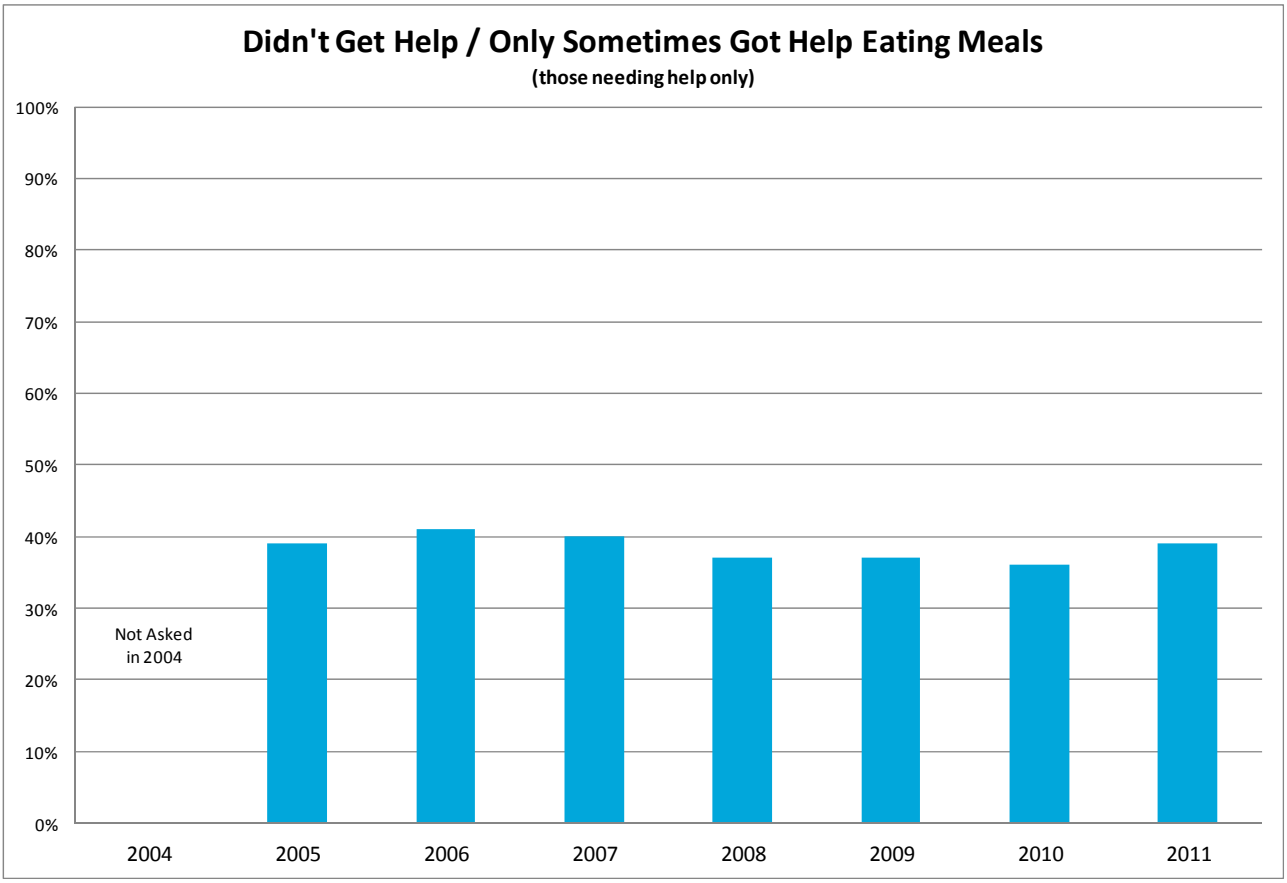

Not Enough Information Given
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2004
2005
2006
2007
2008
2009
2010
2011


Not Told / Only Told to Some Extent About Med Side Effects
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2004
2005
2006
2007
2008
2009
2010
2011



Within this picture of immobility lie Trusts that have improved their performance and Trusts where performance has fallen back. In many Trusts, however, it is clear that, despite good intentions, the level of inertia is such that specific and clear actions are not taken to improve the patient experience, and that specific responsibility for taking such actions is not nailed down and monitored effectively. There is very strong empirical evidence from some sectors of the NHS that strong performance management of the issues by the executive team can radically transform the patient and service user experience, raising scores by 20% or more on particular questions.

In each year, there is a consistency in that specialist Trusts, usually performing a restricted range of treatments and procedures in a limited range of specialties, have survey results which are significantly better than acute Trusts as a whole. The reasons for this are not entirely clear but are very likely to include: the lack of a fully fledged emergency admissions function in most such Trusts; the greater ease with which general and clinical management can be undertaken in such an environment; the likelihood that many patients will feel strong gratitude for the treatment they have received in these environments; and last but not least, the likelihood that specialist centres provide genuinely higher levels of clinical standards than do more generalist units, which higher standards are noticed by patients and reported through the survey instruments.

What is also clear is that the spread of results between the lowest scoring and best performing Trusts is still very wide. On issues such as trust and confidence in staff, food, cleaning, information on medications, etc, there are still spreads of 30-35 percentage points in the scores between top and bottom Trusts as can be seen from the chart below.

What is also clear is that the spread of results between the lowest scoring and best performing Trusts is still very wide. On issues such as trust and confidence in staff, food, cleaning, information on medications, etc, there are still spreads of 30-35 percentage points in the scores between top and bottom Trusts as can be seen from the chart below.

Health Check Core Standards & CQUIN

The Department of Health has previously used 5 questions from the inpatient survey for the purposes of CQUIN. The CQC have discontinued the use of Health Check, but we have nevertheless kept in the paragraphs on HC as a guide to Trust improvement plans.

This section pulls together the questions from the 2011 Inpatient Survey which have been specifically identified in the CQC statement 'Criteria for Assessing Core Standards' (published July 2005), and the 5 CQUIN questions.

The data in each question have been simplified, in all cases to one or two lines, which are most relevant to the assessment of performance. Complete sets of answers to each question can be found in the survey results at the end of this report.

Each of the identified relevant questions is shown twice in the tables below: firstly highlighting how the Trust is performing compared to other Trusts this year, and secondly how the Trust has performed since last year. The numbering of the questions relates to the core questionnaire.

Admission

Fifth Domain: Accessible & Responsive Care

Core Standard C18
"Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably"

		Trust	*All*	*Com*
10.	**Were you given a choice of admission dates?**			
	Yes	27%	25%	▪

		2010	*2011*	*Com*
10.	**Were you given a choice of admission dates?**			
	Yes	35%	27%	↙

The Trust's performance compared to other Trusts on this question is average.

The Trust's performance since last year on this question has fallen.

The Hospital and Ward

Sixth Domain: Care Environment & Amenities

Core Standard C20b
"Healthcare services are provided in environments which promote effective care and optimise health outcomes by being supportive of patient privacy and confidentiality"

		Trust	*All*	*Com*
20.	**Were you ever bothered by noise at night from other patients?**			
	Yes	35%	38%	-

		2010	*2011*	*Com*
20.	**Were you ever bothered by noise at night from other patients?**			
	Yes	41%	35%	↗

		Trust	*All*	*Com*
21.	**Were you ever bothered by noise at night from hospital staff?**			
	Yes	20%	21%	-

		2010	*2011*	*Com*
21.	**Were you ever bothered by noise at night from hospital staff?**			
	Yes	22%	20%	-

The Trust's performance compared to other Trusts on these questions is average.

The Trust's performance since last year on these questions is mixed.

Core Standard C21
"Healthcare services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises"

		Trust	*All*	*Com*
22.	**In your opinion, how clean was the hospital room or ward that you were in?**			
	Very clean	63%	68%	↙

		2010	*2011*	*Com*
22.	**In your opinion, how clean was the hospital room or ward that you were in?**			
	Very clean	63%	63%	-

		Trust	*All*	*Com*
23.	**How clean were the toilets and bathrooms that you used in hospital?**			
	Very clean	55%	62%	↙

		2010	*2011*	*Com*
23.	**How clean were the toilets and bathrooms that you used in hospital?**			
	Very clean	51%	55%	-

The Trust's performance compared to other Trusts on these questions is below average.

The Trust's performance since last year on these questions has stayed about the same.

Fourth Domain: Patient Focus

Core Standard C15a
"Where food is provided healthcare organisations have systems in place to ensure that patients are provided with a choice and that it is prepared safely and provides a balanced diet"

28.	How would you rate the hospital food?	*Trust*	*All*	*Com*
	Very good	18%	21%	-
	Good	36%	35%	-

28.	How would you rate the hospital food?	*2010*	*2011*	*Com*
	Very good	21%	18%	-
	Good	35%	36%	-

The Trust's performance compared to other Trusts on this question is average.

The Trust's performance since last year on this question has stayed about the same.

Care and Treatment

Fourth Domain: Patient Focus

Core Standard C16
"Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after care"

40.	**Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?**	***Trust***	***All***	***Com***
	Staff never said different things	65%	65%	-

40.	**Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?**	***2010***	***2011***	***Com***
	Staff never said different things	66%	65%	-

41.	**Were you involved as much as you wanted to be in decisions about your care and treatment?**	***Trust***	***All***	***Com***
	Yes, definitely	54%	52%	-

41.	**Were you involved as much as you wanted to be in decisions about your care and treatment?**	***2010***	***2011***	***Com***
	Yes, definitely	51%	54%	-

42.	**How much information about your condition or treatment was given to you?**	***Trust***	***All***	***Com***
	Right amount	81%	78%	-

42.	**How much information about your condition or treatment was given to you?**	***2010***	***2011***	***Com***
	Right amount	81%	81%	-

64.	**Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?**	***Trust***	***All***	***Com***
	Yes, completely	82%	75%	↗

64.	**Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?**	***2010***	***2011***	***Com***
	Yes, completely	77%	82%	↗

65.	**Did a member of staff tell you about medication side effects to watch for when you went home?**	***Trust***	***All***	***Com***
	Yes, completely	45%	38%	↗

65.	**Did a member of staff tell you about medication side effects to watch for when you went home?**	***2010***	***2011***	***Com***
	Yes, completely	38%	45%	↗

67.	**Were you given clear written information about your medicines?**	***Trust***	***All***	***Com***
	Yes, completely	69%	65%	▪

67.	**Were you given clear written information about your medicines?**	***2010***	***2011***	***Com***
	Yes, completely	66%	69%	▪

The Trust's performance compared to other Trusts on these questions is above average.

The Trust's performance since last year on these questions has risen.

Leaving Hospital

Second Domain: Clinical & Cost Effectiveness

Core Standard C6
"Healthcare organisations co-operate with each other and social care organisations to ensure that patients' individual needs are properly managed and met"

		Trust	*All*	*Com*
68.	**Did a member of staff tell you about any danger signals you should watch for after you went home?**			
	Yes, completely	50%	42%	↗

		2010	*2011*	*Com*
68.	**Did a member of staff tell you about any danger signals you should watch for after you went home?**			
	Yes, completely	48%	50%	-

		Trust	*All*	*Com*
69.	**Did the doctors or nurses give your family or someone close to you all the information they needed to help care for you?**			
	Yes, definitely	54%	47%	↗

		2010	*2011*	*Com*
69.	**Did the doctors or nurses give your family or someone close to you all the information they needed to help care for you?**			
	Yes, definitely	47%	54%	↗

70.	**Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?**	***Trust***	***All***	***Com***
	Yes	80%	70%	↗

70.	**Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?**	***2010***	***2011***	***Com***
	Yes	77%	80%	-

71.	**Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?**	***Trust***	***All***	***Com***
	Yes, I received copies	70%	51%	↗

71.	**Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?**	***2010***	***2011***	***Com***
	Yes, I received copies	58%	70%	↗

The Trust's performance compared to other Trusts on these questions is above average.

The Trust's performance since last year on these questions has risen.

Overall

Fourth Domain: Patient Focus

Core Standard C13a
"Healthcare organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect"

		Trust	*All*	*Com*
73.	**Overall, did you feel you were treated with respect and dignity while you were in the hospital?**			
	Yes, always	78%	80%	-

		2010	*2011*	*Com*
73.	**Overall, did you feel you were treated with respect and dignity while you were in the hospital?**			
	Yes, always	79%	78%	-

The Trust's performance compared to other Trusts on this question is average.

The Trust's performance since last year on this question has stayed about the same.

CQUIN Questions

41.	**Were you involved as much as you wanted to be in decisions about your care and treatment?**	***Trust***	***All***	***Com***
	Yes, definitely	54%	52%	-

41.	**Were you involved as much as you wanted to be in decisions about your care and treatment?**	***2010***	***2011***	***Com***
	Yes, definitely	51%	54%	-

44.	**Did you find someone on the hospital staff to talk to about your worries and fears?**	***Trust***	***All***	***Com***
	Yes, definitely	49%	41%	↗

44.	**Did you find someone on the hospital staff to talk to about your worries and fears?**	***2010***	***2011***	***Com***
	Yes, definitely	41%	49%	↗

46.	**Were you given enough privacy when discussing your condition or treatment?**	***Trust***	***All***	***Com***
	Yes, always	70%	72%	-

46.	**Were you given enough privacy when discussing your condition or treatment?**	***2010***	***2011***	***Com***
	Yes, always	70%	70%	-

65.	**Did a member of staff tell you about medication side effects to watch for when you went home?**	***Trust***	***All***	***Com***
	Yes, completely	45%	38%	↗
65.	**Did a member of staff tell you about medication side effects to watch for when you went home?**	***2010***	***2011***	***Com***
	Yes, completely	38%	45%	↗

70.	**Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?**	***Trust***	***All***	***Com***
	Yes	80%	70%	↗
70.	**Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?**	***2010***	***2011***	***Com***
	Yes	77%	80%	-

The Trust's performance compared to other Trusts on the CQUIN questions is above average.

The Trust's performance since last year on the CQUIN questions has improved.

Full Survey Results

This section of the report sets out the full results from the National Inpatients Survey ordered in exactly the same way as in the survey questionnaire sent to patients.

Where Trusts undertook additional samples over and above the official sample of 850, results for these are also included in the results set out below.

HOW TO READ THE COLUMNS OF FIGURES

The results are shown firstly in absolute numbers then as percentages. The first pair of columns show the results for the Trust in 2010; the second pair of columns show the results from 2011, and the third pair of columns show the results from all the hospitals where Quality Health undertook the National Inpatients Survey in 2011 (ALL).

The purpose of presenting the figures in this way is to give direct, at-a-glance, comparisons between the Trust's performance in 2010 and 2011, and between the Trust and other Trusts in the UK in 2011.

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

CONVENTIONS

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

The 'Missing' figures show the number of patients who did not reply to that particular question. In some cases, 'Missing' figure is quite high because it includes patients who did not answer that question or group of questions because it was not applicable to their circumstances (e.g. questions A2 and A3).

On some questions there are also some figures which are italicised. These figures have been recalculated to exclude responses where the question was not applicable to the patient's circumstances. For example, questions such as B5 about using bathrooms, where both those not answering (Missing) and those saying they did not use a bathroom are excluded.

ADMISSION TO HOSPITAL		Total	2010	Total	2011	Total	All
A1.	**Was your most recent hospital stay planned in advance or an emergency?**						
	Emergency or urgent	180	50%	187	48%	12565	60%
	Waiting list or planned in advance	171	47%	193	49%	7830	37%
	Something else	11	3%	13	3%	621	3%
	Missing	20		10		797	
A2.	**When you arrived at the hospital, did you go to the A&E Department (the Emergency Department / Casualty / Medical or Surgical Admissions unit)?**						
	Yes	183	93%	182	91%	11987	91%
	No	14	7%	17	9%	1227	9%
	Missing	185		204		8599	
A3.	**While you were in the A&E Department, how much information about your condition or treatment was given to you?**						
	Not enough	26	14%	32	18%	1695	14%
	Right amount	116	64%	114	64%	7638	64%
	Too much	2	1%	0	0%	44	0%
	I was not given any information about my treatment or condition	11	6%	11	6%	1056	9%
	Don't know / Can't remember	25	14%	22	12%	1458	12%
	Missing	202		224		9922	
A4.	**Were you given enough privacy when being examined or treated in the A&E Department?**						
	Yes, definitely	142	76%	134	73%	8688	72%
	Yes, to some extent	28	15%	42	23%	2454	20%
	No	8	4%	2	1%	246	2%
	Don't know / Can't remember	9	5%	5	3%	640	5%
	Missing	195		220		9785	
A5.	**Following arrival at the hospital, how long did you wait before being admitted to a bed on a ward?**						
	Less than 1 hour	33	18%	31	17%	2064	17%
	At least 1 hour but less than 2 hours	39	21%	26	14%	1905	16%
	At least 2 hours but less than 4 hours	40	22%	47	26%	2941	24%
	At least 4 hours but less than 8 hours	36	19%	44	24%	2699	22%
	8 hours or longer	13	7%	13	7%	816	7%
	Can't remember	12	6%	11	6%	945	8%
	I did not have to wait	13	7%	11	6%	694	6%
	Missing	196		220		9749	
A6.	**When you were referred to see a specialist, were you offered a choice of hospital for your first hospital appointment?**						
	Yes	79	33%	78	31%	2748	26%
	No, but I would have liked a choice	37	15%	36	14%	1065	10%
	No, but I did not mind	116	49%	126	51%	6357	59%
	Don't know / Can't remember	7	3%	9	4%	553	5%
	Missing	143		154		11090	

ADMISSION TO HOSPITAL	Total	2010	Total	2011	Total	All
A7. Who referred you to see a specialist?						
A doctor from my local general practice	145	63%	134	56%	6514	62%
Any other doctor or specialist	56	24%	76	32%	2961	28%
A practice nurse or nurse practitioner	9	4%	9	4%	252	2%
Any other health professional	14	6%	10	4%	270	3%
Don't know / Can't remember	6	3%	10	4%	464	4%
Missing	152		164		11352	
A8. Overall, from the time you first talked to this health professional about being referred to a hospital, how long did you wait to be admitted to hospital?						
Up to 1 month	66	31%	59	27%	2915	30%
1 to 2 months	60	28%	55	25%	2036	21%
3 to 4 months	33	15%	35	16%	1740	18%
5 to 6 months	9	4%	22	10%	812	8%
More than 6 months	26	12%	29	13%	1234	13%
Don't know / Can't remember	19	9%	20	9%	886	9%
Missing	169		183		12190	
A9. How do you feel about the length of time you were on the waiting list before your admission to hospital?						
I was admitted as soon as I thought was necessary	165	75%	175	76%	7162	74%
I should have been admitted a bit sooner	33	15%	34	15%	1546	16%
I should have been admitted a lot sooner	23	10%	22	10%	1002	10%
Missing	161		172		12103	
A10. Were you given a choice of ADMISSION DATES?						
Yes	76	35%	62	27%	2482	25%
No	140	64%	166	71%	6888	70%
Don't know / Can't remember	4	2%	5	2%	440	4%
Missing	162		170		12003	
A11. Was your admission date changed by the hospital?						
No	185	83%	182	79%	7915	80%
Yes, once	29	13%	41	18%	1586	16%
Yes, 2 or 3 times	9	4%	7	3%	310	3%
Yes, 4 times or more	1	0%	1	0%	60	1%
Missing	158		172		11942	
A12. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?						
Yes, definitely	35	10%	45	11%	2694	13%
Yes, to some extent	54	15%	72	18%	4226	20%
No	277	76%	275	70%	14160	67%
Missing	16		11		733	

THE HOSPITAL & WARD	Total	2010	Total	2011	Total	All
B13. While in hospital, did you ever stay in a critical care area (Intensive Care Unit, High Dependency Unit or Coronary Care Unit)?						
Yes	64	17%	80	20%	4338	20%
No	285	78%	301	77%	15835	75%
Don't know / Can't remember	18	5%	12	3%	1046	5%
Missing	15		10		594	
B14. When you were first admitted to a bed on a ward, did you share a sleeping area, for example, a room or bay, with patients of the opposite sex?						
Yes	91	25%	57	15%	1939	9%
No	278	75%	333	85%	19284	91%
Missing	13		13		590	
B15. When you were first admitted, did you mind sharing a sleeping area, for example a room or bay, with patients of the opposite sex?						
Yes	21	23%	15	25%	484	24%
No	70	77%	44	75%	1499	76%
Missing	291		344		19830	
B16. During your stay in hospital, how many wards did you stay in?						
1	258	70%	287	73%	12994	61%
2	82	22%	81	21%	6274	30%
3 or more	25	7%	22	6%	1728	8%
Don't know / Can't remember	5	1%	2	1%	259	1%
Missing	12		11		558	
B17. AFTER YOU MOVED to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?						
Yes	16	15%	15	15%	516	7%
No	89	85%	86	85%	7375	93%
Missing	277		302		13922	
B18. AFTER YOU MOVED, did you mind sharing a sleeping area, for example a room or bay, with patients of the opposite sex?						
Yes	8	47%	5	29%	145	27%
No	9	53%	12	71%	390	73%
Missing	365		386		21278	
B19. While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?						
Yes	*59*	*17%*	*44*	*12%*	*2557*	*13%*
Yes, because it had special bathing equipment that I needed	*3*	*1%*	*5*	*1%*	*267*	*1%*
No	*279*	*79%*	*305*	*82%*	*16007*	*80%*
I did not use a bathroom or shower	13	4%	14	4%	1128	5%
Don't know / Can't remember	*14*	*4%*	*16*	*4%*	*1113*	*6%*
Missing	14		19		741	

THE HOSPITAL & WARD	Total	2010	Total	2011	Total	All
B20. Were you ever bothered by noise AT NIGHT from OTHER PATIENTS?						
Yes	150	41%	135	35%	8027	38%
No	220	59%	252	65%	13119	62%
Missing	12		16		667	
B21. Were you ever bothered by noise AT NIGHT from HOSPITAL STAFF?						
Yes	83	22%	79	20%	4395	21%
No	289	78%	308	80%	16770	79%
Missing	10		16		648	
B22. In your opinion, how clean was the hospital room or ward that you were in?						
Very clean	235	63%	247	63%	14538	68%
Fairly clean	128	34%	127	32%	6191	29%
Not very clean	9	2%	16	4%	548	3%
Not at all clean	3	1%	1	0%	91	0%
Missing	7		12		445	
B23. How clean were the toilets and bathrooms that you used in hospital?						
Very clean	*187*	*51%*	*210*	*55%*	*12720*	*62%*
Fairly clean	*141*	*39%*	*144*	*38%*	*6766*	*33%*
Not very clean	*32*	*9%*	*23*	*6%*	*937*	*5%*
Not at all clean	*5*	*1%*	*2*	*1%*	*236*	*1%*
I did not use a toilet or bathroom	9	2%	13	3%	673	3%
Missing	8		11		481	
B24. Did you feel threatened during your stay in hospital by other patients or visitors?						
Yes	10	3%	11	3%	674	3%
No	363	97%	379	97%	20685	97%
Missing	9		13		454	
B25. Did you have somewhere to keep your personal belongings whilst on the ward?						
Yes, and I could lock it if I wanted to	*100*	*30%*	*106*	*30%*	*6393*	*33%*
Yes, but I could not lock it	*219*	*65%*	*230*	*64%*	*11520*	*60%*
No	*15*	*4%*	*18*	*5%*	*789*	*4%*
I did not take any belongings to hospital	33	9%	31	8%	2021	10%
Don't know / Can't remember	*4*	*1%*	*3*	*1%*	*482*	*3%*
Missing	11		15		608	
B26. Did you see any posters or leaflets on the ward asking patients and visitors to wash their hands or to use hand-wash gels?						
Yes	359	95%	363	93%	19108	89%
No	10	3%	11	3%	901	4%
Can't remember	8	2%	17	4%	1398	7%
Missing	5		12		406	

THE HOSPITAL & WARD	Total	2010	Total	2011	Total	All
B27. Were hand-wash gels available for patients and visitors to use?						
Yes	359	95%	364	94%	19690	92%
Yes, but they were empty	7	2%	5	1%	286	1%
I did not see any hand-wash gels	4	1%	8	2%	437	2%
Don't know / Can't remember	7	2%	12	3%	993	5%
Missing	5		14		407	
B28. How would you rate the hospital food?						
Very good	*78*	*21%*	*68*	*18%*	*4282*	*21%*
Good	*127*	*35%*	*135*	*36%*	*7251*	*35%*
Fair	*104*	*28%*	*109*	*29%*	*5940*	*29%*
Poor	*58*	*16%*	*65*	*17%*	*3007*	*15%*
I did not have any hospital food	8	2%	12	3%	824	4%
Missing	7		14		509	
B29. Were you offered a choice of food?						
Yes, always	284	78%	313	81%	16871	80%
Yes, sometimes	59	16%	57	15%	2998	14%
No	22	6%	17	4%	1190	6%
Missing	17		16		754	
B30. Did you get enough help from staff to eat your meals?						
Yes, always	*82*	*67%*	*66*	*55%*	*3816*	*61%*
Yes, sometimes	*19*	*15%*	*28*	*23%*	*1231*	*20%*
No	*22*	*18%*	*27*	*22%*	*1186*	*19%*
I did not need help to eat meals	243	66%	261	68%	14733	70%
Missing	16		21		847	

DOCTORS SWBTB (5/12) 091 (b)

		Total	2010	Total	2011	Total	All
C31.	**When you had important questions to ask a doctor, did you get answers that you could understand?**						
	Yes, always	*248*	*74%*	*259*	*71%*	*12816*	*67%*
	Yes, sometimes	*78*	*23%*	*85*	*23%*	*5199*	*27%*
	No	*7*	*2%*	*19*	*5%*	*1178*	*6%*
	I had no need to ask	41	11%	28	7%	2128	10%
	Missing	8		12		492	
C32.	**Did you have confidence and trust in the doctors treating you?**						
	Yes, always	314	84%	329	84%	17041	80%
	Yes, sometimes	46	12%	51	13%	3580	17%
	No	13	3%	12	3%	747	3%
	Missing	9		11		445	
C33.	**Did doctors talk in front of you as if you weren't there?**						
	Yes, often	25	7%	29	7%	1326	6%
	Yes, sometimes	80	22%	96	25%	4445	21%
	No	266	72%	266	68%	15493	73%
	Missing	11		12		549	
C34.	**As far as you know, did doctors wash or clean their hands between touching patients?**						
	Yes, always	197	53%	200	51%	10211	48%
	Yes, sometimes	40	11%	31	8%	2042	10%
	No	17	5%	18	5%	838	4%
	Don't know / Can't remember	118	32%	145	37%	8287	39%
	Missing	10		9		435	

NURSES SWBTB (5/12) 091 (b)

		Total	2010	Total	2011	Total	All
D35.	**When you had important questions to ask a nurse, did you get answers that you could understand?**						
	Yes, always	*221*	*65%*	*244*	*66%*	*12778*	*66%*
	Yes, sometimes	*102*	*30%*	*109*	*29%*	*5621*	*29%*
	No	*19*	*6%*	*17*	*5%*	*925*	*5%*
	I had no need to ask	31	8%	27	7%	2144	10%
	Missing	9		6		345	
D36.	**Did you have confidence and trust in the nurses treating you?**						
	Yes, always	275	74%	303	77%	16077	75%
	Yes, sometimes	81	22%	77	19%	4669	22%
	No	18	5%	16	4%	713	3%
	Missing	8		7		354	
D37.	**Did nurses talk in front of you as if you weren't there?**						
	Yes, often	33	9%	31	8%	1059	5%
	Yes, sometimes	71	19%	87	22%	3622	17%
	No	268	72%	277	70%	16698	78%
	Missing	10		8		434	
D38.	**In your opinion, were there enough nurses on duty to care for you in hospital?**						
	There were always or nearly always enough nurses	226	61%	240	61%	12513	59%
	There were sometimes enough nurses	111	30%	117	30%	6503	30%
	There were rarely or never enough nurses	36	10%	39	10%	2371	11%
	Missing	9		7		426	
D39.	**As far as you know, did nurses wash or clean their hands between touching patients?**						
	Yes, always	221	59%	219	56%	12225	57%
	Yes, sometimes	50	13%	40	10%	2459	11%
	No	12	3%	20	5%	542	3%
	Don't know / Can't remember	89	24%	114	29%	6219	29%
	Missing	10		10		368	

