Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Churchvale/Hollyoak Rooms, Sandwell Hospital **Date** 25 February 2010 at 1430h

Members

Mrs S Davis	(SD)	[Chair]
Mr R Trotman	(RT)	
Miss I Bartram	(IB)	
Dr S Sahota	(SS)	
Mrs G Hunjan	(GH)	
Prof D Alderson	(DA)	
Mr J Adler	(JA)	
Mr D O'Donoghue	(DO)	
Mr R Kirby	(RK)	
Mr R White	(RW)	
Miss R Overfield	(RO)	

Secretariat

Mr S Grainger-Payne	(SGP)	[Secretariat]

In Attendance

Mr G Seager	(GS)
Miss K Dhami	(KD)
Mrs L Barnett	(LB)
Mrs J Kinghorn	(JK)
Miss J Whalley	(JW)
Mr J Cash	(JC)

Guests

Dr J Chambers	[Item 7]
Merida Associates	[Item 8]
Mrs J Dunn	[Items 8 and 9]
Dr B Oppenheim	[Items 10 and 13.1]
Mrs S Wilson	[Item 14.3]
Prof C Clarke	[Item 14.4]

Item	Title	Reference No.	Lead
1	**Apologies for absence**	**Verbal**	**SGP**
2	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting*	**Verbal**	**All**
3	**Chair's opening comments**	**Verbal**	**Chair**
4	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 28 January 2010 as true and accurate records of discussions*	**SWBTB (1/10) 025**	**Chair**
5	**Update on actions arising from previous meetings**	**SWBTB (1/10) 025 (a)**	**Chair**
6	**Questions from members of the public**	**Verbal**	**Public**
	PRESENTATIONS		
7	**Update on Public Health – Heart of Birmingham tPCT**	**Presentation**	**JC**
8	**Maternity services consultation**	**SWBTB (2/10) 035** **SWBTB (2/10) 035 (a)**	**Merida**
	MATTERS FOR APPROVAL		
9	**Maternity services reconfiguration business case**	**SWBTB (2/10) 045** **SWBTB (2/10) 045 (a)** **SWBTB (2/10) 045 (b)** **SWBTB (2/10) 045 (c)**	**JD**

10	**Infection Control policy**	**SWBTB (2/10) 036** **SWBTB (2/10) 036 (a)** **SWBTB (2/10) 036 (b)** **SWBTB (2/10) 036 (c)**	**BAO**
11	**Consent to treatment policy**	**SWBTB (2/10) 037** **SWBTB (2/10) 037 (a)** **SWBTB (2/10) 037 (b)** **SWBTB (2/10) 037 (c)** **SWBTB (2/10) 037 (d)** **SWBTB (2/10) 037 (e)**	**DOD**
12	**Blood tracking system – transfer of agreement from Olympus to Haemonetics**	**SWBTB (2/10) 040**	**RK**
	MATTERS FOR INFORMATION/NOTING		
13	**Quality and Governance**		
13.1	Quarterly update on infection prevention and control	SWBTB (2/10) 038 SWBTB (2/10) 038 (a)	BAO
13.2	Quarterly update on the Infection Control Assurance Framework	SWBTB (2/10) 046 SWBTB (2/10) 046 (a)	RO
13.3	Quarterly cleanliness report	SWBTB (2/10) 027 SWBTB (2/10) 027 (a)	RO
13.4	Update on ALE 2009/10	SWBTB (2/10) 039 SWBTB (2/10) 039 (a)	RW
14	**Strategy and Development**		
14.1	'Right Care, Right Here' programme: progress report	SWBTB (2/10) 029 SWBTB (2/10) 029 (a) SWBTB (2/10) 029 (b)	RK
14.2	New acute hospital project: progress report	SWBTB (2/10) 028 SWBTB (2/10) 028 (a)	GS
14.3	Update on the IM & T strategy	SWBTB (2/10) 041 SWBTB (2/10) 041 (a)	SWI
14.4	Research and Development strategy	SWBTB (2/10) 030 SWBTB (2/10) 030 (a)	CC
15	**Performance Management**		
15.1	Monthly finance report	SWBTB (2/10) 031 SWBTB (2/10) 031 (a)	RW
15.2	Monthly performance monitoring report	SWBTB (2/10) 044 SWBTB (2/10) 044 (a)	RW
15.3	NHS Performance Framework monitoring report	SWBTB (2/10) 042 SWBTB (2/10) 042 (a)	RW
16	**Operational Management**		
16.1	Executive and Clinical Management structure	SWBTB (2/10) 043 SWBTB (2/10) 043 (a)	JA/RK
17	**Update from the Board Committees**		
17.1	Finance and Performance Management Committee		
▶	Minutes from meeting held 21 January 2010	SWBFC (1/10) 010	RT

18	**Any other business**	**Verbal**	**All**
19	**Details of next meeting** *The next public Trust Board will be held on 25 March 2010 at 1430h in the Anne Gibson Boardroom, City Hospital*	**Verbal**	**Chair**
20	**Exclusion of the press and public** *To resolve that representatives of the Press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).*	**Verbal**	**Chair**

MINUTES

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Trust Board (Public Session) – Version 0.3

Venue Anne Gibson Boardroom, City Hospital **Date** 28 January 2010 at 1430 hrs

Present:	Mrs Sue Davis	Dr Sarindar Sahota	Mr Richard Kirby
	Mr Roger Trotman	Prof D Alderson	Mr Donal O'Donoghue
	Miss Isobel Bartram	Mr John Adler	Miss Rachel Overfield
	Mrs Gianjeet Hunjan	Mr Robert White	
In Attendance:	Mrs Lesley Barnett	Miss Kam Dhami	Mr Graham Seager
	Mrs Jessamy Kinghorn	Miss Judith Whalley	
	Mrs Sally Fox [Item 7 only]	Mrs Andrea Bigmore [Item 12.3 only]	
Secretariat:	Mr Simon Grainger-Payne		

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
There were no apologies received.	
2 Declaration of interests	**Verbal**
No declarations of interest were made in connection with any agenda item.	
3 Chair's opening comments	**Verbal**
The Chair did not make any opening comments, however she invited Mr Kirby to discuss the position regarding the current operational pressures. Mr Kirby reported that both City and Sandwell Hospitals had needed to be closed to visitors due to an outbreak of Norovirus infections at both sites. At Sandwell Hospital, medical wards were reported to be closed to medical admissions. Most cases of Norovirus had been brought into the hospitals from outside, therefore measures were being taken to prevent the spread of the infection internally. The closure of the hospitals to visitors was noted to be a further measure implemented to prevent the spread of the infection. The media was reported to be being briefed on the situation at regular intervals.	
4 Minutes of the previous meeting	**SWBTB (12/09) 257**
The minutes of the previous meeting were accepted as a true and accurate record of discussions held on 17 December 2009.	
AGREEMENT: The minutes of the previous meeting on 17 December 09 were	

approved as true and accurate reflections of discussions held	
5 Update on actions from previous meetings	**SWBTB (12/09) 257 (a)**
The updated actions list was reviewed. There were noted to be no outstanding actions requiring escalation. Mr Adler noted that the action concerning naming of the new hospital, which was marked as for completion in the future, was included on the agenda of the meeting, therefore it was agreed that this item should be closed.	
6 Questions from members of the public	**Verbal**
There were no members of the public in attendance at the meeting.	
7 Listening into Action update	**SWBTB (1/10) 014** **SWBTB (1/10) 014 (a)** **SWBTB (1/10) 014 (b)**
Mrs Sally Fox joined the meeting to update the Board on the progress with and the future plans for the 'Listening into Action' initiative. Mrs Fox outlined the various areas of the Trust that had participated in 'Listening into Action', which was noted to cover the majority of the organisation. A key use of 'Listening into Action' was reported to be in managing change within the organisation. Mrs Fox reminded the Board that the 'Listening into Action' facilitator role was time limited and therefore consideration had been given to the plans to ensure that the momentum of the initiative is maintained and sustained beyond the expiry of this role. It was proposed that a network of 'Listening into Action' leads be established to champion the work across the Trust. A communications programme for the work, including the production of a DVD, is also planned as part of a suite of tools for managers using 'Listening into Action'. A celebration to mark the second anniversary of the introduction of 'Listening into Action' was proposed. Mrs Hunjan highlighted the need to identify internal capacity to continue embedding the approach and ensuring that all areas of the Trust are supported in their use of 'Listening into Action'. Mr Trotman added that staff may become cynical if there is an obvious lack of progress on matters that were agreed as needing to be delivered as an outcome of the 'Listening into Action' work. It was suggested that the approach to engagement should be built into the appraisal process, whereby managers are required to demonstrate their involvement and support for 'Listening into Action'. Mr Cash asked how the funding for the continuation of 'Listening into Action' would be made available. Mrs Fox advised that the initial funding for the work had been provided by the Strategic Health Authority, therefore a case could be made to extend the funding if deemed appropriate. The Trust Board approved the proposed future approach to 'Listening into Action'. It was agreed that the recommendations should be transformed into an action plan that would be considered at a future meeting.	

AGREEMENT: The Trust Board gave its approval to the approach planned for the future of 'Listening into Action'	
8 Care Quality Commission registration	**SWBTB (1/10) 024** **SWBTB (1/10) 024 (a)**
Miss Dhami reminded the Board that the draft guidance and regulations forming the registration process with the Care Quality Commission (CQC) had been last discussed at the October meeting. She advised that the final guidance had been issued at the end of December 2009, which incorporated a number of amendments to the initial guidance. The Board was advised that the registration process replaces the current core standards declaration process, although the most recent declaration will inform the CQC's deliberations of the Trust's application for registration. The key difference with the new process was noted to be that it focuses on outcomes, rather than process and relates to regulated activities in the Trust's various locations. Miss Dhami reported that a pre-application had been made in December 2009, with the final application needing to be submitted by 29 January 2010. The Board was advised that a self-assessment approach had been taken by the responsible Executive lead, to determine whether the Trust was compliant with each regulation and documentation underpinning this evaluation has been gathered. It was reported that the CQC holds a Quality and Risk Profile (QRP) for each Trust, based on the evidence it has available to determine where the risks lie and the likelihood of non-compliance. The Trust's QRP was noted to be being considered at present and evidence gathered to demonstrate that in areas highlighted as high risk, improvement has been made. The Board was advised that the 'Judgement Framework' will be applied, which centres on a number of key regulations, when making decisions about compliance and reaching a decision about registration. Non-compliance with regulations may mean suspension of registration. Miss Dhami advised that the Trust was already registered with the CQC for the hygiene code standards. The Trust is required to pay £60,000 for registration. The charges are determined according to the services undertaken by the Trust and the size of the organisation. Based on the self-assessment exercise that had been undertaken, the Trust Board was asked to approve the proposal that compliance be declared against all regulations. The Chair remarked that the timescale for the preparation of the application had been challenging. Miss Bartram added that the process and detail of the proposed application had been considered by Governance and Risk Management Committee at its meeting earlier in the month. Mr Adler suggested that clarification be sought as to whether the declaration represented the current time or if it represented the expected position as at 1 April 2010, when registration takes effect. Miss Dhami advised that there was an	

expectation that there would be areas of work in progress to address any areas requiring attention, such as achievement of compliance with the Core Standard concerning mandatory training, yet she would check at which point the declaration is expected to represent. It was agreed that the QRP should be shared with the Board and any changes be highlighted as and when appropriate. Mr Cash asked whether, given the cost of the registration, this represented good value for money. Miss Dhami reiterated her support for the process, highlighting that it was positive that registration focussed on outcomes. Mr Cash was further advised that it was not an option for trusts to apply for registration, if they wished to continue operating.	
ACTION: **Miss Dhami to determine at which point the declaration to the CQC represented – the present, or the expected position as at 1 April 2010** **ACTION:** **Miss Dhami to circulate the Quality and Risk Profile to Board members** **AGREEMENT:** **Subject to clarification as to which period the declaration to the CQC represented, the Trust Board approved the declaration of compliance for CQC registration**	
9 Agenda for Change contract of employment	**SWBTB (1/10) 002** **SWBTB (1/10) 002 (a)**
Mrs Barnett advised that a number of changes to the standard Agenda for Change contract had been made to reflect infection control and safeguarding guidelines, together with legislative changes in respect of retirement and criminal convictions. Mr Trotman enquired as to the reason for not replacing existing staff contracts with the amended version. He was advised that the Trust is unable to impose any changes to terms and conditions without consultation and negotiation. Miss Whalley added that there was additionally a small number of staff employed on a Whitley Council contract. Miss Overfield advised that the requirements around infection control and safeguarding had already been added to existing contracts. Dr Sahota asked whether the new contracts were consistent with the new equality bill in terms of age discrimination. He was advised that this was the case. Mr Kirby noted that the term 'NHS Executive' was obsolete. Mrs Barnett agreed to amend this to 'employment charter'. Mr Cash asked whether there were any staff that do not complete a CRB application. He was advised that there are very few staff undertaking roles where this is not required.	
AGREEMENT: **Subject to minor amendment, the Trust Board approved the revised Agenda for Change employment contract**	
10 Trust Board reporting cycle	**SWBTB (1/10) 015** **SWBTB (1/10) 015 (a)**
Mr Grainger-Payne presented the annual cycle of business for the Trust Board, highlighting that it largely followed the format of the 2009 reporting cycle.	

It was agreed that the national patient survey should be added to the reporting cycle on a quarterly basis, although acknowledged that the publication of these results may not exactly fall at the allocated time. Miss Overfield asked for ward review outcomes to be added to the cycle on a twice-yearly basis, in March and September.	
AGREEMENT: Subject to minor amendment, the Trust board approved its reporting cycle	
11 Quality and Governance	
11.1 Update on the implementation of Service Line Management and the Quality Management Framework	**SWBTB (1/10) 003** **SWBTB (1/10) 003 (a)**
Mr O'Donoghue advised that Service Line Reporting and the Quality Management Framework had been introduced in the Integrated Business Plan (IBP) as part of the Trust's application for Foundation Trust status. The Board was advised that to progress the implementation of Service Line Reporting, a steering group had been established. The work was reported to fall into a number of key themes: organisation structures/management//human resources; financial; clinical; and information systems. The aim was ultimately to introduce patient level costing. In terms of the directorates, appointments were reported to have been made to clinical director posts and work to map the estate to the directorates is underway. It is necessary to identify which individuals are involved in the various pathways of care. Further work is needed to map existing structures to the HR and nursing roles. Devolution of responsibility for decision making was highlighted to be an ultimate aim of the work. Mrs Hunjan noted that a costing system had been brought in to support the work but noted that it was currently being evaluated for fitness for purpose. Mr White explained that there were currently issues with obtaining outputs from the system that had been expected and there were minor problems with the feeding mechanisms into the overarching system. Work is underway with the company responsible for delivering the work to address the issues. Mrs Hunjan asked whether there was a possibility of learning best practice from other organisations. She was advised that this was possible, although the system in other trusts had been adapted to suit the needs of the organisation. Mr Trotman observed that there were plans to introduce quarterly reporting from April 2010 onwards. Mr White advised that a twin track approach will be adopted whereby manual reports will be considered alongside the outputs of the new system and would be considered by the Finance and Performance Committee. Miss Bartram asked whether a full structure would be available to review to determine how many directorates span more than one division. Mr Kirby advised that there are in excess of 30 directorates that do not span divisions at present,	

however the structure would be presented at the next meeting of the Trust Board. In terms of reporting, the Board was advised that it would be some time before the information becomes robust enough to form meaningful and reliable information. Until this time the twin track approach using manual information will be retained. Mr Cash noted that it was expected to take two years to complete the first cohort programme and remarked that in technology terms this was a considerable period and asked whether the system can be adapted and maintained during this period. He was advised that the two year timeframe had been built into the project plan for the work and this was a realistic period to ensure that the information is as robust as possible.	
11.2 Mortality update	**SWBTB (1/10) 016** **SWBTB (1/10) 016 (a)**
Mr O'Donoghue presented an update on progress with implementing assurance on mortality within the Trust. He explained that this work was part of the overall Quality Management Framework and will ensure that every death in the Trust is reviewed in a systematic manner. The Board was advised that a mortality pilot had started in December 2009 and since then the notes of every patient who dies in the Trust are reviewed by the relevant clinical directors. The mechanism was noted to link into the risk management processes already established. Further refinement of the system is planned to ensure greater accuracy with regard to the most appropriate clinician being sent the notes to review. Mr O'Donoghue advised that there were plans to continue the pilot. The Chair asked how serious the issue was regarding the mismatch of notes and clinical directors. She was advised that the issue did not impact on the effective processing of notes but was being addressed as a matter of priority. The instances were reported to lie mainly with cases where the consultants involved are different on admission to when the patient dies. Mr Adler added that this was reflective particularly when a complex patient, with multiple co-morbidities is being treated. The plans to introduce the electronic touch screen boards into wards, which link into the Trust's information systems, will assist with this matter. Mr Cash asked what the Trust's standardised mortality rate (SMR) was currently. He was advised that it was 98.0, better than the national average of 100. This follows a recent rebasing exercise. Professor Alderson asked where the work of the mortality steering group would be discussed. He was advised that a regular update would be presented to the Governance Board and by exception this would also be discussed by the Governance and Risk Management Committee. Once the system is embedded further, a regular update will be presented to the Trust Board. Mr Adler noted a discrepancy between the SMR figures in the corporate performance monitoring report and the mortality update. He was advised that this was due to the effect of the recent rebasing exercise.	
11.3 Audit Commission – 'Taking it on Trust'	**SWBTB (1/10) 020** **SWBTB (1/10) 020 (a)** **SWBTB (1/10) 020 (b)**

	SWBTB (1/10) 020 (c)
Mr White reported that the Audit Commission's report, 'Taking it on Trust' had recently been considered by the Governance and Risk Management Committee and Executive Team. The report had concluded overall nationally, that there could be greater use of internal audit and data to provide assurance and that trusts' risk and controls were not always aligned with strategic objectives. Furthermore, the communication of objectives was not always communicated throughout the organisation. A checklist of questions was included in the report to enable trusts to undertake a self-assessment against the findings of the report. At the Governance and Risk Management Committee, it had been concluded that while the Trust performs well in many areas of governance and assurance, that there was further work to do to meet fully the required standards. To address these areas, an action plan had been developed, progress against which will be presented to the Board on a periodic basis. The Chair asked how the self-assessment exercise had been undertaken. Mr White advised that a baseline assessment had been undertaken between himself and internal audit initially, which had then been considered and amended on discussion with the Executive Team.	
11.4 Single Equality Scheme update	**SWBTB (1/10) 009** **SWBTB (1/10) 009 (a)** **SWBTB (1/10) 009 (b)**
Miss Overfield presented an annual report on equality and diversity, together with an updated version of the Single Equality Scheme. She reported that the changes as a result of the new equality bill had been built into the work, particularly in relation to disabled individuals. In terms of activity of the past year, the Service and Policy Assessment Group was noted to be making good progress with ensuring that Equality Impact Assessments are undertaken for services, functions and policies. The Trust also continues to be compliant with its publication duties. Miss Bartram suggested that the update could be supported by more data in future, which Miss Overfield agreed to include. Mr Cash asked to what extent external bodies had been engaged with undertaking equality impact assessments. He was advised that the Trust meets on a regular basis with the independent living group and individuals who are blind, deaf or have a mental or physical disability are consulted on appropriate plans. Professor Alderson noted that Spanish was not included in the list of languages regularly requiring translation services. It was suggested that this be added into the list.	
ACTION: Miss Overfield to include greater level of supportive data into future versions of the equality and diversity updates and amend the list of languages using translation services to include Spanish	
11.5 Patient satisfaction survey update	**SWBTB (1/10) 010** **SWBTB (1/10) 010 (a)**
Miss Overfield presented the results of the latest adult inpatient satisfaction survey,	

which was reported to be undertaken on an ongoing basis.

The survey is now translated into the six most frequently requested languages. A relatives and carers survey is also to be introduced. Work is underway to determine how the results of the internal survey compare with those of the national patient survey.

Miss Overfield advised that there are plans for the internal inpatient survey to be expanded to cover assessment units, critical care and Accident and Emergency departments.

Mr Trotman observed that 25% of patients reported that they were not provided with sufficient information and suggested that they should be asked whether they had requested this information. Miss Overfield agreed but advised that effort was being taken to limit the number of questions included on the survey.

Mr Kirby reported that the question regarding single sex accommodation had been amended to focus on whether a patient had shared sleeping accommodation with a member of the opposite sex.

It was noted that the responses suggested that fewer patients had been made to feel welcome and were treated with dignity and respect. Miss Overfield reported that work was planned to review the information in detail to determine whether there were any key issues or trends in connection with these indicators.

Miss Bartram observed that responses in connection with dietary needs were more disappointing than expected. She was advised that there is more work to be undertaken in relation to nutrition and dietary needs.

Mrs Kinghorn reported that following an initial comparison between the results of the internal and national surveys, that there did not appear to be any outliers of significance.

Professor Alderson remarked that the perception of how patients are dealt with by doctors is a significant factor in satisfaction and asked whether this could be captured. Miss Overfield reported that this is currently included as part of the national survey however was being built into future versions of the internal survey. Professor Alderson recommended that the access to facilities, including information such as what time a patient is asked to come into hospital and at what time they are sent home should be considered. Miss Overfield agreed and offered to circulate a version of the revised survey to the Trust Board for review.

Dr Sahota asked whether the survey is given to all inpatients. He was advised that this was the case.

Mr Cash asked whether patients below the age of 16 were surveyed. Miss Overfield reported that this is undertaken by paediatricians but the results will be added into the overall report.

ACTION: **Miss Overfield to circulate the revised version of the inpatient satisfaction survey**

11.6 Inspection of Safeguarding and Looked After Children Services report – Sandwell MBC

SWBTB (1/10) 011
SWBTB (1/10) 011 (a)

Miss Overfield presented the Inspection of Safeguarding and Looked After Children Services report for Sandwell MBC, which had been recently published by OFSTED. Disappointingly, the report considered that services for looked after children were adequate, but those in respect of safeguarding were inadequate. As part of the report, the Trust was commended for its work supporting community midwives. Likewise, the performance management system was commended. Work to roll out domestic violence training was highlighted as an area that needed further work however, and a flagging system of recurrent child attendees in Accident and Emergency is to be reinstated. Miss Overfield reported that she is a member of safeguarding boards. It was noted that a more detailed report on the health aspects of the review would be issued by the CQC and this would also be brought to the Board.	
11.7 Assurance Framework update – Quarter 3	**SWBTB (1/10) 004** **SWBTB (1/10) 004 (a)**
The Trust Board received and noted the updated Assurance Framework.	
12 Strategy and Development	
12.1 'Right Care, Right Here' programme: progress report	**SWBTB (1/10) 021** **SWBTB (1/10) 021 (a)** **SWBTB (1/10) 021 (b)**
Mr Kirby presented the latest update on progress with the 'Right Care, Right Here' programme. He advised that the exemplar projects are progressing well.	
12.2 New Acute Hospital project: progress report	**Verbal**
Mr Seager reported that the development of the activity model for the new hospital was progressing well. The CPO process is continuing and the order is valid. An inquiry will be arranged, following objections received, which will be undertaken between February and June 2010.	
12.3 Public arts strategy	**SWBTB (1/10) 005** **SWBTB (1/10) 005 (a)**
Mrs Bigmore joined the meeting to update the Board on plans to develop a public arts strategy. She advised that the plans had initially been developed in readiness for the new hospital, however the remit of work had now been extended to the current estate. The Board was advised that the funding for the work had been approved at a recent meeting of the Charitable Funds Committee. The plans involve the commissioning of a set loaned artwork to be displayed around the Trust's hospitals and include a community arts projects involving the local population. The exhibition of artwork will be facilitated by an art map. It is planned to start the work in March 2010, ready to launch in the summer, with an evaluation exercise scheduled for autumn.	

Mr Cash asked which communities had been engaged with the work. He was advised that the work had not yet started, but public members will be engaged when the project is underway. Mr Cash offered to provide some contacts that may be useful to engage. Mrs Kinghorn advised that the shadow FT members would also be engaged with the work.	
12.4 Naming of the new hospital	**SWBTB (1/10) 013** **SWBTB (1/10) 013 (a)**
Mrs Kinghorn reported that the process for the naming of the new hospital had been discussed with the new acute hospital project board. Research into similar exercises undertaken by other trusts has been undertaken to determine best practice. An engagement exercise will be undertaken to generate a list of possible names. Once this list has been developed, legal input will be required to search for whether the names proposed already exist. The Board will be presented with a shortlist of names to review and a competition may be run in parallel to agree the name. A local celebrity will be identified to champion the work and a voting system is likely to be arranged. It was agreed that the exercise should be separated from the naming of the new community hospitals, to avoid any potential confusion. The Trust Board was agreeable to the proposed approach and timings outlined.	
13 Performance Management	
13.1 Monthly finance report	**SWBTB (1/10) 006** **SWBTB (1/10) 006 (a)**
Mr White reported that there had been progress in addressing the financial position in month and a surplus of £160k had been achieved against a target of £124k. A year end surplus of £2.3m continues to be forecast. A fall in the number of WTEs has been seen in month to 40 below plan. The Board was advised that work is underway with the Trust's commissioners to agree the handling of the overperformance against contract. An agreement is anticipated to be reached shortly. Mr Trotman reported that at the meeting of the Finance and Performance Management Committee, concern had been expressed at the control of pay costs and future plans to address the issue.	
13.2 Monthly performance monitoring report	**SWBTB (1/10) 022** **SWBTB (1/10) 022 (a)**
Mr White reported that delayed transfers of care had increased in month mainly as a result of the limited service available from Social Services over the winter vacation. In terms of stroke care services, escalation measures have been put into place, which are hoped to result in an improved performance for the remainder of the year.	

In December, the Trust performed well against referral to treatment time targets, apart from in orthopaedics. The smoking cessation process has been amended to introduce an opt out system, whereby all patients who smoke are automatically referred to a smoking cessation service, unless they express a wish for this referral not to be made. Outpatient cancellations were highlighted to now be being reported, although in future versions of the report, this performance will be contextualised as a percentage of all appointments made. Significant focus is being given to mandatory training at present, with all areas requiring a 75% compliance rate for attendance by the year end. Mt Trotman reported that at the recent meeting of the Finance and Performance Management Committee, there had been a presentation concerning measures put in place to improve theatre utilisation. A further update is due in May 2010. Dr Sahota asked whether performance against the Accident and Emergency four-hour waiting time target was being maintained. Mr Adler reported that the target remains very challenging and a number of local trusts will not be able to meet the year end target. Operational pressures and the recent outbreak of Norovirus are contributing factors to this difficulty. Mr Cash noted the trend in agency staff being used by the Trust and asked whether this was seasonal. He was advised that this level of agency staff is reflective of current operational pressures and was not as a consequence overall of staff sickness.	
13.3 NHS performance framework monitoring report	**Hard copy papers**
Mr White presented the NHS Performance Framework monitoring report. The Board was pleased to note that the Trust remains classified as a 'performing' organisation, despite one amber rating. Mr White advised that the Department of Health had revised a number of the thresholds within this framework, including those associated with cancer waiting times and stroke care.	
13.4 Update on the delivery of corporate objectives – Quarter 3	**SWBTB (1/10) 007** **SWBTB (1/10) 007 (a)**
Mr White presented an update on the delivery of the Trust's corporate objectives. It was noted that progress is rated as red for objectives concerning the identification of key hospital actions to improve public health and the achievement of NHS Litigation Authority risk assessment standards.	
14 Operational Management	
14.1 Sustainability update	**SWBTB (1/10) 012** **SWBTB (1/10) 012 (a) -** **SWBTB (1/10) 012 (e)**

Mr Seager presented an update on the progress made with the sustainability agenda. He advised that the management plan had been further developed and populated by contributions from the recent 'Hop Topics' feedback and all actions had been prioritised. The Board noted the results of the good corporate citizen model, where in terms of workforce the Trust performs well, but performs less well on travel indicators. Some work is underway to achieve the suggested levels. Plans to identify sustainability champions are to be disseminated across the Trust, with training sessions for these individuals planned for March 2010. Miss Whalley asked that any plans take into account measures to avoid disadvantaging minority groups. Mr Cash noted that in terms of community engagement, the Trust was reported as being below average. Mr Seager highlighted that the scores are based on a self-assessment exercise and that the Trust may be better than the position reported. Mr Adler suggested that further work was needed in this area.	
15 Update from the Committees	
15.1 Finance and Performance Management	**SWBFC (12/09) 229**
The Board received and noted the minutes of the Finance and Performance Management Committee meeting held on 17 December 2009.	
15.2 Governance and Risk Management Committee	**SWBGR (11/09) 071**
The Board received and noted the minutes of the Governance and Risk Management Committee meeting held on 19 November 2009.	
15.3 Audit Committee	**SWBAC (12/09) 077**
The Board received and noted the minutes of the Audit Committee meeting held on 3 December 2009.	
15.4 Charitable Funds Committee	**SWBCF (12/09) 021** **SWBCF (1/10) 005**
The Board received and noted the minutes of the Charitable Funds Committee meetings held on 3 December 2009 and 14 January 2010.	
16 Any other business	**Verbal**
The Board was reminded on the forthcoming celebration of 100 years of research and invited to attend if available.	
17 Details of the next meeting	**Verbal**
The next meeting is scheduled for Thursday 25 February 2010 at 14.30pm in the Churchvale/Hollyoak Rooms at Sandwell Hospital.	
18 Exclusion of the press and public	**Verbal**

The Board resolved that representatives of the Press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1 (2) Public Bodies (Admission to Meeting Act 1960).	

Signed ……

Print……

Date ……

Next Meeting: 25 February 2010, Churchvale/Hollyoak Rooms @ Sandwell Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

28 January 2010 - City Hospital

Members present: Mrs S Davis (SD), Mr R Trotman (RT). Ms I Bartram (IB), Mrs G Hunjan (GH), Dr S Sahota (SS), Professor D Alderson (DA), Mr J Adler (JA), Mr D O'Donoghue (DO), Mr R White (RW), Mr R Kirby (RK)

In Attendance: Mrs L Barnett (LB), Miss K Dhami (KD), Mr G Seager (GS), Mrs J Kinghorn (JK), Miss J Whalley (JW)

Apologies: None

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 19 February 2010

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status	Review Date
SWBTBACT. 113	update on delivery of single sex accommodation	Hard copy papers	17-Dec-09	Present an update on delivery of single sex accommodation requirements at the meeting of the Trust Board in March 2010	RK	25-Mar-10		In hand - review next meeting	
SWBTBACT. 118	Patient satisfaction survey	SWBTB (1/10) 010 SWBTB (1/10) 010 (a)	28-Jan-10	Circulate the revised version of the patient satisfaction survey	RO	25-Mar-10		In hand - review next meeting	
SWBTBACT. 084	MRI business case	SWBTB (4/09) 093 SWBTB (4/09) 093 (a)	30-Apr-09	Present a post implementation review of the City Hospital MRI scanner	RK	29-Apr-10	**ACTION NOT YET DUE**	Future	
SWBTBACT. 114	Communication and engagement strategy update	SWBTB (12/09) 251 SWBTB (12/09) 251 (a)	17-Dec-09	Present an update on the communications and engagement strategy at the meeting of the Trust Board in May 2010	JK	27-May-10	**ACTION NOT YET DUE**	Future	
SWBTBACT. 117	Single Equality Scheme update	SWBTB (1/10) 009 SWBTB (1/10) 009 (a) SWBTB (1/10) 009 (b)	28-Jan-10	Include greater level of supportive data into future versions of the equality and diversity updates and amend the list of languages using translation services to include Spanish	RO	29-Apr-10	ACTION NOT YET DUE	Future	
SWBTBACT. 085	New acute hospital: progress report	Verbal	30-Apr-09	Present the process for consultation on the name of the new hospital at the next Trust Board meeting	GS	28-May-09	Discussed at the January meeting	Completed Since Last Meeting	
SWBTBACT. 115	Care Quality Commission registration	SWBTB (1/10) 024 SWBTB (1/10) 024 (a)	28-Jan-10	Determine at which point the declaration to the CQC represented - the present, or the expected position as at 1 April 2010	KD	25-Feb-10	The declaration represents the position as at the time of submission	Completed Since Last Meeting	
SWBTBACT. 116	Care Quality Commission registration	SWBTB (1/10) 024 SWBTB (1/10) 024 (a)	28-Jan-10	Circulate the Quality and Risk Profile to Board members	KD	25-Feb-10	Will be circulated in time for the February meeting	Completed Since Last Meeting	

28 January 2010 - City Hospital

Members present: Mrs S Davis (SD), Mr R Trotman (RT). Ms I Bartram (IB), Mrs G Hunjan (GH), Dr S Sahota (SS), Professor D Alderson (DA), Mr J Adler (JA), Mr D O'Donoghue (DO), Mr R White (RW), Mr R Kirby (RK)

In Attendance: Mrs L Barnett (LB), Miss K Dhami (KD), Mr G Seager (GS), Mrs J Kinghorn (JK), Miss J Whalley (JW)

Apologies: None

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 19 February 2010

Reference No	Item	Paper Ref	Date	Agreement
SWBTBAGR.145	Minutes of the last meeting	SWBTB (12/09) 257	28-Jan-10	The minutes of the previous meeting were accepted as a true and accurate reflection of discussions held
SWBTBAGR.146	Listening into Action update	SWBTB (1/10) 014 SWBTB (1/10) 014 (a) SWBTB (1/10) 014 (b)	28-Jan-10	The Trust Board gave its approval to the approach planned for the future of 'Listening into Action'
SWBTBAGR.147	Care Quality Commission registration	SWBTB (1/10) 024 SWBTB (1/10) 024 (a)	28-Jan-10	Subject to clarification as to which period the declaration to the CQC represented, the Trust Board approved the declaration of compliance for CQC registration
SWBTBAGR.148	Agenda for Change contract of employment	SWBTB (1/10) 002 SWBTB (1/10) 002 (a)	28-Jan-10	Subject to minor amendment, the Trust Board approved the revised Agenda for Change employment contract
SWBTBAGR.149	Trust Board Reporting Cycle for 2010	SWBTB (1/10) 015 SWBTB (1/10) 015 (a)	28-Jan-10	Subject to minor amendment, the Trust Board approved its reporting cycle for 2010

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Improving services for giving birth – Independent Report on the Public Consultation
SPONSORING DIRECTOR:	John Adler, Chief Executive
AUTHOR:	Merida Associates
DATE OF MEETING:	25 February 2010

SUMMARY OF KEY POINTS:

In September 2009 the Trust and PCT Boards agreed to public consultation on the three short-listed options for changes to the way maternity services in relation to intra-partum and Consultant led care, are provided at Sandwell and West Birmingham Hospitals NHS Trust in the medium term i.e. from 2010 until the opening of the new Acute Hospital in 2015/16. Following this public consultation took place between 12th October 2009 and 18th January 2010. The outcome of this consultation has been reviewed by an independent organisation, Merida Associates and this paper is their report on the public consultation.