YOUR CARE & TREATMENT	Total	2010	Total	2011	Total	All
E40. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?						
Yes, often	29	8%	30	8%	1785	8%
Yes, sometimes	97	26%	111	28%	5639	26%
No	247	66%	257	65%	13960	65%
Missing	9		5		429	
E41. Were you involved as much as you wanted to be in decisions about your care and treatment?						
Yes, definitely	188	51%	214	54%	11134	52%
Yes, to some extent	144	39%	139	35%	7877	37%
No	38	10%	41	10%	2291	11%
Missing	12		9		511	
E42. How much information about your condition or treatment was given to YOU?						
Not enough	65	18%	69	17%	4586	21%
Right amount	301	81%	320	81%	16655	78%
Too much	5	1%	8	2%	146	1%
Missing	11		6		426	
E43. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?						
Yes, definitely	*111*	*44%*	*125*	*43%*	*6275*	*42%*
Yes, to some extent	*99*	*39%*	*119*	*41%*	*6157*	*41%*
No	*41*	*16%*	*46*	*16%*	*2573*	*17%*
No family or friends were involved	30	8%	37	9%	2185	10%
My family did not want or need information	74	20%	58	15%	3274	15%
I did not want my family or friends to talk to a doctor	16	4%	12	3%	767	4%
Missing	11		6		582	
E44. Did you find someone on the hospital staff to talk to about your worries and fears?						
Yes, definitely	*91*	*41%*	*122*	*49%*	*5423*	*41%*
Yes, to some extent	*90*	*40%*	*75*	*30%*	*4887*	*37%*
No	*42*	*19%*	*50*	*20%*	*2898*	*22%*
I had no worries or fears	142	39%	146	37%	8104	38%
Missing	17		10		501	
E45. Do you feel you got enough emotional support from hospital staff during your stay?						
Yes always	*0*	*0%*	*152*	*57%*	*7974*	*56%*
Yes sometimes	*0*	*0%*	*80*	*30%*	*4116*	*29%*
No	*0*	*0%*	*34*	*13%*	*2078*	*15%*
I did not need any emotional support	0	0%	129	33%	7185	34%
Missing	382		8		460	
E46. Were you given enough privacy when discussing your condition or treatment?						
Yes, always	257	70%	277	70%	15389	72%
Yes, sometimes	87	24%	94	24%	4266	20%
No	24	7%	25	6%	1590	7%
Missing	14		7		568	

YOUR CARE & TREATMENT	Total	2010	Total	2011	Total	All
E47. Were you given enough privacy when being examined or treated?						
Yes, always	336	90%	347	87%	19037	89%
Yes, sometimes	35	9%	45	11%	2019	9%
No	4	1%	5	1%	332	2%
Missing	7		6		425	
E48. Were you ever in any pain?						
Yes	246	67%	283	72%	13625	65%
No	123	33%	109	28%	7370	35%
Missing	13		11		818	
E49. Do you think the hospital staff did everything they could to help control your pain?						
Yes, definitely	171	70%	203	71%	9715	70%
Yes, to some extent	60	24%	63	22%	3295	24%
No	15	6%	20	7%	892	6%
Missing	136		117		7911	
E50. How many minutes after you used the call button did it usually take before you got the help you needed?						
0 minutes / right away	*36*	*18%*	*41*	*18%*	*1868*	*14%*
1-2 minutes	*65*	*32%*	*99*	*44%*	*4968*	*38%*
3-5 minutes	*61*	*30%*	*49*	*22%*	*3756*	*29%*
More than 5 minutes	*36*	*18%*	*29*	*13%*	*2258*	*17%*
I never got help when I used the call button	*6*	*3%*	*7*	*3%*	*210*	*2%*
I never used the call button	163	44%	166	42%	7914	38%
Missing	15		12		839	

OPERATIONS & PROCEDURES		Total	2010	Total	2011	Total	All
F51.	**During your stay in hospital, did you have an operation or procedure?**						
	Yes	315	84%	315	80%	13263	63%
	No	59	16%	77	20%	7850	37%
	Missing	8		11		700	
F52.	**Beforehand did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?**						
	Yes, completely	*255*	*83%*	*255*	*81%*	*10410*	*80%*
	Yes, to some extent	*47*	*15%*	*48*	*15%*	*2071*	*16%*
	No	*6*	*2%*	*10*	*3%*	*530*	*4%*
	I did not want an explanation	4	1%	5	2%	337	3%
	Missing	70		85		8465	
F53.	**Beforehand did a member of staff explain what would be done during the operation or procedure?**						
	Yes, completely	*218*	*73%*	*239*	*77%*	*9610*	*74%*
	Yes, to some extent	*71*	*24%*	*52*	*17%*	*2694*	*21%*
	No	*9*	*3%*	*18*	*6%*	*679*	*5%*
	I did not want an explanation	9	3%	7	2%	355	3%
	Missing	75		87		8475	
F54.	**Beforehand did a member of staff answer your questions about the operation or procedure in a way you could understand?**						
	Yes, completely	*204*	*77%*	*215*	*78%*	*8837*	*77%*
	Yes, to some extent	*54*	*20%*	*46*	*17%*	*2214*	*19%*
	No	*6*	*2%*	*15*	*5%*	*441*	*4%*
	I did not have any questions	42	14%	42	13%	1795	14%
	Missing	76		85		8526	
F55.	**Beforehand were you told how you could expect to feel after you had the operation or procedure?**						
	Yes, completely	171	57%	191	61%	7551	57%
	Yes, to some extent	83	27%	84	27%	3586	27%
	No	48	16%	39	12%	2078	16%
	Missing	80		89		8598	
F56.	**Before the operation or procedure, were you given an anaesthetic or medication to put you to sleep or control your pain?**						
	Yes	261	86%	285	90%	11151	85%
	No	41	14%	32	10%	1973	15%
	Missing	80		86		8689	
F57.	**Before the operation or procedure, did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain in a way you could understand?**						
	Yes, completely	222	85%	240	85%	9354	83%
	Yes, to some extent	30	12%	34	12%	1309	12%
	No	8	3%	10	4%	542	5%
	Missing	122		119		10608	

OPERATIONS & PROCEDURES	Total	2010	Total	2011	Total	All
F58. After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?						
Yes, completely	195	65%	219	69%	8725	66%
Yes, to some extent	69	23%	69	22%	3020	23%
No	37	12%	28	9%	1407	11%
Missing	81		87		8661	

LEAVING HOSPITAL	Total	2010	Total	2011	Total	All
G59. Did you feel you were involved in decisions about your discharge from hospital?						
Yes, definitely	*175*	*54%*	*206*	*59%*	*10383*	*55%*
Yes, to some extent	*95*	*29%*	*89*	*25%*	*5526*	*29%*
No	*53*	*16%*	*56*	*16%*	*3110*	*16%*
I did not need to be involved	38	11%	44	11%	2221	10%
Missing	21		8		573	
G60. On the day you left hospital, was your discharge delayed for any reason?						
Yes	138	38%	157	40%	8655	41%
No	223	62%	234	60%	12503	59%
Missing	21		12		655	
G61. What was the MAIN reason for the delay?						
I had to wait for MEDICINES	83	63%	100	68%	4981	61%
I had to wait to SEE THE DOCTOR	15	11%	16	11%	1235	15%
I had to wait for an AMBULANCE	11	8%	9	6%	809	10%
Something else	23	17%	22	15%	1173	14%
Missing	250		256		13615	
G62. How long was the delay?						
Up to 1 hour	26	18%	30	19%	1392	16%
Longer than 1 hour but no longer than 2 hours	47	33%	45	29%	2399	27%
Longer than 2 hours but no longer than 4 hours	39	28%	51	32%	2873	33%
Longer than 4 hours	29	21%	31	20%	2080	24%
Missing	241		246		13069	
G63. Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?						
Yes	273	75%	310	80%	13753	66%
No	90	25%	76	20%	7129	34%
Missing	19		17		931	
G64. Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?						
Yes, completely	*229*	*77%*	*265*	*82%*	*12025*	*75%*
Yes, to some extent	*57*	*19%*	*41*	*13%*	*2630*	*16%*
No	*13*	*4%*	*18*	*6%*	*1458*	*9%*
I did not need an explanation	32	9%	29	7%	2281	11%
I had no medicines	36	10%	38	10%	2729	13%
Missing	15		12		690	
G65. Did a member of staff tell you about medication side effects to watch for when you went home?						
Yes, completely	*95*	*38%*	*121*	*45%*	*5338*	*38%*
Yes, to some extent	*41*	*16%*	*50*	*19%*	*2593*	*19%*
No	*116*	*46%*	*96*	*36%*	*5941*	*43%*
I did not need an explanation	75	23%	86	24%	4407	24%
Missing	55		50		3534	

		Total	2010	Total	2011	Total	All
G66.	**Were you told how to take your medication in a way you could understand?**						
	Yes, definitely	*214*	*78%*	*225*	*79%*	*10778*	*76%*
	Yes, to some extent	*42*	*15%*	*38*	*13%*	*2064*	*15%*
	No	*17*	*6%*	*21*	*7%*	*1385*	*10%*
	I did not need to be told how to take my medication	54	17%	72	20%	4138	23%
	Missing	55		47		3448	
G67.	**Were you given clear written or printed information about your medicines?**						
	Yes, completely	217	66%	243	69%	11882	65%
	Yes, to some extent	57	17%	55	16%	2583	14%
	No	40	12%	37	11%	2843	16%
	Don't know / Can't remember	14	4%	15	4%	867	5%
	Missing	54		53		3638	
G68.	**Did a member of staff tell you about any danger signals you should watch for after you went home?**						
	Yes, completely	*142*	*48%*	*157*	*50%*	*6660*	*42%*
	Yes, to some extent	*49*	*17%*	*67*	*22%*	*3350*	*21%*
	No	*104*	*35%*	*87*	*28%*	*5967*	*37%*
	It was not necessary	66	18%	78	20%	4985	24%
	Missing	21		14		851	
G69.	**Did the doctors or nurses give your family or someone close to you all the information they needed to help care for you?**						
	Yes, definitely	*121*	*47%*	*153*	*54%*	*6786*	*47%*
	Yes, to some extent	*61*	*23%*	*66*	*23%*	*3266*	*23%*
	No	*78*	*30%*	*63*	*22%*	*4397*	*30%*
	No family or friends were involved	51	14%	48	12%	3108	15%
	My family or friends did not want or need information	49	14%	59	15%	3471	17%
	Missing	22		14		785	
G70.	**Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?**						
	Yes	280	77%	308	80%	14488	70%
	No	66	18%	56	15%	4467	22%
	Don't know / Can't remember	17	5%	22	6%	1653	8%
	Missing	19		17		1205	
G71.	**Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?**						
	Yes, I received copies	213	58%	269	70%	10526	51%
	No, I did not receive copies	126	34%	89	23%	8427	41%
	Not sure / Don't know	27	7%	25	7%	1707	8%
	Missing	16		20		1153	
G72.	**Were the letters written in a way that you could understand?**						
	Yes, definitely	143	68%	208	76%	7655	73%
	Yes, to some extent	59	28%	45	16%	2347	22%
	No	6	3%	17	6%	308	3%
	Not sure / Don't know	1	0%	4	1%	140	1%
	Missing	173		129		11363	

OVERALL SWBTB (5/12) 091 (b)

		Total	2010	Total	2011	Total	All
H73.	**Overall, did you feel you were treated with respect and dignity while you were in the hospital?**						
	Yes, always	290	79%	306	78%	16746	80%
	Yes, sometimes	66	18%	73	19%	3566	17%
	No	13	4%	11	3%	644	3%
	Missing	13		13		857	
H74.	**How would you rate how well the doctors and nurses worked together?**						
	Excellent	150	41%	153	40%	8366	40%
	Very good	142	39%	155	40%	7925	38%
	Good	44	12%	55	14%	2928	14%
	Fair	23	6%	20	5%	1144	5%
	Poor	7	2%	4	1%	443	2%
	Missing	16		16		1007	
H75.	**Overall, how would you rate the care you received?**						
	Excellent	163	44%	168	43%	9037	43%
	Very good	130	35%	140	36%	7296	35%
	Good	41	11%	51	13%	2843	14%
	Fair	22	6%	20	5%	1185	6%
	Poor	11	3%	11	3%	532	3%
	Missing	15		13		920	
H76.	**During your hospital stay, were you ever asked to give your views on the quality of your care?**						
	Yes	37	10%	92	24%	2390	11%
	No	301	81%	261	67%	16651	80%
	Don't know / Can't remember	32	9%	35	9%	1882	9%
	Missing	12		15		890	
H77.	**While in hospital, did you ever see any posters or leaflets explaining how to complain about the care your received?**						
	Yes	107	29%	135	35%	6189	30%
	No	169	46%	152	39%	9057	44%
	Don't know / Can't remember	92	25%	103	26%	5548	27%
	Missing	14		13		1019	

		Total	2010	Total	2011	Total	All
J78.	**Who was the main person or people that filled in this questionnaire?**						
	The patient (named on the front of the envelope)	0	0%	305	79%	17513	84%
	A friend or relative of the patient	0	0%	36	9%	1388	7%
	Both patient and friend / relative together	0	0%	43	11%	1872	9%
	The patient with the help of a health professional	0	0%	1	0%	106	1%
	Missing	382		18		934	
J79.	**Do you have any of the following long-standing conditions? Deafness or**						
	Deafness or severe hearing impairment.	45	12%	50	12%	2606	12%
	Missing	337		353		19207	
	Blindness or partially sighted	23	6%	32	8%	897	4%
	Missing	359		371		20916	
	A long-standing physical condition	98	26%	107	27%	6472	30%
	Missing	284		296		15341	
	A learning disability	4	1%	5	1%	278	1%
	Missing	378		398		21535	
	A mental health condition	11	3%	17	4%	1048	5%
	Missing	371		386		20765	
	A long-standing illness, such as cancer HIV diabetes chronic heart disease or epilepsy	88	23%	115	29%	6317	29%
	Missing	294		288		15496	
	No I do not have a long-standing condition	139	36%	146	36%	7098	33%
	Missing	243		257		14715	

		Total	2010	Total	2011	Total	All
J80.	**Does this condition(s) cause you difficulty with any of the following?**						
	Everyday activities that people your age can usually do	114	55%	129	56%	7998	61%
	Missing	93		101		5156	
	At work, in education or training	21	10%	25	11%	1909	15%
	Missing	186		205		11245	
	Access to buildings, streets or vehicles	62	30%	69	30%	3717	28%
	Missing	145		161		9437	
	Reading or writing	25	12%	37	16%	1683	13%
	Missing	182		193		11471	
	People's attitudes to you because of your condition	25	12%	30	13%	1577	12%
	Missing	182		200		11577	
	Communicating, mixing with others or socialising	29	14%	33	14%	2680	20%
	Missing	178		197		10474	
	Any other activity	24	12%	43	19%	2249	17%
	Missing	183		187		10905	
	No difficulty with any of these	62	30%	54	23%	3120	24%
	Missing	145		176		10034	
J81.	**What is your ethnic group?**						
	White English / Welsh / Scottish / Northern Irish / British	275	74%	294	77%	18820	92%
	White Irish	15	4%	5	1%	240	1%
	White Gypsy or Irish Traveller	0	0%	0	0%	8	0%
	Any other White background	6	2%	2	1%	328	2%
	White and Black Caribbean	3	1%	0	0%	33	0%
	White and Black African	0	0%	2	1%	21	0%
	White and Asian	2	1%	0	0%	39	0%
	Any other Mixed / muliple ethnic background	0	0%	0	0%	23	0%
	Indian	25	7%	26	7%	293	1%
	Pakistani	7	2%	18	5%	163	1%
	Bangladeshi	1	0%	4	1%	37	0%
	Chinese	2	1%	1	0%	44	0%
	Any other Asian background	5	1%	1	0%	61	0%
	African	4	1%	7	2%	171	1%
	Caribbean	23	6%	17	4%	192	1%
	Any other Black / African / Caribbean background	1	0%	1	0%	31	0%
	Arab	0	0%	3	1%	19	0%
	Any other ethnic group	1	0%	0	0%	25	0%
	Missing	12		22		1265	
J82.	**Are you male or female?**						
	Male	169	45%	177	45%	10030	47%
	Female	203	55%	218	55%	11358	53%
	Missing	10		8		425	

ABOUT YOU		Total	2010	Total	2011	Total	All
J83.	**Age:**						
	16 - 24	13	4%	17	4%	685	3%
	25 - 34	20	5%	17	4%	930	4%
	35 - 44	26	7%	33	8%	1499	7%
	45 - 54	46	12%	48	12%	2493	12%
	55 - 64	67	18%	76	19%	3854	18%
	65 - 74	94	25%	92	23%	5096	24%
	75 - 84	83	22%	90	23%	4806	22%
	85 +	20	5%	23	6%	2141	10%
	Missing	13		7		309	
J84.	**What is your religion?**						
	No religion	0	0%	32	8%	2964	14%
	Buddhist	0	0%	1	0%	63	0%
	Christian	0	0%	296	75%	17056	80%
	Hindu	0	0%	9	2%	180	1%
	Jewish	0	0%	1	0%	89	0%
	Muslim	0	0%	32	8%	399	2%
	Sikh	0	0%	17	4%	83	0%
	Other	0	0%	3	1%	210	1%
	I would prefer not to say	0	0%	5	1%	333	2%
	Missing	382		7		436	
J85.	**Which of the following best describes how you think of yourself?**						
	Heterosexual / straight	0	0%	353	93%	19171	94%
	Gay / Lesbian	0	0%	3	1%	152	1%
	Bisexual	0	0%	0	0%	73	0%
	Other	0	0%	2	1%	156	1%
	I would prefer not to say	0	0%	20	5%	770	4%
	Missing	382		25		1491	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – April 2012
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Management
AUTHOR:	Robert White/Tony Wharram
DATE OF MEETING:	31 May 2012

EXECUTIVE SUMMARY:

The report presents the financial performance for the Trust and operational divisions for the period of April 2012.

Measured against the DoH target, the Trust generated an actual surplus of £8,000 during April against a planned deficit of (£17,000). For the purposes of its statutory accounts, the in month surplus was slightly higher at £37,000.

REPORT RECOMMENDATION:

The Trust Board is requested to NOTE the contents of the report and ENDORSE any actions taken to ensure that the Trust remains on target to achieve its planned financial position.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
x		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

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

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Good use of Resources (under 11/12 OfE, key Strategies & Programmes)

PREVIOUS CONSIDERATION:

Performance Management Board and Trust Management Board on 22 May 2012 and Finance & Performance Management Committee on 24 May 2012.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – April 2012

EXECUTIVE SUMMARY

• For the month of April 2012, the Trust delivered a "bottom line" surplus of £8,000 compared to a planned deficit of (£17,000) (as measured against the DoH performance target).

•At month end, WTE's (whole time equivalents), including the impact of agency staff, were 71 below planned levels. Total pay expenditure for the month, inclusive of agency costs, is £50,000 below the planned level.

• The month-end cash balance was approximately £12.3m 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	25	25	>= Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	32	32	>= Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	50	50	<=Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	(68)	(68)	<= Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	71	71	<= Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	12,253	12,253	>= 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	(17)	8
Capital Resource Limit	445	245
External Financing Limit	---	12,253
Return on Assets Employed	3.50%	3.50%

2011/2012 Summary Income & Expenditure Performance at April 2012	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
Income from Activities	382,178	31,819	31,816	(3)	31,819	31,816	(3)
Other Income	39,298	3,129	3,182	53	3,129	3,182	53
Operating Expenses	(396,313)	(33,186)	(33,204)	(18)	(33,186)	(33,204)	(18)
EBITDA	25,163	1,762	1,794	32	1,762	1,794	32
Interest Receivable	100	8	1	(7)	8	1	(7)
Depreciation & Amortisation	(13,525)	(1,127)	(1,127)	0	(1,127)	(1,127)	0
PDC Dividend	(5,396)	(450)	(450)	0	(450)	(450)	0
Interest Payable	(2,114)	(181)	(181)	0	(181)	(181)	0
Net Surplus/(Deficit)	**4,228**	**12**	**37**	**25**	**12**	**37**	**25**
IFRS/Impairment/Donated Asset Related Adjustments	(353)	(29)	(29)	0	(29)	(29)	0
SURPLUS/(DEFICIT) FOR DOH TARGET	**3,875**	**(17)**	**8**	**25**	**(17)**	**8**	**25**

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.

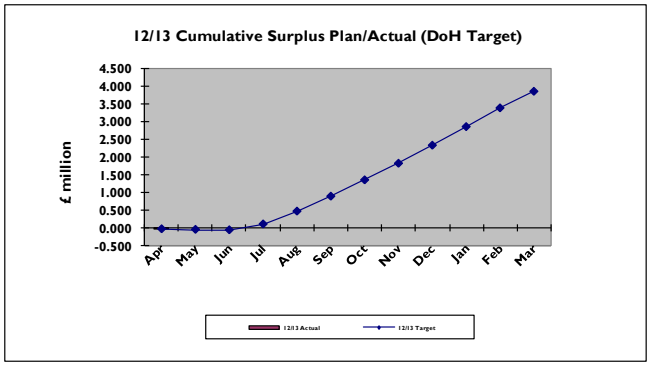
Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – April 2012

Overall Performance Against Plan

• The overall performance of the Trust against the DoH planned position is shown in the adjacent graph. Net bottom-line performance delivered an actual surplus of £8,000 in April against a planned deficit of (£17,000).

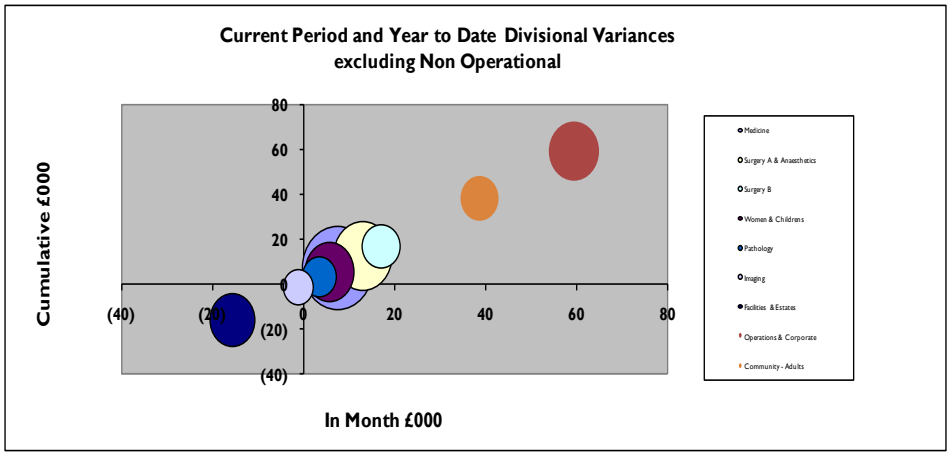


Divisional Performance

• For April, there are no material variances from plan among operational divisions.

• SLA performance is largely assumed to be in line with plan as fully costed data for April is not yet available. Variations from plan are only recorded for relatively small, peripheral, arrangements where performance monitoring takes place outside "mainstream" processes.

• The only two areas with significant variances from plan are Corporate Services and Non Operational. The former is primarily the result of higher than planned Research & Development income offset by higher pay costs and vacancies particularly within Finance and the Chief Executive Divisions. The latter is primarily the result of the need to accrue expenditure where there is a degree of uncertainty and which cannot therefore readily be allocated to operational divisions.



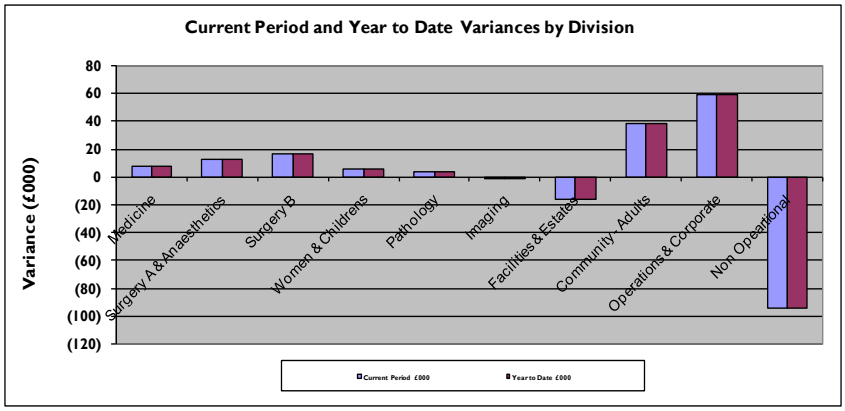
The tables adjacent and below show no significant in month adverse variances from plan.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

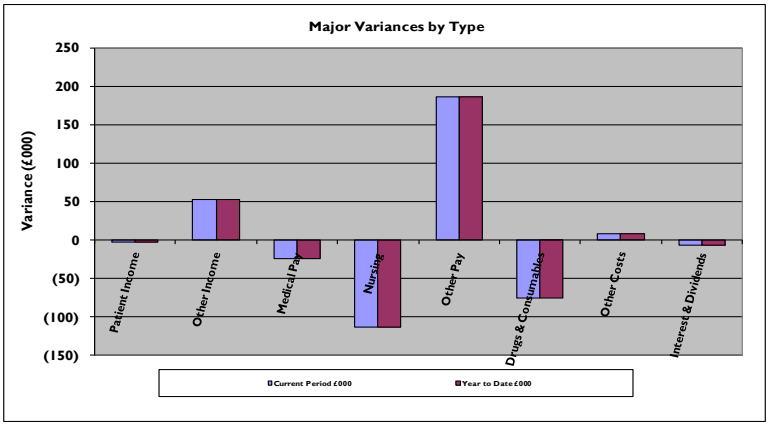
Financial Performance Report – April 2012

Divisional Variances from Plan	Current Period £000	Year to Date £000
Medicine	8	8
Surgery A & Anaesthetics	13	13
Surgery B	17	17
Women & Childrens	6	6
Pathology	3	3
Imaging	(1)	(1)
Facilities & Estates	(16)	(16)
Community - Adults	39	39
Operations & Corporate	59	59
Non Opeartional	(95)	(95)



For April, overall income shows a small positive variance (mainly research & development income) along with pay (primarily in "other" pay groups) but an adverse variance for non pay.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
Patient Income	(3)	(3)
Other Income	53	53
Medical Pay	(24)	(24)
Nursing	(113)	(113)
Other Pay	187	187
Drugs & Consumables	(76)	(76)
Other Costs	8	8
Interest & Dividends	(7)	(7)



Sandwell and West Birmingham Hospitals NHS

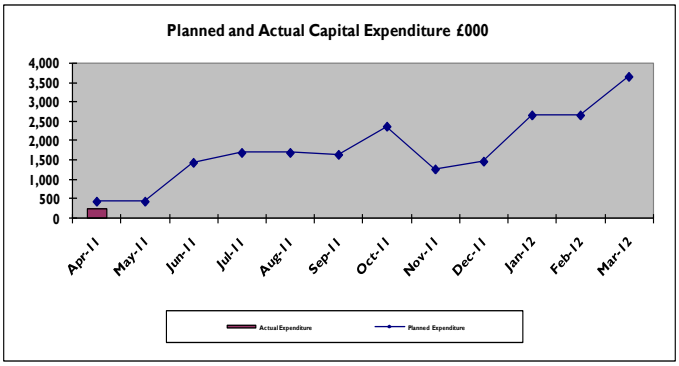
NHS Trust

Financial Performance Report – April 2012

Capital Expenditure

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

•April expenditure lower than planned for the month at £0.2m primarily related to balances on brought forward schemes and land acquisition.

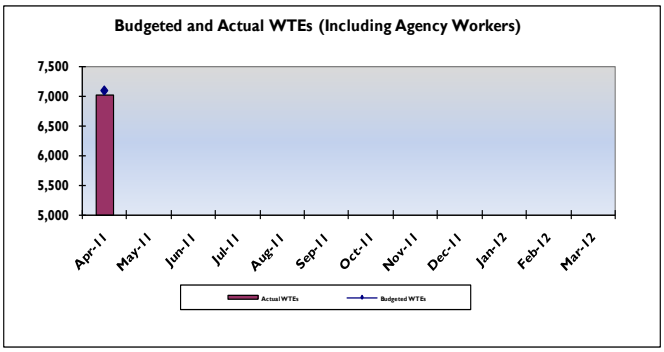


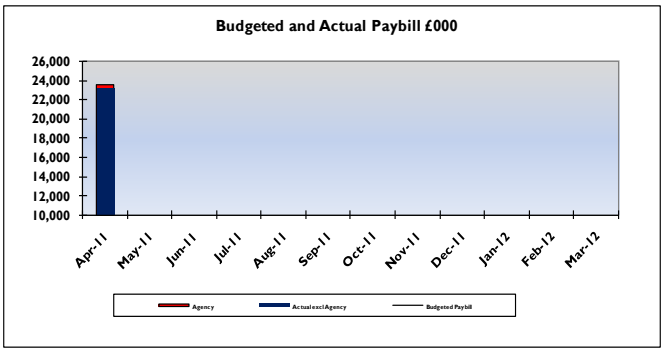
Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are approximately 71 below plan . Excluding the impact of agency staff, wte numbers are around 150 below plan.

• Total pay costs (including agency workers) are £50,000 lower than budgeted levels for the month , particularly on scientific & therapeutic, management and administration and estates pay groups.

• Expenditure for agency staff in April was £391,000 compared with an average of £526,000 for 2011/12 and an April 2011 spend of £698,000. The biggest single group accounting for agency expenditure remains medical staffing.





Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – April 2012

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 April					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	6,240	6,038		226	6,264	(24)
Management	1,283	1,215		0	1,215	68
Administration & Estates	2,629	2,449	82	40	2,572	57
Healthcare Assistants & Support Staff	2,620	2,459	161	0	2,620	0
Nursing and Midwifery	7,184	6,940	293	65	7,297	(113)
Scientific, Therapeutic & Technical	3,649	3,502		61	3,563	86
Other Pay	(22)	2			2	(24)
Total Pay Costs	23,583	22,606	536	391	23,533	50

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 draft statutory accounts for the year ended 31st March 2012.

• Cash balances at 30th April are approximately £40.5m which is around £6.0m higher than at 31st March.

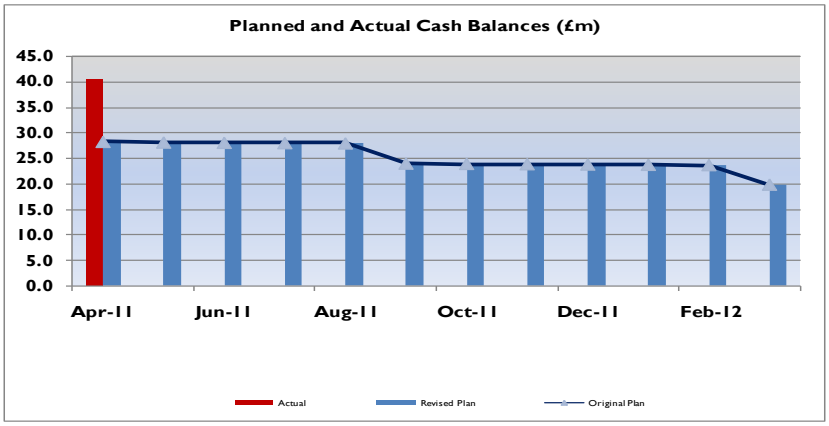
Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION

		Opening Balance as at 1st April 2012 £000	Balance as at end April 2012 £000
Non Current Assets	Intangible Assets	1,075	1,075
	Tangible Assets	227,072	226,190
	Investments	0	0
	Receivables	865	865
Current Assets	Inventories	4,065	4,274
	Receivables and Accrued Income	14,446	12,196
	Investments	0	0
	Cash	34,465	40,505
Current Liabilities	Payables and Accrued Expenditure	(38,987)	(41,360)
	Loans	(2,000)	(2,000)
	Borrowings	(1,166)	(1,175)
	Provisions	(10,508)	(10,267)
Non Current Liabilities	Payables and Accrued Expenditure	0	0
	Loans	(5,000)	(6,000)
	Borrowings	(29,995)	(29,934)
	Provisions	(2,437)	(2,437)
		191,895	191,932
Financed By			
Taxpayers Equity	Public Dividend Capital	160,231	160,231
	Revaluation Reserve	41,228	41,228
	Other Reserves	9,058	9,058
	Income and Expenditure Reserve	(18,622)	(18,585)
		191,895	191,932

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – April 2012



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 April 2012

ACTUAL/FORECAST	Apr-12 £000s	May-12 £000s	Jun-12 £000s	Jul-12 £000s	Aug-12 £000s	Sep-12 £000s	Oct-12 £000s	Nov-12 £000s	Dec-12 £000s	Jan-13 £000s	Feb-13 £000s	Mar-13 £000s	Apr-13 £000s
Receipts													
SLAs: Sandwell PCT	**15,649**	17,165	17,165	17,165	17,165	17,165	17,165	17,165	17,165	17,165	17,165	17,165	17,165
HoB PCT	**11,392**	11,341	11,341	11,341	11,341	11,341	11,341	11,341	11,341	11,341	11,341	11,341	11,341
Associated PCTs	**562**	629	629	629	629	629	629	629	629	629	629	629	629
Pan Birmingham LSCG	**0**	3,500	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750
Education & Training	**1,269**	1,449	1,449	1,449	1,449	1,449	1,449	1,449	1,449	1,449	1,449	1,449	1,449
Loans													
Other Receipts	**2,424**	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900
Total Receipts	31,296	36,984	35,234	35,234	35,234	35,234	35,234	35,234	35,234	35,234	35,234	35,234	35,234
Payments													
Payroll	13,578	14,641	14,534	14,417	14,304	14,266	14,220	14,215	14,215	14,215	14,215	14,214	14,200
Tax, NI and Pensions		9,843	9,771	9,692	9,616	9,591	9,559	9,556	9,556	9,556	9,556	19,110	9,550
Non Pay - NHS	1,230	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	3,000	2,500
Non Pay - Trade	8,197	6,541	5,087	6,541	5,814	5,814	6,541	5,814	4,361	7,995	7,314	9,881	8,000
Non Pay - Capital	1,788	445	445	1,445	1,700	1,700	1,750	2,375	1,275	1,475	2,665	2,665	1,750
PDC Dividend						2,698						2,698	
Repayment of Loans						1,000						1,000	
Interest	175	175	175	175	175	175	175	175	175	175	175	175	175
BTC Unitary Charge		345	345	345	345	345	345	345	345	345	345	690	360
Other Payments	288												
Total Payments	25,256	34,490	32,857	35,115	34,454	38,089	35,090	34,980	32,427	36,261	36,770	53,433	36,535
Cash Brought Forward	34,465	40,505	42,999	45,376	45,495	46,275	43,420	43,564	43,818	46,625	45,598	44,062	25,863
Net Receipts/(Payments)	6,040	2,494	2,377	119	780	(2,855)	144	254	2,807	(1,027)	(1,536)	(18,199)	(1,301)
Cash Carried Forward	40,505	42,999	45,376	45,495	46,275	43,420	43,564	43,818	46,625	45,598	44,062	25,863	24,562

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – April 2012

Risk Ratings			
Measure	**Description**	**Value**	**Score**
EBITDA Margin	Excess of income over operational costs	5.1%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	101.8%	5
Return on Assets	Surplus before dividends over average assets employed	4.8%	3
I&E Surplus Margin	I&E Surplus as % of total income	0.1%	2
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	21.1	3
Overall Rating			**2.9**

Risk Ratings

•The adjacent table shows the Monitor risk rating score for the Trust based on performance at April.
• 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 3.
•I&E Surplus Margin is lower than would normally be expected due to relatively low levels of surplus being delivered in the early months of 2012/13 (surpluses are profiled towards the latter part of the year).

External Focus

• In the latest DoH leadership bulletin, Sir David Nicholson, in his introduction, continues to emphasise the challenges for the NHS in delivering £20b of savings particularly against the backdrop of service reconfiguration and the need to continue to improve the quality of patient care.

• The latest additions to the foundation trust network brings the total number of foundation trusts to 144 with 104 NHS trusts remaining in the FT pipeline. Strategic health authorities continue to lead the remaining NHS trusts towards full FT status. Meanwhile, FT pipeline efficiency has been enhanced with the roll out of phase one of the Single Operating Model (SOM), which focuses on the development and assurance of FT applications. The second phase will be implemented over the next few months and will focus on a model by which SHA clusters can work with trusts as they prepare for life as autonomous FTs.

• At this point in the financial year, it is too early to have any meaningful feedback on potential financial issues being experienced within the NHS, and specifically with local commissioners, although with the current tight financial regime, there can be no doubt that delivering against financial targets will be difficult for all organisations.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – April 2012

Conclusions

• Measured against the DoH target, the Trust generated an actual surplus of £8,000 during April against a planned deficit of (£17,000). For the purposes of its statutory accounts, the in month surplus was slightly higher at £37,000.

• The £8,000 surplus in April is £25,000 better than planned for the month.

• In month capital expenditure is £245,000 which is lower than planned although the plan is significant weighted towards the latter part of the year.

•At 30th April, cash balances are approximately £12.3m higher than the cash plan which is around £6.0m greater than the position at 31st March.

• The only material adverse variance in month is within non operational areas which is the result of recognition of some uncertain commitments which cannot be attributed to divisional positions.

• Monitoring of divisional performance will take place as in previous years with action being taken as necessary to rectify any potential and/or actual variances. Monitoring of the performance of the Transformation Programme will be a key component of this.

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 Corporate Performance Monitoring Report
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of Planning & Performance Management
DATE OF MEETING:	31 May 2012

EXECUTIVE SUMMARY:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April 2012.

REPORT RECOMMENDATION:

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

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		x

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

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

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Accessible and Responsive Care, High Quality Care and Good Use of Resources. National targets and Infection Control. Internal Control and Value for Money

PREVIOUS CONSIDERATION:

Performance Management Board, Trust Management Board and Finance & Performance Management Committee

SANDWELL AND WEST BIRMINGHAM HOSPITALS CORPORATE QUALITY AND PERFORMANCE MONITORING REPORT - APRIL 2012 - 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 (March), and full year thresholds for each of the 9 (national) headline, 2-week, 31-day and 62-day cancer indicators.
Cancelled Operations	▲	■	▲	■	The overall percentage of Cancelled Operations further reduced on both sites to 0.2% overall during the month of April. There were no breaches of the 28-day guarantee reported.
Delayed Transfers of Care	▲	■			During the month (April) Delayed Transfers of Care reduced to 3.6% overall.
Stroke Care	■	▼	▼	▼	Performance against the target for patients who spent at least 90% of their hospital stay on a Stroke Unit continues to be maintained above the 80% threshold, with performance of 84.4% recorded for April 2012. Data for April for TIA (High Risk) Treatment (within 24 hours of initial presentation) indicates performance has reduced to 57.1% overall, influenced by lower performance on the City site.
Accident & Emergency	▼	■			The A/E 4-hour wait target of 95% was met during the month (95.30%).
	▼	■			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. the Trust met 2 of the 5 indicators during the month of April, one in each group.
Infection Control	▲	■			There were 3 cases of C Diff reported across the Trust during the month of April compared with a trajectory for the month of 5, derived from an annual target for 2012 / 2013 of 57. There were no cases of MRSA Bacteraemia reported during the month. The MRSA Bacteraemia target for 2012 / 2013 is 2.
			■	■	Data is included on Elective and Non-Elective MRSA Screening, whereby actual screens undertaken by patient are mapped to eligible patients. This indicates a compliance of 38.1% and 43.3% for Elective and Non-Elective screens respectively for the month of April.
Referral to Treatment	▼	■			All 3 high level RTT Performance Indicators were met in month (April). Exceptions by specialty were Trauma & Orthopaedics and Plastic Surgery for Admitted Care, where 73.1% and 86.6% of patients commenced treatment within 18 weeks of referral (target 90%) respectively, and the same two specialities for Incomplete Pathway Waits of less than 18 weeks, with Trauma & Orthopaedics (87.4%) and Plastic Surgery (85.8%) below the minimum 92% operational threshold.
Diagnostic Waits	■	■			Diagnostic Waits greater than 6 weeks during April of 1.34% exceeded the performance threshold of 1.00% or less. A number of areas exceeded 1.00%; Audiology, Cardiology and Endoscopy (Colonoscopy, Flexi sigmoidoscopy, Cystoscopy and Gastroscopy).
Same Sex Accommodation	■	■			There were No Breaches of Same Sex Accommodation reported during the month of April.
Cervical Cytology			■	■	The Turnaround Time of Cervical Cytology requests remains less than 9 days.
Mortality				▲	The Hospital Standardised Mortality Rate (HSMR) for the Trust for the most recent 12-month cumulative period (ending January 2012) is 93.1, compared with a Peer (SHA) rate of 98.3.
Sickness Absence			▲	▲	Overall Sickness Absence for the month of April reduced slightly to 4.06% (4.13% March), influenced by a reduction in short-term absence. The range by Division is 0.25 - 4.98%. The target for the Quarter is 3.40% or less.
Learning & Development			■	■	PDR (12-month rolling) compliance is 71.6% with over 5300 staff reported as receiving a PDR during the most recent 12 months. Compliance by Division remains variable (28% - 98%). Overall Mandatory Training compliance at the end of April is 74.6%.
CQUIN	■	■			A total of 30 schemes across Acute, Community and Specialised Services have been agreed with a total value of £9.265m. A number of schemes require a baseline assessment to be undertaken during the first quarter following which and end year target and improvement trajectory will be determined. Data for a number of schemes is to be reported quarterly. Available data to date relates to 2 schemes carried forward from last year; VTE Assessment and Mortality Reviews, targets for both of which were met in month.
Referrals			■	■	For 2011 / 2012 overall referrals are 6862 (3.8%) fewer and GP Referrals are 5461 (4.4%) fewer than during 2010 / 2011. For 2011 / 2012 Referrals received from Sandwell PCT are 3552 (3.8%) fewer, HOBtPCT are 613 greater (1.2%) and from Other (non-Sandwell / HOB) PCTs are 3923 (9.6%) fewer than 2010 / 2011.
Activity			■	■	Overall Elective activity for the month is excess of the plan by 9.9% and 0.8% greater than that delivered during the corresponding period last year.
			■	■	Non Elective activity is 2.5% below plan for the month, although 3.0% greater than the corresponding period last year.
			■	■	Outpatient New and Review activity compared with plan for the month is +15.3% and -7.5% respectively, with a Follow Up to New Outpatient Ratio for the month of 2.40 compared with a ratio derived from plan of 2.99.
			■	■	A/E Type I activity during the month of April was 0.6% less than plan for the month. Type II activity is 9.7% less than plan for the month.
Ambulance Turnaround			▼	■	Ambulance Turnaround - the proportion of ambulances waiting greater than 30 minutes increased to 43.6% during April (West Midlands average 36.5%). The number of instances recorded of ambulances with a turnaround time in excess of 60 minutes also increased to 105.

KEY TO PERFORMANCE ASSESSMENT SYMBOLS (compared with previous period)	
▲	Met - Performance improved
■	Met - Performance maintained
▼	Met - Performance deteriorated
▲	Not quite met - performance improved
■	Not quite met - performance maintained
▼	Not quite met - performance deteriorated
▲	Not met - performance improved
■	Not met - performance showing no sign of improvement
▼	Not met - performance shows further deterioration

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	The NHS Performance Framework Monitoring Report and summary NHS FT Governance Risk Rating (FT Compliance Report)
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of Planning & Performance Management and Tony Wharram, Deputy Director of Finance
DATE OF MEETING:	31 May 2012

EXECUTIVE SUMMARY:

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

Service Performance (April) - There were 3 areas of underperformance during the month of April; RTT Delivery in all specialities, Diagnostic Waits and Delayed Transfers of Care. The overall average weighted score for service performance is 2.79. CQC Registration Status remains Unconditional. As such for the month of April the Trust attracts a **PERFORMING** classification.

Financial Performance (April) - The weighted overall score remains 2.95 with underperformance confined to Creditor Days. The classification for the month of April remains **PERFORMING.**

Foundation Trust Compliance Summary report:

Within the Service Performance element of the Risk Rating the Trust is not fully compliant with the, Requirements regarding access to healthcare for people with a learning disability. The Trust is also unable currently to report its performance against the 'Data Completeness Community Services Indicator'.

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

The overall score for the month of April (excluding the Data Completeness indicator) is 0.5, which attracts a GREEN Governance Rating.

REPORT RECOMMENDATION:

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

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		x

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

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

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Accessible and Responsive Care, High Quality Care and Good Use of Resources. National targets and Infection Control. Internal Control and Value for Money

PREVIOUS CONSIDERATION:

Performance Management Board and Trust Management Board on 22 May 2012 and Finance & Performance Management Committee on 24 May 2012.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2012/13

QUALITY OF SERVICE

Integrated Performance Measures

Indicator	Weight	Performance Thresholds: Performing (Score 3)	Score 2	Underperforming (Score 1)	Quarter 4 2011/12	Score	Weight x Score	April 2012/13	Score	Weight x Score
A/E Waits less than 4-hours	1.00	95.00%	94.00 - 95.00%	94.00%	95.30%	3	3.00	95.30%	3	3.00
MRSA Bacteraemia	1.00	0		>1.0SD	1	3	3.00	0	3	3.00
Clostridium Difficile	1.00	0		>1.0SD	27	3	3.00	3	3	3.00
18-weeks RTT 90% Admitted	1.00	=>90.0%	85.00 - 90.00%	85.0%	>90.0%	3	3.00	94.1%	3	3.00
18-weeks RTT 95% Non -Admitted	1.00	=>95.0%	90.00 - 95.00%	90.0%	>95.0%	3	3.00	98.8%	3	3.00
18-weeks RTT 92% Incomplete	1.00	=>92.0%	87.00 - 92.00%	87.0%	>92.0%	3	3.00	96.7%	3	3.00
18-weeks RTT Delivery in all Specialities (number of treatment functions)	1.00	0	1 - 20	>20	10	2	2.00	4	2	2.00
Diagnostic Test Waiting Times (percentage 6 weeks or more)	1.00	<1%	1.00 - 5.00%	5%	0.99%	3	3.00	1.34%	2	2.00
Cancer - 2 week GP Referral to 1st OP Appointment	0.50	93.0%	88.00 - 93.00%	88.0%	96.0%	3	1.50	>93.0%*	3	1.50
Cancer - 2 week GP Referral to 1st OP Appointment - breast symptoms	0.50	93.0%	88.00 - 93.00%	88.0%	97.2%	3	1.50	>93.0%*	3	1.50
Cancer - 31 day diagnosis to treatment for all cancers	0.25	96.0%	91.00 - 96.00%	91.0%	99.8%	3	0.75	>96.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (surgery)	0.25	94.0%	89.00 - 94.00%	89.0%	99.7%	3	0.75	>94.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (drug)	0.25	98.0%	93.00 - 98.00%	93.0%	100.0%	3	0.75	>98.0%*	3	0.75
Cancer - 31 Day second/subsequent treat (radiotherapy)	0.25	94.0%	89.00 - 94.00%	89.0%	100.0%	3	0.75	>94.0%*	3	0.75
Cancer - 62 day urgent referral to treatment for all cancers	0.50	85.0%	80.00 - 85.00%	80.0%	86.8%	3	1.50	>85.0%*	3	1.50
Cancer - 62 day referral to treatment from screening	0.50	90.0%	85.00 - 90.00%	85.0%	99.3%	3	1.50	>90.0%*	3	1.50
Delayed Transfers of Care	1.00	3.5%	3.5 - 5.00%	5.0%	3.70%	2	2.00	3.60%	2	2.00
Mixed Sex Accommodation Breaches (as percentage of completed FCEs)	1.00	0.0%	0.0 - 0.5%	0.5%	0.02%	3	3.00	0.00%	3	3.00
VTE Risk Assessment	1.00	90.0%	80.00 - 90.00%	80.0%	92.60%	3	3.00	92.20%	3	3.00
Sum (all weightings)	**14.00**									
Average Score (Integrated Performance Measures)							**2.86**	* projected		**2.79**

CQC Registration Status

	Unconditional or no enforcement action by CQC	The assessment of non-compliance / outstanding conditions from the initial registration	Enforcement action by CQC	**Performing**	**Performing**

Overall Quality of Service Rating

Performing **Performing**

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK
MONITORING REPORT - 2012/13

Financial Indicators				SCORING			2011 / 2012			2011 / 2012			2011 / 2012			2012 / 2013		
Criteria	Metric	Weight (%)		3	2	1	January	Score	Weight x Score	February	Score	Weight x Score	March	Score	Weight x Score	April	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	0.01%	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	0.24%	3	0.6	0.37%	3	0.6	0.44%	3	0.6	0.00%	3	0.6
	YTD EBITDA		5	Year to date EBITDA equal to or greater than 5% of actual year to date income	Year to date EBITDA equal to or greater than 1% but less than 5% of year to date income	Year to date EBITDA less than 1% of actual year to date income.	5.43%	3	0.15	5.53%	3	0.15	5.40%	3	0.15	5.13%	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	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.	5.56%	3	0.15	5.52%	3	0.15	5.40%	3	0.15	5.97%	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	0.01%	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	0.43%	3	0.15	0.43%	3	0.15	0.44%	3	0.15	0.92%	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	5.56%	3	0.15	5.52%	3	0.15	5.40%	3	0.15	5.97%	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	93.00%	2	0.05	97.00%	3	0.075	96.00%	3	0.075
	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	84.00%	2	0.05	96.00%	3	0.075	95.00%	3	0.075	97.00%	3	0.075
	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	1.16	3	0.15	1.17	3	0.15	1.01	3	0.15	1.04	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	18.31	3	0.15	14.13	3	0.15	13.23	3	0.15	11.31	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	46.62	2	0.1	43.48	2	0.1	36.53	2	0.1	38.09	2	0.1
						Weighted Overall Score			2.90			2.93			2.95			2.95

*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:	Provider Management Regime return – April 2012
SPONSOR (EXECUTIVE DIRECTOR):	Mike Sharon, Director of Strategy & Organisational Development & Kam Dhami, Director of Governance
AUTHOR:	Mike Harding, Head of Planning & Performance Management & Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	31 May 2012

EXECUTIVE SUMMARY:

The Provider Management Regime (PMR) return is to be submitted to the SHA on a monthly basis and comprises a dashboard of performance against key quantifiable targets, together with a declaration of compliance against a series of Board Statements.

The organisational risk ratings as reported for April 2012 are as follows:

Key Area for rating / comment by Provider	Score / RAG rating*
Governance Risk Rating (RAG as per NHS Midlands and East PMR guidance)	G
Financial Risk Rating (Assign number as per NHS Midlands and East PMR guidance)	G
Contractual Position (RAG as per NHS Midlands and East PMR guidance)	G

One declaration of non-compliance with Board Statements is as follows:

- Requirements to meet Level 2 of the IG toolkit

REPORT RECOMMENDATION:

That the Trust Board:

APPROVES the submission of the Provide Management Regime submission.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	X	

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*

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

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

The PMR covers performance against a number of the Trust's Objectives, standards and metrics

PREVIOUS CONSIDERATION:

Routine monthly update.

NHS Midlands and East

SELF-CERTIFICATION RETURNS
Organisation Name:
Sandwell & West Birmingham Hospitals NHS Trust
Monitoring Period:
April 2012

NHS Midlands & East
Provider Management Regime
2012/13

Returns to provider.development@westmidlands.nhs.uk by the last working day of each month

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Medical Revalidation: Update of Organisational Readiness and Next Steps**
SPONSOR (EXECUTIVE DIRECTOR):	**Acting Medical Director and Director of Governance**
AUTHOR:	**Philip Andrew, Head of Medical Staffing**
DATE OF MEETING:	**31 May 2012**

EXECUTIVE SUMMARY:

This report sets out the national guidance on Medical Revalidation, an overview of progress to date and the challenges that will be faced in implementing Medical Revalidation.

REPORT RECOMMENDATION:

The Board is asked to note the national guidance, the plans in place for implementing revalidation and the challenges likely to be faced.

The Board is further asked to note that a business case for resources to support the mandated implementation of medical revalidation will be submitted to SIRG in the near future.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	x	

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

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

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Inclusion in monthly Provider Management Regime return

PREVIOUS CONSIDERATION:

None

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Medical Revalidation: Update of Organisational Readiness and Next Steps

Introduction

1. Medical Revalidation is being introduced to assure patients, the public and the medical profession that doctors are up to date and fit to practice, and to support their development and where necessary, remediation. It will be a positive affirmation that doctors are safe to practise rather than an absence of concerns.

2. It is a legal requirement to be registered with the General Medical Council (GMC) and to have a license to practice in order to practise medicine in the UK. Revalidation will apply to all licensed doctors including trainees and clinical academics in the UK in all sectors (NHS and private) and all branches of practice.

3. The Trust has appointed the Medical Director to the statutory role of Responsible Officer from 1st January 2011 with responsibility for implementing revalidation. Until the new Medical Director commences in post in August 2012 the Acting Medical Director will act as Responsible Officer

4. This paper summarises the national guidance received and the progress which the Trust has made as well as setting out the next steps required to ensure that the processes within the Trust are in place when revalidation is expected to begin in late 2012.

Overview of National Guidance

5. Final guidance on procedures and requirements from the GMC is still awaited. However it has been confirmed that, subject to an assessment of readiness, Designated Bodies will be expected to begin revalidating doctors from late 2012. Responsible Officers will be the first doctors to be revalidated via a process being designed by the Strategic Health Authority (SHA).

6. It is envisaged that future recommendations will be based on a 5 year cycle of Good Medical Practice based appraisals that review approved supporting evidence as outlined by the GMC. However it has been confirmed that during the implementation phase, recommendations can be made by reviewing a smaller number of revalidation-ready appraisals, with the proviso that the Responsible Officer is able to assure him/herself of the quality of the doctor's activities over the previous five year period.

7. Guidance relating to the format of the appraisal has also changed following the pilot of 3,500 doctors undertaken last year. The need to link each piece of evidence to the relevant GMC standard and the responsibility of the appraiser formally to determine the quality of that evidence have both been removed from the requirements.

Overview of Progress

8 The Trust has been working with the SHA via the submission of regular Organisation Readiness Self Assessments (ORSA) to formulate a detailed implementation plan to ensure that all doctors, with whom the Trust has a prescribed connection, achieve a revalidation recommendation by the end of the financial year 2015/16. The most recent ORSA rated the Trust as `red' as there are a number of areas not yet place including an Appraisal Policy with core content that satisfies the requirements of revalidation.

9. A Medical Revalidation Implementation Group (MRIG) has recently been established and is chaired by the Responsible Officer with a membership including representation from Clinical Directors, Consultants, SAS Doctors and management functions. The purpose of this group is to ensure that medical revalidation is implemented effectively and on time.