As part of the public consultation 780 questionnaires were completed and from these the assessment of options was:

- Option 1 Was the preferred option for 201 (26%) people
- Option 2 Was the preferred option for 185 (24%) people
- **Option 3 Was the preferred option for 327 (42%) people**

In addition there were a number of commonly raised concerns around the themes of :

- Travel
- Parking
- Visiting
- Capacity at City Hospital
- Not being able to give birth in Sandwell

These concerns will need to be considered in developing the plans for making changes to the service.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is recommended to note the contents of the report and take these into consideration alongside the Business Case for Change.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High Quality Care - We will provide the highest quality clinical care. Our clinical outcomes will be amongst the best of Trusts of our size and type. Patients and frontline staff will be fully engaged in improving our services.
Annual priorities	Deliver significant improvements in the Trust's maternity services
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

Financial		
Business and market share	**X**	The formal public consultation process asked women for preferences about the type and location of birth setting and their potential use including choice in the situation of there being no option of giving birth in Sandwell (apart from a home birth).
Clinical		
Workforce	**X**	Staff engagement events were held using Listening into Action principles as part of the formal public consultation process.
Environmental		
Legal & Policy		
Equality and Diversity	**X**	The public consultation process was tailored to include consultation with specific groups identified through the initial Equality Impact Assessment process.
Patient Experience	**X**	The formal public consultation included a range of methodologies to ensure a wide range of women's views were captured.
Communications & Media	**X**	Public Consultation has taken place. There will be ongoing extensive internal and external requirements and a comprehensive engagement and communications plan will be required.
Risks		

PREVIOUS CONSIDERATION:

A Report Outlining The Case For Change in maternity services over the medium term was presented to the Trust Board at its meeting in September 2009. The report was also presented to Sandwell PCT and Heart of Birmingham teaching PCT . Following agreement and approval at these meetings public consultation of the short listed options took place between October 2009 and January 2010.

A report presenting the Business Case for Change is also being presented to the Trust Board at its February 2010 meeting.

SWBTB (2/10) 035 (a)

Sandwell NHS
Primary Care Trust

Heart of Birmingham NHS
Teaching Primary Care Trust

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Improving services for giving birth

Proposed changes to Maternity Services from 2010 to 2015 in Sandwell and West Birmingham

INDEPENDENT REPORT ON THE PUBLIC CONSULTATION

February 2010
Merida Associates

Contents Page

Appendices:

Acknowledgements

Many thanks to everyone who has contributed to this consultation.

Merida Associates
t: 01384 375799
e: info@merida.co.uk
w: www.merida.co.uk

1. Introduction

Across the UK, maternity services are changing. The Government has made improving maternity services a priority and as part of the Right Care Right Here programme (RCRH) in Sandwell there is a long term commitment to improving maternity services locally. There will be a midwife-led birth centre and specialist care facility at the new hospital that is due to open in 2015/16 on the Grove Lane site in Smethwick. However, before the new hospital is built there are a number of reasons why maternity services need to be reviewed in the medium term.

In January 2008, the Health Care Commission rated maternity services at Sandwell Hospital as weak (least well performing). A review carried out by an independent external clinical body (also during 2008), also raised concerns about the service. Whilst immediate measures were put in place to address concerns raised, including the appointment of a new Clinical Director, it has become clear that these measures and improvements are unsustainable in the medium and longer term.

In order to address this issue, Sandwell Primary Care Trust (Sandwell PCT) has led a review into the medium term configuration of maternity services in the period up to the opening of the new hospital in 2015/16. The review developed 7 options for maternity services. This 'long list' was then subject to discussions and scoring with partners from Sandwell and West Birmingham Hospitals NHS Trust, Heart of Birmingham teaching Primary Care Trust (HOBtPCT), consultants, midwives and other interested parties, including local people and patients and their representatives. The option appraisal process was also informed by a period of pre-engagement activity lasting two weeks which took place in August 2009, during which time 591 people completed a questionnaire to identify their preferences in regard to maternity services. In addition, 29 women took part in 4 focus groups intended to gather information on the views and experiences of mothers using the Maternity and Newborn Services available at Sandwell and West Birmingham Hospitals.

This scoring process produced a 'short list' of three options for proposed changes to maternity services from 2010 – 2015 in Sandwell and West Birmingham which were then subject to public consultation. The public consultation period commenced on October 12th 2009 and ended on 18th January 2010.

Sandwell PCT commissioned Merida Associates to carry out the public consultation on the options which included working with the Patient and Public Involvement Manager at Sandwell PCT and the Maternity Services Review Steering Group to produce the consultation document, to gather views and analyse the findings.

This report presents the findings of the public consultation.

2. Methodology and Reach

2.1 Data Gathering

Data and information feeding into this document have come from a range of sources and these are outlined below.

In Sandwell, the Merida team arranged 15 focus groups, primarily through Children's Centres and voluntary and community organisations. In the Heart of Birmingham (HOB) area, 6 focus groups were arranged through HOBtPCT's Patient and Public Involvement team. All 21 focus groups were facilitated by Merida who kept written records of each group. Everyone who attended a focus group was encouraged (and supported) to complete a maternity services medium term review questionnaire.

Merida was also in attendance at 7 public meetings (4 in Sandwell and 3 in HOB) and was responsible for taking notes at each of these meetings. Again, everyone who attended a public meeting was encouraged (and supported) to complete the questionnaire in the consultation document.

A complete list of focus groups and public meetings can be found at appendix 1.

In addition to the quantitative and qualitative information gathered through focus groups and public meetings, people could complete the questionnaire in the consultation document and send this directly to Merida for analysis, using a freepost address.

The consultation document also contained links to the websites of Sandwell PCT, Heart of Birmingham teaching PCT and Sandwell & West Birmingham Hospitals NHS Trust (SWBHT) where the home pages of these sites directed people to an electronic version of the consultation document and the opportunity to complete the consultation questionnaire online.

Sandwell and HOBtPCT Patient and Public Involvement (PPI) teams also visited a number of maternity service sessions, such as antenatal clinics, to complete the questionnaire with people accessing services.

Sandwell PPI staff provided questions and comments sheets from presentations given to 125 people from the community though Sandwell Link, the Patient Experience Forum and voluntary and community organisations through a meeting at Sandwell Council of Voluntary Organisations.

HOBtPCT PPI staff provided feedback from presentations given to 151 people through Ward Sub Committee meetings in Lozells and East Handsworth, Soho and Sparkbrook, Patient Networks in Aston and Nechells, Ladywood and Summerfield, Lozells and East Handsworth and Soho, a Neighbourhood Forum in Soho Finger and Gib Heath, a meeting held at Arya Samaj and voluntary and community organisations through the Third Sector Assembly. Staff also attended an Open Day for the Newtown Neighbourhood Management Programme at which over 200 people were present.

As well as these data sources, the findings in this document take into account comments from the Joint Health Scrutiny Committee (OSC held on 12th January 2010), RCRH (30th October 2009) and staff consultation activity carried out by SWBHT with 70+ staff, plus another 11 people through informal consultation.

The consultation phase was informed by both the pre-engagement work and an Equalities Impact Assessment and findings are presented against key themes including young people, men and Black and Minority Ethnic groupings. The Equalities Impact Assessment particularly identified Yemeni and Somali women and the report includes information about the views of these communities.

2.2 Data Analysis

The data gathered through questionnaires and focus groups was subjected to a three stage process of analysis through which the data was systematically and comprehensively reviewed:

Stage 1: **Immersion** - the process by which the team becomes familiar with the collected data.

Stage 2: **Categorising and indexing** - using a coding framework and key word searches to identify both commonalities and anomalies.

Stage 3: **Thematic summaries** - by which the data and information is grouped around emerging themes.

2.3 Reach

780 people completed and returned the Maternity Services Review (MSR) questionnaire.

Completed questionnaires came from a range of sources:

- HOBtPCT PPI team 238 (32.5%)
- Sandwell PCT PPI team 187 (24%)
- Focus groups 174 (23%)
- Completed online 102 (13%)
- Freepost returns 65 ((8%)
- Public meetings 14 (less than 2%)

Of the 780 people who completed the MSR questionnaires:

- 682 (88%) were women
- 63 (8%) were men (35 people gave no answer to the question about gender).
- 30 (4%) identified themselves as having a disability with a further 9 people indicating they were not sure whether or not they were disabled.

The tables on the following page show the breakdown of respondents by both age and ethnicity. It is worth noting that many people in the Somali community will identify themselves as African on ethnicity monitoring forms.

Table 1 Age Profile of Respondents

Age	Total	Percentage	Age	Total	Percentage
under 16	26	3.33%	**40-49**	88	11.28%
16-18	30	3.85%	**50-64**	45	5.77%
19-29	277	35.51%	**65 or over**	13	1.67%
30-39	251	32.18%	**No Answer**	50	6.41%

Of the 780 respondents, 136 (17%) had no children, 139 (18%) were pregnant women or their partners, 37 (5%) were grandparents, 32 (4%) completed the form on behalf of an organisation, 7 (less than 1%) were guardians and 459 (60%) were parents, of which:

- 207 (26.5%) had 1 child
- 212 (27%) had 2 children

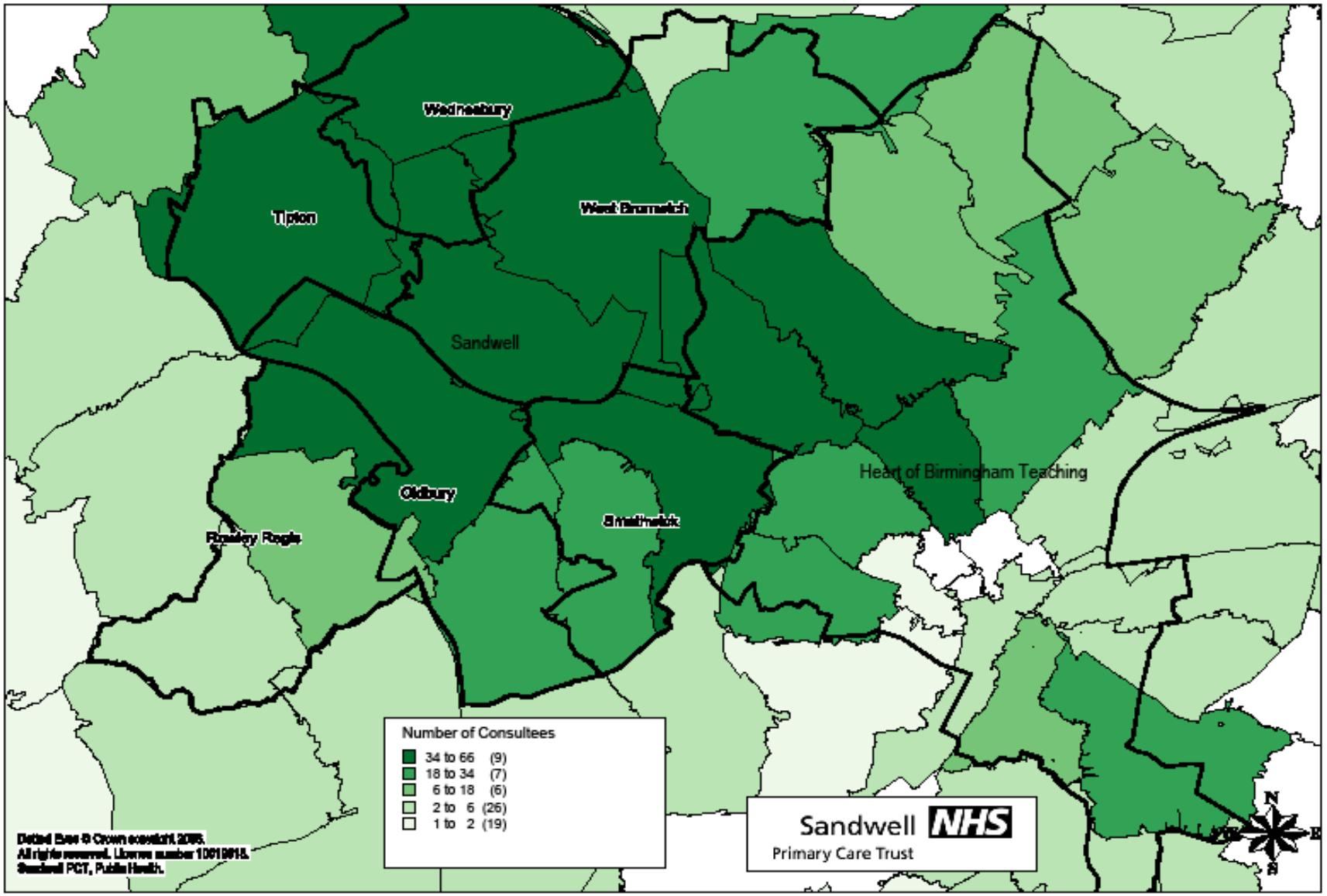
- 190 (24%) had 3 or more children.

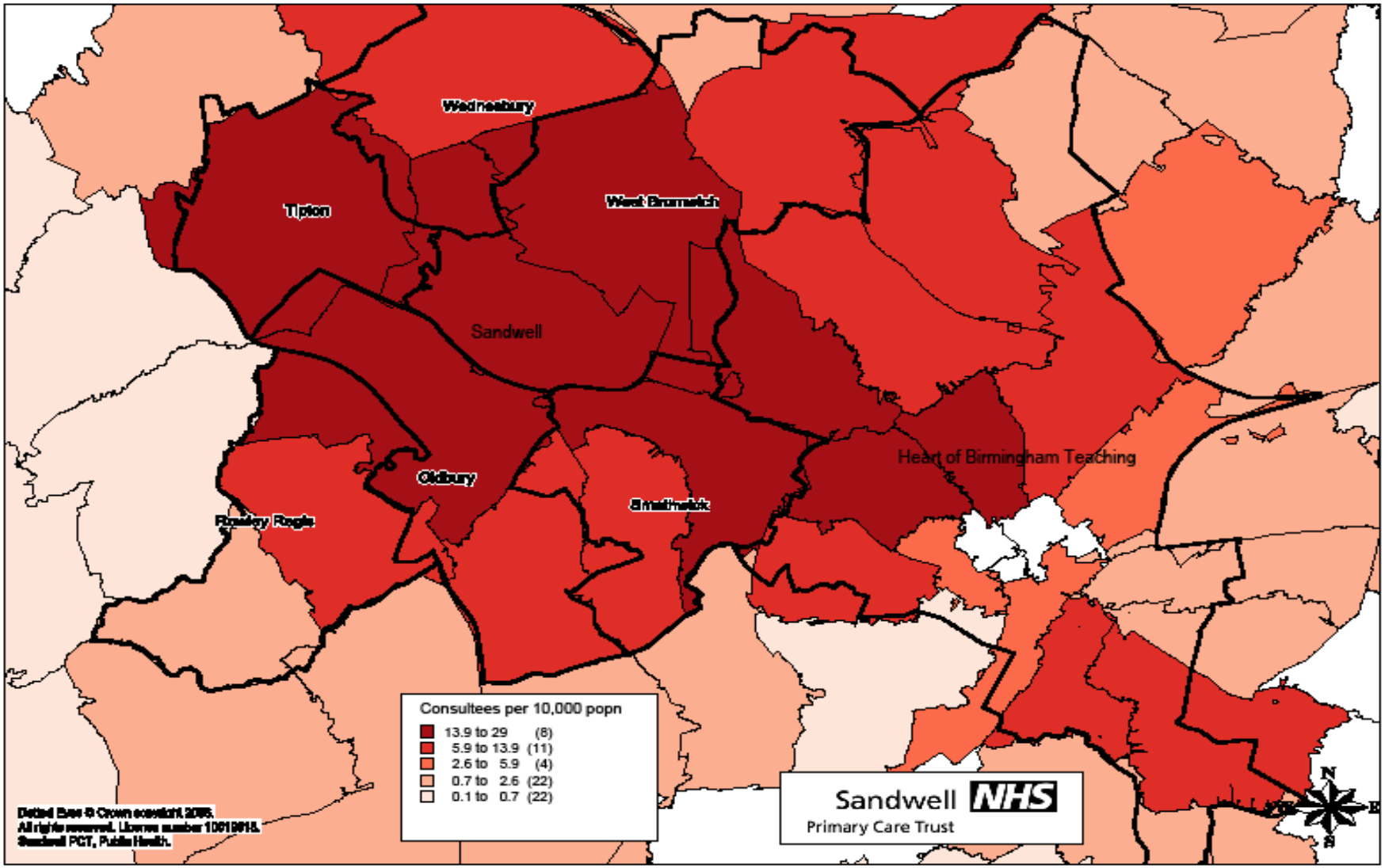
Table 2 Profile of respondents by ethnicity

Ethnic Origin	Number	Percentage	Ethnic Origin	Number	Percentage
African	31	3.97%	**Polish/ Latvian/ Eastern European**	15	1.92%
Bangladeshi	55	7.05%	**White and Black Caribbean**	18	2.31%
Caribbean	56	7.18%	**White British**	298	38.21%
Indian	82	10.51%	**Yemeni**	12	1.54%
Other*	77	9.87%	**I prefer not to say**	5	0.64%
Pakistani	113	14.49%	**No Answer**	18	2.31%

*includes Arab, Chinese, other Asian background, other black background, Irish, Iranian, a full breakdown of this category can be found at appendix 2

The maps on the following pages show response rates by ward and density.


Wednesbury
Tipton
West Bromwich
Sandwell
Heart of Birmingham Teaching
Oldbury
Rowley Regis
Number of Consultees
34 to 66 (9)
18 to 34 (7)
6 to 18 (6)
2 to 6 (26)
1 to 2 (19)
Sandwell NHS
Primary Care Trust
N


Wednesbury
Tipton
West Bromwich
Sandwell
Oldbury
Rowley Regis
Smethwick
Heart of Birmingham Teaching
Consultees per 10,000 popn
13.9 to 29 (8)
5.9 to 13.9 (11)
2.6 to 5.9 (4)
0.7 to 2.6 (22)
0.1 to 0.7 (22)
Sandwell NHS
Primary Care Trust
N

3. Option Preferences

Option 1: All births, except for home births will take place at City Hospital.

- This will include low risk births in the co-located Midwife-Led Birth Centre at City Hospital. All consultant–led antenatal clinics will take place at City Hospital, where there will also be routine antenatal clinics run by midwives, including scans.
- There would be no births or in-patient maternity care at Sandwell Hospital.
- There will be some antenatal clinics run by midwives, including routine scans at Sandwell Hospital.
- All special baby care would be provided at City Hospital.

Option 2: All births, expect for home births will take place at City Hospital. Some women with complicated pregnancies, who need specialist antenatal care will be able to get it at City Hospital.

- This will include low risk births in the co-located Midwife-Led Birth Centre at City Hospital. Most consultant–led antenatal clinics will take place at City Hospital, where there will also be routine antenatal clinics run by midwives, including scans.
- There would be no births or in-patient maternity care at Sandwell Hospital.
- There will be some antenatal clinics run by midwives, including routine scans at Sandwell Hospital and also a small number of consultant-run antenatal clinics at Sandwell Hospital.
- All special baby care would be provided at City Hospital.

Option 3: Temporarily relocate all births (normal and complicated) to City Hospital, and then set up a Community Birth Centre in Sandwell that is not attached to a hospital site.

- Routine antenatal clinics run by midwives for women with normal pregnancies will continue at Sandwell Hospital.
- Once the stand alone Midwife-Led Birth Centre in Sandwell is open, women with normal pregnancies will have the additional choice of having their babies in a Midwife–led Birth Centre in Sandwell.
- Consultant antenatal clinics and births for women with complications will all be at City Hospital.
- All special baby care would be provided at City Hospital.

Option 1 **Was the preferred option for 201 (26%) people**

Option 2 **Was the preferred option for 185 (24%) people**

Option 3 **Was the preferred option for 327 (42%) people**

24 (3%) people stated on the form that they did not wish to chose any of the above options and a further 43 (5.5%) people completed the questionnaire but did not chose an option.

Graph 1 below gives the breakdown of option choices against PCT area. A full list of postcode areas against option choice can be found at appendix 3.

Graph 1 Showing breakdown of option choice against PCT area

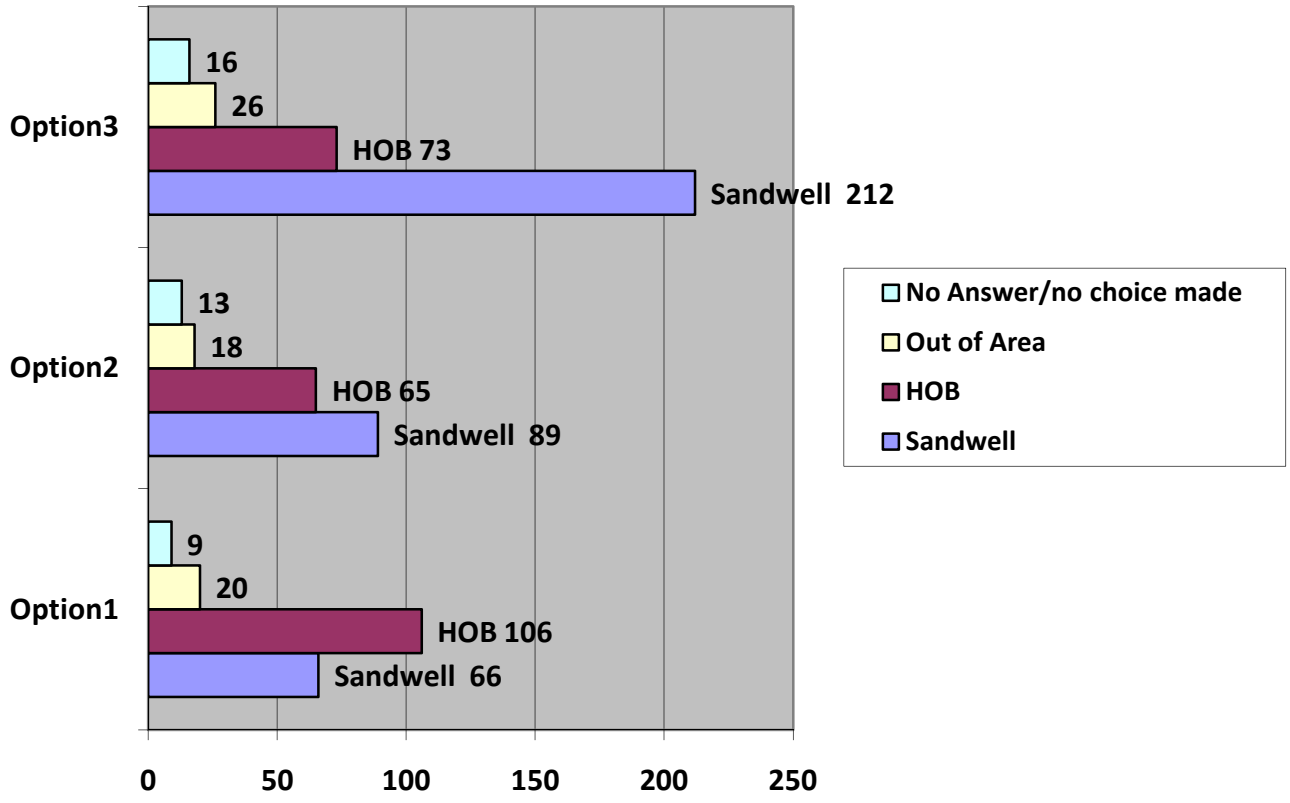


Table 3 on the following page gives a breakdown of option choice against age, ethnicity and status.

Table 3 Complete profile of respondents against option choice

Gender	Option 1		Option 2		Option 3	
Female	180	23.08%	154	19.74%	287	36.79%
Male	12	1.54%	19	2.44%	27	3.46%
Age						
under 16	5	0.64%	10	1.28%	8	1.03%
16-18	7	0.90%	12	1.54%	7	0.90%
19-29	78	10.00%	62	7.95%	124	15.90%
30-39	76	9.74%	57	7.31%	96	12.31%
40-49	19	2.44%	23	2.95%	38	4.87%
50-64	3	0.38%	10	1.28%	25	3.21%
65 or over	1	0.13%	2	0.26%	5	0.64%
Status						
Parent	115	14.74%	110	14.10%	193	24.74%
Grandparent	3	0.38%	11	1.41%	18	2.31%
Pregnant Women/Partner	49	6.28%	23	2.95%	58	7.44%
Guardian	0	0.00%	3	0.38%	2	0.26%
Completing on behalf of an organisation	9	1.15%	12	1.54%	10	1.28%

3.1 Common Concerns

Across all the options, there were a number of commonly raised concerns and these have been summarised below.

3.1.1 Travel

Travel was the most commonly raised issue for the focus groups, public meetings, consultation events and staff consultation, as well as featuring heavily in the comments made on completed questionnaires.

The key issues relating to travel are:

- The distance between where people lived and City Hospital – people made comments such as "*City Hospital is too far to travel*," and "*I do not think it would be fair to make residents of Sandwell travel to City Hospital as because of the distance to get to City from where I live it would take me longer."* And "*I think relocating all maternity services to City Hospital is impractical. Health Services are supposed to be accessible to everyone; however City Hospital is in Birmingham and not local to a lot of Sandwell patients."*

- Women were concerned about both the distance and potential travelling time when they were in pain. Comments included *"It is absurd to think that all births should take place at City Hospital. For residents of Sandwell it is too far to travel especially when you are in pain."*

- People were concerned about the time it would take to get from where they lived to City Hospital, particularly during peak travel times. Women who knew they had shorter or more spontaneous labours were concerned whether or not they would get to City Hospital in time to give birth. *"I have babies very quickly; both of my children were born in under 2 hours from the first feeling of going into labour, i.e. contractions to actual birth. The worry of having to travel to City Hospital with no transport and other children to make arrangements for really worries me."* Some women from one focus group would have liked information on estimated travelling times to City Hospital. *"We're told it is more comfortable to stay at home until the last minute, relaxing in our home environment."* Women felt this would be more difficult if they had to travel to City Hospital.

- People were particularly concerned about the time it would take to reach City Hospital in an emergency. They were also concerned about the ability of the ambulance services to cope with any increases in demand.

- The increased cost of travel was a common issue, and for younger women in particular who were concerned that they would not have enough money for taxi fares to travel to City when in labour. Women who needed or who were likely to need consultant-led antenatal care were concerned about the costs of travel to City. *"If parents-to-be have not got enough money how easily will they be able to access the hospital cheaply. Taxi and bus fares can be too expensive for some parents especially single parents*…."

- The transfer time from a stand alone Midwife-Led Unit to City Hospital for any low risk women who experienced unexpected complications in labour or delivery. Again people were concerned about how ambulance services would cope with any increased demand.

- A number of people raised concerns about the lack of public transport routes/links between parts of Sandwell and City Hospital.

3.1.2 Parking

Parking was raised as an issue in focus groups, public meetings, questionnaire comments, consultation events and through staff consultation. The key issues related to parking were mainly connected with the capacity of the City Hospital site to cope with the additional staff and visitor parking requirements.

3.1.3 Visiting

Frequently, in connection with distance and travelling times, people raised the issue of visiting times and access for visitors. Again this was raised in focus groups and in comments on questionnaires. It wasn't raised as an issue at public meetings, at other consultation events or by staff through formal consultation. However an informal consultation opportunity in November with a small group of staff did raise the issue of access for visitors.

The key issues relating to visiting were:

- Access to City Hospital. Women particularly talked about the difficulties likely to be experienced by visitors travelling to City Hospital both in terms of increased travelling time and increased or additional travel costs. Sandwell women were worried that City Hospital may be too far for their visitors to travel, and that this would reduce the number of visitors they received. Women who had already experienced complications during birth talked about how important it was for them to have their families visiting them. Women were also concerned about the logistics for partners and relatives particularly where they were trying to arrange childcare around visiting times. Women felt that other female relatives would find it more difficult to find childcare to come and visit them, given the increased travel time. *"…if women run into complications the support of their families is very important, and this will again prove hard if women give birth at City instead of Sandwell, because of the distance and other children at home and trying to fit in school runs etc as well as travelling on bus to City Hospital a 45 min bus ride away …."* Some women were concerned that people who didn't drive would find it too difficult to visit them at City Hospital.

- Visiting times. People were concerned about visiting hours at City Hospital. Some women at focus groups in the HOB area felt that visiting times at City Hospital were shorter and less flexible than at Birmingham Women's Hospital or Heartlands. Some women at focus groups in Sandwell felt that visiting times at City Hospital were shorter and less flexible than those at other hospitals.

3.1.4 Responding to increased demand at City Hospital

Focus groups, staff, comments on questionnaires and at the consultation events all raised issues relating to the capacity of City Hospital to cope with the increased numbers.

Key issues identified:

- People were concerned about the increase in the numbers of women giving birth and the impact this would have on:
    - Access to birthing pools and other choices for giving birth. Some women told us that they had not been able to have a water birth at City Hospital because of either staff shortages or the facilities were already in use by someone else.
    - Staff time and the support they are able to give to women during and following birth. Staff at City Hospital are already perceived as being over-stretched. One person commented on the questionnaire *"….. Women's care will be unquestionably compromised as there will not be enough staff to care for the women…."* Another *"if no births at SGH how will City cope? Is there enough capacity? Re discharge lounge – will partners be able to accompany mum, will there be privacy for breastfeeding mums?"* Some women commented that concerns about capacity would deter them from going to City Hospital. Another noted "*I had my son in City Hospital this year and although the service I received was great, they were overwhelmed in triage and this led to women in labour, I was one of them, waiting in a queue whilst in labour. This is not acceptable. Therefore if you are going to move the majority of facilities to City you will need to increase staffing and facilities accordingly or women and their babies will be at an increased risk."*
- Some concerns were expressed about the increased numbers of women giving birth at City Hospital and the impact this may have on support services such as catering, housekeeping, cleaning and laundry.

3.2 Comments on and views about the options

3.2.1 Option 1 and Option 2

A small number of respondents who chose options 1 or 2 made positive comments about City Hospital including:

- Satisfied parent "C*ity Hospital to me is the best hospital to have a baby. I have given all two of my children there and the service is excellent."*
- Good service in sad circumstances - *"Having recently had a stillborn baby at 40+ weeks, I still highly rate City Hospital despite our tragic circumstances. We were given so much support, especially from our community and bereavement midwives, that it really made a difference during such a difficult time. I couldn't rate City more highly and will always be appreciative of the care that we were given and continue to be given. If I have another baby I wouldn't want to have it anywhere else as I feel I know the hospital well and highly rate the staff."*
- Ease of access – "*City Hospital is much quicker for me to get to - I live in Smethwick and City Hospital is much easier."*

Focus group and questionnaire comments against both options 1 and 2 centre on the fact that both these options do not provide women with the opportunity to give birth in Sandwell. Comments made about either of these options tended to focus on the issues already identified in the key themes. Some women commented that while they liked the idea of a Midwife-Led Birth Centre it wasn't suitable for them as one person commented *"Birth Centre sounds good, but wouldn't be suitable for me so I have chosen option 2."*

3.2.3 Option 3

Many of the focus group and questionnaire comments made about this option focussed on issues already identified in the key themes.

The key issues that were identified as specific to this option are:

- People 'liked the sound' of a Midwife-Led Birth Centre, but wanted to know more about it.
- Views were mixed about whether people would prefer a stand alone Midwife-Led Birth Centre or a co-located one. However, of the people who answered the choices for giving birth question (on the questionnaire), more people preferred the idea of a co-located unit. (For more information see section 4 on page 17)
- People would like to see any community-based stand alone Midwife-Led Birth Centre built *"on a good bus route."*
- Some people really liked the idea that a Birth Centre would be more homely and felt that such a facility would be able offer more one to one attention and help.
- Others wanted to know more about the arrangements for transferring emergencies between the community-based Midwife-Led Birth Centre and a main hospital site.