10. Appraisal is a key element of revalidation, forming the basis for the recommendation made by the Responsible Officer.

11. The Trust's Appraisal Policy has being reviewed and overhauled to ensure it complies with the requirements of revalidation. The new policy is to shortly go through the consultation and approval process. Once the new policy is in place it will enable all doctors to undertake their annual appraisal in the new revalidation style and prepare them for the changes in reporting performance which revalidation will require.

12. Appraiser training has been arranged in June and July 2012 so that Divisional Directors (DDs) and Clinical Directors (CDs) have the knowledge and skills to undertake effective appraisals. Other approved medical appraisers will need to be established and trained in 2012 as the appraisal process will not just be undertaken by DDs and CDs. Further "Top-up" training for appraisers, to enable them to conduct a revalidation-ready appraisal, will be undertaken by the SHA in Autumn 2012.

13. Alongside the review of the appraisal process, further work is being undertaken to identify the practical requirements of implementation such as contacting all doctors with whom the Trust is believed to have a prescribed connection; agreeing processes for dealing with honorary contract holders and clinical academics; scoping the resources needed to fully implement revalidation in a Trust of this size; and reviewing some of the commercial software packages available to manage the process.

Challenges

14. The Trust faces some significant challenges to the successful implementation of revalidation of which the Board should be aware;

14.1 Final guidance on revalidation requirements is yet to be published with other information being updated and amended on a regular basis. Whilst this is a positive step to ensure that revalidation is fit for purpose, it presents a challenge to the planning process. In this context, it has been to the Trust's advantage that issues such as software procurement, policy finalisation, and appraiser retraining have not

yet been completed, as the requirements have materially altered in the last six months.

14.2 The Trust is one of the largest designated bodies in the West Midlands and is responsible for approximately 500 doctors with a prescribed connection. (Doctors in training have a prescribed connection to the Deanery)

14.3 Revalidation will require significant collection, validation, manipulation and presentation of complex data at an individual and corporate level. Successful achievement of this will require a high level of input from the a number of departments (including IT, Clinical Risk, Clinical Effectiveness, Complaints, Medical Staffing and Medical Director's Office). This is likely to be labour intensive, particularly during set up. In addition there are issues with the quality of some historic data which need to be overcome to ensure accurate and meaningful outputs.

14.4 There are resource implications to successfully implementing and managing revalidation, for which the Trust has a statutory responsibility. Costs to consider include procurement of relevant software and the ongoing administration of systems and processes to ensure doctors are revalidated efficiency and in a timely manner.

14.5 Two points linked to these risks are particularly salient. The first is that the Trust has a legal obligation under the Responsible Officer Regulations 2011 to support and resource the revalidation process. The second is that establishing high quality data flows that link the employment, activity, quality of service and clinical outcomes of doctors and their teams will carry significant importance to the achievement of the Trust's strategic objectives and aspirations.

Going Forward

15. Planning for revalidation is now moving towards the implementation phase. An action plan has been developed and is attached for information. This has been shared with the SHA and will be monitored by MRIG.

16. A business case for resources associated with the implementation of revalidation will be presented to the Strategic Investment Review Group (SIRG) in the near future. This will include items such as software to facilitate the requirement for patient and colleague feedback and support for IT to provide doctors with the activity and performance data they will need to prepare for a revalidation-ready appraisal, which will qualify as evidence for a revalidation recommendation.

Conclusion

17. In conclusion, the Trust is fully committed to successful implementation of revalidation. There is still a significant amount of work to be done to ensure that this happens. However this programme of work does represent an opportunity to further improve quality, safety

and engagement within the medical community whilst also complying with legislative requirements.

Recommendations

18. The Board is asked to note the national guidance, the plans in place for implementing revalidation and the challenges likely to be faced.

19. The Board is further asked to note that a business case for resources to support the mandated implementation of medical revalidation will be submitted to SIRG in the near future.

Philip Andrew
Head of Medical Staffing

May 2012

MEDICAL REVALIDATION ACTION PLAN: 18 MAY 2012

Ref	Area for Development	Source of Recommendation	Action Required & Progress to Date	Owner	Timescale	Status
DOMAIN 1: RESPONSIBLE OFFICER						
	• Establishment of Responsible Officer	Medical Profession (Responsible Officers) Regulations 5 and 7.	• Responsible officer (RO) appointed. The Trust has appointed the Medical Director to act as the RO	MD	Jan 2011	5
	• A second Responsible Officer has been nominated/appointed where a conflict of interest or appearance of bias has been agreed with the level two responsible officer.	Medical Profession (Responsible Officers) Regulations 6	• New MD appointed – will require RO training. The Deputy MD to receive RO training and be appointed as second RO	MD	Sept 2012	4
	• Appropriate responsible officer training is undertaken.	The Role of the RO Guidance 4.48 -4.49	• MD and Deputy MDs to receive any training necessary to undertake RO role	MD	Sept 2012	4
	• Local/regional support is available to the responsible officer.	The Role of the RO Guidance 4.27 and 4.50	• Regional support is available to the RO in the form of the level two responsible officer, SHA Programme Specialist for Revalidation and GMC Liaison Officer • RO has established and will chair the Medical Revalidation Implementation Group (MRIG) consisting of Clinical Director, Consultant, SAS Doctor and Management Representatives to assist the Responsible Officer with the implementation of revalidation.	MD	May 2012	5
	• Provision of funding and resource from the designated body is sufficient to undertake the responsibilities of the role.	Medical Profession (Responsible Officers) Regulations 14 and 19	• Paper to go to SIRG specifying the resources required to support the RO in revalidation.	MD	July 2012	4
DOMAIN 2: APPRAISAL SYSTEM						

STATUS	5	Complete	4	On track	3	Some delay – expect to be completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective revised

Ref	Area for Development	Source of Recommendation	Action Required & Progress to Date	Owner	Timescale	Status
	• A medical appraisal policy with core content is in place.		• New medical appraisal policy has been drafted. The policy has been discussed at May MRIG meeting and comments requested. • To go to LNCC and TMB for approval	HMS	June 2012	**4**
	• An audit has been performed to determine reasons for all missed or incomplete appraisals.	The Role of the RO Guidance 3 and 10	• System to be developed to undertake annual audit for missed or incomplete appraisals. • An audit is currently being undertaken to establish reasons why any 2011/12 appraisals were missed or incomplete	MD/HMS	July 2012	**4**
	• The number of trained medical appraisers is sufficient for the needs of the designated body.	The Role of the RO Guidance 3.9 -3.10	• Ongoing programme of appraisal training to be established. (sessions organised for June and July 2012 for DDs and CDs with further sessions to follow for other appraisers) • Liaise with SHA regarding `Top up' training to be undertaken in Autumn 2012	MD/HMS	June 2012	**4**
	• Medical appraisers are supported in the role through access to leadership and peer support.		• Leadership and advice on all aspects of the appraisal process is available from the Deputy Medical Directors. The CDs should use their DD for initial leadership and advice. • Establish an appraiser forum to allow peer support and the opportunity to discuss handling the difficult areas of appraisal in an anonymised and confidential environment	MD	Sept 2012	**4**
	• Medical appraisers receive feedback on their performance		• Development of feedback and quality assurance of appraisal	MD/HMS	September 2012	**4**

Ref	Area for Development	Source of Recommendation	Action Required & Progress to Date	Owner	Timescale	Status
	in the role which includes feedback from doctors or feedback on the quality of outputs of appraisal.		outputs is included in new Medical Appraisal Policy (to include feedback from doctors on the appraiser's performance in the role and a review of the outputs of completed appraisals egs PDPs and appraisal summaries)			
DOMAIN 3: ORGANISATIONAL GOVERNANCE						
	• A governance structure or strategy is in place (including clinical governance where appropriate)		• Governance structure in place and well established	DG		**5**
	• The governance systems (including clinical governance where appropriate) are subject to external or independent review		• Governance systems are subject to external and independent review	DG		**5**
	• There is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection.	Medical Profession (Responsible Officers) Regulations 16 (3) a	• appropriate systems with IT to ensure that clinical outcome data, audit, complaints and Serious Untoward Incident information and patient safety information is available to indvidual doctors and their medical managers.	MD	Oct 2012	**1**
	• All doctors with whom the designated body has a prescribed connection are able to obtain structured feedback from patients and colleagues in compliance with GMC criteria.	The Role of the RO Guidance 3.5 and 5.18	• GMC requirement is that multi source feedback occurs at least once in every 5 years. • Internal and External options to provide this multi source feedback to be explored. • 2 external providers have presented to MD. Plan for presentations to be made to MRIG.	MD (via MRIG)	September 2012	**4**

Ref	Area for Development	Source of Recommendation	Action Required & Progress to Date	Owner	Timescale	Status
			• Dr David Nicholl, Consultant Neurologist (MRIG member) to roll out pilot of out patient feedback from patients • Dr Frances Aitchison, Consultant Radiologist (MRIG member) to review GMC guidance on multi source feedback and report back to MRIG with recommendations.			
	• The designated body's clinical audit activity is in line with national guidance (including contributions to clinical registers and databases and confidential enquiries).		• The Trust's clinical audit activity is in line with national guidance	DG		**5**
	• There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included at the appraisal meeting, so that development needs are identified.	Medical Profession (Responsible Officers) Regulations 11 (3)	• Build appropriate systems with IT and links with Complaints and Clinical Risk departments to ensure that Complaints and Serious Untoward Incident information to be made available for appraisers and appraisees at the time of appraisal.	HoR	October 2012	**1**
	• There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors.	Medical Profession (Responsible Officers) Regulations 16 (2)	• Review pre employment check process and to ensure that previous appraisal information (including PDP) is captured for all new starters (excluding doctors in training) • Review process when entering into honorary contract arrangements to gain information on appraisal.	HMS	August 2012	**1**
	• There is a process in place to ensure fitness to practise	Medical Profession (Responsible Officers)	• A system to be developed so that collated activity data and other relevant data is	MD	October 2012	**1**

Ref	Area for Development	Source of Recommendation	Action Required & Progress to Date	Owner	Timescale	Status
	evaluations and appraisals take account of all available information relating to the doctors fitness to practise, from the work carried out for the designated body and for any other organisation	Regulations 11(1) (3)	available at the point of appraisal. • ROs from different designated bodies to agree system for sharing information with each other where there are concerns with a doctor who as part of their job plan works in a number of organisations			
	• A process is established for the investigation of capability, conduct, health and fitness to practise concerns.	Medical Profession (Responsible Officers) Regulations 11(2) (b)	• Update and relaunch Procedure for raising concerns about conduct, performance or health of colleagues • Formalise fortnightly meeting between MD, Deputy MDs, DG, DDW and HMS in which issues of concern are discussed and action plans agreed.	HMS	September 2012	**4**
	• A policy (with core content) for re-skilling, rehabilitation, remediation and targeted support is in place.	Medical Profession (Responsible Officers) Regulations 16 (4) (h)	• A policy for this will need to be written. • Link with Dr Verow, Occupational Health Physician and Dr Hughes Postgraduate Dean for their advice and input.	HMS	September 2012	**1**
	• Where a doctor is subject to conditions imposed by, or undertakings agreed with the GMC, the responsible officer monitors compliance with those conditions or undertakings.	Medical Profession (Responsible Officers) Regulations 11 (2) (d)	• The current system where MD and HMS share and manage information on GMC issues to be formalised and recorded in a central system. • MD and HMS have regular meetings with the GMC Liaison Officer to discuss current cases.	HMS	September 2012	**1**
	• A description of the support available from the designated body for doctors to keep their knowledge and skills up to date is in place		• The Management of Career Grade Doctors Absence Policy confirms that trust supports CPD, Might need to be enhanced • Medical Education Strategy is been written which should include the necessary description required.	MD	September 2012	**4**

Ref	Area for Development	Source of Recommendation	Action Required & Progress to Date	Owner	Timescale	Status
	• Relevant appraisal, revalidation and human resource policies are fair and non-discriminatory.	The Role of the RO Guidance 4.47 and 6.9	• An Equality Impact Assessment will be undertaken as part of implementation plan of Medical Appraisal Policy.	HMS	July 2012	**4**
	• Ensure all medical staff in the Trust are aware of the impending introduction of medical revalidation		• Regular updates from RO to all doctors with whom there is a prescribed connection. • Communication plan to be drawn up by Mr Stan Silverman, Consultant Vascular Surgeon (MRIG member).	MD (via MRIG)	July 2012	**4**

KEY

MD	Medical Director
DMD	Deputy Medical Director
DG	Director of Governance
DDW	Deputy Director Workforce
HMS	Head of Medical Staffing
HoR	Head of Risk

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	'Right Care Right Here': Progress Report
SPONSOR (EXECUTIVE DIRECTOR):	Mike Sharon, Director of Organisational Development and Strategy
AUTHOR:	Jayne Dunn, Redesign Director – RCRH
DATE OF MEETING:	31 May 2012

EXECUTIVE SUMMARY:

The paper provides a progress report on the work of the *Right Care Right Here* Programme as at the end of April 2012.
It covers:

- Progress of the RCRH Programme including activity monitoring for the period April-January 2012.

REPORT RECOMMENDATION:

The Trust Board is asked to ACCEPT the progress made with the Right Care Right Here Programme.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

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

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Supports strategic objective to be an engaged, effective organisation.

PREVIOUS CONSIDERATION:

Monthly report to Trust Board

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

RIGHT CARE RIGHT HERE PROGRAMME: PROGRESS REPORT MAY 2012

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 beginning of May 2012. It summarises the Right Care Right Here Programme Director's report that was presented to the Right Care Right Here Partnership Board in May. It should be noted that a RCRH Service Redesign Report was not produced for the May meeting. 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

RCRH Programme activity performance reports related to service redesign were not produced during May due to timing issues in relation to meetings.

Transfer of Activity: QIPP (Quality Innovation Productivity and Prevention) Schemes

The LDP agreement for 2012/13 has set a target for the cessation of and transfer out of acute activity into community or primary care worth £10 million of acute SWBH income. The schemes that will deliver this reduction in acute activity will be identified as QIPP schemes. It has been agreed that this activity and income reduction will be delivered through a range of schemes falling into three broad headings:

- Schemes identified within our Transformation Plan that result in a reduction in acute activity and/or transfer of acute activity to community or primary care.
- Schemes identified by the Sandwell and West Birmingham GP Clinical Commissioning Group (SWB GP CCG) to reduce the demand for acute care.
- Implementation of the approved RCRH care pathways.

Work is underway to translate these schemes into a detailed schedule with clear agreement between ourselves and the SWB GP CCG about how and when they should be implemented and arrangements to monitor progress. A coherent programme of communication and engagement with clinical staff, patients and the public will be essential to successful delivery.

An initial meeting has been held with executive and senior clinical and managerial representatives from both the Trust and SWB GP CCG to discuss the approach to these QIPP schemes. It was agreed that this group would meet monthly in order to oversee progress with delivery of the schemes and enable any implementation issues to be promptly resolved.

RCRH Activity and Capacity Model

As reported last month the RCRH Activity and Capacity Model has formed the basis for both our long term plans (including the Outline Business Case for the Midland Metropolitan Hospital) and the PCTs' long term commissioning plans. The model was last updated in 2010/11 (version 5.3) and work continues to produce an updated version as part of their Foundation Trust application and transformation plan process. This has now been agreed with commissioners and forms version 5.7 of the model. A full revision of the RCRH Activity and Capacity model is also

overdue and discussions continue within the local health economy to develop the next phase of this work.

RCRH Partnership

The RCRH Partnership Board has discussed the need for a refresh of the Partnership/Programme and planning has started for an away-event in July.

The functions of the RCRH Programme Team will be incorporated within the structure of the SWB GP CCG. This will address the challenge of retaining focus around service redesign and implementation, together with maintaining key partnership arrangements.

In preparation for the above changes the RCRH Programme Team is actively involved in a stocktake of areas of work, with a view to ensuring that key topics are not overlooked and where appropriate are handed over to a responsible organisation in a structured way.

Recommendations:

The Trust Board is asked to ACCEPT the progress made with the Right Care Right Here Programme.

Jayne Dunn
Redesign Director – Right Care Right Here
22nd May 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Clinical Services Reconfiguration Programme - Progress Report
SPONSOR (EXECUTIVE DIRECTOR):	Mike Sharon, Director of Organisational Development and Strategy
AUTHOR:	Jayne Dunn, Redesign Director – RCRH
DATE OF MEETING:	31 May 2012

EXECUTIVE SUMMARY:

The paper provides a progress report on the work of the Clinical Services Reconfiguration Programme as at the middle of May 2012.

It covers an update of progress with each area of clinical service reconfiguration that the Trust is involved in, including a range of wider SHA/health economy plans for clinical service consolidation. These areas include:

- The transfer of Breast Surgery Services from Sandwell to the BTC
- The regional Trauma Network and our submission to be a designated Trauma Unit
- The proposed reconfiguration of our Stroke Services
- The proposed transfer of our elective inpatient Orthopaedic services to Sandwell Hospital as part of an integrated inpatient Trauma and Orthopaedic Service

REPORT RECOMMENDATION:

The Trust Board is recommended to:

1. ACCEPT this progress report regarding our ongoing clinical service reviews and reconfiguration projects.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

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

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

This report aligns to our Corporate Objective 2: High Quality Care and the following priorities for 2012/13:

- Delivering the quality priorities set out in our Quality Account
- Delivering the Transformation Plan
- Progressing the "Right Care Right Here" vision of service change

PREVIOUS CONSIDERATION:

February 2012: Progress report relating to Clinical Service Reconfiguration
March 2012: Vascular Surgery Reconfiguration – the Case for Change

Sandwell & West Birmingham Hospitals NHS Trust

CLINICAL SERVICES RECONFIGURATION PROGRAMME
May 2012

1. Introduction

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

The purpose of this paper is to provide the Trust Board with an update of progress with each area of clinical service reconfiguration following the meeting of the Clinical Service Reconfiguration Programme Board on 17th May 2012.

2. Service Reconfigurations in the Implementation Phase

2.1 Breast Surgery

The reconfiguration plans to consolidate all Breast Surgery services at City Hospital, primarily in the Birmingham Treatment Centre (BTC) have been approved by SIRG and have been discussed with GP commissioners. The Joint Health Scrutiny Committee at its meeting in December 2011 confirmed that formal public consultation is not required for this reconfiguration but emphasised the importance of ongoing patient engagement and information. The Breast Surgery Team has undertaken a series of patient and staff engagement events. Work is progressing in line with the implementation plan including a review of staffing arrangements and clinics. The mammography equipment has been procured and is being installed during May and June.

An implementation date for the transfer of Sandwell Breast Services to the BTC, has been confirmed for 2nd July 2012.

2.2 Major Trauma Centres

The Major Trauma Network for the West Midlands went 'live' on 26th March. We are part of the Birmingham, Black Country, Hereford and Worcester Trauma Network that has an adult Major Trauma Centre (MTC) at the new Queen Elizabeth Hospital (QEH) in Birmingham and children's MTC at Birmingham Children's Hospital (BCH).

Activity information for the first 5 weeks suggests that within the West Midlands on average 33 patients a week are being taken to the MTCs with 16 of these going to the MTC at QEH and 3 to the MTC at BCH. At City Hospital we saw 7 major trauma cases at City Hospital and 2 at Sandwell Hospital. None of these patients require onward transfer to a MTC. We will continue to monitor the activity and financial implications of the Trauma Network arrangements for the Trust.

We have provisional Trauma Unit status for Sandwell and City Hospitals subject to full compliance with the Trauma Unit standards by the end of June. We continue to make progress against our action plan to achieve full compliance with these standards and we submit our updated action plan to the Specialised Commissioning Team on a monthly basis. Our Trauma Steering Group meets monthly and is chaired by Dr Peter Ahee our Clinical Lead for Trauma.

The Specialised Commissioning Team has confirmed there will be a formal peer review site visit to confirm compliance with the standards in September.

2.3 Vascular Surgery Services

The Board approved the Case for Change for Vascular Surgery at its meeting in March, subject to a full Equality Impact Assessment and action plan being presented to the Board in May – this is the subject of a separate report to the Board.

3. Potential Service Reconfigurations in the Planning Phase

3.1 Stroke Services

The formal public consultation process, led by the Black Country PCT Cluster, for the plans to reconfigure our inpatient stroke and Transient Ischaemic Attack (TIA) services finished at the end of April. The responses from the consultation are being collated and analysed by an independent company and will be fed back to the Project Board at the end of May.

We have been undertaking work on the activity, capacity and financial analysis for the short listed options in preparation for the Business Case for Change. This has included working with commissioning leads and the West Midlands Ambulance Service to model likely patient flows for each option and the potential implications for other Hospitals.

In addition we are undertaking further work to understand the wider context for our stroke services and in particular in relation to the Birmingham and Black Country review of Hyper-Acute Stroke Services (which is part of the wider Strategic Health Authority review).

The plan is for the outcome of the three strands of work described above to be considered by the Project Board in June in order to identify a recommended preferred option. The consultation report will be presented along with a Business Case for the Preferred Option to the Board, the PCT Cluster Boards and SHA in July 2012. Prior to this we will discuss the consultation report and recommended preferred option with the Joint Health Scrutiny Committee and the Sandwell and West Birmingham Clinical Commissioning Group.

3.2 Orthopaedic Services

Following a formal public consultation in 2006/2007 the Trauma and Orthopaedic inpatient services were reconfigured in 2009 resulting in Trauma inpatients with a length of stay over 24 hours being consolidated at Sandwell Hospital and elective Orthopaedic patients with a length of stay of 2 days or more being consolidated at City Hospital. Day case, outpatient and therapy services are provided at both Sandwell and City Hospitals. As part of our Transformation Plan we are now proposing to consolidate elective Orthopaedic inpatient services (i.e. patients requiring a length of stay of 2 days or more) at Sandwell Hospital to give an integrated Trauma and Orthopaedic inpatient service delivered on two acute wards at Sandwell Hospital.

The main clinical need for change centres around being able to offer an equitable, high quality, consistent and developing service for all patients referred to the Trauma and Orthopaedic service. In order to deliver this there needs to be access to specialist staff and facilities along with a sufficient critical mass of staff to give flexibility to provide a consistent service that is able to meet changing demand with adequate senior presence. This is best achieved through providing all Trauma and Orthopaedic inpatient services on one site.

In addition we will continue to redesign our services to reduce the time patients need to spend in hospital and for elective Orthopaedic patients the majority of procedures currently staying under 2 days in hospital will be undertaken as a day case overnight stay. As a result the majority of elective Orthopaedic patients treated at City Hospital will continue to be treated there after the proposed reconfiguration. Around 1060 patients who would currently receive elective Orthopaedic inpatient treatment at City Hospital and stay in hospital for 2 days or more, would following the change receive this at Sandwell Hospital. In 2011/12 around 60% of these patients were registered with a Sandwell GP. The plan is to implement the proposed change in August 2012.

We presented our plans to consolidate elective Orthopaedic inpatient services at Sandwell Hospital, to the Joint Health Scrutiny Committee on 18th May along with a communications and engagement

plan, in order to seek their advice as to whether formal public consultation is appropriate for this service change. The Committee has asked us to meet with them again in July to feedback on progress with our communications and engagement plan and any concerns raised through this. They will then consider again whether formal public consultation is appropriate. The Committee has also asked us to liaise with the Royal Orthopaedic Hospital to ensure they could accommodate any elective Orthopaedic inpatients who would currently be treated at City Hospital and might choose the Royal Orthopaedic Hospital rather than Sandwell Hospital once we have implemented the change.

4. Conclusion

We are undertaking or involved in a number of clinical service reviews which are generating options involving the consolidation of services onto one hospital site and away from others, i.e. clinical service reconfiguration. This report has provided the Board with an update of progress with these clinical service reviews and reconfiguration projects.

The Trust Board is recommended to:

1. ACCEPT this progress report regarding our ongoing clinical service reviews and reconfiguration projects.

Jayne Dunn
Redesign Director Right Care Right Here
18th May 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Vascular Surgery Reconfiguration Equality Impact Assessment And Progress With Implementation Plan
SPONSOR (EXECUTIVE DIRECTOR):	Mike Sharon, Director of Organisational Development and Strategy
AUTHOR:	Jayne Dunn, Redesign Director – RCRH
DATE OF MEETING:	31st May 2012

EXECUTIVE SUMMARY:

In March 2012 the Trust Board considered the Case for Change for Vascular Surgery Reconfiguration. This would result in a single model of care for Vascular Surgery services across our Trust and University Hospital Birmingham NHS Foundation Trust (UHBFT) with the inpatient element of the service and Vascular Interventional Radiology being transferred to the Queen Elizabeth Hospital within UHBFT. Our Trust would retain Vascular Surgery day case and outpatient work at both City and Sandwell Hospitals. The Board approved the proposal to reconfigure Vascular Surgery services subject to the presentation of a further paper at its meeting in May 2012, which would share the results of the equality impact assessment and outline an implementation plan.

This report presents the full Equality Impact Assessment that has been undertaken and related action plan.

The SWBH Vascular Surgery Reconfiguration Project Team and the joint Vascular Surgery Reconfiguration Project Board with UHBFT have continued to work with operational managers and clinical leads to develop an implementation plan. This report presents the high level implementation milestones and progress against these.

A revised implementation date of 10th September has been identified which although later than the previous proposed date of July still allow implementation in line with SHA timescales and ahead of introduction of the AAA (Abdominal Aortic Aneurysm) Screening Programme in Sandwell and Birmingham in October 2012.

A number of key implementation issues have been identified around:

- The need to agree staff transfer arrangements with UHBFT in time to undertake formal staff consultation.
- Development of Service Level Agreements between the Trusts for SWBH staff time and costs undertaken at UHBFT in relation to Vascular Surgery and Vascular Interventional Radiology services.
- The need for UHBFT to confirm exact theatre sessions and other capacity for SWBH

consultant sessions at UHBFT in order to be able to review consultant job plans and SWBH clinical sessions and reschedule these where required.

Delays in resolving these and in particular the agreement around staff transfer arrangements may put the implementation date of 10th September at risk.

REPORT RECOMMENDATION:

The Board is recommended to:

- ACCEPT the Equality Impact Assessment and related action plan.
- ACCEPT the revised implementation date of 10th September, and the related high level implementation milestones.
- DISCUSS the key implementation issues and the potential risk these present to the implementation date.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		X

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

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

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

This report aligns to our Corporate Objective 2: High Quality Care and to our priority for 2012/13 to deliver Right Care Right Here and key service developments including the reconfiguration of Vascular Surgery.

PREVIOUS CONSIDERATION:

March 2012: Vascular Surgery Reconfiguration – the Case for Change

VASCULAR SURGERY RECONFIGURATION
EQUALITY IMPACT ASSESSMENT AND PROGRESS WITH IMPLEMENTATION PLAN
MAY 2010

1. INTRODUCTION

In March 2012 the Trust Board considered the Case for Change for Vascular Surgery Reconfiguration. This would result in a single model of care for Vascular Surgery services across our Trust and University Hospital Birmingham NHS Foundation Trust (UHBFT) with the inpatient element of the service and Vascular Interventional Radiology being transferred to the Queen Elizabeth Hospital within UHBFT. Our Trust would retain Vascular Surgery day case and outpatient work at both City and Sandwell Hospitals.

The Board approved the proposal to reconfigure Vascular Surgery services subject to the presentation of a further paper at its meeting in May 2012, which would share the results of the equality impact assessment and outline an implementation plan.

The purpose of this report is to present:

- The equality impact assessment and related action plan
- The high level implementation milestones and progress against these.