"Although I have chosen Option 3 because it seems the least centralised option I do have concerns regarding distance between community birthing centre and main hospital."

3.3 Influences on option choice

The questionnaire used in focus groups asked people to identify what had influenced their choice when thinking about the three options for the reconfiguration of services. Table 4 identifies the factors taken into account. While this is limited to the people who attended a focus group and who answered this question, it is presented here as it may be helpful to understand what factors focus group participants took into account when making their option choice.

Table 4 Factors that potentially affect option choice.

Influencing factors	Number %*	Influencing factors	Number %*
It's closest to where I live	64 (43%)	I like the sound of a midwife-led birth unit	55 (37%)
It's easy to get to by car	35 (24%)	I might be able to have a baby in Sandwell	32 (22%)
I might be able to get specialist antenatal care in Sandwell	28 (19%)	It's close to relatives and or friends.	25 (17%)
It's easy to get to on public transport	24 (16%)	It has a good reputation	21 (14%)
I know people who have given birth there	15 (10%)	Other	15 (10%)
Close to work	6 (4%)		

*Percentages have been rounded up or down

3.4 The importance of giving birth in Sandwell

A small number of respondents welcomed the proposal to transfer all birth services to City Hospital. The following reasons were given:

- Dissatisfaction with standards - *"Maternity services in Sandwell are currently very poor. I am pleased that a review has been initiated."*
- Poor reputation – *"I would only ever use Walsall hospital only and would not use Sandwell hospitals as I know of too many bad experiences at Sandwell hospitals,"* and *"(My) daughter had a horrendous experience in Sandwell."*

- Bad experience – "S*andwell hospital was really bad. My baby wasn't meant to be sent home as the next day he was in hospital wiv suspected septicaemia."*

However, the majority of people in Sandwell wanted to be able to give birth in Sandwell for a number of reasons:

- Ease of access for themselves and their families - *"Sandwell covers a wide area and I feel that the option of giving birth close to where you live should be considered….."*

- Some respondents did not agree with any of the options - they wanted to be able to have children born in Sandwell. Comments on the questionnaire included *"None of the above, I would like to give birth to my baby and all future babies that I may have at Sandwell Hospital as I feel that Sandwell offers the best care….."* and *"I hope we don't lose maternity services in Sandwell. I was born in Sandwell, my children were born in Sandwell and now my grandchildren,"* and *"I haven't ticked any of the options because the outcome I want is births to continue at Sandwell…."* and "*I would want Sandwell Maternity Services to stay open as it is closer and I am comfortable with Sandwell and I know where I am."*

- Familiarity – focus group participants in Sandwell said they felt comfortable with the hospital, that they knew how to get there, that they knew the journey time and knew their way around the site. As one person commented on their questionnaire "I *am very upset to hear that Sandwell Hospital maternity and labour ward is closing down. I think that we should have an option to keep the maternity and labour ward at Sandwell Hospital, because it was close and convenient and also easy to reach for me and my family."* Another noted, "*People who have had babies at Sandwell and are happy and comfortable at that hospital, we shouldn't have to be uprooted to another hospital, being in a strange environment is going to be extremely upsetting during labour. I think we should be given the choice of which hospital we want to give birth. I am not happy with the plans. I think there is nothing wrong with Sandwell!!"*

- Across focus groups and questionnaire comments, it is clear that people feel that Sandwell is fine as it is – even when the consultation document and presentations at consultation events, public meetings and focus groups talked about issues of quality and safety. Questionnaire comments included "*I don't understand why you feel that Sandwell can't stay as it is, they do a great job. My true opinion would be leave things as they are….we are happy to stay with Sandwell,"* and "….*I would like to give birth to my baby and all future babies that I may have at Sandwell Hospital as I feel that Sandwell offers the best care, and I am aware that all of the above hospitals have a poor standard of care and attitude towards woman in their maternity departments,and some of the*

above hospitals have a high infant mortality rate, and I personally would feel safer delivering my baby in Sandwell as I would feel that I am receiving the very best care …."

- People would like to see improvements made to the existing Sandwell facilities as one person commented on their questionnaire "…*Timing is really important, being able to use the local transport or drive there yourself or be taken to hospital. Being able to walk to the hospital is needed too. I feel really upset because I was told that Sandwell hospital staying opened was not an option today. ….. We understand it needs improvement but is it not better to work with a unit that is up and running rather than starting from scratch."*

3.5 Where would you go to give birth if you were not able to have your baby in Sandwell?

The questionnaire asked Sandwell residents to tick where they would prefer to have their baby if maternity services were transferred to City Hospital. The data was filtered to ensure that only those respondents with Sandwell postcodes were included in the analysis.

Of the 404 Sandwell respondents[1] to this question:

- 119 (29%) would prefer to go to City Hospital
- 78 (19%) would prefer to go to Russells Hall Hospital.
- 67 (17%) would prefer to go to Walsall Manor Hospital
- 48 (12%) would prefer to go to Birmingham Women's Hospital
- 44 ((11%) gave no answer to this question
- 43 (11%) would prefer to have a home birth.
- 5 (1%) would prefer to go to New Cross Hospital.

Pie charts showing an analysis of each of the options against Sandwell Postcode areas and ethnicity can be found at appendix 4.

People who attended focus groups were asked to answer an additional question intended to identify what (if anything) influenced their answer to the question above. 94 people answered this question and their views are presented in table 5. Over half of respondents identified that their choice of hospital was influenced by proximity to where they lived.

[1] Percentages have been rounded up or down for ease of reading

Table 5 Focus Group Data – influences on where to go to give birth if not in Sandwell

Reason for birth choice (Multiple choice options)	Number	% of data set choosing this reason
It's closest to where I live	54	57%
It's easy to get to in a car	39	42%
It has a good reputation	27	29%
I know people who have given birth there	27	29%
It's easy to get to by public transport	18	19%
It's close to relatives/friends	17	18%
Other (not named) reasons	17	18%
It's close to work	7	7%
It's close to where my partner works	7	7%

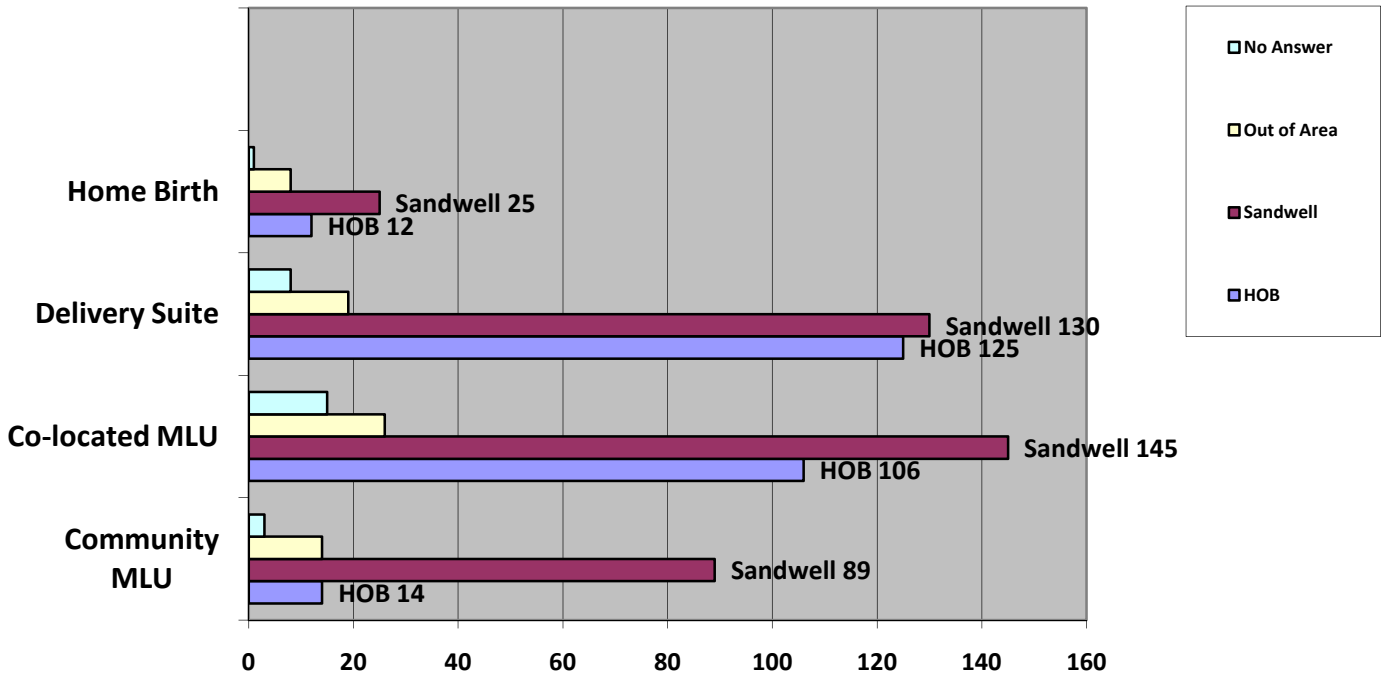
4. About Giving Birth

One of the questions in the questionnaire asked people to choose one option (from a list of 5, with the option for them to write in another choice) to indicate their preferences for giving birth.

The graph below presents an analysis of their choices shown against corresponding PCT area. A full list of postcodes and tables showing preference against ethnicity can be found at appendix 4.

Comments about both home births and midwife-led birth centres can be found on the following pages, along with factors that may influence these choices that were identified through both questionnaire comments and focus groups.

Graph 2 Birth Choices



4.1 Midwife-Led Birth Centre

Overall, women liked the sound of a midwife-led birth centre or unit (MLU), they welcomed the idea of having a more relaxed atmosphere and a more homely environment. Typical comments include: *"A midwife-led birth centre is a good idea – it would be excellent. There is more knowledge out there now about more natural births. I would definitely go for that."*
"(I) like the idea of a midwife-led birth centre … More relaxed …Good idea – but it wouldn't apply to me because I need a consultant".

Women from some Black and Minority Ethnic groups, such as Pakistani and Somali, felt that a midwife-led unit offered the opportunity for a homely women-centred environment. As one woman commented *"(I) would rather have a midwife – it's their domain*". Some women thought an MLU would offer more continuity of care: *"It is important to have a midwife who knows you – sometimes during pregnancy you can see a lot of midwives".*

Some women knew about birth centres from seeing them on television, women in the HOB area were more familiar with the idea because of facilities at Birmingham Women's Hospital. A few Sandwell women had asked about access to birth centres or water births and were told they were not available in the area. One or two had tried to use the birthing pool at City but it had been unavailable at the time. Several respondents highlighted the need for more birthing pools.

In focus groups and in comments on the questionnaire there were mixed views about whether they preferred co-located or stand alone - some women felt that it should be co-located so that they had easier access to the full range of specialist services, whilst others felt that the idea of a local level unit in the community for women without complications would be both easily accessible for women and their families and offer a comfortable place to give birth. Overall however, when asked to make a choice (though the questionnaire) over twice as many women chose a co-located unit (251) rather than a stand alone unit in the community (103).

A range of concerns were expressed about what would happen in a stand alone birth centre if women experienced complications. Some people across 6 focus groups felt it might be frightening or risky to give birth without consultants close by: *"It's frightening that there would be no medical back up and at least 30 minutes ambulance ride to a hospital."* Two Roma women said they did like the idea of a midwife-led unit but would prefer it to be co-located as they liked the idea of having clinicians around for *"comfort and support in times of danger"* and this view was echoed across most groups. Bangladeshi women in a focus group identified this as a safety issue, one woman said her sisters would be happy with Option 3, but if women "*had complications it would be sad for them because they would have to travel to City*". Generally, people did not like the idea of transferring to a hospital unit by ambulance whilst experiencing a complicated labour, for this reason several women felt Option 2 was preferable to Option 3.
One woman noted that although she had chosen Option 3 *"because it seems least centralised option,"* she did have concerns about the distance between a community birth centre and the main hospital. Another said "*City is too far, takes around 1hour, (…) It would be a nightmare to go to City. A community based birth centre would be fab."*

Many women wanted more information about MLUs – stand alone or co-located. Questions included:

- What pain relief would women be able to have at an MLU?
- Could there be an opportunity to visit a Midwife-Led Birth Centre to see what is was like?
- How long would the transfer in traffic take for Option 3?
- Do women stay at a birth centre after having baby (more recovery time) or are they discharged?
- Does the baby have a consultant check at the birth centre e.g., for clicky hips, etc?

- Would make sense to do classes at MLU too

Respondents made some suggestions relating to any proposed stand alone MLU, such as that it would need to be on a good bus route. There were also a few suggestions of combining Options 2 and 3: *"I like Option 3 but not the idea of splitting antenatal services and specialist clinics. I wouldn't want to keep going to different locations".* And *"Wouldn't it be better if Option 3 still had a consultant antenatal clinic at Sandwell?"*

4.2 Home births

On the whole, most women across all groupings had not considered a home birth as an option, even though most knew it might be possible. One young parent said she had thought about it because she doesn't like hospitals, but decided she had not got enough space at home. Another woman said that a home birth would be fine if you lived close to the hospital but that it would take too long to get to City if complications arose.

Some women said that they would choose a home birth over other hospitals, if Sandwell were to close. One woman had wanted a home birth but had ended up giving birth in Sandwell because her baby was breech. Her original midwife had not been supportive about having a home birth so she had changed midwives. She will try for a home birth next time. Another woman had a friend that had a home birth for her fourth child but would not consider for her first. Another said:

"I received excellent care from both my community midwife and the team at Sandwell General Hospital when I gave birth to my son in November 2009. As it was my first child, I did not go for a home birth, but would seriously consider it next time if there were no health issues."

Some migrant women who responded to the consultation, such as Roma women and Yemeni women did not think home births were a good idea; they had experienced home births in Romania and the Yemen and preferred to be in hospital. Somali women sometimes have complicated births due to Female Genital Mutilation and the view from the focus groups was that they would not have home births in their community.

4.3 Factors that may influence where women give birth

Analysis of both focus group data and comments on the questionnaires identified a number of key themes that influence where women (and their partners) choose to give birth.

- Travelling times and distances both for themselves and for any potential visitors.
- Cleanliness and hygiene, for example sheets changed regularly, bins emptied and shower and toilet facilities been kept clean.

- Reputation of the hospital amongst friends, family and the wider community. A small number of people commented that prior to making a choice about where to give birth they had read online reviews about a number of maternity services locally.

- Safety, knowing that support was on hand, the delivery suite had easy access to doctors and medical facilities – so that women felt confident that should any unexpected complications arise they know that they will be dealt with.

- High quality care with supportive and attentive staff, this was typified by comments that discussed:

    - The need for expert and skilled staff, well trained and well resourced.

    - Staff who listen to women and their partners, who have time to explain things to people in a way they can understand, who are respectful of people and who are able to show cultural sensitivity and have a positive attitude to people who speak English as an additional language.

    - Being given good and timely information about progress and being told what is happening and why.

    - A welcoming atmosphere.

    - Everyone being treated as an individual.

- Comfortable surroundings, that are homely and not too clinical, but that are also open and spacious. People would like to be able to make their own drinks and to have their own shower and toilet facilities. Some women would prefer to have these facilities in their own room, whilst others would prefer to be on a small ward and to have people around them.

- Support for breastfeeding, women would like more information about breastfeeding while they are pregnant and more support from midwives to help them breastfeed. Some women commented that *"Breastfeeding is not always encouraged and you have to ask about it. The staff are too quick to give bottles if you are having a few problems rather than persevering."* Women from Bangladeshi and Pakistani communities in particular highlighted this as an issue. They felt that midwives did not have the time to encourage women to breastfeed. An older woman talked about the support she was given to breastfeed and the time that the midwife had spent with her helping her to wrap her breast so that she could do it very discreetly and relieve some of her physical discomfort by supporting the breast with the wrapping. She felt that midwives didn't have this sort of time any longer and that this lack of time contributed to women not breastfeeding.

- Flexibility and timing of visiting hours with partners being able to stay all day or visit at any time during the day.
- Being offered a range of choices about how to give birth, including options on birthing positions and access to specialist equipment such as a birthing pool.
- Continuity of care, particularly for first time mums.

5. Thematic Analysis

5.1 Young People

Young people (identified as those people who are either under 16 or aged 16 -18) made up just over 7% of all respondents with 56 completing the questionnaire.

Of this 56:

- 47 were young women
- 7 were young men (2 people did not answer this question)

As can be seen from table 6 below the majority of the young people were either already parents or about to become parents.

Table 6 Status of young people completing questionnaire

Status	Number
Completing on behalf of an organisation	7
Guardian	1
Parent	25
Pregnant women/partner	9
None of the above	3
No Answer	11

Young people preferred option 2 with:

- 12 people choosing option 1
- **22 people choosing option 2**
- 15 people choosing option 3
- 2 people didn't chose any of the options
- 5 people gave no answer to this question

5.1.1 Comments on the options

Generally, young people in focus groups felt City Hospital was too far away from a lot of parts of Sandwell and parts of the heart of Birmingham and this was specifically mentioned by the young men at a focus group in Sparkhill. There was a general concern that all the options would put increased pressure on City Hospital.

The comments by young people on questionnaires were generally in favour of retaining services in Sandwell or against going to City: *"It is important to give moms to be a choice. I now live in Sandwell so I thought I'd like my next child at Sandwell Hospital - as my pregnancy would be more than likely consultant led due to me having cholestasis, that would mean going to City, which I would NOT want to do. Hence I would get a choice via 'choose & book' & opt for Birmingham Women's any day."* Another commented *"I want to have my child at Sandwell hospital"* and another said *"I do not want to have to go to city to have my baby thank you very much."*

One group of young people discussed the importance of having Sandwell Hospital as a choice, saying they would like to have the option to give birth where they, or a family member, had been born. Young women said (in their experience) not everyone is offered a choice of hospital. The general view about a stand alone MLU was that it might be frightening or risky if consultants are not close by. Some young women did identify a need for more birthing pools and stated a preference for having their own room.

Generally, young people want good support during labour/birth, with regular checks to provide re-assurance that everything is going well, *"someone should check up on her"* (young man),

5.1.2 Issues raised by young people

Transport and Access

Like most respondents, young people/parents were concerned about difficulties in getting to City Hospital, in particular for friends and family. Young people clearly identified the need for support from their partners, family and friends during pregnancy, labour and birth and want the hospital to be easy for them all to get to.

Parking was a big concern, with worries that there wouldn't be enough parking at City if Sandwell closed and that *"it would be expensive (to park) if the woman has a lot of antenatal appointments"* (young man in focus group). One suggestion was that *"they could put a couple of parking vouchers in the bounty pack"* (young person in focus group).

Flexible visiting arrangements were important to young people. Both young women and young men want partners to be able to stay all day. One young man said: *"It's a good feeling when you have your first-born, (you) would want to be with your son or daughter".* Young men in a focus group mentioned that the '2 visitors to a bed' restriction can be difficult for big families. Young women want their families to be able to visit.

Attitudes to young people

Strong views were expressed in focus groups by young women who had experience of maternity services at City Hospital. They commented that staff were neither helpful or polite - especially to younger women. Staff were described variously as being impatient with younger women and not treating them with the respect older women get.

Young parents want staff to answer questions and respond (positively) to requests for reassurance. Young people said it was important that staff are helpful, supportive and sympathetic.

Young men strongly expressed their wish to feel welcomed and involved in the maternity unit, not *"ostracised, ignored or stigmatised"* They said they would want to be involved all through the pregnancy and one said some fathers might feel scared to be at the birth (and would need support).

5.2 Men

63 men completed and returned the questionnaire. As can be seen from table 7 below the majority of the men who responded were either already parents, or had a partner who was pregnant.

Table 7 Showing status of men who completed questionnaire

Status	Number
Completing on behalf of an organisation	1
Grandparent	2
Parent	32
Pregnant women/partner	10
None of the above	9
No Answer	9

Men preferred option 3 with

- 12 men choosing option 1
- 19 men choosing option 2
- **27 men choosing option 3**
- 1 man did not choose any of the options
- 4 men didn't answer this question

5.2.1 Comments on the options

Some fathers in Sandwell preferred not to choose an option on the questionnaire as they felt strongly that services should remain in Sandwell and made comments such as *"None of the above as my wife has had all of our children at Sandwell and that is the way we would prefer it to stay, as at Sandwell we know she is well cared for as is our baby and that she is safe during her labour, thanks."* Another said *"None of the above, I would be happier if my daughter could give birth in Sandwell as she wants to,"* and *"I want my wife to have the baby at Sandwell as it is a better hospital in my opinion."*

In contrast, fathers at a Children's Centre stay and play focus group in Sandwell unanimously expressed the view that it was not important for births to take place in Sandwell, as safety was their prime concern. Interestingly they were the only group to express this view.

5.2.2 Issues raised by men

Choice

A recurring view from men was that it is important to have a choice where to give birth, as one commented on the questionnaire: *"As an expectant father I would not be happy at the prospect of travelling to City (would be much more inclined to travel to Walsall Manor). I understand the need to have everything under one roof logistically, but feel that this should be located more centrally to allow ALL people in Sandwell fair access to the unit. I fear that many births will now move away from the unit, with people choosing Walsall Manor or Russell's Hall instead. My overriding feeling is that there is no choice. The decision has already been made".*

Men in focus groups mentioned that online reviews and feedback on hospitals had informed their partners' choice of where to go to give birth. Sandwell and City both had poor reviews, whereas Russells Hall and Birmingham Women's both had good feedback from patients one man commented *"Would not use City, crossed it off list last time because of online reviews."*

Most men concurred with the view that City Hospital was too far to travel and inconvenient for families, particularly non-drivers: *"I think relocating all maternity services to City Hospital is impractical. Health Services are supposed to be accessible to everyone; however City Hospital is in Birmingham and not local to a lot of Sandwell patients."* And *"City would be last choice*" (father in Tipton).

Facilities

Men feel it is important to have comfortable, spacious rooms for giving birth, that have facilities for making drinks/seating/shower for example. Several mentioned the need for more birthing pools, especially if more women would be coming into City Hospital from Sandwell.

Staff

Men reported that it is important that staff are helpful, supportive, sympathetic and give a good standard of care. They also felt that there should be adequate resources and that staff had time to give women individual support and attention. Men expressed a range of views all of which identified that women should be properly looked after and attended to.

Home Births

Men expressed number of opinions about home births. Some focus group participants felt that home births would be fine, as long as the hospital was not too far away, and they felt City Hospital would be too far. One man expressed the view that if Sandwell wasn't available, a

home birth would be the only option. Other men felt that a home birth would be too dangerous and scary. One man shared his experience of a hospital birth *"It is reassuring to have Consultants around. My wife had complications and the Consultants were very professional and helpful."*

Being Involved

There was a general view from men that they want to be included in their partners' pregnancy, during labour and at the birth. Some said it is important for people (men and women) to be involved in decision making during labour and birth. Also, there were some strongly expressed views by both fathers and young men at the two focus groups that men should not be 'left out' or ignored by maternity staff, or stigmatised. Young men in particular wanted to be able to stay all day with their partner.

Suggestions

Men identified the need for counselling and/or follow up services for women after a miscarriage or stillbirth. Young men identified the need for parent craft classes.

5.3 Responses by ethnic grouping

Responses from ethnic groups have been summarised to highlight where views appear specific to that group. The general views across all responses have not been highlighted except where they are particularly strongly expressed. They are presented in order of sample size and questionnaire comments have been supplemented with focus group information where this can be accurately attributed.

Issues of common concern across Black and Minority Ethnic (BME) groups included the need for family to be able to visit easily to provide support to the pregnant woman/new mother; the need to be consulted effectively on their own care, through an interpreter if necessary ("*There … needs to be better access to language interpreting services - particularly on labour wards and in emergency maternity")*; and the need for continuity of care – seeing the same professionals for appointments and being familiar with the place where they will give birth – as this inspires confidence and helps women and their families to feel they are in safe hands.

White British

50% of White British respondents chose Option 3

The majority of comments made on questionnaires reflect the key themes from the consultation as a whole with people being opposed either to losing services from Sandwell hospital or to moving services to City, chiefly because it is too far and difficult for patients and visitors to get to.

Pakistani

44% of Pakistani respondents chose option 1 (with option 3 at 29%)

The majority of comments on questionnaires supported the retention of maternity services at Sandwell Hospital and there appears to be a common view about services being local and accessible and of people having a feeling of ownership: *"I think a community based midwife-led birth centre and an opportunity to give birth at home are options that my family, sisters, sisters in law, will be OK with but we would love for our local Sandwell hospital to stay opened."*

The main concerns were around the additional pressures the changes will place on City, respondents commented that City was already very busy and wondered if they really would be able to cope with the additional women.

Respondents from one focus group felt that the language barriers presented difficulties at City hospital and they would like staff to *"show an understanding of my culture"* or to have staff who speak their language so that their lack of English isn't a barrier to accessing good support and good services. They identified a need for attentive staff who listened to the women, tried to understand what they were saying and provided reassurance. One person commented: "*the Asian community doesn't complain about poor service – it's not part of our culture – but we do share that information between ourselves*". Another said "*any comments good or bad do get spread across the community and City Hospital you hear such bad things about the level of care".*

One respondent expressed the need, which may be culturally appropriate, for separate toilets for men and women on labour wards at City Hospital and focus group members requested more Asian food options on the menus.

Indian

39% of Indian respondents chose option 3 (with 31% choosing option 2)

A high proportion of respondents were in the Handsworth area, with a further significant cluster around West Bromwich.

Indian respondents raised concerns about the logistics of managing the transition to City; they were concerned about pressures on staff, ambulances and parking expressing the view that the options for change reduced women's choices. One respondent suggested the need to:
"escalate the development on community services – supporting women closer to home".

Black Caribbean

The split on options for Black Caribbean respondents was between option 1 (34%) and 2 (32%)

This is not surprising as a high proportion of respondents in this grouping live in the HOB area around Winson Green/Handsworth, close to City Hospital, and is therefore unlikely to be significantly affected by the closure of the Sandwell site. People who did comment on the questionnaire, therefore, tended to be those from Sandwell who were opposed to the closure of that site or did not want to go to City. Some people felt the options were geared towards a foregone conclusion.

One person expressed the need for a facility for water births in Sandwell. One Black Caribbean focus group member made the following point: *"Pregnancy is a natural thing and not an illness and this should be promoted more especially to mothers from an ethnic background as they often see pregnancy as an illness".*

Bangladeshi

The split against options was divided for Bangladeshi respondents. 33% chose option 1 and 22% option 3, but there were a group of 16 women (29%) from one focus group who chose 'none of the above'

There was a high degree of consensus in this focus group that they did not want to see labour wards transfer from Sandwell to City hospital and they were disappointed that all three options involved this. It was evident that many of the women had come to the focus group in order to lobby to retain current services at Sandwell, and the high turnout at the session (c. 30 participants) was indicative of the strength of feeling in their communities. People from this group had lived in West Bromwich for a long time and felt comfortable with Sandwell Hospital, knew the staff etc.

In common with the Pakistani grouping, respondents from a focus group shared their perceptions that *"people who don't speak English very well are not always treated well"*. They felt it was important that staff treat them with respect and that *"staff … are patient with people who don't understand what they are saying".*

In relation to the language barrier, respondents explained that people who needed an interpreter often have access to a range of people locally, but the further they have to travel for appointments, the more difficult it may be to find someone to go with them. One woman said she often acts as an interpreter to her sisters and sister-in-laws, but wouldn't be so able to do so if she had to go over to City as it would take more of her time up.

Another particular theme for this grouping was the need for continuity of care: *"It's important to have continuity of health workers to give mothers confidence. Seeing the same midwife and*

doctor during your pregnancy puts your mind at rest and you have trust in them. Also I can only speak from my community but mothers with ethnic backgrounds have difficulty interacting with different people and get confused and lack confidence to ask questions". Women in one focus group commented how difficult it was to have to keep explaining the same things time and again to different midwives.

One focus group participant felt it was not appropriate to wait a long time in a triage room (with male partners of other women) when in labour.

African

Overall, 48% of African respondents preferred option 1

Most African respondents live within relatively easy reach of City Hospital, including a cluster in Smethwick, mostly made up of Somali women. There are 2 specific comments from other African respondents, one happy with City and the other happy with the status quo.

<u>Somali women</u>

The need to engage the Somali community in the consultation was highlighted in the pre-consultation Equalities Impact Assessment. No-one identified as 'Somali' on questionnaires so Somali respondents may have identified as 'African'. 7 women from Somalia attended a focus group, all had children, and some had given birth at City Hospital and some at Sandwell. The general feeling from this group was that Sandwell had a better reputation in the Somali community than City Hospital, especially when catering for women who did not speak English fluently and couldn't communicate their needs. One woman who had delivered at both City and Sandwell found staff at Sandwell to be more helpful, they gave her more attention and consulted her more. Her experience was that at City people just made decisions for her. What was important for her was being treated with respect and consulted about decisions affecting her. Other women in the group agreed that although City was closer and Sandwell more difficult to access on public transport, City had a poor reputation in the community.

Women knew they had choices about whether or not to have a natural birth but their view was that if things go wrong, the doctor decides what to do. The group explained that nobody in the Somali community has home births. FGM (Female Genital Mutilation) is an issue in the community which brings with it a higher risk of pregnancy and birth complications and this is why women do not choose to have home births.

There was a consensus in the group that Option 3 would be their preferred option. As a group they had mainly had normal births and would prefer a separate site with just midwives. The group felt that people with complications should be in hospital but for everyone else all they need is a midwife. Option 2 was seen as being their second choice.

White and Black Caribbean

This grouping was split between option 2 (44%) and option 3 (38%)

One respondent was concerned about the impact of the impending changes on staff morale and, consequently, levels of patient care.

Polish/Latvian/Eastern European

66% of Polish/Latvian/Eastern European respondents chose option 3

Yemeni

66% of Yemeni respondents chose option 3

The need to secure views from the Yemeni community were highlighted in the Equalities Impact Assessment. The majority of respondents were located in West Bromwich. The most important issue raised in questionnaire comments was about the cost of transport to City, particularly for non-car owners dependent on taxis, a shuttle bus was suggested by two respondents. The need for interpreting services was also mentioned.

Women from Yemen in a focus group were aware of the choice between home births and hospital births, but their experience of home births in Yemen was not good, so they preferred to be in hospital.

Women from this community would like to visit a Midwife-Led Birth Centre and to be able to find out more about it.

6. Stakeholder Views

The following groups provided written responses to the consultation:

6.1 The Right Care Right Here Partnership Board response to the consultation noted that:

"There was general support for the proposals in the consultation document, requiring the rationalisation of maternity services, with the consolidation of the majority of services onto one hospital site."

In the comments (which can be found in full at appendix 5) the Board noted that the whilst the presentation they were given and the information about the options clearly indicated that services would be consolidated at City Hospital there was insufficient detail as to why such as consolidation could not occur at Sandwell. They also noted that there was no detail relating the 2007 Users Survey which *"indicated that the service was judged to be 'least well performing' and that service users were unhappy about the quality of care provided."*

6.2 Sandwell LINks Health Subgroup (LINks) in their formal response to the consultation recommended that:

"The transport needs of Sandwell women receiving services from City Hospital needs greater consideration, especially for those who are classified as high risk. Changes that take place now should be sustainable after the opening of the new hospital in 2015. If option 3 is selected as the best option then it must be ensured that the stand alone unit is in a central point and have good transportation links."

In their response LINks also raises a number of concerns (which along with the recommendations can be found in full at appendix 6) namely:

- The impact moving services will have on the morale of both staff and Sandwell as a town.
- About what support would be put in place in terms of transport – particularly for *"those women who were considered to be at risk*."
- These are interim proposals does this mean that services would change again after 2015.

In addition to these concerns the response also notes that for some Sandwell residents City Hospital is closer than Sandwell.

6.3 The Joint Health Scrutiny Committee through the minutes of their meeting on 7th January 2010 made the following resolution:

"Whilst the Joint Committee would ideally have preferred that full maternity provision would remain at Sandwell, in light of the evidence which it had received regarding maternity services it supported the adoption of Option 3 of the public consultation document "Improving services for giving birth" which is "temporarily relocate all births (normal and complicated) to City Hospital and then set up a Community Birth Centre in Sandwell that is not attached to a hospital site" with the with the caveat that the Midwife-led Birth Centre be built and be operational in Sandwell before maternity services are withdrawn from Sandwell Hospital."

The resolution (which can be found in full at appendix 7) also goes on to say that if this resolution is not supported by the Board of Sandwell PCT, the Joint Committee "*is minded to refer the matter to the Sectary of State for Health"* and identifies the grounds on which it would do so.

6.4 Other Stakeholders – Sandwell

The Public and Patient Involvement team at Sandwell PCT provided questions and comments sheets from presentations given to the following:

- Community Health Network.

- Labour Party Constituency Meeting.
- Patient Experience Forum which included representatives from the patient experience fora and local voluntary organisations.
- A Women's Group at Sandwell College of Adult Learners (at a session in Cape Primary School).
- Voluntary Sector Organisations event.

The key themes arising from these groups are:

- The ability of City Hospital to cope with increased demands for beds, facilities such as birthing pools and car parking which was mentioned by 3 of the groups.
- The distance some women may have to travel to City Hospital was an issue for 2 of the groups.
- Staffing - with questions about access to training for midwives, the working time directive and staff numbers being asked across 3 of the groups.

The Sandwell Patient Experience Forum through their questionnaire response noted: *"We agree with the proposals 1 & 2 believing option 3 to be too risky of things (going) wrong. Option 2 is preferred by the membership and we accept that services at City are superior to Sandwell. We are concerned that an increase from 4k to 6.5k births at City will put extra pressure on soft facilities such as parking, catering etc. We accept that the clinical increase at City may be well covered but access to City for visitors (particularly evenings & weekends) is poor from many areas previously accessed at Sandwell."*

6.6 Other Stakeholders – Heart of Birmingham

The Public and Patient Involvement team at HOBtPCT provided information on the key themes arising from presentations given to the following:

- Arya Samaj a city-wide Hindu organisation.
- Aston and Nechells Patients Network.
- Ladywood and Summerfield Patients Network.
- Lozells and East Handsworth Patients Network.
- Lozells and East Handsworth Ward Sub Committee.
- Soho Patients Network.
- Soho Ward Sub Committee.
- Soho Finger and Gib Heath Neighbourhood Forum.
- Sparkbrook Ward Sub Committee.
- Third Sector Assembly – voluntary and community organisations.

In addition, members of the PPI team attended the Newtown Neighbourhood Management Programme Open Day.

The key themes arising from these meetings were:

- The ability of City Hospital to cope with any additional demands.
- What will happen to existing staff?
- Concerns about travelling times particularly in emergencies.
- Concerns that *"New communities don't understand current system let alone a community birth centre model."*
- How will patient experience issues be dealt with?
- How is the review going to deal with the high infant mortality rates.
- Why can't services be kept at both sites?

6.7 Staff engagement

This section contains the report on Maternity Staff Engagement Events conducted by Sandwell and West Birmingham Hospitals NHS Trust.

Introduction
A number of staff engagement events were held within SWBH NHS Trust as part of the public consultation process for 'improving services for giving birth'. The events were held on both City and Sandwell Hospital sites in November 2009 and followed on from staff engagement events held in the pre-consultation phase of the review. The 3 main events were open to all staff and run by the Trust Service Redesign Team in co-operation with the Divisional Management Team for Women's Services. In addition smaller specific events were held in December and January with staff from the Imaging Department, the Maternity team based at Sandwell and paediatric consultant staff.

Purpose
The purpose of the events was to seek the views of staff regarding (i) the three short listed service options for Maternity Services, (ii) ascertain their views on how the Trust might manage the medium term transition of services and (iii) how staff want to be engaged in the process of planning implementation of the changes.

Attendees
Over 70 staff attended the staff engagement events with representation from the wide range of professional groups and specialities involved in delivering maternity services. The table below shows this representation in more detail.

Role	Number of Attendees	Specialities
Consultants	16	Obstetrics, paediatrics, anaesthetics, neonates
Junior Doctors	12	Obstetrics, anaesthetics
Midwives	19	Maternity – including matrons, students, managers
Nurses	3	Neonates, gynaecology
Health Care Assistants	5	Maternity
Sonographers and other Imaging staff	12	Imaging
Administrative staff	7	Receptionists, ward clerks, co-ordinators

Key Findings

Most staff remain very positive and enthusiastic about the plans to join up the services and believe that, in addition to improving services to women, this will offer staff more career opportunities, as long as issues relating to the changes are managed sensitively.

Staff raised some important issues and they had some positive ideas and contributions to make as to how issues should be managed and resolved.

The main issues raised include:

- **Loss for Sandwell mothers** – some staff felt Sandwell mothers will feel let down if they are unable to give birth in Sandwell and that some will therefore choose to go elsewhere to have their babies.
- **Communication** - this is very important to staff, who are keen to ensure that all information should be available to both staff and local women at the same point in time to avoid discrepancies.
- **Staff support** - all groups of staff raised the need to ensure support is available to help them through the anxieties they have about the changes all options would involve to their working practices. These anxieties include having to work in a new location, different shift patterns, working with a new team of colleagues and whether the changes would affect their job security.
- **Travel, transport and parking** – is a major concern for many Sandwell staff from both a patient and staff perspective. This included the ability to travel to City Hospital by public transport and being able to park at City Hospital if they drive.
- **Capacity** - staff stressed the importance of having enough birth rooms, in-patient beds, neonatal cots and ultrasound machines for all the activity that will be concentrated at City Hospital.
- **Students** – staff are keen to ensure that any new service model provides good training opportunities and experience for students in all the professions involved in delivering

maternity services (e.g. midwives, doctors in obstetrics and anaesthetics, sonographers etc).

Next steps in staff engagement:
Information gathered at the staff engagement events will be used in the planning process for implementing changes once the preferred option has been agreed. This will include developing action plans for the main issues raised by staff.

Strong staff engagement will be central to this planning process in order to ensure the successful implementation of change and delivery of the new service model. A variety of ways of engaging staff will be required and will be based on the suggestions made by staff as part of the consultation process.

Conclusion

This independently produced report presents the findings from the consultation and as such it includes a representative selection of the comments and opinions expressed during the public and staff consultations on the proposed medium-term changes to Maternity Services in Sandwell and West Birmingham, together with the views of other stakeholders. It does not speculate upon the reasons for the views given, other than those stated by respondents, it simply presents a balanced summary of the responses received.

Merida Associates
February 2010

Appendix 1 Focus groups and public meetings

Focus Groups

3rd Nov	10-12 pm	Sure Start Smethwick Uplands Children's Centre	Sandwell
4th Nov	9 -11.00	Sure Start Friar Park	Sandwell
9th Nov	9.30 - 11.00	Wednesbury North Children's Centre	Sandwell
9th Nov	1.00 - 2.30	Cherry Orchard Primary School and Children's Centre	HOB
10th Nov	9.00 - 11.00	Galton Valley Children's Centre	Sandwell
12th Nov	10 -12.00	Ileys Community Association Smethwick,	Sandwell
12th Nov	1.00 - 2.30	Greets Green Children Centre	Sandwell
16th Nov	10.00 - 11.00	Greenacres Children's Centre	Sandwell
17th Nov	2 -00 - 3.30	Ashiana 21-25 Grantham Road Sparkbrook	HOB
27th Nov	10.11.30	Bright Futures Children Centre	Sandwell
30th Nov	9.30 - 11.45	Sure Start Tipton Children's Centre	Sandwell
30th Nov	4.00 - 6.00	Parent Education Centre, 1st Floor Maternity Unit City Hospital	HOB
3rd Dec	1.00 - 2.15	6 Ways Children's Centre	HOB
9th Dec	9.30 - 12.00	Hillside Children's Centre	Sandwell
10th Dec	10.00	Roma families - ASDA coffee bar Smethwick	Sandwell
11th Dec	11.00 -12.30	Confederation of Bangladeshi Organisations (CBO)	Sandwell
11th Dec	10.12.30	Great Barr and Hamstead Children's Centre	Sandwell
15th Dec	2.00 -3.30	Concord Youth Centre Young men's groups	HOB
11th Jan	10.00 – 12.00	North Smethwick Resource Centre	Sandwell
11th December	10.00 – 12.00	Sparkhill Women's Centre	HOB
16th Jan	11.00 - 1.00	Burnt Tree Children's Centre dads group	Sandwell

Public Meetings

28th Oct	6.00pm	Salvation Army Centre Cradley Heath	Sandwell
11th Nov	6.00pm	Medical Education Centre Sandwell Hospital	Sandwell
14th Nov	1.00pm	Laurel Road Sports Centre	HOB
26th Nov	6.00pm	Summerfield Centre	HOB
2nd Dec	1pm	Mu'ath Trust	HOB
2nd Dec	6pm	New Testment Church of God Dudley Port Tipton	Sandwell
8th Dec	10.30	ASRA	Sandwell

Appendix 2 Profile of respondents by ethnicity – breakdown against the 'other' category

Ethnic Origin – Other	Numbers
Anglo-Arab	1
Arab	3
Asian British	1
Bosnian	1
Canadian	1
Chinese	6
English	2
Iranian British	2
Iraq	1
Irish	9
Moroccan	1
No Answer	1
Other Asian Background	12
Other Black Background	10
Other Mixed Background	7
Other White Background	5
Romanian	1
Spanish	1
Turkish	1
White and Asian	6
White English	1
White South African	1

Appendix 3 Tables to show postcode[2] against option choice

SANDWELL

Postcode	Area	Option 1	Option 2	Option 3
B43	Great Barr	8	4	1
B64	Cradley Heath		1	
B65	Rowley Regis	2	5	7
B66	Smethwick	15	14	17
B67	Smethwick	5	7	16
B68	Oldbury	4	4	17
B69	Oldbury	2	9	21
B70	West Bromwich	8	15	29
B71	West Bromwich	8	14	36
DY4	Tipton	10	10	35
WS5	Tamebridge / Yew Tree/ Bescott	1	1	1
WS10	Wednesbury	6	5	22
	TOTALS	**66**	**89**	**212**

HOB

Postcode	Area	Option 1	Option 2	Option 3
B1	City Centre/Ladywood	1		
B2	City Centre/Ladywood			
B3	City Centre/Ladywood			
B4	City Centre/Ladywood			
B5	Digbeth			2
B6	Aston	9	5	2
B7	Nechells	2		
B8	Washwood Health/ Saltley/Ward End*			1
B9	Bordesley Green	1		1
B10	Small Heath	2		1
B11	Sparkhill/Tyseley	3	7	13
B12	Balsall Heath/Sparkbrook	2	3	3
B13	Moseley		1	4
B15	Edgbaston/Chad Valley	1		
B16	Edgbaston/Ladywood	5	7	7
B17	Harborne*	2		1
B18	Winson Green	10	5	3

[2] Postcodes taken from Sandwell PCT Map – postcodes covering Sandwell and HOB PCT's [2] Please note there is some very small overlap of postcodes between areas in B71and B18, B43 and B66 postcodes

Postcode	Area	Option 1	Option 2	Option 3
B19	Lozells/Newtown/Birchfield	19	5	4
B20	Birchfield/Perry Barr	13	13	6
B21	Handsworth	16	10	15
B23	Erdington/Short Heath*	6	5	
B24	Erdington/Tyburn*	1	1	1
B42	Perry Barr/Great Barr/Hampstead	6	2	6
B44	Perry Barr/Kingstanding/Great Barr	6	1	1
	TOTAL	**106**	**65**	**73**

*Very small parts of these postcodes are in the HOB boundaries but have been included for completeness

Appendix 4 Where would Sandwell women go to give birth if Sandwell Hospital MU closed. Based on 404 Sandwell only responses.

Preference	Totals (Numbers)	Totals (%)
Birmingham Women's Hospital	48	11.88%
City Hospital	119	29.46%
Home birth	43	10.64%
New Cross Hospital	5	1.24%
Russells Hall Hospital	78	19.31%
Walsall Manor Hospital	67	16.58%
No Answer	44	10.89%
Total Sandwell Responses	404	100.00%

City Hospital No. of women 119 (29.46%)

Chart 1 : Women who would go to City Hospital by postcode

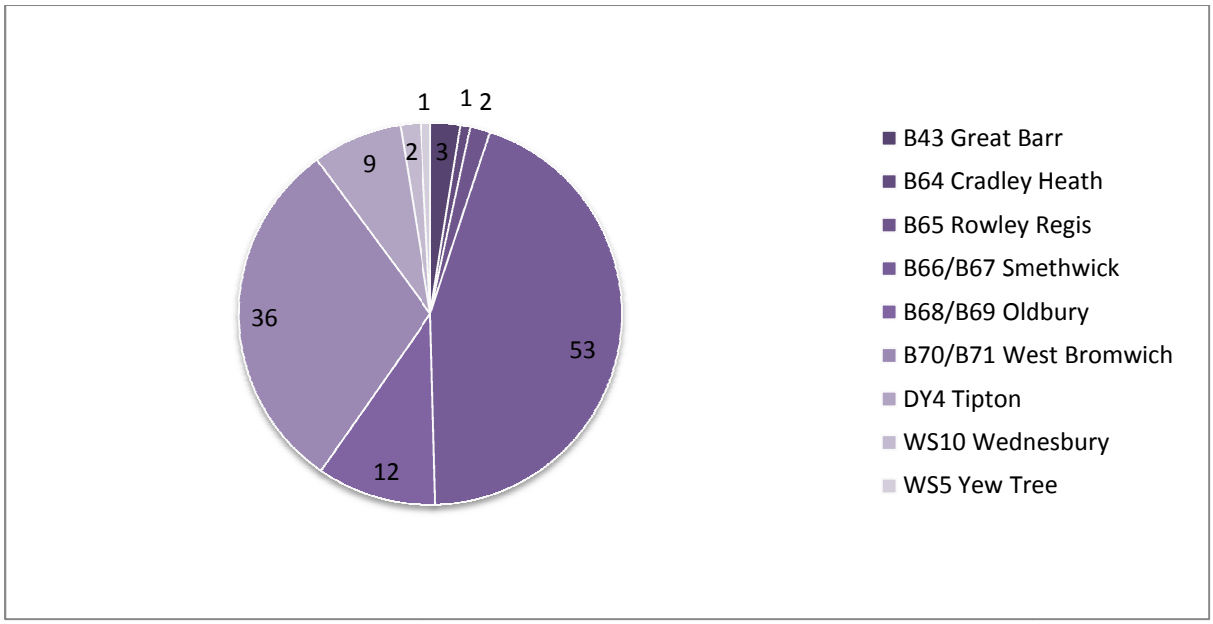
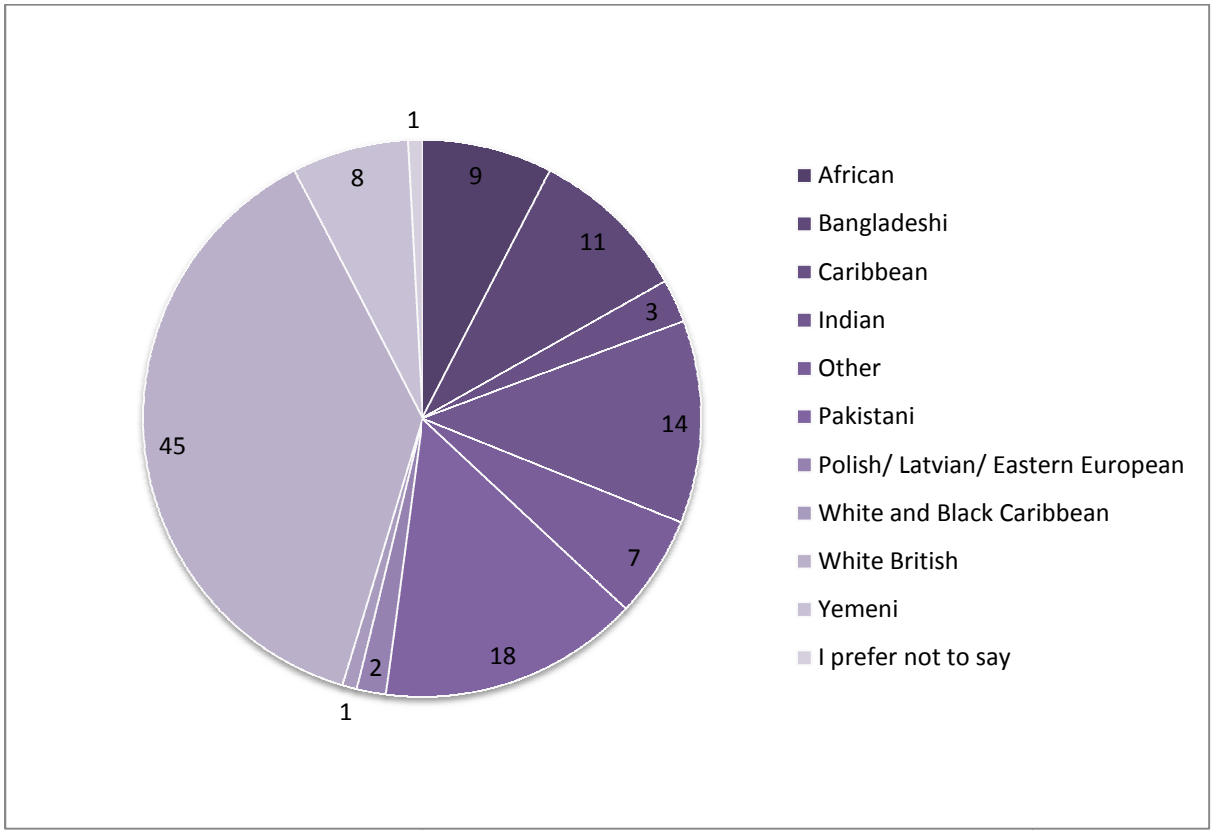


Chart 2: Women who would go to City Hospital by ethnic grouping



Birmingham Women's Hospital No. of women 48 (11.88%)

Chart 3 : Women who would go to Birmingham Women's Hospital by postcode

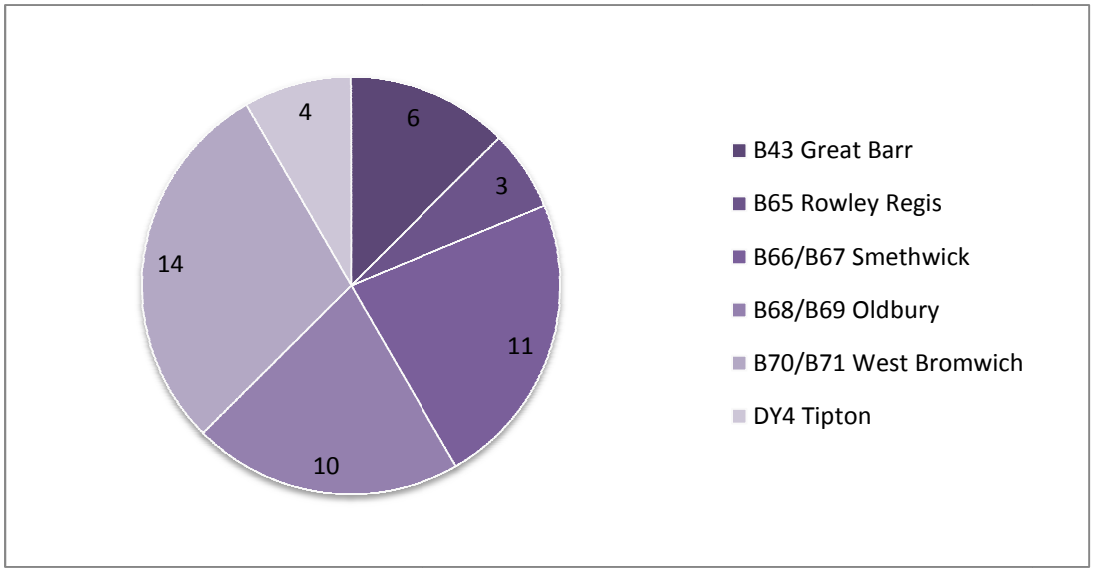
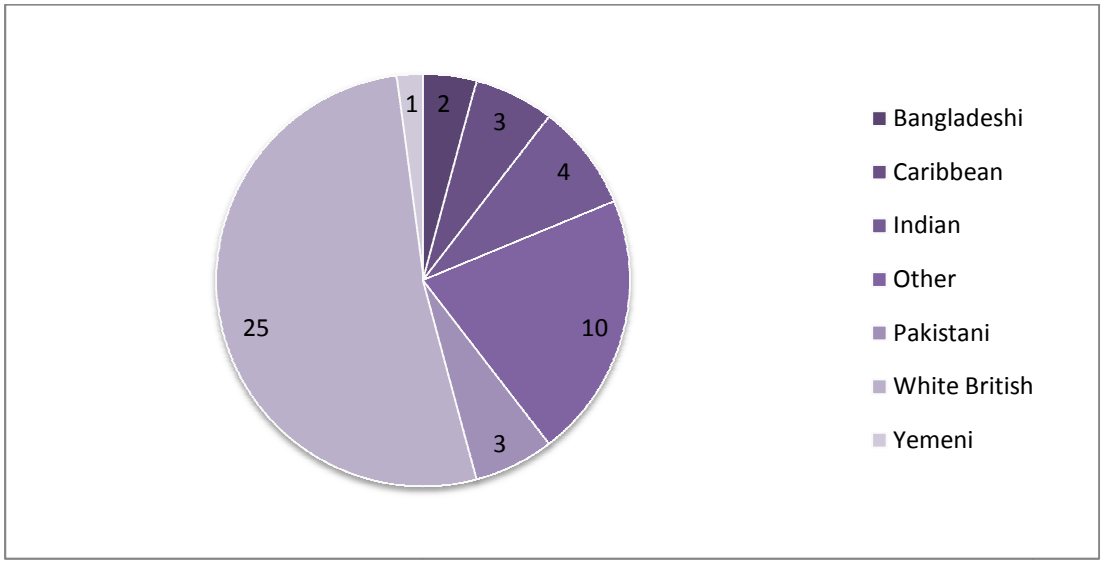


Chart 4: Women who would go to Birmingham Women's Hospital by ethnic grouping



Russells Hall Hospital No. of women 78 (19.31%)

Chart 5: Women who would go to Russells Hall Hospital by postcode

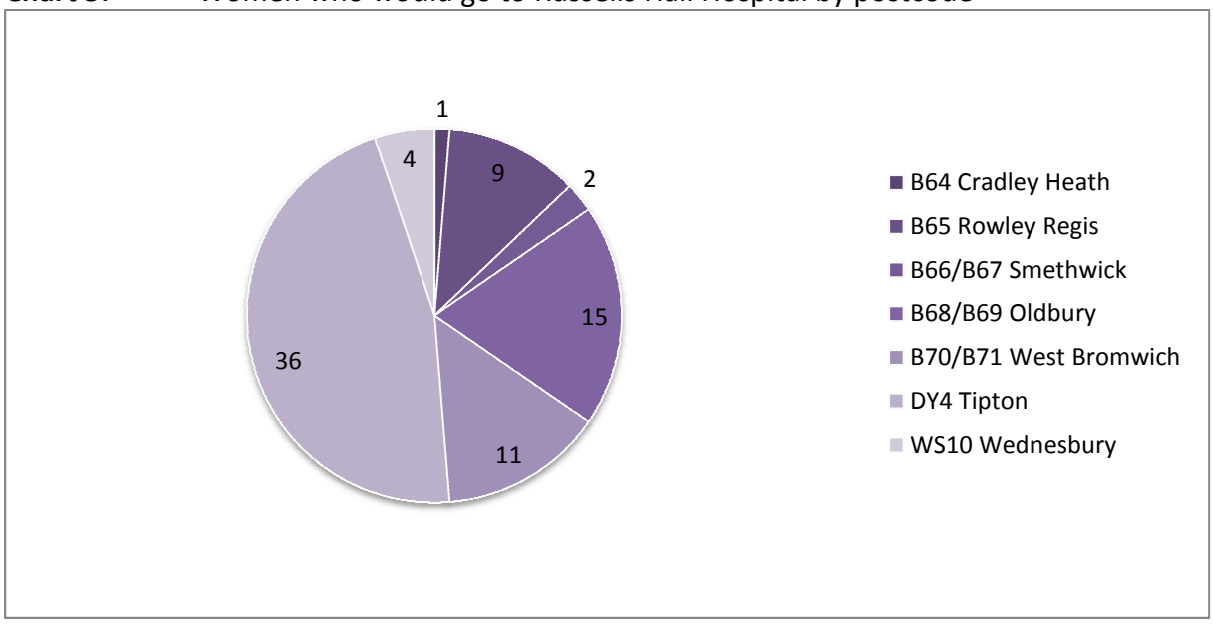
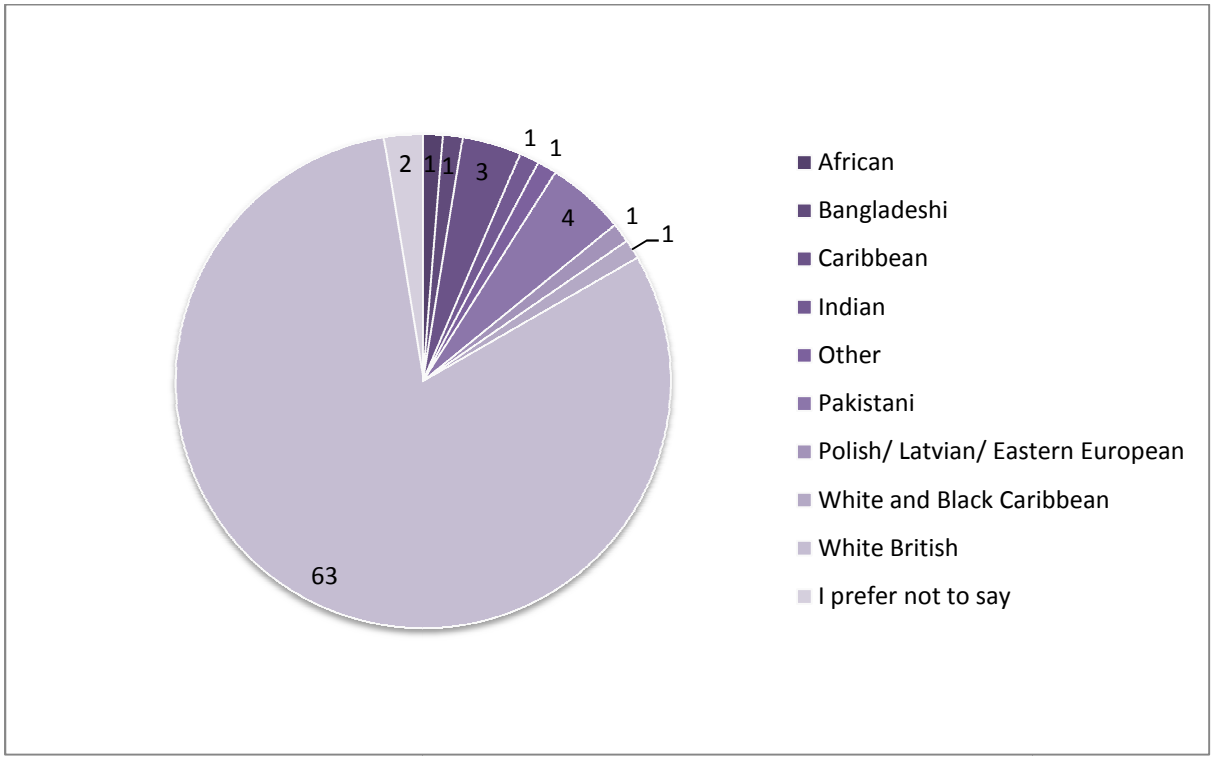


Chart 6: Women who would go to Russells Hall Hospital by ethnic grouping



Walsall Manor Hospital No. of women 67 (16.58%)

Chart 7: Women who would go to Walsall Manor Hospital by postcode

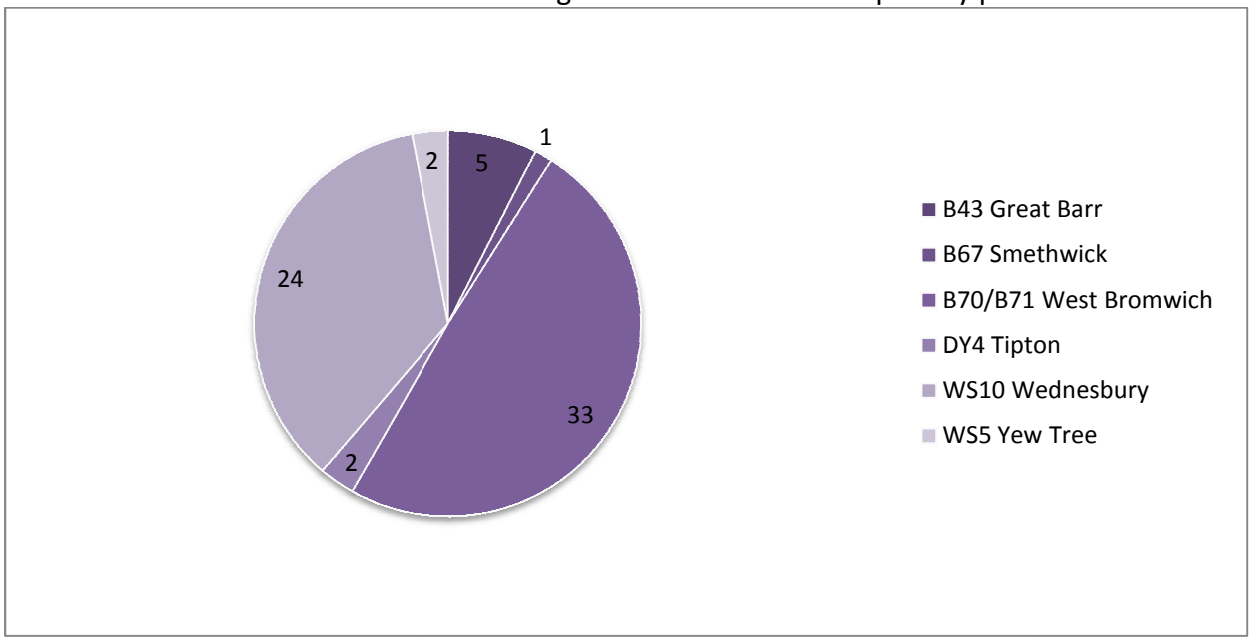
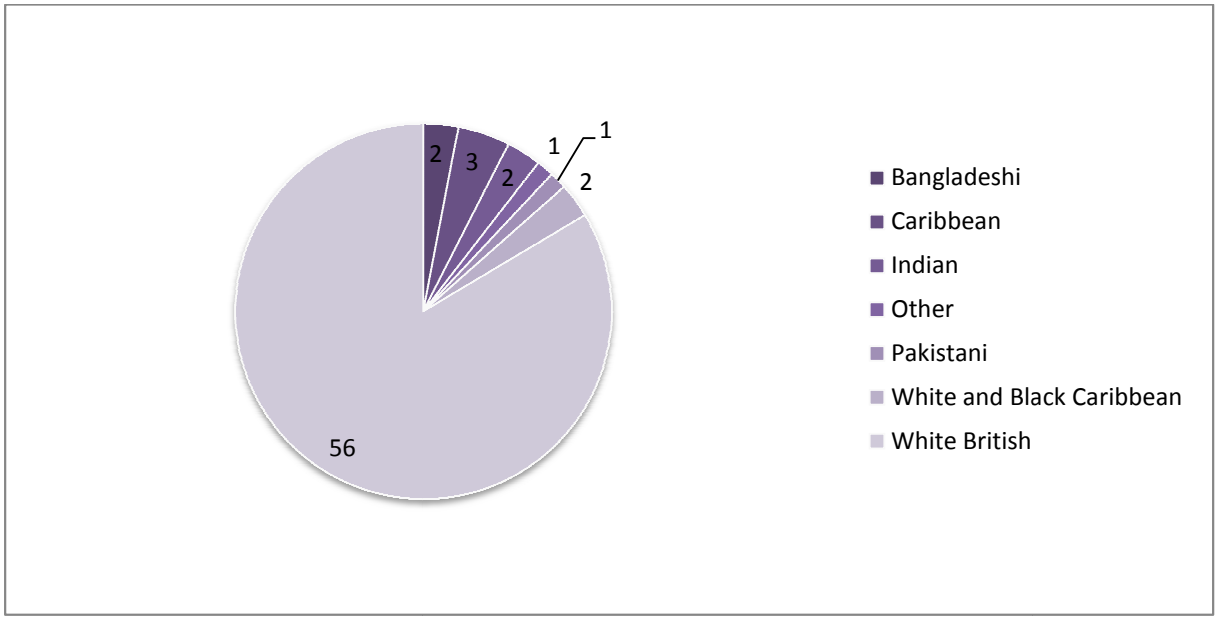


Chart 8: Women who would go to Walsall Manor Hospital by ethnic grouping



New Cross Hospital No. of women 5 (1.24%)