2. EQUALITY IMPACT ASSESSMENT

The Case for Change for Vascular Surgery Reconfiguration included the results of an initial screening Equality Impact Assessment (EqIA) for Vascular Surgery reconfiguration. This demonstrated that a full EqIA would need to be undertaken because the changes in service provision will affect the elderly and disabled groups in particular as they are likely to have to travel further for inpatient treatment and this may impact on their ability to plan and change their usual travel arrangements to hospital. A full EqIA has now been undertaken and an action plan developed. These are included in Appendix 1 and have been reviewed and agreed by Pauline Richards, Head of Equality & Diversity.

In summary the full EqIA confirmed that the patient groups considered to be vulnerable in relation to the reconfiguration were:

- Elderly groups,
- Groups with pre-existing disabilites/impairments and
- Groups characterised by race/ethnicity.

The EqIA also considered staff groups that may be vulnerable and in particular staff who currently provide in-patient vascular services. This identified that the majority of staff in this group are female with a mixed age profile and so this group are considered vulnerable.

The Communications and Engagement Plan for Vascular Surgery Reconfiguration has been reviewed to ensure these potentially vulnerable groups have been included in the plan.

An action plan to address the negative impact identified through the EqIA has been developed. In summary this addresses the potential negative impact on patients through the development of appropriate patient information as part of the implementation plan and GPs offering patients a choice of provider at the point of referring to the service. In relation to staff the action plan includes ongoing communication with staff about the

reconfiguration, staff being asked to complete preference forms and once staff transfer arrangements have been agreed with UHBFT there will be a formal consultation with staff, this will include one to one meetings.

3. IMPLEMENTATION PLAN

The SWBH Vascular Surgery Reconfiguration Project Team and the joint Vascular Surgery Reconfiguration Project Board with UHBFT continue to work with operational managers and clinical leads to develop an implementation plan. These groups will continue to meet fortnightly.

From this work it has been agreed that the implementation date should be 10th September 2012. This is later than the proposed date in the Case for Change for Vascular Surgery Reconfiguration of July in order to allow sufficient time to engage fully with clinical and operational leads to develop and deliver detailed implementation plans including the development of key operational policies and transfer arrangements. It also allows for a review of capacity in key facilities (for example operating theatres and wards) at UHBFT in order to give clarity about the capacity and sessions available to our Vascular Surgeons and to allow any required changes to job plans and other clinical sessions (e.g. clinics) to accommodate these. This revised implementation date still delivers the change ahead of the introduction of the AAA (Abdominal Aortic Aneurysm) Screening Programme in Sandwell and Birmingham (this is part of a national programme and being co-ordinated by the SHA) in October 2012.

It should be noted that key implementation issues are:

- The need to agree staff transfer arrangements with UHBFT in time to undertake formal staff consultation for which a 90 day period is recommended (although this length of time may not be required). On this basis agreement with UHBFT is required by the middle of June. Agreement later than this may put at risk the implementation date of 10th September.
- Development of Service Level Agreements between the Trusts for SWBH staff time and costs undertaken at UHBFT in relation to Vascular Surgery and Vascular Interventional Radiology services. These nee to be agreed before the implementation date.
- The need for UHBFT to confirm exact theatre sessions and other capacity for SWBH consultant sessions at UHBFT in order to be able to review consultant job plans and SWBH clinical sessions and reschedule these where required.

The table below summarises key implementation plan milestones and progress with these.

Milestone / Action	Comments	Lead	Progress	Date
UP TO END OF APRIL 2012				
Business Case for Change	Approved by SWBH Trust Board at its meeting at the end of March subject to full EQIA & Action Plan being presented to May Trust Board Meeting	JD	Complete	29/3/12
Business Case for Change	Approved by UHBFT CEO Advisory Group in April 12.	LW (UHBFT)	Complete	End of April 12
Clinical Workshop	Three Clinical Workshops with clinicians from both Trust's held. Next workshop arranged for 1st June.	LW (UHBFT)	On track	Ongoing
MAY 2012				
Task and Finish Groups	Task and finish working groups with joint SWBH & UHBFT membership have been set up to develop detailed implementation action plans, operational policies etc. Each group has clear terms of reference, membership and objectives and will report back to the Joint Project Board.	YM & EC (UHBFT)	On track	Ongoing
Agree Staff Transfer/ TUPE arrangements	Ongoing discussions between SWBH & UHBFT regarding whether TUPE applies and number of staff & costs that will transfer to UHBFT or work at QE under SLA. Both Trusts need to resolve the outstanding TUPE and workforce issues before middle of June 2012, to allow 90 days to complete the consultation process with staff ahead of implementation on 10th September.	MS, LB & KB (UHBFT)	Work in progress	Mid June 12
Staff management of change process	Define timeline for Staff consultation and methodology Produce plan – need agreement on TUPE & staff transfer before can progress further	ANF	Work in progress	May 2012
EQIA & Action Plan	EQIA undertaken, action plan developed, agreed with Pauline Richards. To be presented to Trust Board on 31/5	YM & JD	On track	31/5/12
Implementation Plan	Work started on Implementation Plan. High level milestones identified. Progress report presented to SWBH Clinical Reconfiguration Programme Board 17th May. To be presented to Trust Board on 31/5.	YM & JD	On track	31/5/12
JUNE 2012				
Theatre sessions at UHBFT	UHBFT theatre capacity to be reviewed and session for SWBH consultants to be confirmed.	LW (UHBFT)	Work in progress	Early June 12
Review job plans, rotas & implications for SWBH	Consultant job plans to be reviewed and confirmed once UHBFT have confirmed inpatient capacity and days for theatre sessions etc (see above).	PN SS RS	Work in progress	June 2012
SWBH sessions to be confirmed	SWBH Vascular Surgery Day Case, Clinic and Stroke MDT sessions to be confirmed once theatre sessions at UHBFT confirmed (see above) and in time to allow rescheduling of SWBH sessions and patients (minimum of 12 weeks notice)	YM	Work in progress	18/6/12
SLAs	Develop Service Level Agreements (SLAs) with UHBFT in relation to SWBH staff time and costs undertaken at UHBFT (for staff where TUPE not applicable)	MB & LW (UHBFT)	On track	End June 12
Formal staff consultation	Formal staff consultation to start in line with staff consultation plan. Dependant upon agreement with UHBFT – see above.	YM & AN	Work in progress	11/6/12
Implementation Plan	Develop and confirm detailed Implementation Plan	YM & EC (UHBFT)	On track	Mid June

JULY & AUGUST 2012				
Agree SLAs	Agree SLAs with UHBFT in relation to SWBH staff time and costs undertaken at UHBFT	MB & LW (UHBFT)	On track	Mid August 12
Work with WMAS	Establish contact, agree transfer arrangements between SWBH EDs and UHBFT.	YM & EC (UHBFT)	On track	July 2012
Implementation Plan	Deliver Implementation Plan.	YM & EC (UHBFT)	On track	Ongoing to 10/9/12
SEPTEMBER 2012				
Implement Change	This date is dependant upon both Trusts resolving the outstanding TUPE and workforce issues by mid June to allow 90 days consultation period with staff.	MB & LW (UHBFT)	On track	10/9/12

Progress against the implementation milestones and plan will be monitored via the SWBH Project Team and the joint Project Board with UHBFT for Vascular Surgery reconfiguration. Progress against the implementation plan will be reported by exception within both Trusts. Within SWBH this will be to the Executive Team.

4. CONCLUSION AND RECOMMENDATIONS

Since approval of the Case for Change for Vascular Surgery Reconfiguration in March 2012 a full Equality Impact Assessment has been undertaken and a related action plan developed.

The SWBH Vascular Surgery Reconfiguration Project Team and the joint Vascular Surgery Reconfiguration Project Board with UHBFT have continued to work with operational managers and clinical leads to develop an implementation plan. Through this work a revised implementation date of 10th September has been identified which although later than the previous proposed date of July still allow implementation in line with SHA timescales and ahead of introduction of the AAA (Abdominal Aortic Aneurysm) Screening Programme in Sandwell and Birmingham in October 2012.

High level implementation milestones have been identified and are presented along with progress against them as part of this report. A number of key implementation issues have been identified around:

- The need to agree staff transfer arrangements with UHBFT in time to undertake formal staff consultation.
- Development of Service Level Agreements between the Trusts for SWBH staff time and costs undertaken at UHBFT in relation to Vascular Surgery and Vascular Interventional Radiology services.
- The need for UHBFT to confirm exact theatre sessions and other capacity for SWBH consultant sessions at UHBFT in order to be able to review consultant job plans and SWBH clinical sessions and reschedule these where required.

Delays in resolving these and in particular the agreement around staff transfer arrangements may put at risk the implementation date of 10th September.

The Board is recommended to:

- ACCEPT the Equality Impact Assessment and related action plan.

- ACCEPT the revised implementation date of 10th September, and the related high level implementation milestones.
- ACCEPT the key implementation issues and the potential risk these present to the implementation date.

Appendix 1

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Equality Impact Assessment

Stage 2
Initial Assessment form

The Initial Impact Assessment is a quick and easy screening process. It should:

1. Identify those policies, functions, services, functions or strategies which require a full EIA by looking at:

   - Negative, positive or no impact on any of the protected characteristics.
   - Opportunity to promote equality for the protected characteristics.
   - Data / feedback prioritise if and when a full EIA should be completed

2. Justify reasons why a full EIA is not going to be completed

Division:	**Surgery A**
Is it a Service, Policy or Function:	**Service**
Lead officer:	**Yvette Moore**
Title of policy, function or service:	Vascular In-patient services

Existing: ☐

New/proposed: √

Changed: ☐

Equality & Diversity Team

Q1) What is the aim of your policy/service/function (you may want to refer to the Operational Policy for your service)?

Transfer of in-patient vascular services from SWBHT to UHB

Q2) Who benefits from your policy /service/function?

Vascular Patients

Q3) Do you have any feedback data that influences, affects or shapes this policy, function or service?

Yes	No
√ Please complete below.	☐ Please go to question 4

What is your source of feedback?

- ☐ Previous EIAs
- √ National Reports
- ☐ Internal Audits
- √ Patient Surveys
- ☐ Complaints / Incidents
- ☐ Focus Groups
- ☐ Equality & Diversity Training
- ☐ Equality & Diversity Team
- √ Other

What does this source of feedback reveal?

The Vascular Society for Great Britain & Ireland and NCEPOD recently published recommendations around emergency vascular provision. They stated that the best outcomes are achieved in specialist vascular units with dedicated vascular teams available 24 hours a day, seven days a week. According to VSBGI (2009) Surgeons, who are able to maintain high volumes of vascular surgery, achieve mortality rates 2 - 4% lower than surgeons who perform low volumes of vascular surgery each year.

These aforementioned documents also suggest it is in the best interests of patients that hospitals should come together to provide high volume units. Evidence suggests that clinical outcomes can be improved, uptake of new technologies enhanced, quality developed and efficiency optimised if arterial services are undertaken in considerably fewer high volume units and venous services continue locally, the VSGBI recommend that the coalescence of adjacent vascular services onto a single site is the optimal model for service delivery.

The Vascular Surgical Society of Great Britain and Ireland (VSBGI) have developed guidance for the provision of emergency and elective vascular surgery services (vascular services). There is also published evidence

regarding minimum numbers of procedures that vascular units should undertake and linking surgeon volume with outcome. National recommendations and guidelines suggest a single in patient hub and spoke service for populations of around 800,000.

SWBHT currently has 3 Vascular Specialist Consultant Surgeons. This Number is insufficient to provide a 24/7 service regardless of clinical commitments, annual leave, study leave etc. Therefore SWBHT already works with Vascular Services at UHB in order to provide OOH vascular emergency cover. In addition and for similar reasons the Trust is currently unable to provide 24/7vascular interventional radiology (IR) services, however, there are currently no arrangements in place with UHB to provide 24/7 OOH cover for IR.

In order to ensure appropriate 24/7 cover for all aspects of vascular in-patient service provision it is necessary to align services to concentrate the critical mass of in-patients across both SWBH and South Birmingham (UHB) at one site. UHB currently have 4 Vascular Specialist Consultant surgeons and therefore this reconfiguration would provide a total of 7 specialists; a sufficient number able to provide 24/7 cover.

Q4) Thinking about each group below does or could the policy, function, or service have a negative impact on members of the protected characteristics below?
(Please refer to pages 3 & 4 for further definitions of protected characteristic)

Protected Characteristic	Yes	No	Unclear
Age	√	☐	☐
Disability	√	☐	☐
Ethnicity	☐	☐	√
Sex	☐	√	☐
Gender Reassignment	☐	√	☐
Sexual Orientation	☐	√	☐
Religion or belief	☐	√	☐
Other socially excluded groups	☐	√	☐

If the answer is “yes” or “Unclear” please complete a full EIA

Q5) Who was involved in the EIA and how?

Who:

√ Staff members
√ Consultants
√ Doctors
√ Nurses
√ Local patient/user groups
☐ Other

Please specify

How were they involved?

√ Surveys
√Team Meeting
☐ Via the Single Equality Scheme
√Divisional Review
☐ Other

Please specify:

Q6) Have you identified a negative/potential negative impact (direct /indirect discrimination)?

No	☐	yes	√

Q6a) If 'No' Explain why you have made this decision?

Q6b) If 'yes' explain the negative impact – you may need to complete a full EIA

Vascular patients are often elderly and may have reduced mobility and/or impaired circulation due to their medical condition. Some patients have undergone previous amputation of their limbs as part of their care. If services are transferred to UHB it is likely to mean that patients who live locally to Sandwell and City Hospitals will have further to travel to the Queen Elizabeth Hospital, Birmingham and may incur additional travel and parking costs compared to now.

In addition the population of Sandwell and West Birmingham is diverse with many different languages being spoken. It is unclear whether or not UHB is used to dealing with such a large diverse population and / or whether a similar level of interpreting services that are currently in place at SWBHT will be available at UHB.

As part of the transfer of services it is anticipated that staff who currently work at SWBHT on the in-patient wards will transfer with the service and be TUPE transferred to work at UHB – consultation and negotiation is currently underway to confirm the exact number of assignments that will transfer. Other staffing groups supporting the delivery of these services

are also under review to confirm contracting arrangements for sessional work and service level agreements between both organisations. This may have a negative impact for some staff who proposed to retain their working arrangements within SWBH.

If a negative impact has been identified please continue to Stage 3. If no negative impact has been identified please submit your Initial Equality Impact Assessment to Equality&Diversity@swbh.nhs.uk.

Please note: Issues relating to either interpreting/translating, ensuring single-sex accommodation or Bariatric issues have been identified as corporate trends, therefore if the negative impact you have identified falls within these categories a full impact assessment is not required. However, should you go full impact assessment the corporate trends need to be recorded within the Action Plan on page 18.

Justification Statement:
As member of SWBH staff carrying out a review of an existing or proposal for a new service, policy or function you are required to complete this EIA by law. By stating that you have not identified a negative impact, you are agreeing that the organisation has not discriminated against any of the protected characteristics. Please ensure that you have the evidence to support this decision as the Trust will be liable for any breaches in the Equality Legislation.

Completed by:

Name:	Yvette Moore	Gill Gadd
Designation:	Deputy Divisional Manager	Service Redesign Manager
Date:	1 May 2012	
Contact number:	4580	
Head of Service:		

This EIA has been approved by the Divisional General Manager:

Name:	Mike Beveridge
Designation:	Divisional Manager
Date:	May 2012
Contact number:	0121 507 4581

This EIA has been signed off by the Head of Equality & Diversity:

Name:	**Pauline Richards**
Signature:	
Date:	**21st May 2012**
Contact number:	**Ext 5169**

Step 7) Now that you have ensured a full impact assessment does not need to be completed we need to publish your results for the public to view.

Tick list

☐ Send an electronic copy of ratified EIA to the Equality and Diversity team who will publish it on the website

Equality & Diversity team contact details

For further advice, please contact:

- Pauline Richards (Head of Equality & Diversity) 0121 507 5169
- Belinder Virk (Equality & Diversity Advisor) 0121 507 5561
- Estelle Hickman (Equality & Diversity Advisor) 0121 507 5561

Equality & Diversity Team
Arden House
City Hospital
Birmingham B18 7QH

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Equality Impact Assessment

Stage 3
Full Assessment Form

Having completed the Initial EIA Screening Form (Appendix A) which identified a negative or potential negative impact, you are required to complete this Full Assessment form. This will involve you questioning aspects of a proposed/existing service or policy and forecasting the likely effect on different groups.

Step 1) What is the impact?

Why have you carried out this Full Equality Impact Assessment?

Patients will no longer be able to access in-patient vascular services at SWBHT instead they will need to be admitted to UHB. This assessment aims to ensure that the following issues are considered:

1. The reconfiguration will improve and not worsen existing, or create new inequalities in access, outcomes and experience of vascular services for the groups that should benefit.

2. The impact on diverse groups, protected by equality legislation has been considered in the development of the business case for vascular services.

3. Robust evidence of the equality impact of the vascular service reconfiguration option informs the decision making process for the Board of Sandwell and West Birmingham Hospitals NHS Trust.

In addition staff currently working at SWBHT within the in-patient ward based setting have the potential to be TUPE transferred across to work at UHB which is currently under discussion and negotiation between Trusts and their legal advisors.

1. It is envisaged that staff will not be disadvantaged with regard to their existing roles supporting vascular in-patient services as it is proposed these transfer under law with the service they currently support to the new hosting organisation.
2. The organisation is compiling activity profiles to assign ward based nursing staff to in-patient work which will evidence TUPE regulations need to be applied for this staffing group. The assignment of staff will protect staff contracts of employment as they would upon agreement that TUPE does apply, transfer with them to

UHBFT.

3. The affected staff groups will have access to formal information and consultation in line with TUPE, and upon agreement of a transfer of services - staff will also retain the same terms and conditions of employment as part of that transfer. In addition these staff members will continue to be managed under SWBH policies and procedures until such time as the new organisation consult with the workforce regarding any harmonisation of policies and procedures or for organisational change purposes which is not by reason of the TUPE transfer to be taking place.

Please mention any additional impacts in the box below. This could include contributing factors or conflicting impacts/priorities (e.g. environment, privacy and dignity, transport, access, signage, local demography) that has resulted in indirect discrimination.

Travel and Transportation for both Patients and Staff

The connections between transport and health are multiple, complex, and socio-economically mixed. Poorer families tend to have lower mobility and research indicates that over a twelve month period, 1.4 million people fail to attend, turn down or choose not to seek medical help because of transport problems (SEU, 2002). There are also an estimated 9.5million disabled people of driving age in the UK and this figure is expected to increase. Disability will impact on travel arrangements for individuals according to their level of disability. Poorer families may rely more heavily on public transport and currently there is not a direct bus from either Sandwell or City to UHB.

In addition staff can often plan where they live and child care arrangements around travel times to their existing place of work. A change in the direction of travel to UHB may have the potential to impact on travel arrangements, time and cost. As this is a merger of services, staff extended travel commitments would need to be looked at in line with SWBH policies and procedures and in line with national Agenda For Change protection arrangements changed by reason of a merger or transfer.

1a) Identify the Equality group(s) that will be affected by the negative impact:

Ethnicity	Sex	Gender Reassignment	Age	Disability	Religion or Belief	Sexual Orientation	**Other**
√	☐	☐	√	√	☐	☐	☐

1b) What about other socially excluded groups or communities e.g. rural community, carers, areas of deprivation, low literacy skills, obesity? Please mention any additional issues here.

Step 2) What are the differences?

2a Explain how the Equality group(s) identified is affected in a different way to others as a result of the policy, function or service?

1.The patient groups considered to be vulnerable were identified as:

- Groups characterised by Race / Ethnicity
- Elderly groups
- Groups with pre-existing disabilities / impairments
    - mental health impairments and disabilities
    - cognitive impairments / communication issues
    - dementia – orientation / compliance
    - Sensory disability or impairments
    - Physical disability or impairments

Race (Culture, Ethnicity & Language):
A rich level of diversity exists within the populations of Sandwell and the Heart of Birmingham. In Sandwell, 20.3% of the population is from Black and Minority Ethnic groups; by contrast, the Heart of Birmingham has the largest Black and Minority Ethnic population amongst all PCTs in the country, representing 68% of the population.

The picture of racial diversity varies across the wards in Sandwell with the greatest concentrations of black and minority ethnic communities in the East and centre of the borough in the wards of Smethwick, Soho and Victoria, St Paul's and Central West Bromwich at between 40-55%; the greatest concentration of white groups are in the West of the borough in the wards of Friar Park, Princes End, Rowley, Tividale, Black Heath, Cradley Heath & Old Hill at between 90-95% of the populations.

Language and communication:
Access to and the availability of trained impartial interpreters throughout the patient pathway is seen as vital in ensuring good quality care and a positive patient / carer experience.

Access to interpreters is an issue, with many people not being able to access interpreters and using family to interpret. Interpretation services should be routinely available across the pathway. It should be

- Impartial
- appropriate

Currently a service is available at SWBH which meets our patients needs. The level of service provided at UHB is unknown.

Elderly Groups
Older people maybe less informed about their condition and the range of support available. They are more likely to live alone, which means they tend to need more support if they return home to live after amputation surgery as they may have no family members living near to them. They are also more likely than younger people to have other pre-existing health issues which may compound their needs when recovering from vascular disease.

- Older people may refuse hospital services without fully understanding the implications for them.
- Advocacy support maybe important for older groups whom are less likely, or feel less able to articulate their concerns.
- Concerns that some groups do not feel listened to.
- Carers should be involved in all stages of the pathway and a partner in all decision making.
- Potential for elderly patients to be confused (changing hospital sites during their pathway of care, outpatient to inpatient).

Disability Groups

Services should be in place to support patients that become disabled as a result of either vascular surgery or as a result of vascular disease that may lead to stroke e.g personality disorders can result in families being unable to cope and care for the patient

Accessibility / Travel

Distance of the hyper-acute unit from the local community should be considered with respect to:

- Accessibility for families and carers to patients if it is not near local community
- Ambulance transfers between sites and difficulty this may cause for carers.
- Distance between departments/wards at UHB

Accessibility / site

Access to and availability of appropriate equipment across the pathway eg. Handling, Chairs for patients and staff, carers.

Access to service needs to be equitable and timely

Commissioner /stakeholder impact.

- Blue light transfers from one site to another –cost implications

2. The Staff Groups identified as being vulnerable include:

Those individuals who provide in-patient vascular services to patient groups.
The workforce profile compliments a diverse cultural workforce mix, the gender mix within the ward based nursing groups for this service is predominantly female, and of mixed age profile. Extended travel for this group of staff may prove to be a problem

Step 3) You are almost there - now all you need to do is to consult!

3a Have you consulted on your policy, service or function and if so, who have you communicated with?

The key aims of the Communications and Engagement Plan for Vascular Services are:

- To involve staff in the process of change;
- To ensure patients are fully aware of the changes provided by SWBH;

- To keep GPs updated about changes;
- To promote the benefits of the changes being made within Vascular Services.

The primary audiences this plan seeks to reach are:

- Patients including patient groups
- Public including community groups
- SWBH staff
- UHB staff – vascular team/matron/divisional manager
- Sandwell PCT
- HoBt PCT
- WMAS
- SHA
- GPs
- GP Commissioning Clusters and Clinical Commissioning Group
- The Media
- Birmingham and Sandwell LINks
- Birmingham and Wolverhampton University

The regular methods for communication will be through the Trust's existing internal and external communications channels including Heartbeat, Hot Topics, the Trust website, GP homepage and press releases. Other channels of communication will also be used.

Informal staff engagement and updates have already been held with staff from affected staffing groups.

The Trust has published regular updates in the staff bulletin, and monthly newsletter – Heartbeat to support updates on the proposals for change.

In addition ward based staffing, and Interventional Radiology staff groups have attended informal staff engagement events to review progress with the project and the drivers for changes being considered, and given an opportunity to raise any informal discussion/questions – no formal consultation has commenced whilst both Trusts agree the status for the project to proceed and negotiate on the workforce profile enabling this change to proceed. Upon approval of the Business Case by both Trusts and agreement on the workforce aspects of the project formal consultation will commence both with the recognised Trade Unions, and the workforce directly and indirectly affected by these changes.

Formal consultation with the workforce is proposed after agreement on the workforce status which is anticipated after 9th May 2012 when both Trusts formally meet to agree the workforce status supporting this transfer.

3b If you have not consulted yet, please list who you are going to consult with and the methods of consultation you will be using to seek their views? (Staff, specific groups or communities)

	Audience	Action	Comments/ Key Messages	

SWBH Affected staff	Face to face briefings on wards	Update from project team
All SWBH staff	Brief article in Heartbeat	To update staff on new timing for implementation and invite feedback
All SWBH staff	Email	Updated timeline in staff bulletin
Inpatients (City site)	Face to face briefing and opportunity to feedback. With letter and freepost envelope given out, so patients can add any further comments once they've had a chance to think about plans	To ensure patients are aware of the changes and gather feedback – highlighting any areas of concern
Outpatients (City and Sandwell sites)	Face to face briefing and opportunity to feedback. (With letter given out as above)	To ensure patients are aware of the changes and gather feedback – highlighting any areas of concern
UHB staff	TBA – comms planning meeting organised for 2/5/12	
HOBtPCT	Information stand	To attend a PLT event run for HOBtPCT GPs
All SWBH staff	Article in Hot Topics	Update on implementation
The Media esp Birmingham Mail, Post and Express and Star.	Joint SWBH / UHB briefing re what the changes mean for patients	* Need positive case study
GPs	Message on GP Homepage and on GP section of new website	To advise of plans
Sandwell PCT HoBt PCT	Letter to Chief Executives for info and cascade	To advise of plans
WMAS	Letter to Chief Executive	To advise of plans
WMAS	Article in staff newsletter	To advise of plans
The Public	Article on Trust website	To advise of plans
Sandwell PCT HoBt PCT	Article in staff newsletters	To advise of plans
Universities – Birmingham and Wolverhampton	Letter	To advise of plans
Inpatients (City site)	Face to face briefing and opportunity to feedback.	To ensure patients are aware of the changes and gather feedback
Outpatients (City and Sandwell sites)	Face to face briefing and opportunity to feedback. (With letter)	To ensure patients are aware of the changes and gather feedback.
Affected staff	Email	Update from project team
All staff	Update in Hot Topics	To let all staff know about what is happening within Vascular Services
All staff	Heartbeat	Detailed article about the implementation of changes
Inpatients (City site)	Face to face briefing and opportunity to feedback.	To ensure patients are aware of the changes and gather feedback
Outpatients (City and Sandwell sites)	Face to face briefing and opportunity to feedback. (With letter)	To ensure patients are aware of the changes and gather feedback.
Affected staff	Face to face briefings on wards	Update from project team
All staff	Update in Hot Topics	
GP Commissioning Clusters / Clinical Commissioning Group	Letter	To advise implementation will be complete next month
The Public	Article in member newsletter (7,500 people)	
GPs	Letter / leaflets to all GPs	
Inpatients (City site)	Face to face briefing and opportunity to feedback.	To ensure patients are aware of the changes and gather feedback
Outpatients (City and Sandwell sites)	Face to face briefing and opportunity to feedback. (With letter)	To ensure patients are aware of the changes and gather feedback.
The Media	Press release	To announce final implementation of the plan is complete.
All SWBH staff	Heartbeat	To advise final implementation of the plan is complete.
UHB staff	TBA	
All SWBH staff	Article in Hot Topics	To announce final implementation of the plan is complete.

	GPs	Message on GP Homepage and on GP section of new website	To announce final implementation of the plan is complete, and advise who to contact with any queries.
	Sandwell PCT HoBt PCT	Letter to Chief Executives for info and cascade	To announce final implementation of the plan is complete.
	WMAS	Letter to Chief Executive	To advise final implementation of the plan is complete.
	WMAS	Article in staff newsletter	To announce final implementation of the plan is complete.
	The Public	Article on Trust website	To announce final implementation of the plan is complete.
	Sandwell PCT HoBt PCT	Article in staff newsletters	To announce final implementation of the plan is complete.
	Universities – Birmingham and Wolverhampton	Letter	To advise final implementation of the plan is complete.

Step 4) Choose & answer the questions relevant to your EIA.

4a This EIA indicates that there is insufficient evidence to judge whether there is differential impact. Please state why below.

4b This EIA shows that the service, policy or function has a differential impact which is not negative. Please state why below.

The impact sited are proposed to be mitigated by clear referral pathways, communication between the service providers, patients and staff.

4c This EIA reveals a differential impact which also amounts to a negative impact. Please state why below.

Until the workforce position is confirmed between both organisations there is uncertainty of staff roles assigned to the transfer.

Scoring your adverse impact

You will also need to score each of your negative impacts and record the scoring in your Action Plan (page 18).

Matrix for Full Equality Impact Assessments (Stage 3)

1. **PROBABILITY -** What is the likelihood of the service, policy or function having an impact on staff or patients of the Trust? Use the table below to assign this incident a category code.

MEASURES OF PROBABILITY		
Descriptor	**Level**	**Description**
Rare	1	The service, policy or function will only impact under exceptional circumstances
Unlikely	2	The service, policy or function is not expected to have an impact but will do in some circumstances
Possible	3	The service, policy or function may have an impact on occasion
Likely	4	The service, policy or function is likely to impact, but not on a persistent basis
Almost Certain	5	The service, policy or function is likely to impact on many occasions and on a persistent basis

2. **SEVERITY OF IMPACT -** Identify the highest possible impact of the **service, policy or function.** (Use this table as a general guide)

Descriptor	Potential Impact on Individual(s)	The Potential for complaint/ Litigation	Potential Impact on Organisation	Number of Persons likely to be affected
Negligible 1	• No impact or adverse outcome	• Unlikely to cause complaint/ litigation	• No risk at all to organisation	0-1 Person
Low 2	• Short term impact	• Complaint possible • Litigation unlikely	• Minimal risk to organisation	2-4
Medium 3	• Semi-permanent impact	• Litigation possible but not certain. • High potential for complaint.	• Needs careful PR • Reportable to SHA • External investigation (e.g. HSE)	5-10 Persons
High 4	• Permanent impact	• Litigation certain expected to be settled for < £1M	• Service closure • Threat to Divisional/Directorate objectives/priorities • Local publicity	10-20 Persons
Very High 5	• Permanent and severe impact	• Litigation certain expected to be settled for > £1M	• National adverse publicity • Threat to Trust objectives/priorities	Over 20 persons

3 **Equality Impact Score** - Use the matrix below to grade the risk.
E.g. 2 x 4 = 8 = Yellow or 5 x 5 = 25 = Red

	SEVERITY OF IMPACT				
PROBABILITY	**Negligible 1**	**Low 2**	**Medium 3**	**High 4**	**Very High 5**
1 Rare	**1**	**2**	**3**	**4**	**5**
2 Unlikely	**2**	**4**	**6**	**8**	**10**
3 Possible	**3**	**6**	**9**	**12**	**15**
4 Likely	**4**	**8**	**12**	**16**	**20**
5 Almost Certain	**5**	**10**	**15**	**20**	**25**

Roles and Responsibilities

Equality & Diversity Team

- To review all Full Impact Assessment Action Plans.
- To review each action against the EIA Matrix
- To report all Medium, Very High and Extreme impacts to the Service & Policy Assessment Group (SPAG)

Service & Policy Assessment Group (SPAG)

- To agree and discuss likely outcome and agree actions to follow.

Examples of Discrimination according to descriptor.

Descriptor	
Negligible 1	Patient complaining that their dignity has been infringed due to having to wait in reception after eyes being dilated.
Low 2	Temporary relocation of Clinic due to refurbishment. Patients required to travel longer distance to attend clinic.
Medium 3	Uneven surfaces making it dangerous for wheelchair users to manoeuvre across.
High 4	Service excludes particular patients due to their religious requirements.
Very High 5	Emergency Fire Escape: Lack of accessible escape routes for disabled patients.

Step 5) Plan to address your Negative Impact

1. It is now time to complete your action plan using the table below. Please detail how you are going to address the negative impact, stating the timescales involved.

Negative Impact	Negative Impact Rag Rating	Action Required	Expected Outcome	Lead	Timescale (specify dates)
Workforce Less than 20 persons likely to be affected by transfer to UHB The extra distance To travel to work may be a problem for staff with disability issues or elderly staff Ethnicity should not be a problem	8 4 x 2 Medium	Formal consultation of change 1-1 Meetings Visit to new site Staff have been asked to complete preference forms which will be taken into consideration when identifying those to transfer with the service. Those who can not be accommodated will be managed under the organisational change policy	Agreement to transfer	Service leads Matron HR Unions	May to June Consultation September implementation
Patients For Disability and Age Disability will impact on travel arrangements for individuals according to their level of disability.	4 2 x 2 Short term impact	Information for patients Choice offered of alternative provider Patient choice / GP refer to alternative provider if UHB is too far for them to travel	Agreement to use UHB as provider or GP refer to alternative provider		Ongoing as patients present to GP

NB: As a requirement of the Divisional Review process, please ensure that you include the above actions within your Implementation Plan.

Step 6) Congratulations you have made it.

Completed by:

Name:	Yvette Moore
Designation:	Deputy Divisional Manager
Date:	1 May 2012
Contact number:	4580
Head of Service:	

This EIA has been approved by the Divisional General Manager:

Name:	Mike Beveridge
Designation:	Divisional Manager
Date:	May 2012
Contact number:	4581

This EIA has been signed off by the Head of Equality & Diversity:

Name:	**Pauline Richards**
Signature:	
Date:	**21st May 2012**
Contact number:	**Ext 5169**

Step 7) Now we need to publish your results for the public to view.

Please complete the tick list below.

`

☐ Please tick to indicate that this EIA has been approved by your Divisional General Manager.

☐ Please send your completed EIA to the Equality and Diversity team for approval. Once approved, your EIA will be placed on the SWBH webpage for the public to view.

Please email all EIAs to Equality&Diversity@swbh.nhs.uk

Equality & Diversity team contact details

For further advice, please contact:

- Pauline Richards (Head of Equality & Diversity) 0121 507 5169

- Belinder Virk (Equality & Diversity Advisor) 0121 507 5561
- Estelle Hickman (Equality & Diversity Advisor) 0121 507 5561

Equality & Diversity Team
Arden House
City Hospital
Birmingham B18 7QH

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Revised Workforce Strategy – 2012-2018**
SPONSOR (EXECUTIVE DIRECTOR):	**Mike Sharon, Director of Strategy and Organisational Development**
AUTHOR:	**Gayna Deakin, Deputy Director of Workforce (Strategy and Planning)**
DATE OF MEETING:	**31st May 2012**

EXECUTIVE SUMMARY:

The Trust's Workforce Strategy has been revised over the spring of 2012 and is an integral part of the Trust's application for Foundation Trust status. It fully supports the delivery of the vision that this describes and seeks to ensure that the direction of travel for our workforce is clearly understood, planned for and managed. The success of this strategy will be an important means of achieving our strategic objectives and becoming an NHS Foundation Trust.

The Strategy, and work programme for 2012/13, has been developed with the engagement of key stakeholders and through our staff themselves. It sets out the following aims:

- To build an engaged, highly performing workforce
- To improve workforce productivity and efficiency
- To enhance HR capacity and capability
- To become the 'employer of choice'

It seeks to ensure that the Trust's staff are managed in the best way possible:

- By having the best leaders that are capable of increasing levels of staff engagement and leading the change and improvements required to be a successful Foundation Trust
- By staff having the right skills and experience and being flexible and adaptable as change occurs
- By embedding excellent human resources management practice across all areas of the Trust
- By staff feeling that the Trust is a good place to work and they feel valued and recognised for their contribution to delivering high quality services

It outlines the role of strategic workforce planning and human resources management in making this happen by setting the direction:

- For further embedding workforce planning across the Trust and strengthening our links with education and training providers to ensure the right numbers of staff with the right skills, knowledge and behaviours
- For championing new ways of working to support service developments and redesigned services
- For increasing staff engagement and staff satisfaction levels further through staff development and involvement in decision making and change
- For stronger alignment of HR to service delivery
- For strengthening strategic human resources management
- For effective and efficient HR services to support workforce management and development

It sets out in Appendix 1 the annual work programme of key priority areas for action in 12/13.

REPORT RECOMMENDATION:

Trust Board is asked to approve the Trust's revised Workforce Strategy - 2012-2018 and Work Programme for 12/13

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	x	

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

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

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Enabling Strategy to support Integrated Business Plan for the Foundation Trust application and delivery of the Trusts vision and strategic objectives.

PREVIOUS CONSIDERATION:

Organisational Development Steering Group (March 2012) and Trust Management Board on 22 March 2012.

SWBTB (5/12) 100 (a)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

WORKFORCE STRATEGY 2012-2018

Where EVERYONE Matters

Document Control

Document Location	Strategy Directorate

Revision History

Version	Date	Author	Summary of Changes
0.1	27.2.12	Gayna Deakin	First draft
0.2	16.4.12	Gayna Deakin	New section 11 on leadership and new section 12 on staff working differently added following input from Strategic Workforce Planning Steering Group
0.3	11.5.12	Gayna Deakin	Areas of strategy and work programme strengthened and amended as a result of work in progress and to reflect feedback from Trust managers and staff
0.4	16.5.12	Gayna Deakin	Amendments to strengthen focus on quality, links with education and training and new sub-section 14.5 on widening participation added following feedback from Chief Nurse
0.5	21.5.12	Gayna Deakin	Minor amendments following feedback from Director of Strategy and OD
0.6	23.5.12	Gayna Deakin	References added Final amendments to take account of remainder of outputs from staff engagement process inc trade unions Timeframe for strategy changed to 2012-2018 following discussion at TMB Format and layout completed

Engagement This Strategy requires engagement with the following Forum/Stakeholder:

Version	Group	Date	Signature
	HR and Strategy/Planning leads (Reference Group)	w/c 27.2.12	
	Organisational Development Steering Group	5.3.12	
	Trade Unions (JCNC)	5.4.12	
	Senior Leadership Team (e-mail)	April 2012	
	All Staff (Hot-Topic subject/Heartbeat)	April 2012	
	RCRH Partnership Workforce Leads	April 2012	
	Black Country Cluster/NHS Midlands and East	April 2012	
	Trust Management Board	May 2012	

Approval This Strategy requires the following approvals

Version	Group	Date	Signature
	Organisational Development Steering Group	May 2012	
	Trust Board	May 2012	

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Workforce Strategy
2012 - 2018

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SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Workforce Strategy

2012 – 2018

1. Executive Summary

The Trust's Workforce Strategy has been revised over the spring of 2012 and is an integral part of the Trust's application for Foundation Trust status. It fully supports the delivery of the vision that this describes and seeks to ensure that the direction of travel for our workforce is clearly understood, planned for and managed. The success of this strategy will be an important means of achieving our strategic objectives and becoming an NHS Foundation Trust.

The Strategy, and work programme for 2012/13, has been developed with the engagement of key stakeholders, including our staff themselves. It sets out the following aims:

- To build an engaged, highly performing workforce
- To improve workforce productivity and efficiency
- To enhance HR capacity and capability
- To become the 'employer of choice'

It seeks to ensure that the Trust's staff are managed in the best way possible:

- By having the best leaders that are capable of increasing levels of staff engagement and leading the change and improvements required to be a successful Foundation Trust
- By staff having the right skills and experience and being flexible and adaptable as change occurs
- By embedding excellent human resources management practice across all areas of the Trust
- By staff feeling that the Trust is a good place to work and they feel valued and recognised for their contribution to delivering high quality services

It outlines the role of strategic workforce planning and human resources management in making this happen by setting the direction:

- For further embedding workforce planning across the Trust and strengthening our links with education and training providers to ensure the right numbers of staff with the right skills, knowledge and behaviours
- For championing new ways of working to support service developments and redesigned services
- For increasing staff engagement and staff satisfaction levels further through staff development and involvement in decision making and change
- For stronger alignment of HR to service delivery
- For strengthening strategic human resources management
- For effective and efficient HR services to support workforce management and development

This Strategy provides the strategic direction for workforce and will be implemented through an annual work programme of key priorities and the Trust's 5-year workforce plan.

2. Introduction

The Trust's strategic vision is to help to improve the health and well-being of people in Sandwell, western Birmingham and surrounding areas, working with our partners to provide the highest quality of healthcare in hospital and closer to home. Maintaining a highly performing workforce and developing progressive HR and employment practices, with a strong emphasis on organisational effectiveness, is essential to achieving this vision.

This Workforce Strategy describes how the Trust will improve its performance through its people management over the coming years. It sets out the approach and key strategic themes to ensure that we can acquire the right number of staff, with the right skills, working in the right place, at the right time, and at the right cost to deliver the Trust's six strategic objectives.

This long term strategy has been developed through a programme of stakeholder engagement including staff, managers, trade unions and partner organisations. It will support the Integrated Business Plan for Foundation Trust status and will be implemented through an annual work programme of key priorities for action that will be developed as part of the yearly integrated planning process and the Trust's 5-year workforce plan. The work programme for 2012/13 is attached in Appendix 1.

3. Scope

The Trust's strategic direction means that we have to make significant changes to the way in which healthcare is organised and delivered and this has major implications for the way our workforce is configured and the way our leaders and staff will be required to work in the future.

The scope of this Strategy is to ensure that the Trust can acquire and retain a highly performing workforce that is affordable, appropriately skilled, is flexible to the needs of our patients and service users and provides the highest and safest quality of care. **Central to this challenge is – how will the Trust maintain and improve levels of staff engagement whilst at the same time reducing the overall size of the workforce and introducing new ways of working.** This can only be achieved through effective leadership and people management, and careful change management.

4. The Environment

The context within which the Trust, along with the rest of the NHS, is operating has changed from an environment that has over the past ten years been relatively stable and predictable to one that is uncertain, more competitive and complex and with an increasing demand for our services against the backdrop of reduced income. The demands on our services are increasing and will require us to organise and run our services even more efficiently. This will impact significantly on the size and type of workforce we will require for the future. The increased rate of technological change and advances in clinical practice will continue to create further opportunities and challenges.

A combination of a national pay freeze, uncertainty over the future of the NHS pension scheme and fears about job losses all contribute to an employee relations climate that is the most challenging for many years. Effectively engaging with staff at all levels to ensure the delivery of the Trust's strategic objectives is more important than ever.

5. National HR Context

This Workforce Strategy operates against a background of several key national policy drivers and human resources requirements to ensure the delivery of high quality services and improve the working lives of staff, including:

(5.1) A High Quality Workforce: NHS Next Stage Review 2008

High Quality Care for All established that quality should be the organising principle for the NHS, including utilising capacity and embracing change and reform to transform services to deliver high quality care for patients with a particular emphasis placed on patient safety, patient experience and effectiveness of care.

The work undertaken by Lord Darzi highlighted key areas for development in relation to workforce, namely: workforce planning, leadership, values and pledges and the key principle of employee engagement. The NSR also highlighted the importance of well-defined career frameworks, plans for modernising healthcare careers, improving the quality of education and training, offering education and training to respond to new models of care and ensuring continuous professional development for all staff.

(5.2) NHS Constitution (2009)

The NHS Constitution set out the principles and values that guide how the NHS should act and make decisions and further reinforced that a high quality workforce where staff and volunteers are engaged, trained and supported is seen as key to the delivery of safe and effective care. It includes four main pledges to staff:

Pledge 1: to provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities;

Pledge 2: to provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed;

Pledge 3: to provide support and opportunities for staff to maintain their health, well-being and safety; and

Pledge 4: to actively engage staff in decisions which affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.

AND a set of responsibilities against which staff will abide:

- to maintain the highest standards of care and service, taking responsibility not only for the care you personally provide, but also for your wider contribution to the aims of your team and the NHS as a whole

- to play your part in sustainably improving services by working in partnership with patients, the public and communities

- to view the services you provide from the standpoint of a patient, and involve patients, their families and carers in the services you provide, working with them, their communities and other organisations, and making it clear who is responsible for their care

- to take up training and development opportunities provided over and above those legally required of your post

- to be open with patients, their families, carers or representatives, including if anything goes wrong; welcoming and listening to feedback and addressing concerns promptly and in a spirit of co-operation. You should contribute to a climate where the truth can be heard and the reporting of, and learning from, errors is encouraged

(5.3) QIPP Challenge

The Chief Executive of the English NHS in his 2008/2009 annual report said that:

> "The NHS must be prepared for a range of scenarios, including the possibility that investment will be frozen for a time. We should also plan on the assumption that we will need to realise unprecedented levels of efficiency savings between 2011 and 2014 – between £15 billion and £20 billion across the service over three years."

This has been termed both the quality and productivity challenge and the QIPP (Quality, Innovation, Productivity and Prevention) initiative and is characterised in a vision of a sustainable NHS with care closer to home, earlier intervention, fewer acute beds, more standardisation by reducing variation, empowered patients and reduced unit costs. Much of this programme relies on significantly developing community and primary care services.

(5.4) Health and Social Care Act 2012

In July 2010, the Department of Health published its NHS White Paper, *Equity and Excellence: Liberating the NHS* which set out the Government's long term vision for the future of the NHS that will:

- Put patients at the heart of the NHS through an information revolution and greater choice of any provider
- Reduce mortality and morbidity, increase safety, and improve patient experience and outcomes for all
- Devolve power and responsibility for commissioning services to the health care professionals closest to patients: GP Clinical Commissioning Groups
- Establish an independent and accountable NHS Commissioning Board
- Increase the freedom of foundation trusts giving NHS staff the opportunity to have a greater say in the future of their organisations, including all employee led social enterprises
- See all Trust's become or be part of a foundation trust
- Require the release of up to £20 billion of efficiency savings by 2014
- Radically delayer and simplify the number of NHS bodies, including the abolition of SHAs and PCTs by March 2013

(5.5) Liberating the NHS: Developing the Healthcare Workforce *From Design to Delivery*

This policy framework sets out a new approach and a new NHS Education and Training Operating system for planning educating and training the healthcare workforce by empowering health care employers and local clinical leaders to take a leading role in workforce planning and development. The system hosts an educational outcomes framework that will drive quality improvements in education and training provision and clinical practice placements and in time it will confirm how the training funding system will operate.

(5.6) The Operating Framework for the NHS in England 2012/13

This framework describes the operating context in 2012/13 as one that is the second year of the quality and productivity challenge (QIPP) and the final year of the transition to the new commissioning and management system for the NHS. It sets out the requirement for NHS leaders to respond to four inter-related challenges:

- The need to maintained continued strong performance on finance and service quality
- The need to address the difficult changes to service provision to meet the QIPP challenge in the medium term
- The need to complete the transition to the new delivery system set out in *Liberating the NHS*
- The urgent need to ensure that elderly and vulnerable patients receive dignified and compassionate care in every part of the NHS

Key workforce areas for action include:

- Compliance with the Equality Act using the Equality Delivery System
- Preparing for medical revalidation
- Accreditation of Occupational Health Services
- Duty to test the language competence of staff

Improving staff health and well-being, using the role of the staff survey in improving staff experience and services for patients and the role of training in ensuring the dignity of care are also highlighted as priorities.

6. Local Context

The Trust has been successful in recent years with strong financial and clinical performance and improved levels of staff satisfaction and staff engagement. We have a good track record of managing large scale change programmes and recent examples include high profile service reconfigurations and achieving the smooth integration of community health services (TCS).

A single Clinical Commissioning Group centred on the population served by the Trust is developing and there are early signs that a constructive relationship with the CCG is being developed. The CCG has restated its commitment to the Right Care Right Here shared vision.

7. Trust Strategy and Objectives

Our strategic direction is captured in our ambitious vision for the future of our services:

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

We will achieve this through delivering our 6 key strategic objectives, to:

- Provide Accessible and Responsive Care
- Provide Safe High Quality Care
- Deliver Care Closer to Home
- Make Good Use of Resources
- Provide 21st Century Facilities

- Be an Engaged, Effective Organisation

Our specific priorities for 2012/13 can be summarised as:

- Continuing to improve the quality and safety of care for our patients by delivering the quality priorities set out in our Quality Account
- Delivering the Transformation Plan
- Achieving the key access targets
- Progress towards becoming a Foundation Trust
- Progressing with the 'Right Care Right Here' vision of service change

Our strategic objectives and key priorities are aligned to our vision and provide the reference point that will guide **'what we do'**. They set the expectation against which this strategy and all HR and employment policies, processes and priorities will be framed and against which decisions will be made.

8. Trust Values and Behaviours

To achieve our strategic objectives we have a clear set of values that define **'how things are done'**. Our initial set of values included the first four values; the fifth one 'Engaging and Empowering' was incorporated following a detailed staff engagement exercise to develop our values further:

- Caring and Compassionate
- Accessible and Responsive
- Professional and Knowledgeable
- Open and Accountable
- Engaging and Empowering

Our staff have given our values practical expression through our Customer Care Promises which define the behaviours that patients can expect to experience at all times when attending any of our services:

- I will …make you feel welcome
- I will …make time to listen to you
- I will …be polite, courteous and respectful
- I will …keep you informed and explain what is happening
- I will …admit to mistakes and do all that I can to put them right
- I will …value your point of view
- I will …be caring and kind
- I will …keep you involved
- I will …go the extra mile

9. Workforce Vision

Our vision is to transform our workforce to deliver large scale system change and improve our competitive advantage by making the Trust more effective and efficient. In the future, our workforce will be smaller in size and re-profiled in line with our service development and re-configuration plans and our plans to more closely integrate our hospital and community services.

Our staff will be highly performing, motivated and engaged and they will be capable of being deployed in the most appropriate way to ensure high quality and safe care, customer satisfaction and value for money. This means that all staff will be signed up to the Trust's values and our customer care promises, will be responsible and accountable, will work flexibly, will embrace new ways of working and will constantly strive to be better at what they do.

The working environment will be one where high quality care is everyone's top priority and the patient is at the centre of everything we do from planning and designing services through to delivering care and treatment. Our Trust will be one that staff will recommend as a place to work or receive treatment.

10. Key Drivers of Change

Becoming a Foundation Trust presents an exciting opportunity to use new freedoms to be innovative in the way that we go about improving the health of our local community and our staff will play an important part in shaping the future direction of our new organisation.

Virtually all staff will have the opportunity to become 'members' of the Foundation Trust and, through this, arises the opportunity to become a staff governor on the council of governors who will oversee the Foundation Trust's strategy and direction. To support this change we will build upon our approach to 'Owning the Future' and our experience of electing staff ambassadors whilst at the same time we do recognise that staff will need training, induction and support to carry out the role of governor successfully.

There are a number of key drivers that will require us to **reduce, reshape, restructure** and **retrain** our workforce and these include:

- Improving the quality and safety of our services whilst meeting demanding national efficiency expectations
- Reducing clinical activity provided in our acute hospitals and delivering a substantial proportion in community settings
- Delivering clinical and financial stability of services over the next 5 years
- More closely integrating our hospital and community services
- Advances in technology and clinical practice

The Trust's Transformation Plan will deliver the Trust's savings plans through large scale service improvement and redesign and through our workforce **'working smarter not harder'**. This includes achieving a set of ambitious workforce efficiency targets and changes to working practices. A series of themes have been designed to save £125m over the next five years (£25m each year):

- Demand and capacity planning
- Outpatients efficiency
- Urgent care redesign
- Theatre Productivity
- Effective patient flow and bed utilisation
- Community service efficiency and integration
- Workforce efficiency
- Medical workforce efficiency
- Diagnostics
- Procurement
- Corporate services and facilities efficiency
- Estates rationalisation
- Strategic IT enablement

11. The Leadership Challenge

The Trust faces the critical challenge of continuing to develop the strategic leadership capabilities needed to ensure that we can make further progress in creating working environments where teams will perform highly and where staff feel engaged, empowered and satisfied, that will improve patients' experiences and their health outcomes and that encourages and enables integrated working across health and social care.

Our approach is in keeping with the vision set out by the NHS National Leadership Academy and has been significantly influenced by our commitment to increase levels of staff engagement. This has positioned our leaders as coaches, enablers and facilitators, with an emphasis on allowing staff to help to shape the services they deliver, whilst still retaining clear accountability for outcomes. Staff from aspiring supervisors to senior managers and directors can access a range of leadership development programmes to ensure that our management levels are adequately skilled and competent to lead their teams successfully. Our Leadership Development Strategy and Framework will continue to be refined and adapted as our plans for managing talent and succession planning are further developed.

12. Staff Working Differently

The combined financial and demographic challenges will mean that there will be relatively fewer staff providing care for more people with more complex needs. The overall impact of the changes in the way care will be organised and delivered in the future means our staff in the future will be:

- More focused on prevention of ill health aiming to prevent the development of long term conditions
- Demonstrating better quality outcomes to meet the quality and productivity challenge
- Delivering healthcare closer to home with the development of community based teams, and individual staff members having greater autonomy and less direct supervision
- Smaller in numbers and delivering a range of highly specialised acute hospital care or community services
- Working in more flexible ways across organisational and professional boundaries and, in some cases, for different employers
- Up-skilled to undertake extended roles
- Working new patterns of employment e.g. 24/7, 7-day working and delivering routine services in the evenings and at the weekends
- Embracing new ways of working to provide safe and efficient services

- Increasingly more involved in shaping our future direction and our plans for how we go about improving the health of our local community

13. Strategic Workforce Aims and Objectives

This strategy sets out four strategic workforce aims, each with a set of strategic objectives for delivery linked to them, to achieve the scale of workforce change required to deliver the Trust's strategic objectives. This sets the context for the annual work programme:

Strategic Aim 1: Building an Engaged, Highly Performing Workforce

- To recruit and retain the best staff and ensure the right numbers of staff with the right skills in the right place at the right time
- To maintain a highly skilled, engaged and satisfied workforce
- To enhance the Trust's leadership capacity to deliver large scale strategic change across sectors, organisational boundaries and professional groups

Strategic Aim 2: Improving Workforce Productivity and Efficiency

- To reduce the overall size of the workforce and contain and reduce our pay costs
- To accelerate the up-take of new ways of working to ensure best use is made of highly trained professionals and competent support workers
- To increase workforce flexibility and ensure that staff are capable of responding and adapting as change occurs

Strategic Aim 3: Enhancing HR Capacity and Capability

- To further integrate and embed workforce planning for service improvement and workforce efficiency
- To ensure excellent human resources management practice across all areas of the Trust
- To maintain a sound employee relations climate and effective partnership working with Trade Unions

Strategic Aim 4: Becoming the 'Employer of Choice'

- To develop the Trust's approach to recognition and reward
- To continue to support our workforce to achieve a better work-life balance
- To further enhance our strategies to support the health and well-being of the workforce and encourage staff to look after themselves

14. Strategic Workforce Planning

An integral component of effective change management is planning for the future to ensure that the organisation has the right people, with the right skills, at the right time, and against an environment of budget cuts 'right cost' is an important consideration.

(14.1) Workforce Planning System

Making further connections and embedding workforce planning into the Trust's strategic planning system, including our service development and service transformation processes, is essential to achieve the large scale workforce change required to ensure that we have can recruit and retain staff with the right skills to deliver high quality services to meet the health needs of the local population in future years.

Our approach to workforce planning and modelling must continue to be aligned to the Trust's financial and service plans at a number of levels, including:

- Annual corporate business planning
- Divisional/Directorate business planning
- Transformation Plans
- Long Term Financial Modelling
- New Hospital Project modelling
- 'Right Care Right Here' joint workforce planning for system wide service redesign
- Black Country Cluster System Planning

The external focus and increasing scrutiny on workforce assurance, along with a new NHS education and training operating system, will continue to demand that our workforce plans are robust and affordable and that the Trust Board is assured that the impact of our service changes and transformation plan will not compromise the quality and safety of the care that we deliver to our patients.