Chart 9: Women who would go to New Cross Hospital by postcode

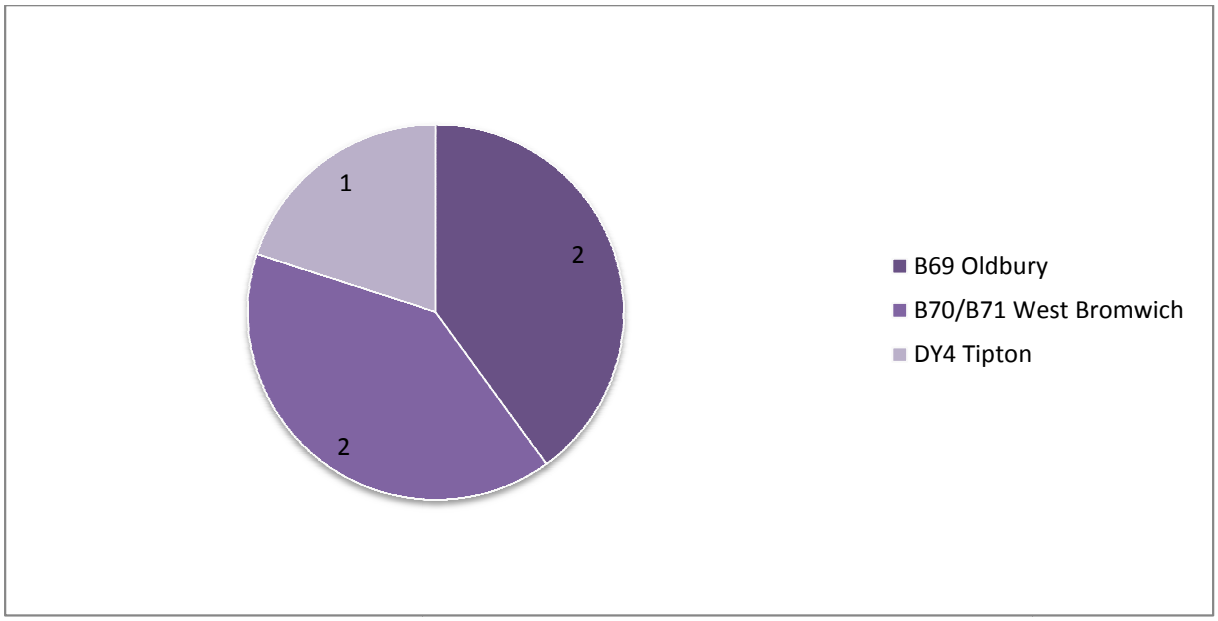
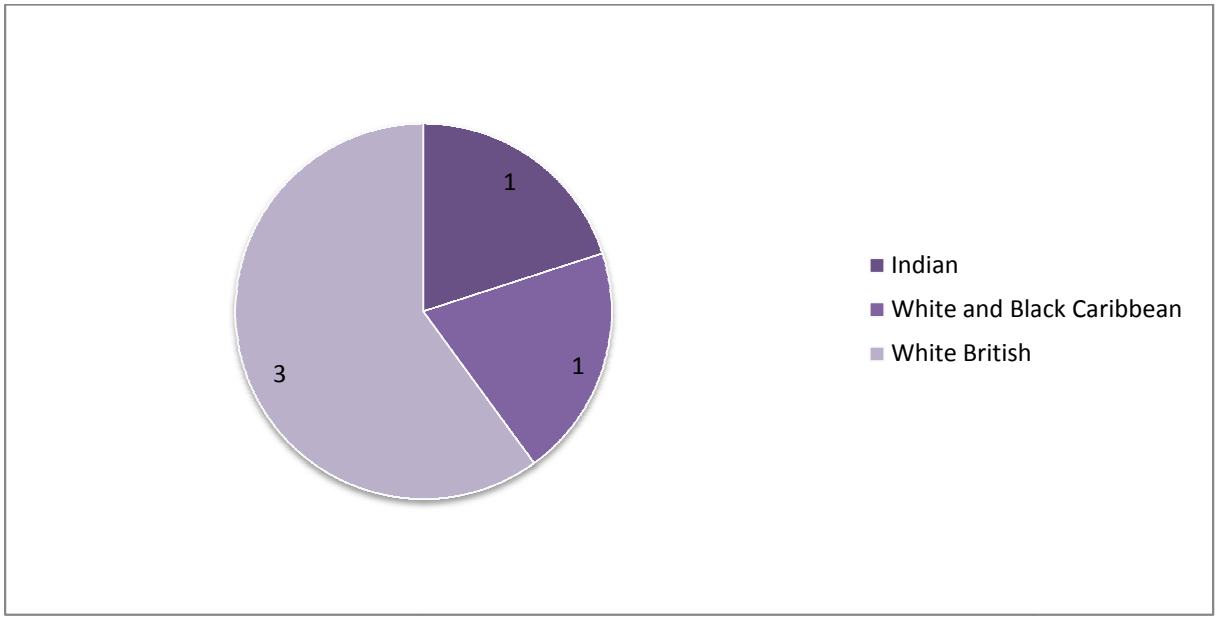


Chart 10: Women who would go to New Cross Hospital by ethnic grouping



Home birth No. of women 43 (10.64%)

Chart 11: Women who would have a home birth by postcode

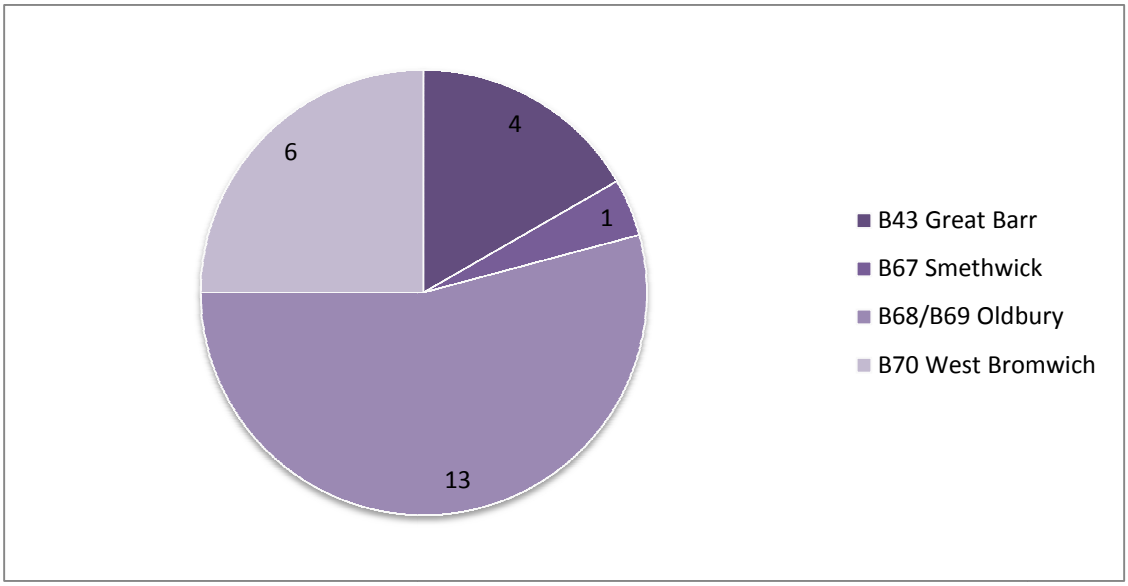
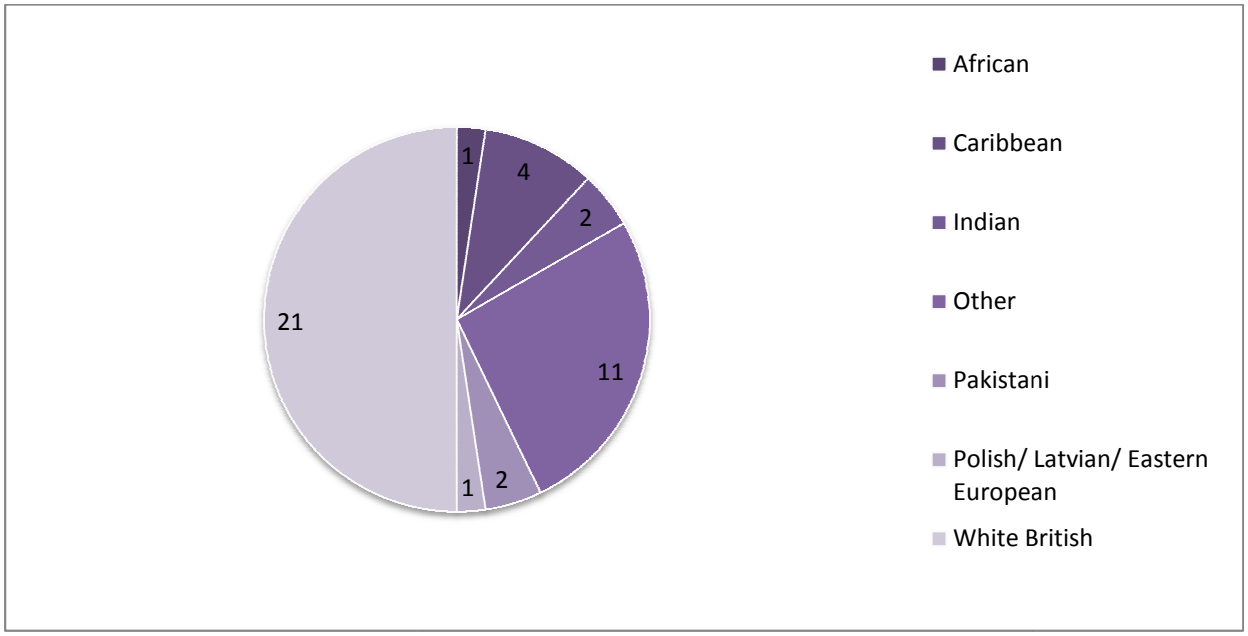


Chart 12: Women who would have a home birth by ethnic grouping



Appendix 5 Comments from the Right Care Right Here Partnership Board to on the Medium Term Maternity services Review

- There was general support for the proposals in the consultation document, requiring the rationalization of maternity services, with the consolidation of the majority of services onto one hospital site.

- The presentation and options clearly indicate that City Hospital will be the site where this consolidation occurs and members felt that there was insufficient detail to explain why this could not occur on the Sandwell Hospital site, particularly in view of the fact that for the immediate term, there will still need to be a level of provision at the Sandwell site. It was suggested that this could be presented as a two stage presentation, in which the first identifies the need for better provision for high risk pregnancies and the second delineates the arguments for and against the City and Sandwell sites.

- The Questions and Answers section had no reference to some of the issues raised in the past, in particular there was no detail relating to the Users Survey in 2007 which indicated that the service was judged to be 'least well performing' and that service users were unhappy about the quality of care provided. It was also felt that it was legitimate to be open about the demographics of the user population with particularly a growing younger population in Heart of Birmingham, which would make consolidation at City a sensible option.

- It was suggested that you may also wish to consult with the education and training providers about the implications for the need for trained staff arising from the options.

- It was noted that the suggestion to extend the consultation response period because of postal strikes should be balanced by the need to complete the consultation prior to any potential general election purdah.

Appendix 6 Comments from the Sandwell LINks Health Subgroup (LINks) the Medium Term Maternity services Review

Response:

Below follows the key concerns of Sandwell LINk towards the consultation;

- Sandwell LINk members were concerned that services were moving away from Sandwell and worried about the impact that this would have on both staff moral and the moral of Sandwell as a town.

- There was some concern about whether or not there would be support for Sandwell women in terms of transport if maternity services were to be relocated to City Hospital. This concern was particularly heightened for those women who were considered to be at risk.

- LINk members were concerned that the proposals only cover the interim period between now and the development of the new hospital, meaning services would change again after 2015.

- It was raised by a LINk member through the proxy system of contributing to Sandwell LINk discussions that City Hospital was in fact closer to some residents of Sandwell than Sandwell Hospital.

Recommendations:

After hearing the three proposals and having the opportunity to have any questions answered Sandwell LINk make the following recommendations;

- The transport needs of Sandwell women receiving services from City Hospital needs greater consideration, especially for those who are classified as high risk.

- Changes that take place now should be sustainable after the opening of the new hospital in 2015.

- If option 3 is selected as the best option then it must be ensured that the stand alone unit is in a central point and have good transportation links.

Appendix 7 Birmingham City Council and Sandwell Metropolitan Borough Council Joint Health Scrutiny Committee - 7th January, 2010

Resolved:

(1) that, whilst the Joint Committee would ideally have preferred that full maternity provision would remain at Sandwell, in the light of the evidence which it had received regarding maternity services it supported the adoption of Option 3 of the public consultation document "Improving services for giving birth" which is "temporarily relocate all births (normal and complicated) to City Hospital, and then set up a Community Birth Centre in Sandwell that is not attached to a hospital site" with the caveat that the Midwife-led Birth Centre be built and be operational in Sandwell before maternity services are withdrawn from the Sandwell Hospital;

(2) that if resolution (1) above is not supported by the Sandwell PCT Board the Joint Committee is minded to refer the matter to the Secretary of State for Health under Section 4 Paragraph 7 of the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 since it believes the proposals in the consultation document as they stand are not in the interests of the health service in the area of the Committee's local authorities because of the following reasons:-

(a) they do not fit with the national choice guarantee (as introduced in the 2007 Department of Health guidance document "Maternity Matters") and care closer to home agenda, set out in "Our Health Our Care Our Say";

(b) the capacity of provision at City Hospital to deal with an increase in the numbers of mothers using its maternity services was questionable particularly due to other NHS consultations in the Birmingham area around future provision of maternity services potentially also having an impact on the numbers using City Hospital;

(c) it believes more research is required to give a full regional perspective on future requirements for maternity provision;

(3) that the two chairs of the Joint Committee request an invitation to the Sandwell PCT Board when the decision is made over the future commissioning of maternity services in Sandwell and West Birmingham;

(4) that if a different decision is made by the Sandwell PCT Board to the options contained in the consultation document or the Joint Committee's recommendation contained in (1) above then the Joint Committee will meet as a matter of urgency to decide a response to the decision of the PCT Board;

(5) that the PCT Board provide members of the Joint Committee with a step by step process for decision making regarding the future arrangements for maternity service in Sandwell and West Birmingham, including dates;

(6) that in light of the safety issues around maternity services at Sandwell Hospital the Care Quality Commission be requested to undertake a review of maternity services at the City Hospital site to make assurances that the services provided there are safe;

(7) that the PCTs contract and performance monitoring arrangements regarding the commissioning and delivery of maternity services by the Acute Trust be provided to a future meeting of the Joint Committee;

(8) that the Joint Committee continue to meet at least every six months to consider performance information around maternity services which could also include any other information that members may ask for around the commissioning and delivery of maternity services in Sandwell and West Birmingham;

(9) that in any future consideration of maternity services in Sandwell and West Birmingham commissioners be requested to pay closer and more thorough attention to regional planning.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Maternity Service- Medium Term Review : Business Case for Change
SPONSORING DIRECTOR:	John Adler, Chief Executive
AUTHOR:	Jayne Dunn, Redesign Director – Right Care Right Here
DATE OF MEETING:	25 February 2010

SUMMARY OF KEY POINTS:

In September 2009 the Trust and PCT Boards agreed to public consultation on the three short-listed options for changes to the way maternity services in relation to intra-partum and Consultant led care, are provided at Sandwell and West Birmingham Hospitals NHS Trust in the medium term i.e. from 2010 until the opening of the new Acute Hospital in 2015/16. Following this public consultation took place between 12th October 2009 and 18th January 2010. The outcome of this consultation has been reviewed by an independent organisation, Merida Associates and their report has been presented to the Board.

During the public consultation period the Project Steering Group leading the medium term review of maternity services, undertook more detailed work on the short listed options in relation to activity, capacity, finance, staffing, risks, feasibility, timescale for implementation and equality impact assessment. The Project Steering Group also considered responses to the consultation document.

The purpose of this report is to present the Project Steering Group's recommended option and set out the Business Case for the related service changes.

The Project Steering Group is recommending Option 3 i.e. All consultant led care and, all in-patient services and, temporarily all births would transfer to City Hospital. A Stand Alone Midwifery Led Birth Centre would be developed within Sandwell and, once operational, some midwifery led low risk births would relocate to the new centre in Sandwell. Low risk midwifery led antenatal care and routine screening will be available in Sandwell and at City Hospital. Consultant led antenatal care would be relocated to City Hospital. All Neonatal care would be provided at City Hospital.

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is recommended to:

- AGREE the business case for change.
- APPROVE the Project Steering Group's recommended option i.e. Option 3.
- APPROVE the capital and revenue investment required to support Option 3 and the Income and Expenditure analysis for Option 3.
- AGREE to the Project Steering Group's undertaking further work to identify a way to minimise the time between reconfiguring consultant led/high risk births to City Hospital and opening a stand alone Birth Centre in Sandwell without delaying the reconfiguration of consultant led/high risk births. This may require additional capital investment by the Trust or PCT and additional revenue relating to capital charges and facilities costs depending upon the final location.
- AGREE to a more detailed implementation plan being presented to the Trust Board at its May meeting.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High Quality Care - We will provide the highest quality clinical care. Our clinical outcomes will be amongst the best of Trusts of our size and type. Patients and frontline staff will be fully engaged in improving our services.
Annual priorities	Deliver significant improvements in the Trust's maternity services
NHS LA standards	Maternity NHSLA standards
Core Standards	
Auditors' Local Evaluation	

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

Financial	**X**	The recommended option requires: • A capital investment by the Trust of £1.85 million • Endorsement of the financial consequences i.e. targeting an overall improvement in the trading position of maternity services by 2013/14 of £508 589 • Recognition that 100% of future maternity income streams translate into resources available to the Women and Children Division
Business and market share	**X**	The recommended option identifies: • an initial catchment loss of births from Sandwell • a repatriation of 400 low risk births once the stand alone birth centre in Sandwell is open and • over three years a repatriation of 600 local births in Birmingham from other hospitals in Birmingham
Clinical	**X**	• Clinical drivers for change • Changes to clinical practice • Compliance with national guidance
Workforce	**X**	The recommended option includes the following workforce impact: • Workforce implications from the reconfiguration of high risk births including change of base site for staff, increase in consultant labour ward cover to 60 hours a week, dedicated maternity theatre team at Sandwell will no longer be required, • Development of a midwifery team with skills and experience to run a stand alone birth centre including investment in additional posts for this team
Environmental		
Legal & Policy		The pre-consultation engagement work and the formal public consultation has been undertaken in line with Section 7 of the Health and Social Care Act 2001 and Section 242 of the Health Act 2006. The project management methodology has followed the Department of Health guidance on significant service review set out in *Changing for the Better* (2008).
Equality and Diversity	**X**	The Project Steering Group has followed an Equality Impact Assessment process. This is summarised within

		the report.
Patient Experience	**X**	The recommended option will result in high risk Sandwell women no longer being able to receive consultant led antenatal care or to give birth in Sandwell Hospital. High risk women will access a range of specialist consultant led antenatal care at City Hospital. Low risk women will have the choice of giving birth in the stand alone birth centre in Sandwell once this is operational. This will be in addition to the choice they will have of giving birth in the co-located birth centre at City Hospital, Delivery Suite at City Hospital or a home birth.
Communications & Media	**X**	Public Consultation has taken place. There will be ongoing extensive internal and external requirements and a comprehensive engagement and communications plan will be required.
Risks		As set out in the report

PREVIOUS CONSIDERATION:

A Report Outlining The Case For Change in maternity services over the medium term was presented to the Trust Board at its meeting in September 2009. The report was also presented to Sandwell PCT and Heart of Birmingham teaching PCT . Following agreement and approval at these meetings public consultation of the short listed options took place between October 2009 and January 2010.

A report presenting the Outcome of Public Consultation is also being presented to the Trust Board at its February 2010 meeting.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MATERNITY SERVICE- MEDIUM TERM REVIEW
THE BUSINESS CASE FOR CHANGE
FEBRUARY 2010

Version 2 :17th Feb 2010

EXECUTIVE SUMMARY

Introduction

In September 2009 the Trust and PCT Boards agreed to public consultation on three short-listed options for changes to the way maternity services, in relation to intra-partum and Consultant led care, are provided at Sandwell and West Birmingham Hospitals NHS Trust in the medium term i.e. from 2010 until the opening of the new Acute Hospital in 2015/16. Following this public consultation took place between 12th October 2009 and 18th January 2010. The outcome of this consultation has been reviewed by an independent organisation, Merida Associates and their report is being presented to the Board at its meeting in February 2010.

During the public consultation period the Project Steering Group leading the medium term review of maternity services, undertook more detailed work on the short listed options in relation to activity, capacity, finance, staffing, risks, feasibility, timescale for implementation and equality impact assessment. The Project Steering Group also considered responses to the consultation document.

The purpose of this report is to present the Project Steering Group's recommended option and set out the Business Case for the related service changes.

Option Appraisal and Preferred Option

A short list of three options was approved for public consultation. These are outlined below along with the Do Minimum position which did not form part of the public consultation but is considered as a baseline position for the option appraisal work.

Option 1: Transfer all births and consultant activity to City Hospital and retain low risk Midwifery led antenatal services at Sandwell and City Hospitals including routine screening (scans). There would be no births at Sandwell Hospital and all Consultant antenatal clinics would transfer to City Hospital concentrating all high risk care to one site. All Neonatal care would be provided at City Hospital.

Option 2: All births and in-patient maternity care would be located at City Hospital. There would also be a full range of antenatal services at City Hospital. A small number of Consultant antenatal clinics would remain at Sandwell Hospital along with a full range of Midwifery antenatal services including routine screening. There would be no births or inpatient maternity care at Sandwell Hospital. High risk in-patient care will be provided at City Hospital. All Neonatal care would be provided at City Hospital.

Option 3: All consultant led care and, all in-patient services and, temporarily all births would transfer to City Hospital. A Stand Alone Midwifery Led Birth Centre would be developed within Sandwell and, once operational, some midwifery led low risk births would relocate to the new centre in Sandwell. Low risk midwifery led antenatal care and routine screening will be available in Sandwell and at City Hospital. Consultant led antenatal care would be relocated to City Hospital. All Neonatal care would be provided at City Hospital.

Do Minimum Position: Retain all consultant led and maternity services at Sandwell Hospital and improve standards. There would be no change to the current service model with the requirement to improve the facilities to achieve the recommended standards, and also the need to improve clinical leadership, operational management and workforce capacity.

Each option was considered against a range of issues including risks, non-financial benefits, public consultation, financial impact. The outcome of this analysis is summarised in the table below.

Summary of Option Appraisal

	Do Minimum	**Option 1**	**Option 2**	**Option 3**
Clinical Case for Change	Does not meet NCAT or RCOG recommendations	Partly meets NCAT and RCOG recommendations	Partly meets NCAT and RCOG recommendations	Meets NCAT and RCOG recommendations
Non- Financial Option Appraisal Scores	Lowest score	Second highest score	Third highest score	Highest score
Public Consultation	Not included	26% of respondents preferred	24% of respondents preferred	43% of respondents preferred
Capital Costs	£3.3m	£1.8m	£1.8m	£1.8m
Affordability (based on the forecast Obstetrics trading position in 2013/14 and compared to a baseline deficit of £4.6m.)	-£5,231k	-£3,187k	-£3,187k	- £3,272k
Investment Ranking	3	1	1	2
Cash Flow	3	1	1	2
Risks - Clinical	Highest (numbers of red & amber)	Joint lowest (numbers of amber)	Joint lowest (numbers of amber)	Second Highest (numbers of amber)
Risks – Financial & Activity	Lowest	Middle	Middle	Highest

In summary the 'Do Minimum' position had the weakest position in the most areas of analysis.

Options 1 and 2 had the best position from a financial and risk analysis but neither of Options 1 and 2 were the preferred option from public consultation and neither fully meets the recommendations from external clinical reviews.

Option 3 has the strongest non financial appraisal score and is clearly the preferred option from public consultation. In addition Option 3 meets the recommendations of the external clinical reviews. However, it is weaker from a financial (although not significantly weaker) and risk analysis. In terms of the risk analysis Option 3 carries similar financial and activity risks to those of options 1 and 2 and whilst it has no red clinical risks post mitigation it does have the additional risks associated with attracting sufficient births to the stand alone Birth Centre to make this clinically and financially viable.

On this basis Option 3 is the recommended option from the Project Steering Group i.e,

All consultant led care and, all in-patient services and, temporarily all births would transfer to City Hospital. A Stand Alone Midwifery Led Birth Centre would be developed within Sandwell and, once operational, some midwifery led low risk births would relocate to the new centre in Sandwell. Low risk midwifery led antenatal care and routine screening will be available in Sandwell and at City Hospital. Consultant led antenatal care would be relocated to City Hospital. All Neonatal care would be provided at City Hospital,

The Joint Health Scrutiny Committee also supported Option 3 but with the caveat that the stand alone Birth Centre is built and operational in Sandwell before maternity services are withdrawn from Sandwell Hospital.

The Project Steering Group has considered this carefully and whilst not able to recommend the caveat on clinical safety and quality grounds, it does recognise the significance of the concerns raised and agrees it is important to minimise the time between reconfiguring consultant led/high risk births to City Hospital and opening the stand alone Birth Centre in Sandwell, without delaying the reconfiguration of consultant led/high risk births. The Project Steering Group is therefore recommending further detailed work to analyse and find an approach to achieve this.

The tables below summarise the financial analysis for Option 3 as the recommended option. They do not include any additional costs the Trust might incur as part of an approach to minimise the time between reconfiguring consultant led/high risk births to City Hospital and opening the stand alone Birth Centre in Sandwell without delaying the reconfiguration of consultant led/high risk births. If such an approach requires refurbishment work on one of the Trust's sites it is estimated there will be an additional capital cost of £1.5 million and associated additional revenue costs relating to capital charges and facilities costs.

Changes to Income and Expenditure associated with Option 3 (recommended option)

Category	£000's	Comments
Income	1851	
Pay	(353)	
Non Pay	(1)	Includes net saving in capital charges for decanting of Sandwell Maternity block
Net Change	1274	

Summary of Capital Consequences of Option 3 (recommended option)

Category	£000's	Comments
Capital	1851	
Depreciation	(130)	
Rate of Return	15%	
Maintenance Costs/Facilities Charge	(150)	Facilities charge from Sandwell PCT for use of premises

Net Additional Activity Consequences of Option 3 (recommended option)

Category		Comments
Inpatients		
Births	1012	Net Increase over the 4 year period
All Other HRGs	438	Net Increase over the 4 year period
Outpatients		
New	575	Net Increase over the 4 year period
Review	(4707)	Net decrease over the 4 year period

Funding Source for Change

Source	Tick	Comments
Baseline Budgets	✓	
Tariff Income	✓	An Additional 400 births phased over years for the MLU
Cost Savings (Internal Divisional)	✓	Disestablishment of 2.00 wte midwifery posts
Cost Savings (External to Division)	✓	Saving of a theatre team
Other (please specify)		

The qualitative benefits from the service changes in Option 3 are:

- Promotion of normality in birth
- Safe care
- Continuity of care
- Better care closer to home
- Increased choice and control for service users
- Improved patient experience
- Maintain and improve public confidence
- Ensure that the workforce is fit for purpose
- Value for Money of the stand alone Birth Centre

The final decision to approve a preferred option for the medium term changes to the way maternity services, in relation to intra-partum and Consultant led care, is provided at Sandwell and West Birmingham Hospitals NHS Trust in the medium term, i.e. from 2010 until the opening of the new Acute Hospital in 2015/16, will be taken by Sandwell PCT Board at its meeting in February 2010. This will be based upon the outcome of public consultation and the business case for change presented in this report.

In making this decision Sandwell PCT will seek the view taken of the preferred option by Sandwell and West Birmingham NHS Trust Board and also Heart of Birmingham teaching PCT Board.

The Trust Board is recommended to:

- AGREE the business case for change.

- APPROVE the Project Steering Group's recommended option i.e. Option 3.

- APPROVE the capital investment of £1.85 million required to support Option 3 and endorse the financial consequences of Option 3 i.e. targeting an overall improvement in the trading position of maternity services by 2013/14 of £508 589, recognising that to achieve this 100% of future maternity income streams need to translate into resources available to the Women and Children Division.

- AGREE to the Project Steering Group undertaking further work to identify a way to minimise the time between reconfiguring consultant led/high risk births to City Hospital and opening a stand alone Birth Centre in Sandwell without delaying the reconfiguration of consultant led/high risk births. This may require additional capital investment by the Trust or Sandwell PCT and additional revenue relating to capital charges and facilities costs depending upon the final location.

- AGREE to a more detailed implementation plan being presented to the Trust Board at its May meeting.

1. INTRODUCTION

In September 2009 the Trust Board agreed a short list of three options for changes to the way maternity services, in relation to intra-partum (labour and birth) and Consultant led care (ante-natal care, and care during and immediately after birth) are provided at Sandwell and West Birmingham Hospitals NHS Trust for the time period up to the opening of the new Acute Hospital in 2015/16. The need to undertake a formal public consultation on these options was also agreed. Sandwell Primary Care Trust, as lead commissioner and lead organisation for the medium term review of maternity services gave final approval to proceed with the public consultation at its Board meeting in September 2009 having sought the agreement of the Trust Board and the Heart of Birmingham teaching Primary Care Trust (HoBtPCT) Board.

Public consultation on '*Improving Services for Giving Birth,'* took place between 12th October 2009 and 18th January 2010. The outcome has been reviewed by an independent organisation, Merida Associates and their report is also being presented to the Board at its meeting in February 2010.

During the public consultation period the Project Steering Group leading the medium term review of maternity services, undertook more detailed work on the short listed options in relation to activity, capacity, finance, staffing, risks, feasibility, timescale for implementation and equality impact assessment. The Project Steering Group also considered responses to the consultation document.

The purpose of this report is to:

- Present the Project Steering Group's response to the issues raised by the consultation.
- Present the Project Steering Group's recommended option and related service changes.
- Set out the business case for change.
- Seek Trust Board approval of the recommended option and related service changes.
- Seek Trust Board approval for the required capital investment and the Income and Expenditure Analysis for the recommended option.

2. STRATEGIC CONTEXT

2.1 Long Term Vision for Maternity Care

The expected standards for maternity care within England have been defined by the Department of Health (DoH) in the Maternity Standard within the *National Service Framework for Children, Young People and Maternity Services* (DoH, 2004). The Maternity Standard identifies safety, normality, women's choice and involvement, and a focus on wide accessibility as key elements of a high-quality service which for low risk pregnancies should be community and midwifery based. The Department of Health publication *Maternity Matters: Choice, access and continuity of care in a safe service* (DoH, 2007) confirms the importance of these factors and sets out, from a national perspective, expectations relating to the delivery of these.

The service provided and the models of care delivered should encompass the central role of midwives as autonomous practitioners of normal labour and birth, together with their role as partners with obstetricians, anaesthetists and paediatricians, in the care of women with complex and complicated labours.

The *Right Care Right Here Programme* through the Strategic Model of Care Group (SMOC) for Maternity, Neonatal and Newborn services has set out a vision and service model for maternity and associated services for the local health economy. The SMOC group advocates, '…the normalising of pregnancy and birthing experience through a midwifery-led approach, based in local communities and integrated with primary care' (RCRH Maternity and Newborn SMOC, 2009, page 3). In developing its

strategy the SMOC group took into account national policy and guidance and the work of the West Midlands Maternity and Newborn Darzi Group (2008). The Strategy's overarching vision is that:

> ' Women and their partners in Sandwell and HoBtPCT will have easy access to supportive, high quality and safe maternity, neonatal and newborn services, designed around their individual needs and those of their babies and infants.
>
> Health and well being will be promoted and delivered through coordinated programmes of care which will include prevention and early intervention to assess health inequalities and support self care.' (Ibid, page 4).

In relation to intra-partum care the proposed service model includes an individual initial risk assessment to identify the most appropriate antenatal care pathway and a subsequent delivery risk assessment to identify, from a range of birthing locations, the most appropriate taking account of individual clinical risks and choice. The proposed birth locations include home birth, a birth centre in a community setting, a co-located birth centre (adjacent to an obstetric delivery suite) and an obstetric led delivery suite in an Acute Hospital setting.

The long term plan for the Trust's maternity service therefore envisages a model of community based ante- and post-natal care, with a centralised delivery and specialist care facility in the new Acute Hospital in Smethwick which is due to open in 2015/16. The delivery facility will be clearly split between a higher risk obstetric-led unit and a low risk midwifery-led unit (co-located birth centre).

2.2 Compliance With Trust Priorities

Over the past 2-3 years there has been an intense focus on developing and improving the Trust's maternity service with the aim of ensuring the quality and safety of the service, in response to national guidance and to local concerns. These efforts have produced good results with clear improvements in the Trust's maternity services but there remain continuing concerns about medium term sustainability, particularly in respect of the Consultant led component of the service. These concerns along with the longer term vision for maternity services within the local health economy are recognised within the Trust's corporate objectives.

Of particular relevance is the Trust's strategic objective to deliver:

> ' High Quality Care - We will provide the highest quality clinical care. Our clinical outcomes will be amongst the best of Trusts of our size and type. Patients and frontline staff will be fully engaged in improving our services.' (SWBH, Annual Plan 2009 -10, March 2009, page 10)

During 2009/10 there were two annual objectives linked to this strategic objective and relating directly to maternity services. These were to:

> ' Deliver significant improvements in the Trust's maternity services' and
> 'Achieve NHSLA standards Level 2 (general) by December 2009 and new Level 1 (maternity) by March 2010.' (Ibid, page 13).

In pursuing these objectives the Trust has established an internal Maternity Action Team chaired by the Chief Executive and a Maternity Taskforce, with members from key external stakeholders and led by the Trust Chair. In order to bring together the various strands of existing work and give a framework for further development, an Integrated Maternity Development Plan was produced which was approved by the Trust Board (and the two local Primary Care Trust Boards) in the second half of 2008.