(14.2) New Ways of Working and Role Redesign

New roles and new ways of working that are patient centred and improve the experience of the service user will be driven to further improve the quality of care delivered by helping to meet demand, provide greater patient choice and further enhance the career prospects of staff.

Role redesign will continue to be an essential building block in the Trust's workforce planning process through securing a more productive and efficient workforce by the creation of new blended roles and the reshaping and development of existing roles and skill mix.

(14.3) Education and Training

Having the right number of staff with the right skills, knowledge and behaviours is fundamental to being the provider of high quality services and achieving the Trust's strategic objectives. We will continue to build upon our co-ordinated approach to workforce planning and education commissioning that ensures that our local plans for education and training are aligned to the changing requirements of our workforce. Our education commissioning returns and learning and development activity will need to continue to be closely informed by the training needs identified from the Trust's workforce plans and the appraisal/PDR process.

Liberating the NHS: Developing the Healthcare Workforce - From Design to Delivery (Jan 2012) published a policy framework for a new approach to education and training that empowers healthcare employers and local clinical leaders to take a leading role in planning and developing the workforce. A new national body Health Education England (HEE) will be established as a Special Health Authority in June 2012 to support the delivery of excellent health care and health improvements through ensuring that the healthcare workforce has the right skills, behaviours and training and is

available in the right numbers. HEE will take on the education and training functions currently undertaken by the Department of Health to provide national leadership and will authorise the Local Education and Training Boards (LETBs)

The LETBs will take on the education and training functions of the Strategic Health Authorities (SHAs) and their postgraduate deaneries and will account for the investment of NHS education and training resources and the outcomes achieved. An Education Outcomes Framework will set out the outcomes against which HEE and the wider system will be held to account.

Engaging in and fully understanding the opportunities and risks associated with the new NHS Education and Training system and structure in particular those relating to the Education Outcomes Framework, MPET funding allocation, workforce planning capacity and capability and the impact upon clinical practice placement provision and management will be a high priority over the early years of this strategy.

(14.4) NHS Knowledge and Skills Framework

In addition to describing the knowledge and skills that our staff will need to be safe and competent at what they do, and providing an annual system of review and development, the Knowledge and Skills Framework (KSF) enables the Trust to engage staff in the delivery of the Trust's strategic objectives and get their commitment to it.

The KSF is a key enabler to enhancing recruitment decisions, more closely linking pay progression and reward, identifying training needs and skill gaps and facilitating new ways of working. At the same time as providing assurance that our staff are equipped with the skills to perform their role and understand the expectations of them, the KSF also provides another route for increasing levels of staff engagement and staff satisfaction further.

(14.5) Widening Participation

Our apprenticeship strategy (Apprenticeships – A Strategy 2011-2015) describes the Trust's vision for Widening Participation through access to and increasing opportunities for health care support staff to participate in learning through work and to gain relevant skills and qualifications. Its main objective is to provide structured careers advice and work experience placements and the development of bands 1-4 by providing a career framework for non-professionally affiliated staff to enter into and progress within health care roles.

Central to this framework is our recently approved business case to open a 'Learning Hub' in our local community. This will provide local people from all backgrounds with a fair chance of accessing careers within the health sector through pre-employment training and support, provision of careers advice and guidance and supported access into employment opportunities. This development is being pursued with our Right Care Right Here Partners and is a key enabler in the wider RCRH regeneration and economic development strategy.

15. Human Resources Management

We recognise that our workforce is key to our success and we spend around 68% of our total income on pay costs. Our success and long term sustainability can only be achieved through recruiting and retaining a well managed highly skilled and engaged workforce who have the opportunity to learn and develop, and by effectively managing our pay costs.

(15.1) Human Resources Management Model

Our approach to human resources management is through the alignment of employment policies and practice with the Trust's vision, strategic objectives and service developments. Our longer term vision is that through developing our workforce we will sustain our future in a competitive choice driven and diverse health and social care environment and continue to be a provider of high quality and safe care and to become the 'employer of choice'.

The challenges ahead and the move to Foundation Trust status require the HR function to respond in different ways to continue to be successful. Our approach to this is based on the Ulrich HRM Model and includes continuing with the re-design and re-positioning of the function to achieve the strategic workforce aims and objectives set out in this strategy. The focus of HR activity will increasingly focus on:

- Stronger alignment of HR to service delivery
    - Development of HR business approach
    - Developing managers competencies and capabilities for HRM with a clear accountability framework
- Strengthening Strategic Human Resources Management
    - Stronger Integrated Workforce Planning
    - Focus on evidence based practice and benchmarking
    - Greater integration of HR, Finance and Service Strategies
- Effective and Efficient Central Services
    - Greater use of new technology to enable more efficient workforce management
    - Self help information and self service processes which add value to managers in delivering their objectives
    - Enhanced workforce information and workforce reporting

(15.2) Employee Relations

Central to the effective implementation of this strategy is the ongoing partnership and dialogue with staff representatives through the Trust's employee relations structure. Our recognised trade unions will continue to have a vital role to play in the development and consistent application of employment policy and practice, in the effective management of change, and in raising issues and concerns on behalf of our workforce. We have a good employee relations climate and recognise that this has contributed to the many improvements for our patients and staff over the years, this will continue to be instrumental in making further improvements for the experience of our patients and the working lives of our staff.

(15.3) Equality and Diversity

The Trust is committed to offering an environment which is welcoming and inclusive regardless of people's race, gender, disability, age, sexual orientation, faith or status and takes great pride in the diversity of our staff, patients and visitors. We aim to treat everyone in a consistent and non-discriminatory manner and our strategic approach is to ensure that equality and diversity becomes a core operating principle for our service planning and delivery and workforce development.

(15.4) Staff Communication and Engagement

We will continue to communicate our direction of travel and our key strategic objectives and plans to our staff through a whole range of staff communication methods currently in place including, regular

briefings through intranet, email, chief executives key messages, monthly Hot-Topics delivered by the Chief Executive (this includes a specific theme or topic about which all staff are asked to feed back their views).

Our bi-monthly staff magazine 'Heartbeat' will continue to be distributed to every member of staff. This provides the opportunity to communicate and engage with staff on matters such as key strategic issues, local news stories and what matters to staff. We will continue to run the section on 'Your Right to be Heard' that provides an alternative method whereby staff can write in, anonymously if they wish, to find out from those directly responsible what is happening in the Trust and why.

We will continue to build upon our successful approach to staff engagement, called Listening into Action (LiA), for managing change and engaging our staff in driving service improvement and service changes. This is an essential component for maintaining and increasing levels of staff engagement throughout the delivery of the Transformation Plan and significant workforce change ahead.

Owning the Future (OtF) and the introduction of staff ambassadors is the Trust's approach to further developing the culture of ownership and engagement by putting the voice and views of staff at the fore-front of decision making and service improvement. We are in a strong position to develop further the opportunities presented for staff membership by becoming a new Foundation Trust organisation.

The National Staff Survey results are an important measure of staff opinion on how the Trust is doing with regards to quality and safety and what it is like to work at the Trust and as such will continue to inform HR strategy and practice, and measures of levels of staff engagement and leadership quality.

Our staff will be an important membership group in governing our organisation in the future. Staff that meet the criteria for membership will become active members of our Foundation Trust governance structure unless they choose to opt out.

16. Associated Strategies and Frameworks

This Strategy and its component parts do not exist in isolation and should be considered in conjunction with other associated and supporting Trust strategies and frameworks i.e:

(16.1) Quality and Safety Strategy

The Trust's Quality and Safety Strategy describes the Trust's strategic approach to ensuring that our patients receive safe, effective care and a positive patient experience. The key principle is that quality is everyone's responsibility and will be delivered through all staff.

(16.2) Staff Health and Well-Being Strategy

This Strategy and action plan set out the approach that the Trust is taking to respond to the recommendations arising from the NHS Health and Well-Being Review (the Boorman Report) and provides a framework for creating healthy working environments and a more preventative approach to sickness absence aimed at improving staff health and reducing levels of sickness absence further.

(16.3) IT Strategy

Advances in clinical practice, underpinned by technological developments, will continue to drive further process redesign and new ways of working to enable improvements in service delivery and flows and to enable clinicians and other staff to work more efficiently and more effectively through systems improvement.

(16.4) Organisational Development Strategy

The Trust's approach to organisational development is to deliver appropriate OD interventions to improve the effectiveness, efficiency and capability of the organisation over the long term through six key objectives:

- Achieving congruence and integration in organisational development activity
- Preparing for Foundation Trust status
- Achieving greater organisational efficiency through a more coherent approach to large scale change management
- Achieving a 'cultural shift' where everyone feels responsible for the delivery of high quality care
- Investing in leadership
- Improving the quality of our services to patients

(16.5) Leadership and Management Development Strategy and Framework

Our leadership framework sets out a range of programmes and approaches for developing our leaders for the future. This is supported by a model of leadership behaviours that was heavily influenced by what our staff said are important characteristics of a good leader and this sets the Trust's expectation of all leaders.

(16.6) Learning and Development Strategy

Our approach is to encourage and enable our staff to develop and achieve their full potential and a lifelong career in healthcare as a central part of our delivery of high quality services and contributing to the wider workforce planning agenda. Our educational approaches will be informed by learner needs and organisational demands, based on latest evidence and best practice and delivered flexibly and efficiently through a range of methods.

Developing closer working relationships with our local universities, colleges of further education, external skills agencies and our Local Authority partners are critical to developing our workforce and our local communities as we continue to explore the provision of educational opportunities and new ways of working that transcend the boundaries of health and social care.

(16.7) Equality Delivery Scheme

This system will replace the Trust's Single Equality Scheme and will ensure that our equality objectives are embedded in mainstream business planning. The process for implementation and monitoring will be the responsibility of the Equality and Diversity Committee.

17. Monitoring and Assurance

The HR dashboard contains a selection of metrics and trends against which HR performance is measured and monitored.

(17.1) HR Key Performance Indicators

A range of HR KPIs are hosted within the Trust's performance management system and quality framework and will continue to be used to indicate how our Trust is performing against our strategic and corporate objectives. The indicators routinely used to operationally manage and ensure effective workforce utilisation, measure leadership quality, levels of staff engagement and the effectiveness of HR policy and practice include:

- Staff survey results
- Staff in Post
- Vacancies
- Sickness absence
- Staff turnover
- Agency spend
- PDR/appraisals
- Mandatory training
- Diversity analysis

We are participating in the implementation of the SHA Workforce Assurance Tool to introduce a single reference point for assessing workforce variables to provide an assessment of the current workforce and the likely impact of future changes on quality and safety.

(17.2) Governance Arrangements

The implementation of this Strategy will be overseen and monitored as set out below:

- Organisational Development Steering Group

  The delivery of this strategy and the implementation of the key priority areas set out in the annual work programme will be overseen and monitored through the Organisational Development Steering Group.

- Strategic Workforce Planning Steering Group

  This group will set the strategic direction for the production of live and flexible workforce plans and staffing models to support the delivery of the Trust's strategic objectives and in particular the Transformation Plan (including the Workforce Efficiency Workstream) and the emerging clinical services strategy and associated specialty specific strategies.

- Learning and Development Committee

  The Trust's process for determining the education commissioning requirements for the annual national commissioning rounds and the effectiveness of the NHS Knowledge and Skills Framework is overseen and monitored by the Learning and Development Committee.

18. Key Outcomes of Success

The annual work programme will set out the key benefits and measures of success for ensuring that this strategy is implemented effectively, in overall terms these can be summarised as follows:

- Year on year improvement across the range measurable HR key performance indicators

- Maintaining a positive CQC Quality Risk Profile on all staffing domains and indicators

- Achieving Level 2 NHSLA Risk Management Standards re-accreditation for competent and capable workforce

- Improved scores across the whole range of national staff survey key findings, in particular job satisfaction and staff engagement, work-life balance and the quality of staff appraisals

- Year on year improvement on local staff survey questions relating to LiA and leadership quality

- To be in the top 20% of all comparable Trusts for national staff indicators relating to staff recommendation of the Trust as a place to work or receive treatment, care of patients is the Trust's priority and numbers of staff receiving an annual appraisal within the last 12 months.

- To receive partial or full assurance ratings from all external workforce planning quality assurance processes and workforce management returns and reviews

- A year on year reduction in the number of reported violence and aggression incidents

- A year on year reduction in the number of patient complaints received relating to poor staff attitude and poor communication

- An increase in the number of staff working in redesigned roles and working in new ways to deliver redesigned services.

- An overall reduction in the number of staff in post and staff pay costs in line with the Transformation Savings Plans

19. Conclusion

This Strategy sets our future workforce vision for building a high quality workforce that is committed to delivering excellent care and ensuing that our patients' needs are placed at the centre of everything we do. It seeks to ensure that the direction of travel for our workforce is clearly understood, planned for and managed by setting out a clear framework that describes the context, key drivers and a set of strategic aims and objectives that are then translated into programme of key priority areas for action.

It highlights the opportunities for staff working in a new Foundation Trust, and how our leaders and staff will be required to work in the future to deliver our strategic objectives.

The Strategy has been produced following an extensive engagement process with key stakeholders and this has shaped its development. It will be implemented through an annual work programme that will be reviewed yearly to ensure alignment with the Trust's strategic objectives and key priorities and the Trust's 5-year workforce plan.

20. References

1. Department of Health, High Quality Care for All: NHS Next Stage Review Final Report (2008)
2. Department of Health, A High Quality Workforce: NHS Next Stage Review (2008)
3. Department of Health, NHS Chief Executive's Annual Report (2008/09)
4. Department of Health, NHS Constitution 2009 (updated 2010)
5. Department of Health, Equity and Excellence: Liberating the NHS, white paper, (2010)
6. Department of Health, Liberating the NHS: Developing the Healthcare Workforce: From Design to Delivery (January 2012)
7. Department of Health, The NHS in England: Operating Framework 2012/13

APPENDIX 1

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

WORKFORCE STRATEGY

2012/13 WORK PROGAMME

Key Priorities	Timeframe	Key Benefits/Measures of Success	Trust Committee / Group*	Exec/Op Lead
Strategic Aim 1: Building an Engaged, Highly Performing Workforce				
Strategic Objective 1.1 **To recruit and retain the best staff with the right skills in the right place at the right time**				
1.1.1 Revise the Trust's Annual Workforce Plan for the period 2012-2017 (Education Commissioning for submission to SHA)	May-Sep 12	• Workforce plan is integrated with finance and service plans and consistent with operating plan • Partial or full workforce assurance rating from SHA/Cluster	SWPSG	MS/GD
1.1.2 Continue to strengthen the link between workforce planning, education and training commissioning and training needs analysis for 12/13	by Jun 12	• Education and training plan reflects training needs that correlate with changes identified in workforce plans	SWPSG LDC	RO/MS/ GD
1.1.3 Establish the impact of the new workforce planning education and training operating system (HEE, LETBs and LETCs) and determine associated opportunities and risks, arrangements for engagement and changes in system/planning and processes required	Jun-Sep 12	• Trust is able identify and take action to respond to the threats and opportunities posed by the new operating system in terms of workforce planning and MPET funding allocation	SWPSG LDC	MS/GD
1.1.4 Introduce the SHA Workforce Assurance Tool	Pending SHA implementation plan	• Single reference point in place for assessing workforce variables to provide an assessment of the current workforce and the likely impact of future changes on quality and safety	SWPSG	RO/LB
1.1.5 Ensure that the Trust's recruitment and retention policy and practices are efficient.	by Oct 12	• 'Time to hire' standards are achieved • Reduction in 'hard to fill posts' • Staff turnover and vacancy levels are within acceptable threshold	F&PC/TMB	RO/LB

Key Priorities	Timeframe	Key Benefits/Measures of Success	Trust Committee / Group*	Exec/Op Lead
Strategic Objective 1.2 **To maintain a highly skilled, engaged and satisfied workforce**				
1.2.1 Review and revise the Trust's approach to appraisal/KSF	Jun-Oct 12	• Introduction of a 'lean' KSF and appraisal system, inc use of IT • Improvement in the number (90%) and quality of appraisals	LDC	RO/GD
1.2.2 Review and revise the medical staff appraisal process and introduce validation arrangements	by Oct 12	• More robust system of evidence of 'fitness to practice'	Medical Revalidation Implementation Group	DS/KD
1.2.3 Implement the National Staff Survey action plan	Apr-Sep 12	• Maintain/improve the Trust's response rate • Increase performance in key findings including areas targeted for improvement • Maintain/improve staff engagement and staff satisfaction scores	ODSG	MS/GD
1.2.4 Implement the 'LiA' and 'Owning the Future' action plans	by Mar 13	• Maintain/improve staff engagement and staff satisfaction scores	ODSG	JA/JK
Strategic Objective 1.3 **To enhance the Trust's leadership capacity to deliver large scale strategic change across sectors, organisational boundaries and professional groups**				
1.3.1 Undertake management capacity review	On-going	• Reduction in management costs and WTEs	WEG	RO
1.3.2 Implement the Trust's Leadership Framework	On-going	• Delivery of Trust priorities for 2012/13 • Improved staff health and well-being • Increased levels of staff engagement and satisfaction	ODSG LDC	RO/MS
1.3.3 Implement the Board Development Programme	by Mar 13	• Development programme delivered	FTPB	KD

Key Priorities	Timeframe	Key Benefits/Measures of Success	Trust Committee / Group*	Exec/Op Lead
		• Delivery of Trust priorities for 2012/13		
Strategic Aim 2: Improving Workforce Productivity and Efficiency				
Strategic Objective 2.1 **To reduce the overall size of the workforce and contain and reduce our pay costs**				
2.1.1 Implement local on-call agreement in line with DH requirements	Sept 12	• Equal pay risk alleviated	WEG	RO/LB
2.1.2 Introduce measures to link incremental pay progression to performance (KSF/Appraisal review)	Oct 12-Mar 13	• A reduction in formal capability and conduct management cases	WEG	RO/LB
2.1.3 Review AfC pay bands	Oct 12-Mar 13	• Reduction in future pay costs	WEG	RO/LB
2.1.4 Introduce a Job Planning Policy for Consultant medical staff and SAS doctors			Medical WEG	KD
2.1.5 Deliver the Trust's TSPs	by Mar 13	• Reduce the overall WTE position by delivering the actions in the Workforce Implications Workstream/Workforce Efficiency Programme (reduced hours, VR, AVER, MARS, Redundancy) • Reduction in pay spend in bank, agency and premium rate working	WEG	RO/LB
2.1.6 Reduce sickness absence	by Mar 13	• Achievement of national sickness target of 3.39% • Reduction in bank and agency spend	WEG	RO/LB
Strategic Objective 2.2 **To accelerate the up-take of new ways of working to ensure the best use is made of highly trained professionals and competent support workers**				
2.2.1 Implement the enabling actions in the New Roles Workstream Action Plan	by May 13	• An increase in the uptake of redesigned roles and new ways of working	SWPSG WEG	MS/GD RO/LB
2.2.2 Develop a new roles forecast for the next 5 years (pilot in urgent care transformation project)	by Sep 12	• Opportunities for role redesign identified for key staff groups	SWPSG	MS/GD
2.2.3 Integrate process for supporting workforce changes, including new ways of working, required to deliver clinical strategies and service transformation	Jun-Nov 12	• Achievement of TSPs and progress towards implementing specialty strategies	SWPSG	MS/GD

Key Priorities	Timeframe	Key Benefits/Measures of Success	Trust Committee / Group*	Exec/Op Lead
Strategic Objective 2.3 **To increase workforce flexibility and ensure that staff are capable of responding and adapting as change occurs**				
2.3.1 Ensure that all models of employment, HR policies, processes and practices facilitate greater workforce flexibility and new ways of working (contracts of employment, recruitment decisions, appraisal, approach to organisational change etc)	by Mar 13	• Less resistance to change in adopting new ways of working to deliver redesigned services	WEG	RO/LB
2.3.2 Further embed LiA as 'the way we do things' and in particular at first line manager level and as a key tool in the delivery of the Trust's Transformation Plan	by Mar 13	• increased levels of staff and patient satisfaction	Engagement Sponsor Group	JA/SF
Strategic Aim 3: Enhancing HR Capacity and Capability				
Strategic Objective 3.1 **To further integrate workforce planning for service improvement and workforce efficiency**				
3.1.1 Ensure that workforce planning is integral to the Trust's planning processes for business/specialty strategies, Transformation Plan, workforce management and translated into operational plans i.e. recruitment strategies, delivery of TSPs	by Sep 13	• 5 year workforce plans for key staff groups • WTE changes and workforce impact described for TSPs	SWPSG	MS/GD
3.1.2 Further develop the Trust's approach to workforce and scenario modelling to deliver bottom up workforce changes arising from TSPs	Jun 12 – Mar 13	• More detailed workforce plans to deliver TSP savings	SWPSG	MS/GD
Strategic Objective 3.2 **To ensure excellent human resources management practice across all areas of the Trust**				
3.2.1 Deliver a bespoke development programme *'building high performance through exemplary people management'*	from Oct 12	• Increased levels of staff engagement and staff satisfaction • Improved team working	LDC	RO/LB
3.2.2. Maximise the use of new technology for more efficient workforce management through IT and system enablement: • E-learning • OLM • ESR Manager Self Serve (MSS) • E-recruitment • Workforce Information • Supporting roll out of e-rostering • Workforce intranet site/toolkits	Jun 12-Mar 13	• Introduction of more e-based processes • Increase in 'paper light' transactions	ESR Steering Group	RO/LB

Key Priorities	Timeframe	Key Benefits/Measures of Success	Trust Committee / Group*	Exec/Op Lead
3.2.3 Maintain relevant related NHSLA Level 2 Risk Management Standards compliance	by Feb 13	• Achievement of NHSLA Level 2 re-re-accreditation	NHSLA Project Group	RO/LB
3.2.4 Revise and strengthen further the integration of HR KPIs into the Trust's performance management framework and reporting arrangements (via workforce dashboard)	Jun-Aug 12	• Workforce trends, issues and risks impacting on service delivery and patient safety clearly identified	Learning and Development Committee	RO/LB
3.2.5 Introduce a single staff network to support the Equality and Diversity agenda and improve equal opportunities monitoring and workforce analysis to ensure E&D issues are identified and addressed	By Dec 12	• Compliance with Equality Delivery Scheme • Improvement in staff survey findings relating to discrimination and equality of opportunity	Equality and Diversity Steering Group	RO/LB
Strategic Objective 3.3 **To maintain a sound employee relations climate and effective partnership working with Trade Unions**				
3.3.1 Ensure effective communication consultation and engagement throughout the workforce efficiency programme	Apr 12–Mar 13	• Less resistance/barriers to change • Workforce efficiency WTEs reduced and savings achieved	JCNC	RO/LB
3.3.2 Review and update the Trust's Recognition Agreement	by Dec 12	• Agreement revised and signed • Effective partnership working	JCNC	RO/LB
Strategic Aim 4: Becoming an 'Employer of Choice'				
Strategic Objective 4.1 **To develop the Trust's approach to recognition and reward**				
4.1.1 Develop Recognition and Reward Strategy	by Dec 12	• % increase in staff feeling valued by Trust (national staff survey)	ODSG	MS/GD
Strategic Objective 4.2 **To continue to support our workforce to achieve a better work-life balance**				
4.2.1 Review of Flexible working policy and develop detailed awareness/implementation plan	Dec 12	• Increase in the uptake of flexible working options • Improved health and wellbeing and a reduction in sickness absence	SHWBC	RO/LB
4.2.2 Implementation of 'annual hours' toolkit	Aug 12			
Strategic Objective 4.3 **To further enhance our strategies to support the health and well-being of our workforce and encourage staff to look after themselves**				
4.3.1 Continue to strengthen the role of Occupational Health services and their relationship with the wider organisation	by Mar 13	• Increased focus on health and well-being and creating healthy working environments • Proactive and more timely management of sickness absence	SHWBC	RO/LB

Key Priorities	Timeframe	Key Benefits/Measures of Success	Trust Committee / Group*	Exec/Op Lead
4.3.2 Delivery of the sickness absence action plan	by Mar 13	• Achievement of national target • Reduction in bank and agency spend	SHWBC	RO/LB
4.3.3. Continue roll-out of health and well-being programme of quarterly themes	by Mar 13	• Increased staff engagement • Reduction in sickness absence /stress related absences • Reduction in sickness absence	SHWBC	RO/LB
4.3.4 Develop quarterly web-site information to support staff access to health and well-being interventions including self-care	by Oct 12		SHWBC	RO/LB

TRUST COMMITTEE / GROUP		LEADS	
F&PC	Finance and Performance Committee	RO	Rachel Overfield, Chief Nurse (Exec Lead for Workforce)
FTPB	Foundation Trust Programme Board	MS	Mike Sharon, Director of Strategy and OD
JCNC	Joint Consultation and Negotiation Committee	KD	Kam Dhami, Director of Governance
LDC	Learning and Development Committee	DS	Deva Situnayake, Deputy Medical Director
MRIG	Medical Revalidation Implementation Group	LB	Lesley Barnett, Deputy Director of Workforce (Operations)
Medical WEG	Medical Workforce Efficiency Group	GD	Gayna Deakin, Deputy Director of Workforce (Strategy and Planning)
ODSG	Organisational Development Steering Group		
WEG	Workforce Efficiency Group		
SHWBC	Staff Health and Well-Being Committee		
SWPSG	Strategic Workforce Planning Steering Group		
TMB	Trust Management Board		

Gayna Deakin
Deputy Director of Workforce (Strategy and Planning)
May 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Foundation Trust Programme: Programme Director's Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Mike Sharon, Director of Strategy and Organisational Development**
AUTHOR:	**Mike Sharon, Director of Strategy and Organisational Development**
DATE OF MEETING:	**31 May 2012**

EXECUTIVE SUMMARY:

The Project Director's report gives an update on:

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

REPORT RECOMMENDATION:

To review the planned activities and issues that require resolution as part of the FT Programme

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
x		x

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

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

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

'Becoming an effective organisation' and 'Achieving FT Status'

PREVIOUS CONSIDERATION:

FT Programme Board on 31 May 2012

FT Programme Director Report May 2012 – Overall status: Red

Activities this period

- Public engagement findings report compiled
- Draft outline TFA timetable and case for change agreed by SHA
- DH has informally agreed 5 year IBP approach
- First draft patient access modelling report received
- Market research to inform activity flow modelling commissioned
- Board Quality Governance self assessment preparation
- Revised activity and capacity model agreed by CCG/PCTs
- Seminar programme for Board developed
- CIP/TSP requirements and allocations to Divisions for 2013/14 to 2018/19 agreed

Activities next period

- Preparation of seminar briefing material to commence
- Formal renegotiation of TFA with DH
- Final patient access modelling report received
- Draft report on patient and GP market research activities received
- Work to commence on revised downside scenario
- Board Quality Governance self-assessment to be undertaken
- Work on detailed two year CIP/TSP to commence
- Work to commence on developing the draft Constitution, Board of Governors proposal, Membership Strategy and Governance Rationale
- Chapter leads to commence rewriting chapters for IBP revision in July

Issues for resolution and risks in next period

- Reach agreement with DH on revised approach to developing 5 year IBP

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Audit Committee – Version 1.0

Venue Executive Meeting Room, City Hospital **Date** 9 February 2012

Members Present		In Attendance		Secretariat	
Mrs G Hunjan	[Chair]	Mr R White		Mr S Grainger-Payne	
Dr S Sahota		Mr T Wharram			
Mr P Gayle		Mrs S-A Moore	(KPMG LLP)	**Guests**	
Prof D Alderson		Mr P Capener	(CW Audit)	Miss K Dhami	[Item 5.3]
		Mrs R Chaudary	(CW Audit)	Mr M Harding	[Item 6.2]
		Mr D Ferguson	(CW Audit)	Mrs R Monaghan	[Item 6.3]

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
Apologies were received from Mr Andy Bostock and Mrs Olwen Dutton.	
2 Minutes of the previous meeting	**SWBAC (12/11) 068**
Subject to minor amendment concerning the record of discussions on the process for CRB checks undertaken by KPMG, the minutes of the meeting held on 1 December 2011 were approved as a true and accurate reflection of discussions held.	
AGREEMENT: Subject to amendments suggested, the minutes of the meeting held on 1 December 2011 were approved	
3 Matters arising	**SWBAC (12/11) 068 (a)**
The Committee received and noted the updated actions log.	
3.1 Process for Internal Audit CRB checks	**Verbal**
Mr Capener advised that as part of the formal process of appointment, contractors employed by CW Audit are routinely CRB checked at present.	