2.3 Current Maternity Service Provision

In relation to intra-partum and acute Consultant led elements of the Trust's maternity services the current service model in summary has:

- Two obstetric (consultant) led Delivery Suites with associated inpatient beds and Antenatal Day Assessment Units, one at Sandwell Hospital and one at City Hospital, that primarily provide a medical model of care.
- Consultant led antenatal clinics are also held on both sites.
- The Trust delivers around 6100 babies a year with 3500 deliveries at City Hospital and 2600 deliveries at Sandwell Hospital (see table 1 below). During 2007/08 the Trust supported 27 home births.
- There is a Level 2 Neonatal Unit at City Hospital that admits babies delivered from 26 weeks gestation requiring intensive or special care.
- There is a Level 1 Neonatal Unit at Sandwell Hospital that admits babies from 34 weeks gestation requiring special care. As a result women presenting at Sandwell Hospital in labour between 26 and 34 weeks gestation are transferred to City Hospital for delivery (or if there is no capacity at City another Hospital with an onsite Level 2 Neonatal Unit). It is estimated that up to about 200 women a year presenting at Sandwell will require this type of transfer.
- Women presenting at Sandwell or City Hospital in labour under 26 weeks gestation are transferred to a Hospital with an onsite Level 3 Neonatal Unit (locally these are the Birmingham Women's Hospital and Heartlands Hospital).
- In order to offer women with low risk pregnancies the advantages of more choice, a less technical and clinical environment and a midwifery led model of care with less likelihood of medical interventions, the Trust is developing a Midwifery Led Birth Centre at City Hospital, co-located to the main Delivery Suite. This will open at the end of March 2010 and it is anticipated that once it is fully established, 30% of women delivering at City Hospital will be eligible to deliver in the Centre.

Table 1: SWBH Births by Hospital Site

	2007/08		**2008/09**		**2009/10 Forecast based on Month 9 actual activity**		**Estimate for 2010/11 (Based on RCRH Activity Model V5)**		**Estimate For 2011/12 (Based on RCRH Activity Model V5)**	
Site	Swell	City	Swell	City	Swell	City	Swell	City	Swell	City
Number of Births	2 628	3 607	2 611	3 508	2 670	3 649	2 645	3 752	2 692	3 924
Trust Total	6 235		6 119		6 318		6 397		6 616	

The Trust's maternity services sit in the context of over 10 000 births a year to women resident in the local health economy of which 4 300 take place in other hospitals - primarily Dudley Group of Hospitals, Walsall Manor Hospital, Birmingham Women's Hospital and Heartlands Hospital. The Trust provides community midwifery services to a total of 8 200 women per year.

2.4 The Clinical Case for Change

In addition to the internal focus described above the Trust has also undertaken some work in conjunction with external bodies in order to address specific local issues so as to ensure the maintenance of a safe and effective maternity service that is also in line with national Policy Imperatives. These external bodies include the Healthcare Commission, West Midlands Strategic Health Authority, Sandwell and Heart of Birmingham Primary Care Trusts, the Royal College of Obstetricians and Gynaecologists (RCOG), and the Local Supervisor of Midwives (who has carried out regular independent supervisory reviews). The input of these external bodies has been invaluable, particularly in providing an independent perspective, in benchmarking the Trust's performance against its peers and in making clear recommendations for areas of further action.

These efforts have produced good results with clear improvements in the Trust's maternity services but there remain continuing concerns about medium term sustainability, particularly in respect of the Consultant led component of the service. It is these concerns along with the need to plan a transition to the new service model outlined for the new Acute Hospital under the *Right Care Right Here Programme* that led to the medium term review.

As one of the first steps in the Medium Term Review of Maternity Services a report was produced in June 2009 that set out the clinical case for change. This report identified a number of drivers for change to the intra-partum and acute consultant led elements of the Trust's maternity services. In summary these included:

- New and increasingly challenging national standards.
- The need to ensure that the actions which have been taken to improve quality and safety are sustainable in the medium term.
- Given national staffing shortages, the need to attract and retain high calibre staff (obstetric and midwifery).
- The increasing complexity of the population the Trust serves, with a rising birth rate.
- The need to move towards the long term plan for the Trust's maternity services.

The clinical case for change concluded that from a clinical perspective a further change in the configuration of services is required in order to enable the continued promotion of normality for women with low risk factors and also the strengthening and further development of acute services for high risk women in line with the drivers for change. The consolidation of obstetric-led, high risk deliveries and associated acute care on one site would facilitate further improvements more rapidly (e.g. extended consultant cover for labour ward) than trying to achieve this on two sites and would also more robustly ensure the improvements would be sustained in the medium term particularly in relation to clinical leadership and presence. In addition such consolidation would ensure integration of staff from the two sites into one team working to the same clinical policies and processes ahead of the opening of the new Acute Hospital. This clinical case for change was approved by the Chief Executives of the Trust, Sandwell PCT and Heart of Birmingham teaching PCT.

In accordance with national guidance, as set out in *Changing for the Better* (DoH 2008), the focus of the review has been on improving the quality of services. The Department of Health also requires that all new reconfiguration proposals (since 1st April 2008) are subject to initial clinical assurance provided by the National Clinical Advisory Team (NCAT). The purpose of the NCAT is to provide a pool of clinical experts to support, advise and guide the local NHS on local service reconfiguration proposals to ensure safe, effective and accessible services for patients.

In line with this requirement a visit by NCAT took place in July to review the clinical case for change for the medium term service review of maternity services. The conclusion from this visit was support for the clinical case for change with the following recommendations:

- Plan to transfer all high risk maternity services to one consultant unit at the City Hospital.
- Set up job swaps to break down barriers and encourage consistency of approach.
- Develop MLU at City Hospital.
- Consider developing MLU within Sandwell if and when sufficient midwifery staff have been trained and/or recruited.
- In the interim introduce a community midwifery team in Sandwell to test acceptability with users and build up midwifery capacity.
- Consider retaining some consultant ante natal care in Sandwell to minimise the need for women to travel.
- Consider re alignment and reconfiguration of gynaecological services between Sandwell and City to maximise on efficient delivery of care being cognisant of on call requirements and training issues.
- Develop strategic plan centred on Community communication for proposed plans to enable community and political support for these moves.

- Develop a strategic workforce plan for Women's Services across the Trust, highlighting midwifery recruitment and retention, specialist training and on call commitments and the future working practices of consultants.
- Consider an academic presence in midwifery and/or obstetrics and gynaecology, (separate from oncology), which might generate a more challenging atmosphere at the work place.

These recommendations supported those made by the Royal College of Obstetricians and Gynaecologists in May 2008. In relation to service configuration for intra-partum care these were:

'The Review Team recommends strongly that the Trust consider an interim reconfiguration of obstetric services prior to the 2010 Project [now *Right Care Right Here Programme*] coming to fruition, i.e.:

- Expand the delivery suite on the City Hospital site and relocate Sandwell obstetric in-patient care to City Hospital.
- Establish a modern midwifery-led unit at the City Hospital, co-located to the main consultant unit.
- Convert the Sandwell Hospital unit to a midwifery-led unit.'

In addition they concluded that,

' The advantages of the above moves in driving the workforce together and improving morale cannot be overestimated. The advantages for women … in terms of both safety and choice cannot be underestimated.'

Having established the clinical case for change the Project Steering Group identified a number of potential options for the reconfiguration of maternity services (see below).

3. PLANNED OUTCOMES AND BENEFITS

The Project Steering Group identified and agreed the benefits that a reconfiguration of the Trust's intra-partum maternity services should deliver. These are summarised below. The Project Steering Group is undertaking further work to develop a detailed Benefits Realisation Framework based on these

Table 2. Benefits

Benefit	**Operational Definition**
Promotion of normality in birth	Promotion of midwifery-led care during labour and birth in a setting with a home-like ambience for women identified as being low risk.
Safe Care	All services facilitate normal child birth where possible with medical interventions recommended only when they are of benefit to the woman and/or her baby. Immediate, safe transfer available for any mother or baby who needs to transfer to consultant care in labour or after delivery and/or Neonatal Services. Consultant led services have adequate facilities, expertise, capacity and backup for timely and comprehensive obstetric emergency care. The level of transfer outside of SWBH should not increase above current levels
Continuity of care	One to one care from a named midwife during labour and birth. The ratio/level of 1:1 intrapartum care should not decrease.
Better care closer to home	Availability of midwifery led care in appropriate locations for low

	risk women in addition to Consultant led services provided for high risk women in hospital.
Increased choice and control for service users	Every woman is able to choose the most appropriate place and professional to attend her during child birth based on her wishes and cultural preferences and any medical and obstetric needs she or her baby may have.
Improved Patient Experience	In addition to high quality clinical care women should have a positive experience with regard to all other aspects of labour and birth including facilities, choice, personalised care, information, physical and emotional well being.
Maintain and improve public confidence	The majority of the public have confidence in the service model and find it acceptable. Women who use the service are involved in planning and reviewing the service provision.
Ensure that the future workforce is fit for purpose	Develops skills, capacity and capability through the recruitment and retention of high quality experienced staff. Supports new roles and ways of working. Underpinned by sound education/training.
Value for money of the stand alone Birth Centre	Sufficient births undertaken in the stand alone Birth Centre to maintain clinical and financial viability.

4. OPTIONS

4.1 Short Listed Options

Having established the clinical case for change, the Project Steering Group developed a number of options for the configuration of acute maternity services in the medium term. These were evaluated against an agreed set of criteria (see below) by the Project Steering Group and subsequently reviewed by an extended Reference Group and a small group of stakeholders and users. This process resulted in the three short listed options that the Trust Board then approved for public consultation, at it's meeting in September.

For the purposes of the business case the 'Do Minimum' option (retain all consultant led and maternity services at Sandwell Hospital and improve standards) will be considered although this did not form part of the public consultation on the basis of advice from the Working Group of the Joint Health Scrutiny Committee in order to ensure the consultation document was clear and offered the public choice over a realistic and feasible set of options.

Table 3: Short Listed Options

Option	Description
1	Transfer all births and consultant activity to City Hospital and retain low risk Midwifery led antenatal services at Sandwell and City Hospitals including routine screening (scans). There would be no births at Sandwell Hospital and all Consultant antenatal clinics would transfer to City Hospital concentrating all high risk care to one site. All Neonatal care would be provided at City Hospital.
2	All births and in-patient maternity care would be located at City Hospital. There would also be a full range of antenatal services at City Hospital. A small number of Consultant antenatal clinics would remain at Sandwell Hospital along with a full range of Midwifery antenatal services including routine screening. There would be no births or inpatient maternity care at Sandwell Hospital. High risk in-patient care will be provided at City Hospital. All Neonatal care would be provided at City Hospital.
3	All consultant led care and, all in-patient services and, temporarily all births would transfer to City Hospital. A Stand Alone Midwifery Led Birth Centre would be developed within Sandwell and, once operational, some midwifery led low risk births would relocate to the new centre in Sandwell. Low risk midwifery led antenatal care and routine screening will be available in Sandwell and at City Hospital. Consultant led antenatal care would be relocated to City Hospital. All Neonatal care would be provided at City Hospital.
Do Minimum	Retain all consultant led and maternity services at Sandwell Hospital and improve standards. There would be no change to the current service model with the requirement to improve the facilities to achieve the recommended standards, and also the need to improve clinical leadership, operational management and workforce capacity.

4.2 Stand Alone Birth Centre

A midwifery led unit or birth centre is a place that offers care to women with a predefined uncomplicated pregnancy and where midwives are the lead professional for ante-natal, intra-partum and post natal care. A stand alone birth centre is a midwifery led birth centre set up in a location away from and on a different site to a Consultant led unit.

Medical services including obstetric, neonatal and anaesthetic care are available in a Consultant led unit.

A review of available literature and research around midwifery led birth centres suggests that there are many benefits of giving birth in a midwifery led birth centre for women who are healthy and have a straight forward (low-risk) pregnancy. These are similar to the benefits of home birth. National policy is to increase women's choice for place of birth and access to midwife-led care and in England the policy is that from 2009 access to a birth centre will be 'guaranteed'. The Trust will be in a position to provide such access from April 2010 through the co-located Birth Centre at City Hospital. The main additional benefit of a stand alone birth centre within Sandwell would be more local access for Sandwell women.

Other identified benefits to delivering in a stand alone birth centre include:

- High levels of normal births
- Low levels of caesarean sections
- Higher levels of intact perineum
- Lower episiotomy rates
- More babies remaining with their mothers
- Lower transfer rates for women

- Shorter labours
- Lower rates of intra-partum analgesia
- Greater continuity of care and greater satisfaction with care
- Women are more likely to breastfeed their babies
- Higher personal satisfaction and self-esteem
- Women experience fewer problems in infant/maternal attachment processes.

The risks associated with birth centres relate to the need to transfer women in labour to a Consultant led delivery suite if complications arise. There are a number of mitigating actions including clear risk assessment throughout pregnancy and labour, clear exclusion criteria, robust transfer policies and arrangements, appropriately experienced and skilled midwives. Transfer from a stand alone birth centre will require an ambulance with paramedic crew and midwife escort. The evidence is that transfer rates are higher in stand alone (20-30%) birth centres (compared to transfer rates of 18-20% from a co-located birth centre) and the decision to transfer will be made at an earlier stage.

The proposal in Option 3 is for a stand alone birth centre in a community location in Sandwell but not on the Sandwell Hospital site. This is felt necessary to ensure that women understand that this is a stand alone birth centre without the back up and support of an onsite consultant led delivery suite and so any complications will require an ambulance transfer to another hospital. There is a risk that if the stand alone Birth Centre was on an Acute Hospital site women may perceive there to be emergency back up on site because there are operating theatres and doctors from other specialities when in reality this is not the case because there is not a consultant led Delivery Suite on site. It is important to ensure that only women who meet the clinical criteria are booked to the stand alone Birth Centre and that other women with high risk pregnancies don't present to the stand alone Birth Centre assuming a full range of emergency back up and support and thereby increase the risk to themselves and their babies of complications and the need for emergency transfer to a consultant led Delivery Suite in another hospital.

The Project Steering Group are identifying potential locations in Sandwell for the stand alone Birth Centre and in the meantime have used a potential location in Wednesbury for the purposes of developing some financial planning assumptions.

It is proposed that the stand alone Birth Centre should provide 3 birthing rooms and one birthing pool. The model is based on an average length of stay post birth of 6 hours with this taking place in the birth room. There will be no 'inpatient beds' in the Birth Centre and no plans to undertake any antenatal outpatient activity in the Birth Centre (this will take place either at home or in other community locations). The development of a stand alone Birth Centre in Sandwell is in line with national guidance in terms of choices offered to women and with the *Right Care Right Here* Strategic Model of Care for Maternity services. The stand alone Birth Centre if financially and clinically viable would therefore be a longer term development and could remain in place once the new Acute Hospital is open.

The proposed staffing model is an integrated team across the community and Birth Centre but with a minimum of one trained midwife and one HCA on duty in the Birth Centre at all times. This requires an additional 5.5wte (whole time equivalent) midwives and 5.5wte Health Care Assistants.

The number of anticipated births for the first year of operation is approximately 100-300 with an estimate for future years of 400 births. The initial work undertaken on the financial analysis suggests that a stand alone Birth Centre in Sandwell would need the proposed 400 births to break even (see below).

Option 3 recognises that the stand alone Birth Centre would require a period of planning and development over 18 months to 2 years in order that staff development, leadership, and training can be put in place to support the new service model of care and for further public engagement to take place which would be essential to increase public understanding about the nature of a stand alone Birth Centre.

5. NON FINANCIAL OPTION APPRAISAL

5.1 Non Financial Evaluation Criteria and Scores

The identified benefit criteria (see table 2 above) were used as evaluation criteria to assess the long list of options in order to agree a short list to go forward for a more detailed option appraisal and public consultation. The benefit relating to the value for money of the stand alone Birth Centre was not included as an evaluation criteria as this is covered in the financial analysis.

A long list of seven options were then evaluated against the evaluation criteria by the .Project Steering Group and subsequently reviewed by an extended Reference Group. The long list was also shared with a small group of stakeholders and users through an event for potential service users, who currently reside in Sandwell and HoBtPCT areas at which users were invited to evaluate each of the 7 options. Four of the evaluation criteria scored by the Project Steering Group (*continuity of care, safe care, ensure that the future workforce is fit for purpose, value for money of the stand alone Birth Centre*) were excluded as criteria for the stakeholder evaluation as it was felt that stakeholders would not have the knowledge to be able to score these.

A short list of options was drawn up based on support for the option (in the form of at least 50% of the total possible score) from at least two of the Steering Group, Reference Group and Stakeholder/User event. The Project Steering Group considered whether to weight the evaluation criteria but decided against this on the basis that the number and range of criteria gave sufficient emphasis to the criteria that would have attracted a higher weighting (i.e. clinical safety, public confidence, etc). A retrospective sensitivity analysis with weighted criteria has since been undertaken and produced the same results in terms of short listed options.

The original short list was further amended to take account of feedback from the pre-engagement work with users and the advice from the Working Group of the Joint Health Scrutiny Committee. This resulted in the addition of option 2 to the short listed options and removal of the Do Minimum option from the short listed options.

The scores (un-weighted) for the three short listed options that have been consulted on and the Do Minimum option are summarised in table 4.

Table 4: Option Scores

		Option Scores			
Benefit Description	**Maximum Score Possible**	**Do Minimum**	**Option 1**	**Option 2**	**Option 3**
Promotion of normality in birth	8	2	5	5	7
Safe care	8	2	6	3	7
Continuity of care	4	2	3	1	4
Better care closer to home	8	4	1	3	4
Increased choice and control for service users	8	2	1	3	4
Improved patient experience	8	3	4	4	5

		Option Scores			
Benefit Description	**Maximum Score Possible**	**Do Minimum**	**Option 1**	**Option 2**	**Option 3**
Promotion of normality in birth	8	2	5	5	7
Maintain and improve public confidence	8	3	4	2	4
Ensure that the future workforce is fit for purpose	4	0	3	1	4
Total Score	52	18	27	22	39

5.2 Consultation

Section 242 (1B) of the NHS Act 2006 came into force on 3 November 2008 and applies to SHA's, PCT's and NHS trusts and NHS foundation trusts. It places a duty (formal legal requirement) on NHS organisations to make arrangements to involve users, whether directly or through representatives in:

- planning the provision of services
- the development and consideration of proposals for changes in the way services are provided, and
- decisions to be made affecting the operation of services.

The pre-consultation engagement activity and formal public consultation undertaken as part of the medium term review of Maternity Services is in line with Section 242 (1B) of the NHS Act 2006.

In addition wide engagement (i.e. in addition to users also with key stakeholders and staff) is a significant feature of good project management for reviews with the potential to involve service change. The Project Steering Group recognises and supports this view and such engagement has been an important feature of the pre-consultation phase of the review as well as the formal public consultation phase.

The pre-consultation engagement phase involved work with service users regarding maternity services through two sets of activities:

- People were asked to complete a questionnaire which focused on their preferences with regard to the type of maternity services they would like to receive. Questionnaires were completed by 544 people across Sandwell and West Birmingham, the large majority of whom were women.

- Focus groups were held with mothers in order to ascertain the views and experiences of mothers using maternity and newborn services available in Sandwell and West Birmingham.

A number of significant issues were highlighted (these were reported to the September meeting of the Board) and these were used to test and amend the short list of options and in particular resulted in the inclusion of option 2 in the short list for public consultation.

As part of the pre-consultation engagement, three staff engagement workshops were held at an early stage with frontline staff involved in providing maternity services within the Trust. These workshops

followed the principles of *Listening into Action* (LiA) and asked staff to consider a number of potential service models and to highlight benefits and issues with each for women and staff. 110 staff attended the workshops and included staff based at both Hospitals and from a range of professional backgrounds and specialities. The feedback from these events was used to inform the development of options and the evaluation criteria.

The Project Steering Group attended two meetings of the Working Group of the Joint Health Scrutiny Committee as part of the pre-consultation engagement and shared proposals, short listed options, the draft consultation document and proposed consultation framework. Discussion at these meetings raised some important issues and resulted in helpful changes to the short listed options to be included in the consultation (in particular the exclusion of the 'Do Minimum' option), draft consultation document and framework.

Following agreement at the September meetings of the Trust and Sandwell PCT Boards, Sandwell PCT commenced formal public consultation on the three short listed options was commenced on 12th October 2009. An external consultancy developed the consultation document, recorded public meetings, received and analysed the responses to the consultation to produce a document presenting the outcome of the public consultation. In addition six staff engagement events, following Listening into Action principles, were held for Trust staff involved in delivering maternity services, with over seventy staff from a range of roles, grades and speciality areas attending these events. The Project Steering Group attended two Joint Health Scrutiny Committee meetings – one in October to present the consultation and one in January to present the interim findings from the public consultation and answer further questions.

The document reporting the outcomes of public consultation is being presented to the Board at its meeting in February 2010 but key issues are summarised here. The findings from the public consultation process are taken from a variety of sources including:

- 21 focus groups (15 in Sandwell and 6 in Heart of Birmingham areas), facilitated by Merida Associates (who kept written records of each group).
- 7 public meetings (4 in Sandwell and 3 in HOB).
- Sandwell PCT and HOBtPCT Patient and Public Involvement (PPI) teams visited a number of maternity service sessions, such as antenatal clinics, to complete the questionnaire with people accessing services.
- Sandwell PCT PPI staff provided questions and comments sheets from presentations given to 125 people from the community though Sandwell Link, the Patient Experience Forum and voluntary and community organisations.
- Comments from Joint Health Scrutiny Committee (12th January 2010)
- Comment from RCRH (30th October 2009) and
- Staff consultation activity carried out by SWBH Trust with over 70 staff, plus another 11 people through informal consultation.

Everyone who attended a focus group or public meeting was encouraged (and supported) to complete a maternity services medium term review questionnaire.

The above resulted in 780 completed questionnaires from within the consultation document or via websites and sent directly to Merida Associates for analysis, using a freepost address.

Of the 780 people who completed the questionnaires:

- 682 (88%) were women
- 63 (8%) were men (35 people gave no answer to the question about gender).
- 30 (4%) identified themselves as having a disability with a further 9 people indicating they were not sure whether or not they were disabled.

From the completed questionnaires the assessment of options was:

- Option 1 Was the preferred option for 201 (26%) people
- Option 2 Was the preferred option for 185 (24%) people
- Option 3 Was the preferred option for 327 (42%) people

In addition:

- 24 (3%) people stated on the form that they did not wish to chose any of the above options and
- a further 43 (5.5%) people completed the questionnaire but did not chose an option.

On the basis of the above, Option 3 is clearly the preferred option from public consultation.

Across all the options, there were a number of commonly raised concerns and these have been summarised below.

Table 5: Common Concerns Raised in Public Consultation

Issue	Concerns
Travel	• The distance between where people lived and City Hospital • Women were also concerned about the potential travelling time when they were in pain. • The time it would take to get from where they lived to City Hospital, particularly during peak travel times. • Women who knew they had shorter or more spontaneous labours were concerned whether or not they would get to City Hospital in time to give birth. • The time it would take to reach City Hospital in an emergency. • The ability of the ambulance services to cope with any increases in demand. • The increased cost of travel was a common issue • The transfer time from a stand alone Midwife-Led Unit to City Hospital for any low risk women who experienced unexpected complications in labour or delivery. • A number of people raised concerns about the lack of public transport routes/links between parts of Sandwell and City Hospital.
Parking	• The capacity of the City Hospital site to cope with the additional staff and visitor parking requirements.
Visiting	• Increased travelling time and increased or additional travel costs for visitors. • Visiting hours at City Hospital were felt to be shorter and less flexible.
Capacity from increased births at	• Access to birthing pools and other choices for

City Hospital	giving birth. • Staff time and the support they are able to give to women during and following birth. • Impact this may have on support services such as catering, housekeeping, cleaning and laundry.
The majority of people in Sandwell wanted to be able to give birth in Sandwell for a number of reasons including	• Ease of access for themselves and their families. • Familiarity – focus group participants in Sandwell said they felt comfortable with the hospital, that they knew how to get there, that they knew the journey time and knew their way around the site. • In addition some respondents did not agree with any of the options - they wanted to be able have children born in Sandwell. • Across focus groups and questionnaire comments, it is clear that people feel that Sandwell is fine as it is – even when the consultation document and presentations at consultation events, public meetings and focus groups talked about issues of quality and safety. • People would like to see improvements made to the existing Sandwell facilities.

The Project Steering Group recognises the importance of these concerns and the need to ensure plans for making changes to the service consider and address these. The Project Steering Group's initial response is:

Travel:

- Include clear travel directions, including common bus routes in patient information given to women when they book with the service.
- Continue discussions with public transport providers about bus routes.
- Promote the option of women using the Trust shuttle bus service between Hospital sites.
- Continue to liaise with the ambulance service.

Parking:

- Undertake a survey of Sandwell maternity staff to establish how many travel to work by car.
- Promote the Trust shuttle bus service between Hospital sites and keep the times it operates under review.
- Review car parking capacity at City Hospital.

Visiting:

- Work with women to agree the best visiting times.

Capacity at City Hospital:

- Opening of the co-located Birth Centre at City Hospital will help to increase capacity with additional birth rooms and birthing pools and offer women more choice for giving birth.
- Undertake some refurbishment work at City Hospital to increase bed capacity and capacity on Delivery Suite.
- Maintain midwifery to birth ratios at current levels as a minimum.
- Transfer maternity staff from Sandwell to City Hospital.

Concerns about not being able to give birth in Sandwell:

- Be clear that the consolidation of consultant led maternity services, including births at City Hospital is an interim position until the new Acute Hospital opens in Smethwick in 2015/16. The consultant led maternity services will then transfer into the new Acute Hospital and so women will then be able to give birth in Sandwell.
- Be clear about the improvements to services for high risk women including consultant presence on Delivery Suite for longer hours, introduction of specialist consultant led antenatal clinics and better recruitment of staff.
- Establish a stand alone Birth Centre in Sandwell.

The Project Steering Group will produce a dissemination plan to ensure that the Trust and PCTs fulfil their responsibilities to report on consultation findings to all those who participated.

5.3 Equality Impact Assessment

The requirement to undertake an Equality Impact Assessment is contained within the Race Relations (Amendment) Act 2000. This requires listed public authorities to conduct an assessment of the impact of their current or intended policies, programmes and service delivery for any disadvantageous experiences or outcomes to black and minority ethnic groups and to take action to remove inequalities.

In addition, the Disability Discrimination Act 2005 has placed a duty to promote disability equality on all public sector authorities. This duty includes arrangements for impact assessment with regards to disadvantageous experiences or outcomes of people with disabilities. The Equality Act 2006 creates a duty to promote equality between men and women which includes conducting impact assessments for gender equality and a requirement to take account of religion and sexual orientation in the provision of education and services.

The assessment of impact is undertaken through the implementation of a robust Equality Impact Assessment (EQIA). The EQIA is a systematic way of assessing whether any of the proposed service model options could potentially have a differential impact on diverse groups covered by Equality legislation.

The Trust and Sandwell PCT have extended the scope of their equality impact assessment process beyond legal requirements for monitoring impact, to include groups characterised not only by race, disability and gender or gender identity; but also to include age, sexual orientation and religion or belief.

In addition, the significant impact of the proposed changes to maternity services has facilitated the need for this approach to be revised in two ways:

- To extend the scope of the equality impact assessment to include the impact on groups resulting from social economic status. This is particularly important due to the significant high levels of social and economic deprivation amongst population groups that will access maternity services within the Sandwell and Heart of Birmingham PCT patient boundaries.

- To amalgamate the EQIA screening and full assessment process into one continual assessment to ‘run alongside’ the medium term maternity review decision making process. This will ensure that the equality impact assessment outcomes underpin, strengthen and inform the medium term maternity services decision making process at each stage of the review.

The Project Steering Group in undertaking this amalgamated approach to the EQIA assessment is following the stages outlined below.

Stage 1 – 4

The process commenced with a workshop for members of the Project Steering Group, facilitated by the Sandwell PCT Head of Equality and Diversity, to identify:

- The intended beneficiaries of the 3 short listed maternity options.
- The benefits or outcomes each beneficiary should expect to receive from the 3 short listed maternity options.
- The potential for any of the beneficiaries identified above, to receive differential outcomes or not to receive the intended outcomes, in comparison to other groups resulting from differences characterised by:
    - Race
    - Disability
    - Gender and Gender identify
    - Age
    - Sexual Orientation
    - Religion and Belief
    - Social and Economic Deprivation

Information gathered from this stage of the equality impact assessment along with the progress and findings to date are contained within a progress report which will be developed as further work is completed and will culminate in a Full Equality Impact Assessment Report once all stages described here are complete.

Some of the key outcomes of this stage of the EQIA process are presented below:

- The groups about which further information and evidence of potential impact is required: Limited evidence was available about the impact of existing maternity services on Lesbian and Transgendered women, new migrant communities and women that have experienced female genital mutilation (FGM). The consultation plan was revised to include additional engagement with the following groups: Somali women / FGM, BME women, Disabled groups, Travelling Communities

- The equality impact assessment of the 3 selected proposed maternity service models identified a number of benefits which included; overall improvement to services and birthing experience for all women experiencing antenatal and intra partum care. Those women deemed to have high risk pregnancies will benefit from improved access to senior clinicians and specialist services. Women with low risk pregnancy would benefit from reduced levels of medical intervention, increased choice and control in labour, resulting in “normalizing” of the birth experience.

- The equality option appraisal also revealed distinct benefits for the workforce; through the possibility to extend the variety of experience within the service models likely to be attractive across the age profile of the work force; thereby positively impacting on recruitment, retention and succession planning.

- Conversely, the assessment process highlighted the potential disadvantageous or negative impact on groups. An action plan for addressing these will be developed and implemented by the Project Steering Group. This work is currently in progress.

The findings of the work above were fed into the consultation process to ensure engagement with the various groups identified.

Evidence is currently being gathered to substantiate the decisions of the Project Steering Group and will be included in the Full Equality Impact Assessment Report.

Stages 5 – 9:

Following agreement of on the preferred option, the following process will be completed:

Stage 5 Review proposed actions for the selected option
Stage 6 Involve relevant groups in developing the implementation plan and ensure ongoing consultation and engagement with identified groups
Stage 7 Implement an equality action plan to address issues identified through the assessment
Stage 8 Monitor impact of selected option in line with issues identified
Stage 9 Publish the assessment of this monitoring.

6. ESTIMATED CAPITAL COST AND FUNDING

6.1 Capacity

The proposed activity analysis (see below) has been used to determine the capacity required under each of the short-listed options along with assumptions about improved service models. These assumptions include:

- Average length of stay in main Delivery Suite of 12 hours
- Average length of stay in Birth Centre (collocated or stand alone) 18 hours
- Women who give birth in the Birth Centre are discharged home 6 hours after birth
- Women who give birth in main Delivery Suite are admitted to a maternity bed on a ward after birth
- Average length of stay in maternity bed on a ward is 1.8 days
- Average occupancy in all areas is 75%.

The proposed delivery room and maternity bed capacity in each option is summarised below.

Table 6: Proposed Capacity

	Delivery Rooms		**Maternity Beds**	
	Sandwell	**City**	**Sandwell**	**City**
2009/10	***Delivery Suite:*** 8 (no triage rooms or birth pool. No induction, High Dependency or Recovery beds)	***Delivery Suite:*** 12 (including 1 birth pool) & 4 triage rooms, 2 High Dependency Beds, 2 recovery beds	21	21
Do Minimum	***Delivery Suite:*** 8 en suite & 4 triage rooms, 1 birth pool, 2 High Dependency beds	***Delivery Suite:*** 12 (including 1 birth pool) & 4 triage rooms, 2 High Dependency Beds, 2 recovery beds ***Co-located Birth Centre:*** 5 (including 1 fixed birth pool but option of portable birth pools in all birth rooms)	21	21
Option 1	0	***Delivery Suite:*** 11 (including 1 birth pool) & 6 triage rooms, 2 High Dependency beds, 4 recovery beds, 2 Induction	0	42 with ability to increase by an additional 4 beds at peak times

		beds ***Co-located Birth Centre:*** 5 (including 1 fixed birth pool but option of portable birth pools in all birth rooms)		
Option 2	0	***Delivery Suite:*** 11 (including 1 birth pool) & 6 triage rooms, 2 High Dependency beds, 4 recovery beds, 2 Induction beds ***Co-located Birth Centre:*** 5 (including 1 fixed birth pool but option of portable birth pools in all birth rooms)11 (& 6 triage rooms and 2 induction beds) in Delivery Suite & 5 in MLU	0	42 with ability to increase by an additional 4 beds at peak times
Option 3	***Stand Alone Birth Centre:*** 3 (including 1 fixed birth pool but option of portable birth pools in all birth rooms)	***Delivery Suite:*** 11 (including 1 birth pool) & 6 triage rooms, 2 High Dependency beds, 4 recovery beds, 2 Induction beds ***Co-located Birth Centre:*** 5 (including 1 fixed birth pool but option of portable birth pools in all birth rooms)	0	42 with ability to increase by an additional 4 beds at peak times

6.2 Refurbishment Work

All of the short listed options require capital work to improve and expand facilities. Details of the work required are summarised below.

Table 7: Capital Costs

Expenditure/Funding Item	Do Minimum			Option 1			Option 2			Option 3		
	£'000s 10/11	£'000s 11/12	£'000s Total	£'000s 10/11	£'000s 11/12	Total	£'000s 10/11	£'000s 11/12	Total	£'000s 10/11	£'000s 11/12	Total
Buildings & Equipment	2,424	932	**3,356**	1,521	330	**1,851**	1,521	330	**1,851**	1,521	330	**1,851**
Funding												
Other Externally Generated Funds - Loan			**3,356**									
Trust Capital Programme						**1,851**			**1,851**			**1,851**

A detailed appraisal of capital costs has been undertaken for each option and can be found in Appendices 1-4. Estimated values and timelines are included within the above table. The key assumptions are:

Do Minimum: Capital costs are associated with a refurbishment of the Sandwell site including a new build extension to the existing Delivery Suite at Sandwell Hospital to provide accommodation to the size and standard required to meet current standards for a Delivery Suite.

The scheme duration is assumed to overlap two financial years and funding is assumed to come from loans, rather than the Trust's own Capital Programme.

Options 1&2: The capital costs associated with these options are the same. The capital expenditure is split across two years to reflect the improvements required to Maternity infrastructure on the City site, £1.5m to increase bed and Delivery Suite capacity in order to accommodate the activity transferred from Sandwell. This involves:

- Relocation of an admin office to a portacabin
- Loss of the Maternity Board Room
- Relocation of the Antenatal Day Assessment Unit and Transfer Lounge (from M1)
- Refurbishment work on ward M1
- Refurbishment work on Delivery Suite to increase triage, improve reception and the waiting area, introduce an induction area, increase recovery spaces, improve the scrub facilities in the second theatre, upgrade the birthing pool.

In addition it includes decanting and decommissioning the vacated Maternity block at Sandwell Hospital in 2011/12, £330k. This involves relocating the services that would otherwise remain in the Maternity block (including offices, Colposcopy facilities, Alpha Suite, HIV clinic facilities) so that the building can be closed to release facility costs and capital charges.

This scheme has been earmarked for prioritisation within the Trust's Capital Programme for 2010/11 and 2011/12.

Option 3: Option 3 is identical to Options 1& 2, but it should be noted that the location of a stand alone Birth Centre in the Sandwell borough has been assumed to not require Trust capital resources. It is expected that this facility would be located within PCT premises and all capital associated costs would be borne by the PCT. The revenue position therefore assumes a premises rental charge of circa £150k (as identified by the PCT).

7. ESTIMATED REVENUE COSTS AND INCOME (FULL YEAR EFFECT)

A detailed analysis of each Options' I&E position between 2010/11 and 2013/14 can be found within appendices (1 to 4). A snapshot summary of the 2013/14 position is included within section 7 to reflect the first year where comparison may be made as full implementation has occurred.

7.1 Context

The basis for assessing the overall financial impact on Obstetric services stems from Service Line Reporting (SLR) results for 2007/08, 2008/09 and relevant updates to reflect any impact of the Trust's operational plans for 2009/10. This analysis forms the baseline trading assessment for Obstetric services and shows an overall trading loss across all maternity related services of £4.56 million.

7.2 Option Appraisal

The financial appraisal undertaken to assess future income and costs across four years for all options can be found by reference to appendices 1 to 4. The following provides a flavour of the key changes taking place for each option.

Do Minimum: This option maintains the Obstetrics service provision on the Sandwell site and seeks to reinforce the infrastructure in both building stock and additional staffing costs to enable safe practice to be achieved.

Key changes which impact upon the long-term financial position include:

- Additional capital charges/loan interest charges to service the required capital expenditure of circa £250k by 2013/14.
- Additional Consultant cover, 1whole time equivalent (wte)

- Additional Midwives, 2 WTEs
- Additional support to maternity theatres at City by introducing a 24/7 "theatre runner" resulting in 5.5 additional WTEs
- To partially compensate for these additional costs an assumption has been made that projected activity growth in births and associated activities will be undertaken at a 70% marginal cost, thus generating a 30% contribution to affording this option. This assumption is common to all options.

In headline terms the option worsens the SLR trading position by circa £570k by the end of 2013/14 resulting in a forecast deficit of £5.213 million.

Options 1 & 2: The financial consideration of these options has been taken together as, although they are slightly different in content, they are the same in overall financial and economic terms.

There are a number of important assumptions which underpin these options, in particular,

- Future birth activity forecasts have been amended from 2011/12 to assume a catchment loss of 22% of Obstetric related activity (circa 600 births). This is consistent with the catchment change principles embedded within RCRH modelling. This assumes circa £1.6 million worth of income is lost in 2011/12. No specific offsetting reductions to direct costs have been applied because,
- Growth of circa 200 births per annum (£550k) has been included for non Sandwell commissioners for births which may be repatriated to City Hospital post full implementation of the option to a maximum of 600 births. No additional costs have been included for these births as no cost have been removed for the Sandwell catchment loss; however, phasing of the birth repatriation assumes a three year trajectory as opposed to catchment loss occurring all in one year.
- The assumption of only 70% of new growth ("non repatriation") related income requiring new costs is included within both options.
- These options also include a forecast reduction in capital charges (£766k) associated with closing and revaluing the current Sandwell maternity block from 2011/12 onwards. The resultant need for an economic impairment of circa £1.7 million has not been included within this analysis, thus delivery of the depreciation saving will be dependant upon the Trust's ability to afford the technical impairment. The Trust would envisage submitting an application to the StHA "Strategic Change Fund" for 2011/12 to gain financial assistance in dealing with the economic impairment.
- Additional costs are included to cover the "theatre runner" as indicated earlier but a saving of a theatre team has been including reducing costs by £550k by the end of 2011/12.

The impact on overall affordability depends upon whether one includes the capital charge savings and sets aside the impairment, or whether one assumes this will not be possible within the scope of the business case. In either case both options deliver an improved overall SLR trading position by the end of 2013/14. The magnitude of the improvement is dependant upon the capital charge/impairment issue but is within the range of circa £500k to £1.3 million. Consideration of how the Trust may handle the economic impairment has not been factored into the long-term financial forecasts which are presented assuming the impairment becomes affordable. The Overall Financial appraisal ranking table (Table 11 below) demonstrates the headline changes on financial viability over the four year period assuming the capital charge savings are realised. The table also reflects the overall affordability impact should the targeted capital charge saving not be achievable in this timeline. In this scenario Options 1& 2 still improve affordability but not as significantly as might be possible through generating the capital charge saving.

Option 3: The assumptions, outcomes and risks within Option 3 are largely consistent with Options 1&2. Where they differ is with regard to the introduction in 2012/13 of a stand alone Birth Centre in Sandwell. Modelling assumes a part year effect of 160 births in 2012/13 leading to 400 births in 2013/14. An I&E summary for the stand alone Birth Centre is attached at Appendix 6.

- The stand alone Birth Centre is forecast to generate £900k of income from 400 births by the end of 2013/14.
- Additional investment is required to run the stand alone Birth Centre. This requires an extra 12 wte's at a cost of £143k .
- Sandwell PCT has identified a charge on £150k in respect of site rental/occupation.

Table 8: Summary Affordability Position

	Do Minimum	Option 1	Option 2	Option 3
	2013/14			
	£000's	£000's	£000's	£000's
Income				
Births	13,502	13,517	13,517	14,425
All Other Income	15,021	15,129	15,129	15,029
Total Income	**28,523**	**28,647**	**28,647**	**29,454**
Expenditure				
Pay	(21,881)	(20,996)	(20,996)	(21,439)
Non-pay	(8,812)	(8,644)	(8,644)	(8,944)
Facilities Charge				(150)
Capital Charges	(3,061)	(2,194)	(2,194)	(2,194)
Total Expenditure	(33,754)	(31,834)	(31,834)	(32,726)
Obstetrics Overall Forecast Trading Position Surplus/(Deficit)	**(5,231)**	**(3,187)**	**(3,187)**	**(3,272)**
Costs Saved By 12/13				
Pay				
- Theatre team saving	0	550	550	550
- Disestablishment of 2 midwifery posts	0	105	105	105
Sub-total pay	0	655	655	655
Non-pay				
Capital Charges		766	766	766
Total Savings	**0**	**1,421**	**1,421**	**1,421**

The financial analysis above demonstrates the forecast Obstetrics trading position in 2013/14 following all of the issues outlined above. In the 2013/14 year the trading position across options is forecast to be:

- Do Minimum-£5,231k
- Option 1-£3,187k
- Option 2- £3,187k
- Option 3- £3,272k

Set against a background of a baseline deficit of £4.6 million options 1 to 3 all improve the overall trading position. The "Do Minimum" Option worsens the trading position.

8. STAFFING NUMBERS (FULL YEAR EFFECT)

All of the short listed options involve changes to staffing numbers within the Obstetric services. These are:

Do Minimum: Additional staff to ensure the sustainability of intra-partum care and consultant led services at Sandwell including an additional consultant, a clinical tutor and specialist Diabetic midwife for Sandwell, additional administrative support for these posts and an additional member of the theatre team.

Options 1&2: An additional member of the theatre team at City Hospital. In addition there would be a reduction of 2 senior midwifery posts (Sandwell based Matron and Delivery Suite manager) and of the Sandwell based dedicated maternity theatre team.

Option 3: As for options 1 and 2 but in addition a team of staff for the stand alone Birth Centre (to ensure a minimum of 1 trained midwife and one Health Care Assistant on duty at all times) and administrative support.

Table 9: Additional Staff (wte) Generated From the Detailed Option Appraisal.

Additional Staff	Do Minimum	Option 1	Option 2	Option 3
	wte's	wte's	wte's	wte's
Consultant	1.00			
Theatre Runner	5.50	4.10	4.10	4.10
Midwives	2.00			
Midwives - MLU				11.00
Admin Support	1.00			1.00
TOTAL	9.50	4.10	4.10	16.10

9. ACTIVITY (EXPRESS ON FULL YEAR BASIS)

The activity matrix in appendix 5 identifies the key activity changes per annum across 4 years by option to show the impact upon birth related admitted patient care, non birth related spells and outpatient attendances.

Baseline activity volumes have been derived from RCRH modelling (snapshot taken Summer 2009) amended by revised timeline judgments of catchment loss and targeted activity currently seen elsewhere.

The activity volumes broadly represent growth on this year's forecast outturn and do not consider the impact of the latest version 5.1 RCRH activity and capacity assumptions which materially reduce birth estimates in 2010/11.

10. INVESTMENT APPRAISAL

Table 10: Investment Appraisal

	Do Minimum	OPTION 1	OPTION 2	OPTION 3
	£'000	£'000	£'000	£'000
4 Year Period				
Income	647	771	771	1,579
Expenditure	(1,317)	603	603	(304)
TOTAL SURPLUS/(DEFICIT)	**- 670**	**1,374**	**1,374**	**1,274**
INVESTMENT APPRAISAL SUMMARY				
Average Annual Deficit over the 4 year period	(134)	275	275	255
CAPITAL INVESTMENT	3,356	1,851	1,851	1,851
Internal Rate of Return		15%	15%	14%
Annual Depreciation per annum	(233)	(130)	(130)	(130)
Payback Period in Years	(14)	(14)	(14)	(14)
Discounted Cash Flow	(12,416)	(7,990)	(7,990)	(8,268)
Ranking	**3**	**1**	**1**	**2**

NB
Where IRR is negative the appraisal assumes no actual rate of return

Depreciation payback of proposed capital expenditure is circa 14 years.

Options 1-3 generate a technical rate which reduces the Maternity trading SLR deficit proportionately per annum. The Do Minimum option generates no rate of return as overall costs exceed yet further achievable income levels.

Discounted cash flow techniques have been applied to determine the future value of cash flows and options have been ranked in terms of the lowest NPV generates the best economic solution.

The table below ranks all options in terms of their economic and affordability score.

The ranked financial assessment headed “NPV Over Period” demonstrates the discounted cash flow result over the four year lifespan. The lowest Net Present Value of all the options is 1&2 equally.

The ranking headed “I&E Impact” demonstrates the overall SLR trading impact on Maternity services resulting from these changes. This again demonstrates Options 1&2 are the most advantageous, although the margin between them and Option 3 is minimal. This assessment includes taking the benefit of capital charge savings.

The final ranking reflects the position having removed the capital charge savings from the trading position. As this is removed from Options 1,2 and 3 equally then it does not change the overall ranking assessment.

Table 11: Option Financial Ranking

Options	NPV Over Period	Economic Score	I&E Impact Over Period	Affordability Score	Net Movement over period	I&E Impact Excl CC Benefit
	£		£		£	
Do Minimum	(12,416,482)	3	(670,209)	3	(670,209)	3
1	(7,989,616)	1	1,373,789	1	608,165	1
2	(7,989,616)	1	1,373,789	1	608,165	1
3	(8,268,222)	2	1,274,213	2	508,589	2

11. RISK ASSESSMENT AND MANAGEMENT

11.1 Clinical Risks

A sub group of the Project Steering Group identified clinical risks for each of the Do Minimum and Short Listed (1-3) Options which they then scored, identified mitigation actions and undertook a post mitigation score. These can be found in appendix 7. These risks and scores were then agreed by the Project Steering Group.

It should be noted that whilst many risks are common across all of the short listed options a number are different to reflect the risks specific to each service model. The table below summarises the clinical risk assessment in terms of risk level.

Table 11: Clinical Risks

Option	Total No. of Risks	Risk Assessment			Post Mitigation Risk Assessment		
		Red	Amber	Green	Red	Amber	Green
Do Minimum	12	9	2	1	5	6	1
Option 1	7	0	6	1	0	2	5
Option 2	7	0	4	3	0	2	5
Option 3	12	4	7	1	0	5	7

It can be seen that Do Minimum has the highest number of clinical risks assessed as red both before and after mitigation.

Option 3 is the only other option with red risks pre-mitigation but has no red risks post mitigation although the highest number and proportion of amber risks post mitigation

11.2 Activity and Financial Risks

Each option's financial appraisal is highly sensitive to the assumptions contained within it. The following are the most sensitive which would have the greatest impact upon the financial viability of any given option.

Catchment Loss: Options 1-3 assume 22% catchment loss of Sandwell births if services move to the City Hospital site. This is consistent with RCRH principles but any significant margin of error may lead to either operational capacity problems or further reductions in income which may affect viability.

Target Activity Repatriation: Significant work will be required to target circa 600 births largely from HoBtPCT commissioner and change patterns of referral and preference to grow the forecast City birth volumes. The impact of limited success in this area will worsen financial viability.

Stand Alone Birth Centre Activity: The stand alone Birth Centre in Sandwell, in Option 3 has a target of attracting back 400 births from the assumed catchment loss. Whilst Option 3 was the preferred option from public consultation there was also evidence that the public want more information to understand this option fully and it is a service not currently available locally. The impact of attracting less than 400 births may raise issues about financial, clinical and operational viability of the stand alone Birth Centre.

General Trading Position: Historic SLR analysis has formed the baseline quantum of cost for maternity services. There is an implicit assumption that the SLR exercise has generated a robust understanding of the full maternity cost quantum. It is assumed future iterations of SLR will apply refinements to the understanding of the cost base but will not worsen the trading position.

Costs: Released capital charge savings may accrue from decommissioning the Sandwell Maternity centre. However, the Trust would face a one off impairment cost which it may not be able to consider affording in 2010/11 or 2011/12. External financial assistance may be required to finance this step. Overall costs are assumed to reduce in relation to income as each future birth is forecast to generate a 30% contribution towards option affordability. If these births are not delivered then again financial viability is threatened.

Table 13: Activity & Financial Risks

Risk	Do Minimum	Option 1	Option 2	Option 3
Catchment Loss – 22% of Sandwell births		X	X	X
Repatriated City Births – 600		X	X	X
Stand Alone Birth Centre Births - 400				X
General Trading Position	X	X	X	X
Impairment Cost		X	X	X

12. PREFERRED OPTION

In summary a comparison of the 3 options short listed for public consultation and Do Minimum shows:

Table 14: Summary of Option Appraisal

	Do Minimum	Option 1	Option 2	Option 3
Clinical Case for Change	Does not meet NCAT or RCOG recommendations	Partly meets NCAT and RCOG recommendations	Partly meets NCAT and RCOG recommendations	Meets NCAT and RCOG recommendations
Non- Financial Option Appraisal Scores	Lowest score	Second highest score	Third highest score	Highest score
Public Consultation	Not included	26% of respondents preferred	24% of respondents preferred	43% of respondents preferred
Capital Costs	£3.3m	£1.8m	£1.8m	£1.8m
Affordability (based on the forecast Obstetrics trading position in 2013/14 and compared to a baseline deficit of £4.6m.)	-£5,231k	-£3,187k	-£3,187k	- £3,272k
Investment Ranking	3	1	1	2
Cash Flow	3	1	1	2
Risks - Clinical	Highest (numbers of red & amber)	Joint lowest (numbers of amber)	Joint lowest (numbers of amber)	Second Highest (numbers of amber)
Risks – Financial & Activity	Lowest	Middle	Middle	Highest

On the basis of the above, 'Do Minimum' had the weakest position in most areas of analysis.

Options 1 and 2 had the best position from a financial and risk analysis but neither of Options 1 and 2 were the preferred option from public consultation and neither fully meets the recommendations from external clinical reviews.

Option 3 has the strongest non financial appraisal score and is clearly the preferred option from public consultation. In addition Option 3 meets the recommendations of the external clinical reviews. However, it is weaker from a financial (although not significantly weaker) and risk analysis. In terms of the risk analysis Option 3 carries similar financial and activity risks to those of options 1 and 2 and whilst it has no red clinical risks post mitigation it does have the additional risks associated with attracting sufficient births to the stand alone Birth Centre to make this clinically and financially viable.

Option 3 is therefore the recommended option from the Project Steering Group.

13. CASHFLOW PHASING OF PREFERRED OPTION

Table 15: Cash Flow

			2009/10	2010/11	2011/12	2012/13	2013/14	NPV Over 4 Yrs	Ranking
			£'000	£'000	£'000	£'000	£'000	£'000	
DCF 3.5%			1.00	1.00	0.97	0.93	0.90		
	Do Minimum								
		Income	27,875,559	27,898,819	28,150,754	28,332,506	28,522,675		
		Capital Costs	0	(2,424,027)	(932,318)	0	0		
		Revenue	(29,604,181)	(30,255,914)	(30,625,019)	(30,727,245)	(30,860,363)		
		Cash flow total	(1,728,622)	(4,781,122)	(3,406,583)	(2,394,739)	(2,337,688)		
		Discounted Cash Flow	**(1,728,622)**	**(4,781,122)**	**(3,291,384)**	**(2,235,515)**	**(2,108,461)**	**(12,416,482)**	3
	Option 1								
		Income	27,875,559	27,898,819	27,186,021	27,912,074	28,646,566		
		Capital Costs	0	(1,521,040)	(329,806)	0	0		
		Revenue	(29,604,181)	(29,506,080)	(29,419,584)	(29,506,795)	(29,639,913)		
		Cash flow total	(1,728,622)	(3,128,301)	(2,563,369)	(1,594,721)	(993,347)		
		Discounted Cash Flow	**(1,728,622)**	**(3,128,301)**	**(2,476,685)**	**(1,488,689)**	**(895,942)**	**(7,989,616)**	1
	Option 2								
		Income	27,875,559	27,898,819	27,186,021	27,912,074	28,646,566		
		Capital Costs	0	(1,521,040)	(329,806)	0	0		
		Revenue	(29,604,181)	(29,506,080)	(29,419,584)	(29,506,795)	(29,639,913)		
		Cash flow total	(1,728,622)	(3,128,301)	(2,563,369)	(1,594,721)	(993,347)		
		Discounted Cash Flow	**(1,728,622)**	**(3,128,301)**	**(2,476,685)**	**(1,488,689)**	**(895,942)**	**(7,989,616)**	1
	Option 3								
		Income	27,875,559	27,898,819	27,086,021	28,175,077	29,454,073		
		Capital Costs	0	(1,521,040)	(329,806)	0	0		
		Revenue	(29,589,598)	(29,506,080)	(29,419,584)	(29,882,628)	(30,532,413)		
		Cash flow total	(1,714,039)	(3,128,301)	(2,663,369)	(1,707,551)	(1,078,340)		
		Discounted Cash Flow	**(1,714,039)**	**(3,128,301)**	**(2,573,303)**	**(1,594,017)**	**(972,601)**	**(8,268,222)**	2

The table above shows a detailed discounted cash flow analysis of all options. Options 1 and 2 show the same NPV over the four year period and therefore have the same ranking.

14. PROPOSED TIMETABLE

A detailed implementation plan will be developed once the preferred option has been approved by the Trust and Sandwell PCT at their Board meetings in February. This implementation plan will then be subject to a Gateway Review by the Office of Government Commerce in early May. The Department of Health, as part of its guidance on service reconfigurations requires such Gateway Reviews at critical points during a service reconfiguration project, with one being at the point of Business Case approval and prior to approval of the implementation plan.

In this context key drivers to implementation timescale and proposed dates are summarised below.

Table 16 : Proposed Timetable – High Level

	Expected Date of Commencement	**Expected Date of Completion**	**Comments**
Trust Boards' approval of preferred option (Sandwell PCT, SWBH, HoBtPCT)		End of February 2010	
Development of Implementation plan	February 2010	End of April 2010	
Gateway Review	Preparation – February 2010	Early May 2010	
Trust Boards' approval of Implementation Plan (Sandwell PCT, SWBH, HoBtPCT)		End of May 2010	
Review of all clinical policies and pathways for intra-partum care and consultant led ante-natal care	March 2010	End of September 2010	
Review of staffing arrangements (i.e. rotas, shift patterns, consultation with individuals)	March 2010	November 2010	
City Refurbishment	March 2010 following Trust Board approval	January 2011 with possibility of bringing forward to October 2010 in line with clinical safety concerns	Depends on risks and feasibility of parallel work streams
Transfer of Service		January – April 2011	Depends on completion and operational commissioning of refurbished areas at City Hospital
Decant of Maternity Block at Sandwell	April 2011	Summer 2011	
Establishment of a team of midwives for the stand alone Birth Centre	April 2010 following opening of co-located Birth Centre (at City Hospital)	October 2011	
Stand alone Birth Centre in Sandwell	To be confirmed once location agreed		Depends on location and amount of building work required. Sandwell PCT are looking at options.

15. JOINT HEALTH SCRUTINY COMMITTEE

At its meeting on 7th January 2010 the Joint Health Scrutiny Committee considered its response to the short listed options in *Improving Services for Giving Birth* as part of the public consultation. The Committee resolved that whilst ideally it would have preferred the full maternity provision to remain in Sandwell, it would support Option 3 but with the caveat that the stand alone Birth Centre is built and operational in Sandwell before maternity services are withdrawn from Sandwell Hospital. In addition the Committee resolved that if this option with the caveat is not supported by Sandwell PCT Board, the Committee is 'minded' to refer the matter to the Secretary of State for Health since it believes the proposals in the consultation document as they stand are not in the interests of the local health service because:

- They do not fit with the national choice guarantee or care closer to home agenda
- Concerns about capacity at City Hospital to deal with an increase in the number of births
- More research is required to give a full regional perspective.

The Project Steering Group has carefully considered the caveat proposed by the Committee and has concluded that this is not achievable because:

- The caveat would require delaying the consolidation of high risk births at City Hospital. Such a delay would be clinically unacceptable for all the reasons outlined in the clinical case for change and subsequently endorsed by NCAT. A recent review of the service at Sandwell and the ongoing risks of maintaining this service has shown that whilst there have been improvements there are also significant continuing concerns. Any delay substantially increases the potential for emergency closure of the Sandwell site on clinical grounds. The risks associated with unplanned closure cannot be underestimated for example, City Hospital would not have the capacity to accommodate the Sandwell births until the refurbishment work outlined in this Business Case is complete. There is evidence of limited capacity in other local hospitals and so there is a high possibility that some Sandwell women would need to be transferred out of the local (Birmingham and Black Country) area to give birth in this situation.

- Establishing a stand alone Birth Centre prior to reconfiguring Consultant led / high risk services to City Hospital will detract focus from the mitigation of risks already associated with sustaining services over 2 sites (City and Sandwell) and will, initially at least, introduce a significant further level of risk over and above that already identified at and persisting at Sandwell.

- Perinatal mortality rates in Sandwell are high. Spreading already limited staffing resources over an additional area will further impact upon the quality of care provision across the whole service and potentially exacerbate issues affecting perinatal mortality

- Establishing a stand alone birth centre requires the expertise of highly skilled and experienced midwives familiar and comfortable with this unique model of care i.e. undertaking risk assessments, working independently of doctors, independent decision making etc. Midwives working within the Trust's maternity service are not currently exposed to a midwifery led model of care. This is reflected in the very low percentage of home births and high intervention rates amongst low risk women. Historically, recruitment to the Trust has been poor and is one of the key drivers for making the proposed changes. Recruitment to the co-located Birth Centre at City Hospital in the first instance will allow midwives to develop their skills and expertise and become familiar with this model of care – this will occur in an environment where there is immediate access to emergency medical support and where there is an established infrastructure of training, supervision and support. This cohort of midwives would then be suitably equipped to provide expertise in the stand alone Birth Centre. Developing this expertise will take a minimum

of 18 months. Establishing the stand alone Birth Centre without these skills is clinically unacceptable.

The Project Steering Group however recognise the concerns raised by the Joint Health Scrutiny Committee and consider it important to minimise the time between reconfiguring consultant led/high risk births to City Hospital and opening the stand alone Birth Centre in Sandwell but without delaying the reconfiguration of consultant led/high risk births. The Project Steering Group is therefore recommending further detailed work to analyse and undertake an option appraisal as soon as possible that:

- Enables the reconfiguration of consultant led/high risk births as soon as the additional capacity at City Hospital is open (after the refurbishment work outlined above) – this is forecast to be between January and April 2011.

- Enables the development of a team of midwives with the required skills and experience to run the stand alone Birth Centre in Sandwell. This will involve developing these skills and experience through midwives working in the co-located Birth Centre at City Hospital for 18 months after it opens, as well as recruiting additional midwives – this is therefore forecast to be October 2011.

- Identifies a location in Sandwell and completes any refurbishment work required for the stand alone Birth Centre as far as possible in line with the development of a team of midwives (as above).

- In working to minimise the time between reconfiguring consultant led/high risk births to City Hospital and opening the stand alone Birth Centre in Sandwell it will be necessary to consider a number of options including existing health accommodation that has some spare clinical capacity or where this can easily be created. From the Trust's perspective if this involves one of the Trust's existing sites there is likely to be an additional (to the financial analysis for Option 3 as it currently stands) capital cost of around £1.5 million and associated additional revenue costs (i.e. additional capital charges and facilities costs). In pursuing this approach it will be necessary to undertake a robust option appraisal looking at the advantages and risks of each location as well as costs, feasibility and timescales.

The aim of this approach would be to safely minimise the period when Sandwell women would not have an option of giving birth in Sandwell (other than at home) i.e. between reconfiguration of consultant led/high risk births to City Hospital and opening of the stand alone Birth Centre in Sandwell. While any gap is undesirable, the Project Steering Group is clear that the priority must be the maintenance of the maximum possible level of safety and quality.

16. DECISION MAKING PROCESS

The purpose of this section is to set out and clarify the decision making process associated with different phases of the project.

16.1 Preferred Option

Sandwell PCT Board has the final decision to approve a preferred option for the medium term changes to the way intra-partum (labour and birth) Midwifery and Consultant led care (ante-natal care, and care during and immediately after birth) is provided by Sandwell and West Birmingham Hospitals NHS Trust for the time period up to the opening of the new Acute Hospital in 2015/16. This decision will be based upon the business case for change presented in this report .

In making this decision Sandwell PCT Board will need to take account of approval of the preferred option by Sandwell and West Birmingham NHS Trust Board through the business case being presented at its meeting in February 2010.

Sandwell PCT will also require agreement to the consultation from Heart of Birmingham teaching PCT Board. Due to the timing of the HoBt PCT Board meeting chairman's action has been agreed and will be endorsed at the HoBtPCT Board meeting in March 2010.

In approving a preferred option the Boards will need to consider the outcome of the public consultation.

16.2 Implementation

Once a preferred option has been approved a detailed implementation plan will be developed and will include user and staff engagement. This will be developed over the next two months and will be subject to a further Gateway Review. The aim will be to present the implementation plan and seek approval to implementation from the Board meetings of Sandwell PCT, Sandwell and West Birmingham Hospitals NHS Trust Board and Heart of Birmingham teaching PCT Board in May 2010.

17. CONCLUSION

This report has presented a business case for the preferred option recommended by the Project Steering Group for the medium term review of maternity services. The Business Case has presented a non financial, financial and risk analysis of the three short listed options that formed the basis of public consultation and compared this to the 'Do Minimum' position. In addition it has taken into consideration the clinical case for change presented to the Board in September 2009 and the outcome of public consultation.

The 'Do Minimum' position was not part of public consultation but included in the Business Case as a baseline and had the weakest position in the other areas of analysis.

Options 1 and 2 had the best position from a financial and risk analysis although not significantly better than Option 3. Neither of Options 1 and 2 were the preferred options from public consultation and do not fully meet the recommendations from external clinical reviews.

Option 3 has the strongest non financial appraisal score and is clearly the preferred option from public consultation. In addition Option 3 meets the recommendations of the external clinical reviews. However, it is weaker from a financial (although not significantly weaker) and risk analysis. In terms of the risk analysis Option 3 carries similar financial and activity risks to those of options 1 and 2 and whilst it has no red clinical risks post mitigation it does have the additional risks associated with attracting sufficient births to the stand alone Birth Centre to make this clinically and financially viable.

On this basis Option 3, is the recommended option from the Project Steering Group i.e.
, All consultant led care and, all in-patient services and, temporarily all births would transfer to City Hospital. A Stand Alone Midwifery Led Birth Centre would be developed within Sandwell and, once operational, some midwifery led low risk births would relocate to the new centre in Sandwell. Low risk midwifery led antenatal care and routine screening will be available in Sandwell and at City Hospital. Consultant led antenatal care would be relocated to City Hospital. All Neonatal care would be provided at City Hospital

The capital investment required by the Trust under Option 3 to create the additional capacity required at City Hospital and relocate remaining offices and outpatient based clinical services from the existing women's building at Sandwell Hospital is £1.85 million. The investment appraisal over a 4 year period for Option 3 shows a Net Present Value (NPV) of £8.29 million, an Income and Expenditure impact of £1.27million and an overall improvement in the trading position of maternity services by 2013/14 of

£508 589. Delivery of this financial position requires that 100% of future maternity income streams translate into resources available to the Women and Children Division.

The Joint Health Scrutiny Committee supported Option 3 but with the caveat that the stand alone Birth Centre is built and operational in Sandwell before maternity services are withdrawn from Sandwell Hospital. The Project Steering Group has considered this carefully and whilst not able to recommend the caveat on clinical safety and quality grounds it does recognise the importance of the concerns raised and is recommending that further work is undertaken to explore options to safely minimise the time between reconfiguring consultant led/high risk births to City Hospital and opening a stand alone Birth Centre in Sandwell without delaying the reconfiguration of consultant led/high risk births. Within this context it will be important to be clear that the priority must be the maintenance of the maximum possible level of safety and quality.

18. RECOMMENDATION

On the basis of the above analysis the Trust Board is recommended to:

- AGREE the business case for change.

- **APPROVE the Project Steering Group's recommended option i.e. Option 3:** ***All consultant led care and, all in-patient services and, temporarily all births would transfer to City Hospital. A Stand Alone Midwifery Led Birth Centre would be developed within Sandwell and, once operational, some midwifery led low risk births would relocate to the new centre in Sandwell. Low risk midwifery led antenatal care and routine screening will be available in Sandwell and at City Hospital. Consultant led antenatal care would be relocated to City Hospital. All Neonatal care would be provided at City Hospital.***

- **APPROVE the capital investment of £1.85 million required to support Option 3 and endorse the financial consequences of Option 3 i.e. targeting an overall improvement in the trading position of maternity services by 2013/14 of £508 589, recognising that to achieve this 100% of future maternity income streams need to translate into resources available to the Women and Children Division.**

- AGREE to the Project Steering Group undertaking further work to explore options to safely minimise the time between reconfiguring consultant led/high risk births to City Hospital and opening a stand alone Birth Centre in Sandwell without delaying the reconfiguration of consultant led/high risk births. To be clear however, that the priority must be the maintenance of the maximum possible level of safety and quality.

- AGREE to a more detailed implementation plan being presented to the Trust Board at its May meeting.

APPENDIX 7

DOCUMENT HISTORY

Version	Date	Author	Summary of Changes
Version 2	***25.02.10***	***Business Case submitted to the Trust Board at its meeting in February 2010***	
V2 draft 2	15.02.10	Jayne Dunn (Redesign Directors, Right Care Right Here, SWBH)	Update to incorporate : • Comments from the Project Steering Group
V2 draft 1	10.02.10	Jayne Dunn (Redesign Directors, Right Care Right Here, SWBH)	Updated to incorporate: • Comments from SIRG meeting • Inclusion of sections on Birth Centres, capacity analysis, Joint Health Scrutiny Committee
Version 1	***08.02.10***	***Financial Analysis reviewed by SIRG (SWBH) and agreed for presentation to Trust Board***	
Draft 2	07.02.10	Jayne Dunn (Redesign Directors, Right Care Right Here, SWBH)	Updated to incorporate: • Key findings from Public Consultation as per presentation given by Merida Associates to the Project Steering Group • Financial tables as discussed and agreed at the Maternity Action Team on 05.02.10 • Completion of sections not completed in draft 1 • to include Appendix for Document History
Draft 1	10	Jayne Dunn (Redesign Directors, Right Care Right Here, SWBH)	Initial Draft of Document using SWBH Business Case template and based on work undertaken by the Maternity Medium Term Review Project Steering Group and the SWBH Maternity Staffing and capacity Meetings.