Minutes	Paper Reference
Mrs Hunjan sought and was provided with clarity on the difference between standard and advanced CRB checks.	
4 External Audit Matters	
4.1 External Audit progress report	**SWBAC (2/12) 002**
Mrs Moore provided a summary of work undertaken during the period. The Committee was advised that a refreshed audit plan had been prepared and the implementation of recommendations concerning Payment By Results (PBR) had been reviewed. In terms of the forthcoming quarter, it was reported that the key financial controls would be reviewed, together with the work of Internal Audit. Scoping work was reported to be planned in respect of the Trust's Use of Resources. Regarding the technical updates, Mrs Hunjan asked whether guidance on matters such as compromise agreements were routinely communicated through to the HR department. Mr White advised that this was the case and were often disseminated through the Chief Executive's bulletin for cascading to the relevant staff. Dr Sahota asked for an update on the plans for the Audit Commission. He was advised that further clarity was anticipated by the end of February 2012 and that an update would be provided at the meeting planned for May 2012. Mrs Hunjan noted that views had been sought as to the appropriate interim arrangements pending the clarification of the future of the Audit Commission.	
4.2 External Audit refreshed audit plan	**SWBAC (2/12) 003**
Mrs Moore reminded the Committee that a summary audit letter had been presented in May 2011 and that a refresh of the plan had been undertaken subsequently. Mrs Hunjan noted that the refreshed audit plan required minor amendment, including the scheduling of the Audit Committee meetings being in May and June; not April and May. Mrs Hunjan asked in terms of its risk profile, how the Trust compared to other organisations. She was advised that the profile was consistent with other NHS organisations. It was highlighted that financial standing was flagged as a red risk for a number of organisations at present. Mr Gayle noted that the impact of the transfer of community services affected a number of areas. Mrs Moore agreed and advised that much guidance in this respect remained outstanding, which gave rise to a degree of uncertainty.	

Minutes	Paper Reference
Mrs Hunjan asked whether there was any amendment to timetable for the required submission of the annual accounts. Mrs Moore advised that there was no significant change planned.	
5 Internal Audit Matters	
5.1 Internal Audit progress report, including recommendation tracking update	**SWBAC (2/12) 008** **SWBAC (2/12) 008 (a)**
Mr Capener reported that good progress had been made with the delivery of the Internal Audit plan. The Committee was asked to note that progress was ahead of plan and that there were no concerns that needed to be raised. It was reported that the work concerning the Imaging consultant extra sessions had been completed, outside of the context of the Internal Audit plan. The Committee was asked whether it was necessary to present the outcome of the report at the next meeting. Mr White advised that he had agreed with the Chief Executive that this did not require a separate discussion, a decision supported by the Committee members. A summary of the completed reviews was presented. It was highlighted that the position in terms of financial systems was good and that there was a plan to reduce the regularity of reporting on this area. A 'hot spot' was noted in connection with medicines management, where moderate assurance was provided. It was reported that the recommendation tracking system was working well. The only High Priority recommendation requiring sign off was reported to be in connection with the Information Governance review, which the Committee was advised was awaiting sign off by the Head of IT. Mrs Hunjan asked what process was in place for signing off the recommendation. Noting the Committee's disappointment with the delay in gaining this sign off, Mr Capener agreed to write formally to the Head of IT to gain assurance that the matter had been implemented. Mr White remarked that a conduit for more effectively escalating matters such as this was needed. Mr Capener reported that there had been occasions when there had been difficulties with closing reports requiring sign off by an Executive Director. To assist with resolving this, the Committee was advised that a closer link had been made with the Executive Assistants, who were used to prompt the relevant directors to consider the proposed final reports. The Committee was asked to note that a distinction was made within the performance summary to highlight the time taken to obtain a management response. Mrs Hunjan noted that the assurance gained from the review of cash	

Minutes	Paper Reference
management had fallen from full to significant. Mr Capener advised that this was not a matter of concern. Mr Wharram noted that in this respect a number of elements were outside of the gift of the Finance Department to control.	
ACTION: Mr Capener to write to the Head of IT to confirm that the high priority recommendation arising from the Information Governance review had been implemented	
5.2 Medicines Management internal review	**SWBAC (2/12) 012** **SWBAC (2/12) 012 (a)**
Mrs Chaudary reported that the medicines management review had been requested by the Chief Nurse and had been completed in August 2011. The work was highlighted to concern adherence with the Medicines Management Policy. It was reported that the policy was being updated to address areas of concern flagged by the review. The detail of the action plan arising from the review was considered, including introducing the need to obtain specimen signatures to ensure traceability of authority given in patient notes and prescriptions. It was noted that most medical staff were now in possession of stamps which would be used in place of signatures. The review was also highlighted to provide assurance on the independent monitoring of progress towards achievement of the CQuiN target concerning medicines management, where it had been suggested that the incident reporting process might be used to register any missed doses. Dr Sahota asked whether medicines requiring disposal in a safe manner were sent to Pharmacy. Mrs Chaudary confirmed that this appeared to be the case. Dr Sahota asked whether write off of the drugs was at a ward level. Mr Ferguson advised that write off was undertaken by the Pharmacy. It was reported that the responsibility for this would be clarified in the revised policy. The Committee was advised that awareness raising of the policy within medical staffing was being undertaken by the Head of Medical Staffing. Mr Gayle noted that the field work for the policy had been undertaken in August 2011 and asked what reasons lay behind the delay in reporting the outcome to the Audit Committee. He was advised that the report and its outcomes had needed wide discussion before being finalised. Mrs Hunjan noted that some of the timescales for the implementation of actions were significant and remarked that there may be a possibility of errors occurring between the conclusion of the review and the dissemination of the lessons learned from the audit. Mr Gayle asked whether the completion of actions within the plan would shift assurance from moderate to significant assurance. Mr Capener	

Minutes	Paper Reference
advised that this would be considered as part of the audit plan for the first quarter of 2012/13. Mrs Hunjan suggested that the outcomes of the medicines management audit should be borne in mind as part of the Board walkabouts.	
5.3 Progress with implementation of the recommendations from the Travel Expenses review	**Verbal**
Mrs Chaudary reported that of the recommendations raised through the review of Travel Expenses, four had been implemented and 13 had been assigned revised dates for implementation. It was highlighted that much work was underway to redraft the expenses policy and to harmonise it with that of the Community Services area. It was noted that new software would be implemented to assist with managing travel expenses.	
5.4 Update on actions from the medical staffing Internal Audit review and update on consultant job planning	**Verbal**
Miss Dhami joined the meeting to provide an update on the actions arising from the medical staffing Internal Audit review and with the progress to implement revised consultant job planning arrangements. The Committee was advised that all consultants and SAS doctors were subject to annual job planning reviews. The work to deliver a more robust process around this was highlighted to be part of the medical staffing efficiency workstream of the Transformation Plan and was expected to deliver £600k of savings in 2012/13. Job planning was reported to be one aspect of the medical staffing efficiency work, with others to include planned leave arrangements and the use of agency & locum staff. In terms of the job planning practice, Miss Dhami reported that there had been considerable variation across the Trust and therefore it had been agreed that a Trustwide job planning policy was needed to provide high level guidance on the process. It was reported that key individuals had been consulted as part of the development of the policy, including teaching and research requirements. Implications on direct clinical care were also reported to be being considered as part of the plans. The Committee was advised that the policy was due to be presented to the Local Negotiating and Consultation Committee (LNCC) on 22 February 2012 and that it would be presented subsequently to the Medical Staff Committee. A key impact of the policy was highlighted to be that the payment of 2.5 Programmed Activities (PAs) would need to be more robustly justified and evidenced. It was reported that any savings arising from the introduction of the policy would be made from September 2012 onwards, following a period of policy	

Minutes	Paper Reference
approval and implementation. Mr Capener asked whether there was an intention to reduce the standard level of PAs within consultant job plans to 10. He was advised that the key aim was to ensure that the job planning process was more effective and would therefore generate a more robust set of job plans which would include an appropriate and justified level of PAs. It was highlighted that the plans needed to be aligned with the objectives and targets of the Trust. Mrs Hunjan thanked Miss Dhami for the update and remarked that good progress appeared to be being made in response to the internal audit review and general job planning activity. She asked whether other organisations were in a similar position and was advised that some trusts had better job plans and the Trust had been out of line with other organisations in that a job planning policy was not in place. Mr Capener suggested that a revisit of the area might be needed in future as part of the work of internal audit, which was agreed to be a sensible suggestion.	
5.5 Draft Internal Audit Plan 2012-15	**SWBAC (2/12) 009** **SWBAC (2/12) 009 (a)**
Mr Capener reminded the Committee that an earlier iteration of the Internal Audit Plan 2012-15 had been considered at the December 2011 meeting. He advised that no significant changes had been made to the Plan, apart from that the number of days had altered to 385. The allocated number of days to Data Quality matters was questioned, however Mr White advised that this linked closely to the planned changes in the IM & T area. Mr Capener remarked that there may be a need to determine which of the data sources were the highest priority for review as part of the Plan, particularly given that as the information covered patient data a significant number of transactions were involved, some of which were likely to not be material. Mrs Moore advised that it was good practice for data systems to be reviewed in a cyclical basis. Mr White agreed that a risk-based approach to the review was sensible. Mrs Hunjan noted that the business processes review involved the Medical Director and suggested that the list of 'desirable' audits needed to be finalised prior to Mr O'Donoghue's imminent departure. Mr Capener advised that the requested review followed the work on back office practice to determine whether the required standards had been implemented. Dr Sahota asked whether adherence to the use of the World Health Organisation (WHO) checklist was to be included within the remit of the theatre utilisation review. Mr Capener advised that the scope of this audit had not yet been finalised. Mr White informed the Committee that audits of compliance with the use of the WHO checklist were co-ordinated by the	

Minutes	Paper Reference
Clinical Effectiveness team and reported to the Quality and Safety Committee, therefore to undertake this as part of the work of Internal Audit would be unnecessary duplication. The Committee was asked for and gave its approval to the Internal Audit Plan 2012-15.	
AGREEMENT: The Audit Committee approved the Internal Audit Plan 2012-15	
5.6 Counter Fraud progress report, including an update on open cases	**SWBAC (2/12) 005** **SWBAC (2/12) 005 (a)**
Mr Ferguson reported that the usual Counter Fraud activities had been undertaken during the period, including the delivery of presentations at staff induction. The Committee was advised that the service had also participated in the National Fraud Initiative. The Committee was advised that in connection with case 2011-02, the matter had been found to have been reported to the Police and therefore this discharged the action raised at the last meeting in this respect. It was highlighted that five ongoing cases related to treatment of overseas visitors, with these matters having been referred to the UK Border Agency for handling. It was reported that as part of the 2012/13 plan the outcome of the handling of the these cases would be considered. Mr White highlighted that a policy was in place within the Trust to provide guidance on handling of matters such as this internally. It was reported that clear guidelines were also available from the Department of Health and a clear reciprocal arrangement within the European Union was in place. Mrs Hunjan noted that the cases involved a significant level of write offs. Mr White acknowledged that this was the case and explained that the reason for the situation related to the treatment in the Critical Care Unit which incurred high costs. Dr Sahota noted that one patient had attended three times, yet it appeared that payment had only been requested for the third visit. Mr Ferguson confirmed that payment had also been requested for the previous two attendances. In connection with case 2011-15, Mrs Hunjan asked that an update on the activities to recover the position be presented at the next meeting.	
ACTION: Mr Ferguson to provide an update on progress with delivering the actions in response to case 2011-15 at the next meeting	
5.7 2010/11 Qualitative Assessment action plan	**SWBAC (2/12) 006** **SWBAC (2/12) 006 (a)**
Mr Ferguson presented progress with delivering the actions in response to	

Minutes	Paper Reference
the recommendations arising from the Qualitative Assessment. He advised that a key action concerned the launch of an awareness campaign in April 2012 concerning the reporting of Counter Fraud. Mr White advised that the adoption of NHS Protect recommendations was not mandatory.	
5.8 2012/13 proposed Counter Fraud Plan summary	**SWBAC (2/12) 007** **SWBAC (2/12) 007 (a)**
Mr Ferguson advised that following discussion with Mr White, it had been agreed to reduce the number of days for Counter Fraud work in 2012/13 by 7% in comparison to the plan for the current year. It was highlighted that the detail of the plan had not yet been agreed however and would be presented at the meeting of the Audit Committee planned for May 2012. Mrs Hunjan advised that the plan needed to be enacted from April, despite being presented for approval in May 2012. The Committee was advised that the plan would be aligned to the guidance and requirements provided by NHS Protect.	
5.9 Inclusion of Counter Fraud matters within the ward assessment tool	**Verbal**
In response to an action raised at the meeting of the Audit Committee in December 2011, Mr Ferguson advised that questions concerning Counter Fraud would be included within the ward assessment tool when it was next revised.	
6 Governance matters	
6.1 Self-assessment of the Audit Committee's effectiveness	**SWBAC (2/12) 013** **SWBAC (2/12) 013 (a)**
Mr Capener presented the outcome of the recent Audit Committee self-assessment. Mrs Hunjan remarked that some time may need to be devoted to considering the requirements of the Audit Committee Handbook within the remit of the Non Executive Directors' informal sessions. In terms of clinical audit, it was noted that the matter was considered by the Quality and Safety Committee. Mr Grainger-Payne advised that in this respect, the Committee considered the Clinical Audit forward plan monitoring report. Mrs Moore asked whether Clinical Audit was included within the Internal Audit plan. Mr Capener advised that this was the case. Mr Grainger-Payne highlighted that the minutes of the Quality and Safety Committee were also presented to the Audit Committee as part of the	

Minutes	Paper Reference
routine items for consideration.	
6.2 Update on Data Quality Assurance plans	**SWBAC (2/12) 011** **SWBAC (2/12) 011 (a)** **SWBAC (2/12) 011 (b)**
Mr Harding joined the meeting and reminded the Committee that the Trust had received a communication from the Chair of the NHS West Midlands seeking assurance that the Trust was considering the integrity of the quality of its data. It was reported that the Trust's corporate performance monitoring report had been considered and the various indicators risk assessed. Since this work, however, the Committee was informed that a subset of this information had been given additional focus, with those being most closely scrutinised being the indicators within the NHS Performance Framework. Those being regarded as carrying the highest level of risk were highlighted to be the Accident and Emergency clinical indicators, which it was reported would need to be further validated due to the disparity of systems to capture this information and the lack of an integrated management solution to prepare the data. It was suggested that the assessment of data quality in this respect should form part of the Internal Audit plan for 2012/13. Mr Capener asked whether in terms of the limited functionality of the system, the issue related to an inability to update the software or whether a manual system of recording was needed. Mr Harding advised that the issue concerned both aspects. Dr Sahota remarked that there was a need to mitigate the risks associated with this situation. Mr White suggested that as the matter was an operational issue, the Chief Operating Officer needed to consider the position and report to the Finance and Performance Management Committee. Mr Capener remarked that as the indicators had only recently been introduced, assurance was not available on benchmarked information. It was agreed that Mrs Hunjan would raise the matter at a future meeting of the Finance and Performance Management Committee. It was noted however, that the concerns initially raised in the letter from the Chair of NHS West Midlands had been satisfied.	
ACTION: Mrs Hunjan to raise the issue concerning the data quality of Accident and Emergency Clinical Indictors to the Finance and Performance Management Committee	
6.3 Quality Account action plan	**SWBAC (2/12) 015** **SWBAC (2/12) 015 (a)**
Mrs Monaghan joined the meeting to present an update on the progress with preparing the Quality Account 2011/12. She advised that the work was aligned with that of the External Audit and was monitored routinely by	

Minutes	Paper Reference
the Governance Board. It was noted that the process for developing the Quality Account took into account the need to consult fully and to ensure that the Quality Priorities for the coming year were given adequate consideration. It was highlighted that the format of the Quality Account for aspirant Foundation Trusts and that of Foundation Trusts was to be harmonised. The Committee was advised that it would be presented with the draft Quality Account at its meeting in May 2012 and that following Mr O'Donoghue's departure, Dr Situnayake as Acting Medical Director would assume responsibility for the Quality Account. Mrs Moore confirmed that input by External Audit was required and therefore the process incorporated a phase for review. It was highlighted that External Audit would also issue an opinion on the Quality Account following this work. Dr Sahota asked whether the Quality Account required approval by the Trust Board. He was advised that this was the case.	
6.4 National Accounting and Financial issues	**SWBAC (2/12) 010** **SWBAC (2/12) 010 (a)**
Mr Wharram presented the detail of a number of national accounting and financial issues, including guidance on the transfer of assets acquired as a result of the Transforming Community Services (TCS) exercise and the change to the accounting treatment of donated and government grant funded assets. In terms of segmental reporting, the Committee was asked to note that a key change impacting on this approach had included the development of Service Line Reporting, however it was acknowledged that this was not yet formally part of the routine financial management. In terms of TCS, it was highlighted that at present there remained a rationale that segmental reporting need not be applied, however consideration may need to be given in future as to whether the approach should be adopted for the purposes of the statutory accounts. Mr Capener suggested that practice in other organisations could be considered. Mrs Moore advised that the matter had been under consideration for some time and that some organisations did adopt a segmental reporting approach, however there remained an overriding need for ensuring that internal and external reporting was consistent. Mrs Hunjan summarised that there was agreement in principal that a case for adoption of segmental reporting was not obvious, however the matter should be assessed at a later date, subject to canvassing the views of other organisations, with the method of implementation being discussed between External Audit and the Trust's Finance function.	

Minutes	Paper Reference
6.5 Audit Committee cycle of business	**SWBAC (2/12) 014** **SWBAC (2/12) 014 (a)**
For approval Mr Grainger-Payne presented the proposed annual cycle of business for the Audit Committee. Subject to minor amendment, the cycle of business was approved.	
AGREEMENT: Subject to minor amendment, the Audit Committee approved its annual cycle of business	
7 Minutes from Trust Board Committees	
7.1 Finance and Performance Management Committee	**SWBFC (12/11) 137**
The Committee noted the minutes of the Finance and Performance Management Committee meeting held on the 15 December 2011.	
7.2 Charitable Funds Committee	**SWBCF (12/11) 027**
The Committee noted the minutes of the Charitable Funds Committee meeting held on 1 December 2011.	
7.3 Quality and Safety Committee	**SWBQS (11/11) 059**
The Committee noted the minutes of the Quality and Safety Committee meetings held on 17 November 2011.	
8 Any Other Business	**Verbal**
There was none.	
9 Date and time of next meeting	**Verbal**
The date and time of the next meeting will be 17 May 2012 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** 9 February 2012 at 0930h

Present		**In attendance**	
Dr S Sahota	[Chair]	Mr P Smith	
Mrs G Hunjan		Mr M Burgess	[Barclays Wealth]
Mr R Trotman			
Mr P Gayle		**Secretariat**	
Mr R White		Mr S Grainger-Payne	

Minutes	**Paper Reference**
1 Apologies	**Verbal**
Apologies were received from Mrs Olwen Dutton, Professor Derek Alderson, Mr John Adler, Miss Rachel Overfield, Miss Rachel Barlow, Mr Donal O'Donoghue and Mr Mike Sharon.	
2 Minutes of the previous meetings	**SWBCF (12/11) 027**
The minutes of the meeting held on 1 December 2011 were approved.	
AGREEMENT: The minutes of the previous meetings were approved	
3 Matters arising from the previous meeting	**SWBCF (12/11) 027 (a)**
The Trustees received and noted the updated actions log. It was noted that the outstanding action would be addressed within the investment update due to be given by Mr Michael Burgess from Barclays Wealth. It was noted that the interviews for the Head of Fundraising were to be arranged. Mr Trotman remarked that it was disappointing that there had been a delay with recruiting to the post. Mrs Hunjan agreed with this and encouraged expediency, particularly given the time since the proposal to appoint a Head of Fundraising was first discussed.	

4	**Investment update – Barclays Wealth**	
4.1	**Investment review and valuation from Barclays Wealth for the three month period 1 October 2011 to 31 December 2011**	**Hard copy**
To discharge the action raised at the last meeting, Mr Burgess presented the portfolio performance data against some industry standard benchmarks. He cautioned the interpretation of the information given the difficulty with assessing the bond element of the portfolios. It was reported that overall, the FTSE all stocks gilt index had improved significantly, which was highlighted to have been unexpected due to the prevailing economic conditions but was related to the 'flight to safety' impact in the volatile markets. The return on bonds over the ten year yield was reported to have been 1.92%, which was highlighted to be a significantly low level. In terms of the performance information, the Trustees were advised that the portfolio had underperformed, principally due to the investment in a number of bonds that had generated little return. It was highlighted however that corporate and government bonds were included in the portfolio which were expected to perform better in the longer term. Mr White asked whether this current approach should continue to be supported in view of the under performance. Mr Burgess advised that in retrospect. It may have been appropriate to have invested in gilts rather than corporate bonds. He emphasised that risk reward characteristics associated with the corporate bonds were attractive however, with some out performing some gilts during the first part of the year. The value of the portfolio was noted to be £4,522,970 as at 31 December 2011, although the Trustees were advised that this had increased as at 8 February 2012, due to an improved performance in equities as a consequence of the better economic condition in the United States which had caused a degree of optimism in the markets. Mr Trotman asked what the level of inflation was in China. He was advised that this was 4.2% and the inventory had improved as a result of increased business confidence. Dr Sahota summarised that it appeared that the global economic situation remained uncertain, although it appeared that recovery in Asia appeared to be faster than in many parts of Europe. Mr Burgess was asked whether there was an expectation that the momentum behind the recovery would continue in Asia. Mr Burgess advised that the significant European downturn would impact on emerging markets, which would also be dependent on the situation in the United States. Further developments to note were highlighted to include the increased level of support being provided by the European Central Bank, with the shares from the	

Royal Bank of Scotland improving most considerably.

Mr Trotman asked what the likely impact of Greece withdrawing from the Euro would be. Mr Burgess advised that there was an expectation that the country would retain the Euro, however austerity measures would need to be invoked. The Trustees were advised that should Greece withdraw from the Euro, there was a possibility that economic growth might be promoted in the country, however there might be a default on bonds and loans. It was highlighted however that while the impact of this was minimal to the United Kingdom, the impact would be more keenly felt by the German banks.

The Trustees were advised that the markets had also improved due to activity in the mining sector as natural resources were being consumed to support activity in China.

Dr Sahota remarked that the situation in the Middle East was concerning. Mr Burgess agreed that the position was politically sensitive and the impact on the investment markets would be a rise in the price of oil and the impact on nuclear capabilities of other countries.

Dr Sahota returned to the improved position of the Royal Bank of Scotland share price and noted that those within the Charitable Funds portfolio had been sold. Mr Burgess confirmed that this was the case, however he advised that this had been offset by a reinvestment in the mining sector which had seen considerable improvement. Mrs Hunjan asked whether the shares had been sold at a loss. Mr Burgess advised that this was unclear however he underlined the good return that had been generated by the investment of the proceeds of this sale into other areas. The Trustees were advised that the selection of investments were based on preferred sectors at present, such as in mining and oil.

Mr Burgess drew the Trustees' attention to the tables within the investment report which outlined the performance of the portfolio, which showed the position in reference to the Barclays Sterling Aggregate Index. Mr Trotman asked whether there was any insistence to invest in Barclays products. Mr Burgess confirmed that this was not the case.

Dr Sahota asked to what the investment in iShares related. Mr Burgess advised that these reflected market tracking investments.

Mr White observed that there had been a clear divergence of Spanish, Italian and German debt since 2008. Mr Burgess highlighted that the Italian debt had reduced significantly.

The Trustees were advised that the financial easing measures recently applied were expected to boost liquidity and improved lending to small and mid-sized companies, however this was noted to have the potential to cause inflationary pressures in future.

In conclusion, Mr Burgess recommended that no change was made to the current portfolio asset allocation due to the continued volatility in the economic markets at present, however he suggested that should there be improvement in the next period, then investment in a greater proportion of equities rather than bonds could be considered. The Trustees supported this approach. Mr Burgess was thanked for his useful advice and presentation.	
AGREEMENT: The Trustees agreed that at present, no changes to the current asset allocation should be made	
5 Finance report	**SWBCF (2/12) 002** **SWBCF (2/12) 002 (a) - SWBCF (2/12) 002 (d)**
Mr Smith presented the finance report for the Charitable Funds which it was noted covered the period between 1 November 2011 – 31 December 2011. Income during the period was reported to be £156,915, of which £122,312.66 was noted to be amounts of greater than £1000. Expenditure in excess of £1000 was reported to be £156,079.51. It was highlighted that creation of the children's play area represented a significant item of expenditure during the period and it was suggested that there be some positive publicity arranged to promote this cause. Mr White advised that some snagging issued needed to be resolved prior to any publicity. Mrs Hunjan and Mr Trotman noted that there had been significant expenditure on items associated with the Christmas festivities and asked what process was in place for controlling this spend. Mr White advised that fund managers had the authority to use the funds for the benefit of staff if they so wished. Expenditure for the catering for the Occulus course was questioned by Mr Trotman. Mr White offered to determine the basis on which this had been met from Charitable Funds. It was agreed that a breakdown of expenditure on the Trust Ball should be presented at the next meeting. The Trustees were advised that expenditure against the Oakley Fund was expected shortly which would support the purchase of Phaco machines for Ophthalmology. Mr Smith advised that following this expenditure and the planned payment to the exchequer fund, the cash available was to be £9,388, therefore there may be a need to liquidate some of the portfolio investment to pay for the Ophthalmology equipment. Mr Trotman asked whether the dividends from the portfolio were paid into the Charitable Funds account. He was advised that this was the case. Mr Trotman suggested that a view of the invoices planned was needed to inform the situation. It was agreed that Mr Smith should discuss the matter with Mr Burgess if necessary. Mr Gayle asked when the matter was likely to be resolved. Mr White	

advised that the issue needed to be settled within the current financial year. The Trustees were asked to note that the revaluation reserve balance had reduced significantly as at 31 December 2011. Mr Trotman suggested that the current position regarding funds was attributable largely to the lack of a fundraising manager. Mrs Hunjan concurred with this view.	
ACTION: **Mr Grainger-Payne to organise for a breakdown of expenditure on the 2011 Trust Ball to be presented at the next meeting**	
6 Progress with gathering Charitable Funds expenditure plans	**Verbal**
Mr Smith advised that letters had been sent to all fund managers requesting expenditure plans. It was agreed that explanations should be requested for any forecast delays with achieving the spending of funds. It was agreed that the Head of Fundraising should take responsibility for promoting the measures to increase the funds with managers.	
ACTION: **Mr White to determine the basis on which the catering charge for the Occulus course had been met from Charitable Funds**	
7 Any other business	**Verbal**
There was none.	
8 Details of the next meeting	**Verbal**
The next meeting is to be held on 17 May 2012 at 0930h in the Executive Meeting Room at City Hospital.	

Signed .....

Print .....

Date .....