APPENDIX 8

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Financial Appraisal
OPTION: DO MINIMUM

Outpatients

Heading		SWBH £'s	Year 2010/11 City £'s	Year 2010/11 Sandwell £'s	Year 2010/11 SWBH £'s	Year 2011/12 City £'s	Year 2011/12 Sandwell £'s	Year 2011/12 SWBH £'s	Year 2012/13 City £'s	Year 2012/13 Sandwell £'s	Year 2012/13 SWBH £'s	Year 2013/14 City £'s	Year 2013/14 Sandwell £'s	Year 2013/14 SWBH £'s
Income	All	- 4,139,094	- 2,457,749	- 1,721,280	- 4,179,029	- 2,459,376	- 1,680,931	- 4,140,307	- 2,426,922	- 1,594,020	- 4,020,942	- 2,394,251	- 1,504,845	- 3,899,096
Expenditure														
	Pay	2,567,468	1,710,409	876,627	2,587,036	1,711,206	856,856	2,568,062	1,695,304	814,269	2,509,573	1,679,295	770,573	2,449,869
	N Pay	671,485	492,109	187,762	679,871	484,490	187,250	671,740	459,423	187,250	646,673	433,835	187,250	621,085
	Capital Charges	499,017	228,443	270,574	499,017	228,443	270,574	499,017	228,443	270,574	499,017	228,443	270,574	499,017
Total Exenditure		3,737,970	2,430,961	1,334,963	3,765,924	2,424,139	1,314,680	3,738,819	2,383,170	1,272,094	3,655,264	2,341,573	1,228,398	3,569,971
I&E Position		**- 401,124**	- 26,787	- 386,317	**- 413,104**	- 35,237	- 366,251	**- 401,488**	- 43,752	- 321,926	**- 365,679**	- 52,678	- 276,447	**- 329,125**
Movement in I&E From 2009/10			- 10,007	- 1,974	- 11,980	- 18,456	18,092	- 364	- 26,972	62,417	35,446	- 35,897	107,897	72,000

APC & Community Midwifery

Heading		SWBH £'s	Year 2010/11 City £'s	Year 2010/11 Sandwell £'s	Year 2010/11 SWBH £'s	Year 2011/12 City £'s	Year 2011/12 Sandwell £'s	Year 2011/12 SWBH £'s	Year 2012/13 City £'s	Year 2012/13 Sandwell £'s	Year 2012/13 SWBH £'s	Year 2013/14 City £'s	Year 2013/14 Sandwell £'s	Year 2013/14 SWBH £'s
Income	All	- 23,736,465	- 13,555,108	- 10,164,683	- 23,719,790	- 13,731,459	- 10,278,988	- 24,010,447	- 13,914,788	- 10,396,775	- 24,311,564	- 14,105,402	- 10,518,177	- 24,623,579
Expenditure														
	Pay	18,582,642	10,698,479	8,122,049	18,820,528	10,784,891	8,370,809	19,155,700	10,862,223	8,416,025	19,278,247	10,955,623	8,475,512	19,431,135
	N Pay	7,782,586	4,648,396	3,352,265	8,000,662	4,685,430	3,376,270	8,061,700	4,723,929	3,401,005	8,124,934	4,763,958	3,426,499	8,190,457
	Capital Charges	2,333,220	1,300,145	1,033,075	2,333,220	1,300,145	1,122,463	2,422,608	1,300,145	1,266,311	2,566,456	1,300,145	1,262,035	2,562,180
Total Exenditure		28,698,448	16,647,021	12,507,390	29,154,410	16,770,466	12,869,541	29,640,008	16,886,297	13,083,340	29,969,637	17,019,726	13,164,046	30,183,772
I&E Position		**4,961,984**	3,091,913	2,342,707	**5,434,620**	3,039,008	2,590,553	**5,629,561**	2,971,509	2,686,565	**5,658,074**	2,914,325	2,645,868	**5,560,193**
Movement in I&E From 2009/10			30,117	442,519	472,636	- 22,789	690,366	667,577	- 90,287	786,378	696,090	- 147,471	745,681	598,209

All Service Categories

Heading		SWBH £'s	Year 2010/11 City £'s	Year 2010/11 Sandwell £'s	Year 2010/11 SWBH £'s	Year 2011/12 City £'s	Year 2011/12 Sandwell £'s	Year 2011/12 SWBH £'s	Year 2012/13 City £'s	Year 2012/13 Sandwell £'s	Year 2012/13 SWBH £'s	Year 2013/14 City £'s	Year 2013/14 Sandwell £'s	Year 2013/14 SWBH £'s
Income	All	- 27,875,559	- 16,012,857	- 11,885,962	- 27,898,819	- 16,190,835	- 11,959,919	- 28,150,754	- 16,341,710	- 11,990,795	- 28,332,506	- 16,499,653	- 12,023,022	- 28,522,675
Expenditure														
	Pay	21,150,110	12,408,888	8,998,676	21,407,564	12,496,098	9,227,665	21,723,762	12,557,527	9,230,294	21,787,820	12,634,918	9,246,085	21,881,003
	N Pay	8,454,071	5,140,506	3,540,027	8,680,533	5,169,920	3,563,519	8,733,439	5,183,352	3,588,255	8,771,607	5,197,793	3,613,749	8,811,542
	Capital Charges	2,832,238	1,528,588	1,303,649	2,832,238	1,528,588	1,393,038	2,921,626	1,528,588	1,536,885	3,065,473	1,528,588	1,532,609	3,061,197
Total Exenditure		32,436,418	19,077,982	13,842,352	32,920,334	19,194,605	14,184,221	33,378,827	19,269,467	14,355,434	33,624,901	19,361,300	14,392,443	33,753,743
I&E Position		**4,560,859**	3,065,126	1,956,390	**5,021,515**	3,003,771	2,224,302	**5,228,073**	2,927,756	2,364,639	**5,292,395**	2,861,647	2,369,421	**5,231,068**
Movement in I&E From 2009/10			20,110	440,546	460,656	- 41,245	708,458	667,213	- 117,259	848,795	731,536	- 183,368	853,577	670,209
Capital Expenditure Needs		**-**		2,424	**2,424**		932	**932**			**-**			**-**

Key Movements

Heading		Year 9/10 SWBH £'s	Year 2010/11 City £'s	Year 2010/11 Sandwell £'s	Year 2010/11 SWBH £'s	Year 2011/12 City £'s	Year 2011/12 Sandwell £'s	Year 2011/12 SWBH £'s	Year 2012/13 City £'s	Year 2012/13 Sandwell £'s	Year 2012/13 SWBH £'s	Year 2013/14 City £'s	Year 2013/14 Sandwell £'s	Year 2013/14 SWBH £'s	Cumlative over 4 years SWBH £'s
Income	Prosense V5	-	- 247,922	- 31,338	- 279,260	- 177,978	- 73,957	- 251,935	- 150,876	- 30,876	- 181,752	- 157,942	- 32,227	- 190,169	
	Births Repatriated	-			-			-			-			-	
	Catchment Loss	-			-			-			-			-	
	Additional Activity - MLU														
	Other	-	189,000	67,000	256,000			-			-			-	
	Totall Income	**-**	**- 58,922**	**35,662**	**- 23,260**	**- 177,978**	**- 73,957**	**- 251,935**	**- 150,876**	**- 30,876**	**- 181,752**	**- 157,942**	**- 32,227**	**- 190,169**	**- 647,116**
Expenditure															
	Prosense V5		173,545	21,937	195,482	124,585	51,770	176,355	105,613	21,613	127,226	110,560	22,559	133,118	
	Catchment Loss														
	Births Repatriated														
	Pay Budget Adjustments		- 170,025	- 48,025	- 218,050	-	-		-	-		-	-		
	Pay	-	75,000	263,667	338,667	0	192,750	192,750	- 12,500	- 12,500	- 25,000	0	0	0	
	N Pay	-	512	167,306	167,817	- 7,961	7,961	0	- 18,251	18,251	- 0	- 18,727	18,727	0	
	Sub Total Pay & Non-pay	-	79,032	404,884	483,916	116,623	252,481	369,105	74,861	27,365	102,226	91,833	41,286	133,118	
	Capital Charges														
	- Savings (Maty Block at SGH	-	-	-	-	-	-	-	-	-	-	-	-	-	
	- Additional	-	-	-	-	-	89,388	89,388	-	143,848	143,848	-	- 4,276	- 4,276	
	Sub Total Capital Charges	-	-	-	-	-	89,388	89,388	-	143,848	143,848	-	- 4,276	- 4,276	
	Total Expenditure	**-**	**79,032**	**404,884**	**483,916**	**116,623**	**341,869**	**458,493**	**74,861**	**171,213**	**246,074**	**91,833**	**37,009**	**128,842**	**1,317,325**
	TOTAL MOVEMENT		20,110	440,546	460,656	- 61,355	267,912	206,558	- 76,014	140,336	64,322	- 66,109	4,783	- 61,327	**670,209**

Financial Appraisal
OPTION 1

ıts

	Year 2010/11			Year 2011/12			Year 2012/13			Year 2013/14		
	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s
All	- 4,139,094	- 3,318,389	- 860,640	- 4,179,029	- 4,020,358	-	- 4,020,358	- 3,965,277	-	- 3,965,277	- 3,907,716	-	- 3,907,716
Pay	2,567,468	2,144,035	443,001	2,587,036	2,562,484	5,578	2,568,062	2,503,995	5,578	2,509,573	2,444,291	5,578	2,449,869
N Pay	671,485	582,609	97,262	679,871	668,021	3,719	671,740	642,954	3,719	646,673	617,366	3,719	621,085
Capital Charges	499,017	228,443	270,574	499,017	228,443	270,574	499,017	228,443	270,574	499,017	228,443	270,574	499,017
	3,737,970	2,955,087	810,837	3,765,924	3,458,948	279,871	3,738,819	3,375,392	279,871	3,655,264	3,290,100	279,871	3,569,971
	- 401,124	- 363,301	- 49,803	**- 413,104**	- 561,410	279,871	**- 281,538**	- 589,885	279,871	**- 310,014**	- 617,616	279,871	**- 337,745**
ıE From 2009/10		- 346,521	334,540	- 11,980	- 544,629	664,215	119,586	- 573,104	664,215	91,110	- 600,835	664,215	63,379

ommunity Midwifery

	Year 2010/11			Year 2011/12			Year 2012/13			Year 2013/14		
	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s
All	- 23,736,465	- 17,117,516	- 6,602,274	- 23,719,790	- 19,967,298	- 3,098,365	- 23,065,663	- 20,748,431	- 3,098,365	- 23,846,797	- 21,540,485	- 3,098,365	- 24,638,851
Pay	18,582,642	13,507,758	4,868,570	18,376,328	16,229,961	2,015,938	18,245,900	16,377,498	2,015,938	18,393,436	16,530,385	2,015,938	18,546,324
N Pay	7,782,586	6,117,437	1,745,408	7,862,845	7,628,509	305,374	7,933,882	7,651,738	305,374	7,957,112	7,717,262	305,374	8,022,635
Capital Charges	2,333,220	1,328,094	1,033,075	2,361,169	1,410,896	279,881	1,690,776	1,407,767	289,411	1,697,177	1,405,681	289,026	1,694,706
ə	28,698,448	20,953,288	7,647,053	28,600,341	25,269,366	2,601,193	27,870,558	25,437,003	2,610,723	28,047,726	25,653,328	2,610,338	28,263,666
	4,961,984	3,835,771	1,044,779	**4,880,551**	5,302,067	- 497,173	**4,804,895**	4,688,572	- 487,643	**4,200,929**	4,112,843	- 488,027	**3,624,815**
&E From 2009/10		773,975	- 855,408	- 81,433	2,240,271	- 2,397,360	- 157,089	1,626,775	- 2,387,830	- 761,055	1,051,046	- 2,388,215	- 1,337,168

e Categories

	Year 2010/11			Year 2011/12			Year 2012/13			Year 2013/14		
	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s
All	- 27,875,559	- 20,435,905	- 7,462,914	- 27,898,819	- 23,987,656	- 3,098,365	- 27,086,021	- 24,713,709	- 3,098,365	- 27,812,074	- 25,448,201	- 3,098,365	- 28,546,566
Pay	21,150,110	15,651,793	5,311,571	20,963,364	18,792,446	2,021,516	20,813,962	18,881,493	2,021,516	20,903,010	18,974,676	2,021,516	20,996,192
N Pay	8,454,071	6,700,046	1,842,670	8,542,716	8,296,529	309,092	8,605,622	8,294,693	309,092	8,603,785	8,334,628	309,092	8,643,721
Capital Charges	2,832,238	1,556,536	1,303,649	2,860,186	1,639,338	550,455	2,189,794	1,636,209	559,985	2,196,195	1,634,123	559,600	2,193,724
	32,436,418	23,908,375	8,457,890	32,366,265	28,728,314	2,881,064	31,609,378	28,812,395	2,890,594	31,702,989	28,943,428	2,890,209	31,833,637
	4,560,859	3,472,470	994,976	**4,467,446**	4,740,658	- 217,302	**4,523,356**	4,098,687	- 207,771	**3,890,915**	3,495,227	- 208,156	**3,287,071**
ıE From 2009/10		427,455	- 520,868	- 93,413	1,695,642	- 1,733,146	- 37,503	1,053,671	- 1,723,616	- 669,944	450,211	- 1,724,000	- 1,273,789
iture Needs	**-**	1,521,040		**1,521,040**		329,806	**329,806**			**-**			**-**

ements

	Year 9/10	Year 2010/11			Year 2011/12			Year 2012/13			Year 2013/14			Cumlative over 4 years
	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	SWBH £'s
Prosense V5	-	- 247,922	- 31,338	- 279,260	- 177,978	- 73,957	- 251,935	- 150,853	- 30,876	- 181,729	- 157,942	- 32,227	- 190,169	
Births & Related OP Repatriate	-			-	- 544,323	-	- **544,323**	- 544,323	-	- 544,323	- 544,323	-	- 544,323	
Catchment Loss	-			-		1,609,056	**1,609,056**			-			-	
Additional Activity - MLU														
Other	-	189,000	67,000	256,000			-			-			-	
Total Income	**-**	**- 58,922**	**35,662**	**- 23,260**	**- 722,302**	**1,535,099**	**812,798**	**- 695,177**	**- 30,876**	**- 726,053**	**- 702,265**	**- 32,227**	**- 734,492**	**- 671,007**
Prosense V5		173,545	21,937	195,482	124,585	51,770	176,355	105,597	21,613	127,211	110,560	22,559	133,118	
Catchment Loss														
Births Repatriated														
Pay Budget Adjustments		- 170,025	- 48,025	- 218,050	-	-		-	-		-	-		
Pay	-	3,317,905	- 3,423,438	- 105,533	3,053,444	- 3,326,294	- 272,850	15,129	- 15,129	0	15,791	- 15,791	- 0	
N Pay	-	1,560,052	- 1,530,052	30,000	1,559,108	- 1,549,108	10,000	- 33,516	- 6,484	- 40,000	6,768	- 6,768	0	
Sub Total Pay & Non-pay	-	4,881,477	- 4,979,578	- 98,101	4,737,136	- 4,823,632	- 86,495	87,211	0	87,211	133,118	-	133,118	
Capital Charges														
- Savings (Maty Block at SGH)	-	-	-	-	-	- 765,624	- 765,624	-	-	-	-	-	-	
- Additional	-	27,948	-	27,948	82,802	12,430	95,232	- 3,129	9,530	6,401	- 2,086	- 385	- 2,471	
Sub Total Capital Charges	-	27,948	-	27,948	82,802	- 753,194	- 670,392	- 3,129	9,530	6,401	- 2,086	- 385	- 2,471	
Total Expenditure	**-**	**4,909,425**	**- 4,979,578**	**- 70,153**	**4,819,938**	**- 5,576,826**	**- 756,888**	**84,082**	**9,530**	**93,612**	**131,032**	**- 385**	**130,647**	**- 602,782**
TOTAL MOVEMENT		4,850,503	- 4,943,916	- 93,413	4,097,637	- 4,041,727	55,910	- 611,095	- 21,346	- 632,441	- 571,233	- 32,611	- 603,845	**- 1,273,789**

APPENDIX 3

Sandwell & West Birmingham Hospitals NHS Trust
Maternity Services Reconfiguration
Financial Appraisal
OPTION 2

Outpatients

Heading		Year 2010/11			Year 2011/12			Year 2012/13			Year 2013/14		
		SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s
Income	All	- 4,139,094	- 3,018,210	- 1,160,819	- 4,179,029	- 3,398,557	- 621,801	- 4,020,358	- 3,343,477	- 621,801	- 3,965,277	- 3,285,915	- 621,801	- 3,907,716
Expenditure														
	Pay	2,567,468	1,920,800	666,236	2,587,036	2,231,900	336,162	2,568,062	2,173,411	336,162	2,509,573	2,113,707	336,162	2,449,869
	N Pay	671,485	536,783	143,088	679,871	601,740	70,000	671,740	576,673	70,000	646,673	551,086	70,000	621,085
	Capital Charges	499,017	228,443	270,574	499,017	228,443	270,574	499,017	228,443	270,574	499,017	228,443	270,574	499,017
Total Exenditure		3,737,970	2,686,026	1,079,898	3,765,924	3,062,083	676,736	3,738,819	2,978,527	676,736	3,655,264	2,893,235	676,736	3,569,971
I&E Position		**- 401,124**	- 332,184	- 80,920	**- 413,104**	- 336,474	54,936	**- 281,538**	- 364,949	54,936	**- 310,014**	- 392,680	54,936	**- 337,745**
Movement in I&E From 2009/10			- 315,403	303,423	- 11,980	- 319,693	439,279	119,586	- 348,169	439,279	91,110	- 375,900	439,279	63,379

APC & Community Midwifery

Heading		Year 2010/11			Year 2011/12			Year 2012/13			Year 2013/14		
		SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s
Income	All	- 23,736,465	- 17,117,516	- 6,602,274	- 23,719,790	- 19,967,298	- 3,098,365	- 23,065,663	- 20,748,431	- 3,098,365	- 23,846,797	- 21,540,485	- 3,098,365	- 24,638,851
Expenditure														
	Pay	18,582,642	13,507,758	4,868,570	18,376,328	16,229,961	2,015,938	18,245,900	16,377,498	2,015,938	18,393,436	16,530,385	2,015,938	18,546,324
	N Pay	7,782,586	6,106,974	1,755,870	7,862,845	6,688,719	1,245,163	7,933,882	6,711,949	1,245,163	7,957,112	6,777,473	1,245,163	8,022,635
	Capital Charges	2,333,220	1,328,094	1,033,075	2,361,169	1,410,896	279,881	1,690,776	1,407,767	289,411	1,697,177	1,405,681	289,026	1,694,706
Total Exenditure		28,698,448	20,942,825	7,657,516	28,600,341	24,329,576	3,540,982	27,870,558	24,497,214	3,550,512	28,047,726	24,713,539	3,550,127	28,263,666
I&E Position		**4,961,984**	3,825,309	1,055,242	**4,880,551**	4,362,278	442,616	**4,804,895**	3,748,782	452,146	**4,200,929**	3,173,053	451,762	**3,624,815**
Movement in I&E From 2009/10			763,513	- 844,946	- 81,433	1,300,482	- 1,457,571	- 157,089	686,986	- 1,448,041	- 761,055	111,257	- 1,448,426	- 1,337,168

All Service Categories

Heading		Year 2010/11			Year 2011/12			Year 2012/13			Year 2013/14		
		SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s
Income	All	- 27,875,559	- 20,135,726	- 7,763,093	- 27,898,819	- 23,365,855	- 3,720,166	- 27,086,021	- 24,091,908	- 3,720,166	- 27,812,074	- 24,826,400	- 3,720,166	- 28,546,566
Expenditure														
	Pay	21,150,110	15,428,557	5,534,807	20,963,364	18,461,862	2,352,100	20,813,962	18,550,909	2,352,100	20,903,010	18,644,092	2,352,100	20,996,192
	N Pay	8,454,071	6,643,757	1,898,958	8,542,716	7,290,459	1,315,162	8,605,622	7,288,623	1,315,162	8,603,785	7,328,558	1,315,162	8,643,721
	Capital Charges	2,832,238	1,556,536	1,303,649	2,860,186	1,639,338	550,455	2,189,794	1,636,209	559,985	2,196,195	1,634,123	559,600	2,193,724
Total Exenditure		32,436,418	23,628,851	8,737,414	32,366,265	27,391,660	4,217,718	31,609,378	27,475,741	4,227,248	31,702,989	27,606,774	4,226,863	31,833,637
I&E Position		**4,560,859**	3,493,125	974,321	**4,467,446**	4,025,804	497,552	**4,523,356**	3,383,833	507,082	**3,890,915**	2,780,373	506,697	**3,287,071**
Movement in I&E From 2009/10			448,110	- 541,523	- 93,413	980,789	- 1,018,292	- 37,503	338,818	- 1,008,762	- 669,944	- 264,642	- 1,009,147	- 1,273,789
Capital Expenditure Needs		**-**	1,521,040		**1,521,040**		329,806	**329,806**			**-**			**-**

Key Movements

Heading		Year 9/10	Year 2010/11			Year 2011/12			Year 2012/13			Year 2013/14			Cumlative over 4 years
		SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	SWBH £'s
Income	Prosense V5	-	- 247,922	- 31,338	- 279,260	- 177,978	- 73,957	- 251,935	- 150,853	- 30,876	- 181,729	- 157,942	- 32,227	- 190,169	
	Births Repatriated	-			-	- 544,323	-	- 544,323	- 544,323	-	- 544,323	- 544,323	-	- 544,323	
	Catchment Loss	-			-		1,609,056	1,609,056			-			-	
	Additional Activity - MLU														
	Other	-	189,000	67,000	256,000			-			-			-	
	Total Income	**-**	**- 58,922**	**35,662**	**- 23,260**	**- 722,302**	**1,535,099**	**812,798**	**- 695,177**	**- 30,876**	**- 726,053**	**- 702,265**	**- 32,227**	**- 734,492**	**- 671,007**
Expenditure															
	Prosense V5		173,545	21,937	195,482	124,585	51,770	176,355	105,597	21,613	127,211	110,560	22,559	133,118	
	Catchment Loss														
	Births Repatriated														
	Pay Budget Adjustments		- 170,025	- 48,025	- 218,050	-	-		-	-		-	-		
	Pay	-	3,094,669	- 3,200,202	- 105,533	2,946,095	- 3,218,945	- 272,850	15,129	- 15,129	0	15,791	- 15,791	0	
	N Pay	-	1,503,763	- 1,473,763	30,000	609,327	- 599,327	10,000	- 33,516	- 6,484	- 40,000	6,768	- 6,768	0	
	Sub Total Pay & Non-pay	-	4,601,953	- 4,700,054	- 98,101	3,680,006	- 3,766,502	- 86,495	87,211	0	87,211	133,118	-	133,118	
	Capital Charges														
	- Savings (Maty Block at SGH)	-	-	-	-	-	- 765,624	- 765,624	-	-	-	-	-	-	
	- Additional	-	27,948	-	27,948	82,802	12,430	95,232	- 3,129	9,530	6,401	- 2,086	- 385	- 2,471	
	Sub Total Capital Charges	-	27,948	-	27,948	82,802	- 753,194	- 670,392	- 3,129	9,530	6,401	- 2,086	- 385	- 2,471	
	Total Expenditure	**-**	**4,629,901**	**- 4,700,054**	**- 70,153**	**3,762,809**	**- 4,519,696**	**- 756,888**	**84,082**	**9,530**	**93,612**	**131,032**	**- 385**	**130,647**	**- 602,782**
	TOTAL MOVEMENT		4,570,979	- 4,664,392	- 93,413	3,040,507	- 2,984,597	55,910	- 611,095	- 21,346	- 632,441	- 571,233	- 32,611	- 603,845	**- 1,273,789**

APPENDIX 4

Sandwell & West Birmingham Hospitals NHS Trust
Maternity Services Reconfiguration
Financial Appraisal
OPTION 3

Outpatients

Heading		Year 2010/11				Year 2011/12			Year 2012/13			Year 2013/14		
		SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s
Income	All	- 4,139,094	- 3,318,389	- 860,640	- 4,179,029	- 4,204,592	184,235	- 4,020,358	- 4,149,512	184,235	- 3,965,277	- 4,091,950	184,235	- 3,907,716
Expenditure														
	Pay	2,567,468	2,144,035	443,001	2,587,036	2,562,484	5,578	2,568,062	2,503,995	5,578	2,509,573	2,444,291	5,578	2,449,869
	N Pay	671,485	582,609	97,262	679,871	668,021	3,719	671,740	642,954	3,719	646,673	617,366	3,719	621,085
	Capital Charges	499,017	228,443	270,574	499,017	228,443	270,574	499,017	228,443	270,574	499,017	228,443	270,574	499,017
Total Exenditure		3,737,970	2,955,087	810,837	3,765,924	3,458,948	279,871	3,738,819	3,375,392	279,871	3,655,264	3,290,100	279,871	3,569,971
I&E Position		**- 401,124**	- 363,301	- 49,803	**- 413,104**	- 745,644	464,106	**- 281,538**	- 774,119	464,106	**- 310,014**	- 801,850	464,106	**- 337,745**
Movement in I&E From 2009/10			- 346,521	334,540	- 11,980	- 728,863	848,449	119,586	- 757,339	848,449	91,110	- 785,070	848,449	63,379

Community Midwifery

Heading		Year 2010/11				Year 2011/12			Year 2012/13			Year 2013/14		
		SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s
Income	All	- 6,393,234	- 3,175,868	- 3,098,365	- 6,274,234	- 3,175,868	- 3,098,365	- 6,274,234	- 3,175,868	- 3,098,365	- 6,274,234	- 3,175,868	- 3,098,365	- 6,274,234
Expenditure														
	Pay	3,859,179	1,770,587	1,969,592	3,740,179	1,770,587	1,969,592	3,740,179	1,770,587	1,969,592	3,740,179	1,770,587	1,969,592	3,740,179
	N Pay	548,952	274,476	274,476	548,952	274,476	274,476	548,952	274,476	274,476	548,952	274,476	274,476	548,952
	Capital Charges	215,059	107,530	107,530	215,059	107,530	107,530	215,059	107,530	107,530	215,059	107,530	107,530	215,059
Total Exenditure		4,623,190	2,152,593	2,351,597	4,504,190	2,152,593	2,351,597	4,504,190	2,152,593	2,351,597	4,504,190	2,152,593	2,351,597	4,504,190
I&E Position		**- 1,770,043**	- 1,023,275	- 746,768	**- 1,770,043**	- 1,023,275	- 746,768	**- 1,770,043**	- 1,023,275	- 746,768	**- 1,770,043**	- 1,023,275	- 746,768	**- 1,770,043**
Movement in I&E From 2009/10			-	-	-	-	-	-	-	-	-	-	-	-

All Service Categories

Heading		Year 2010/11				Year 2011/12			Year 2012/13			Year 2013/14		
		SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s
Income	All	- 27,875,559	- 20,435,905	- 7,462,914	- 27,898,819	- 24,171,891	- 2,914,131	- 27,086,021	- 24,897,943	- 3,277,134	- 28,175,077	- 25,632,435	- 3,821,638	- 29,454,073
Expenditure														
	Pay	21,135,527	15,691,405	5,271,959	20,963,364	18,799,180	2,014,782	20,813,962	18,888,227	2,169,782	21,058,010	18,981,410	2,457,282	21,438,692
	N Pay	8,454,071	6,689,584	1,853,132	8,542,716	8,306,992	298,630	8,605,622	8,305,155	519,463	8,824,618	8,345,091	656,963	9,002,054
	Capital Charges	2,832,238	1,556,536	1,303,649	2,860,186	1,639,338	550,455	2,189,794	1,636,209	559,985	2,196,195	1,634,123	559,600	2,193,724
Total Exenditure		32,421,835	23,937,525	8,428,740	32,366,265	28,745,510	2,863,867	31,609,378	28,829,592	3,249,231	32,078,823	28,960,624	3,673,846	32,634,470
I&E Position		**4,546,276**	3,501,620	965,826	**4,467,446**	4,573,620	- 50,264	**4,523,356**	3,931,649	- 27,903	**3,903,746**	3,328,189	- 147,792	**3,180,397**
Movement in I&E From 2009/10			456,605	- 535,434	- 78,830	1,528,604	- 1,551,524	- 22,920	886,633	- 1,529,164	- 642,530	283,173	- 1,649,053	- 1,365,879
Capital Expenditure Needs		**-**	1,521,040		**1,521,040**		329,806	**329,806**			**-**			**-**

Key Movements

Heading		Year 9/10	Year 2010/11			Year 2011/12			Year 2012/13			Year 2013/14			Cumlative over 4 years
		SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	City £'s	Sandwell £'s	SWBH £'s	SWBH £'s
Income	Prosense V5	-	- 247,922	- 31,338	- 279,260	- 177,978	- 73,957	- 251,935	- 150,853	- 30,876	- 181,729	- 157,942	- 32,227	- 190,169	
	Births Repatriated	-			-	- 544,323	-	- 544,323	- 544,323		- 544,323	- 544,323		- 544,323	
	Catchment Loss	-			-		1,609,056	1,609,056			-			-	
	Additional Activity - MLU									- 363,003	- 363,003		- 544,504	- 544,504	
	Other	-	189,000	67,000	256,000			-			-			-	
	Total Income	**-**	**- 58,922**	**35,662**	**- 23,260**	**- 722,302**	**1,535,099**	**812,798**	**- 695,177**	**- 393,879**	**- 1,089,056**	**- 702,265**	**- 576,731**	**- 1,278,996**	**- 1,578,514**
								812,798						
Expenditure															
	Prosense V5		173,545	21,937	195,482	124,585	51,770	176,355	105,597	21,613	127,211	110,560	22,559	133,118	
	Catchment Loss														
	Births Repatriated														
	Pay Budget Adjustments		- 170,025	- 48,025	- 218,050	-	-		-	-		-	-		
	Pay	-	3,357,517	- 3,448,467	- 90,950	3,020,565	- 3,293,415	- 272,850	15,129	139,871	155,000	15,791	271,709	287,500	
	N Pay	-	1,549,589	- 1,519,589	30,000	1,580,033	- 1,570,033	10,000	- 33,516	214,349	180,833	6,768	130,732	137,500	
	Sub Total Pay & Non-pay	-	4,910,627	- 4,994,145	- 83,518	4,725,183	- 4,811,678	- 86,495	87,211	375,833	463,044	133,118	425,000	558,118	
	Capital Charges														
	- Savings (Maty Block at SGH	-	-	-	-	-	- 765,624	- 765,624	-	-	-	-	-	-	
	- Additional	-	27,948	-	27,948	82,802	12,430	95,232	- 3,129	9,530	6,401	- 2,086	- 385	- 2,471	
	Sub Total Capital Charges	-	27,948	-	27,948	82,802	- 753,194	- 670,392	- 3,129	9,530	6,401	- 2,086	- 385	- 2,471	
	Total Expenditure	**-**	**- 4,938,575**	**- 4,994,145**	**- 55,570**	**- 4,807,985**	**- 5,564,873**	**- 756,888**	**84,082**	**385,363**	**469,445**	**131,032**	**424,615**	**555,647**	**212,635**
	TOTAL MOVEMENT		4,879,653	- 4,958,483	- 78,830	4,085,683	- 4,029,774	55,910	- 611,095	- 8,516	- 619,611	- 571,233	- 152,116	- 723,349	**- 1,365,879**

APPENDIX 5

Sandwell & West Birmingham Hospitals NHS Trust
Maternity Reconfiguration Business Case
Developing a Midwifery Led Unit at Wednesbury

High level Income & Expenditure Forecast

Activity	**Financial Years**	
	2012/13	**2013/14**
Estimated Births	160	400

	Financial Years	
	2012/13 PYE £'s	**2013/14 FYE £'s**
Income		
Tariff 10/11 for Routine / Normal Deliveries	(363,003)	(907,507)
Sub Total	**(363,003)**	**(907,507)**
Expenditure		
Pay		
Midwives	142,500	417,500
Administration	12,500	25,000
Sub Total	155,000	442,500
Non Pay		
Medical consumables	50,000	100,000
Other Non Pay	83,333	150,000
Facilities Rental Charge	87,500	150,000
Sub Total	220,833	400,000
Total Expenditure	**375,833**	**842,500**
MLU Forecast Trading Position	**12,830**	**(65,007)**
Average Income Per Birth	**(2,269)**	**(2,269)**
Average Cost Per Birth	**2,349**	**2,106**

Sandwell & West Birmingham Hospitals NHS Trust
Maternity Reconfiguration Business Case

Activity Summary

	08/09 Actual	09/10 Plan	09/10 Forecast Outturn	9/10 - Prosense Forecast Outturn	10/11	11/12	12/13	13/14
	SWBH TOTAL	SWBH TOTAL	SWBH TOTAL	SWBH TOTAL	SWBH TOTAL	SWBH TOTAL	SWBH TOTAL	SWBH TOTAL
Do Nothing								
APC								
- Births	6,115	6,375	2,201	6,397	6,616	6,740	6,868	7,001
- Other Spells	15,923	4,759	12,151	4,127	4,232	4,340	4,451	4,565
Total	**22,038**	**11,133**	**14,352**	**10,524**	**10,849**	**11,080**	**11,319**	**11,566**
Outpatients								
- New	8,140	17,375	9,589	18,220	18,573	18,752	18,752	18,757
- Review	17,982	17,451	22,785	17,329	17,113	16,139	14,383	12,579
Total	**26,122**	**34,826**	**32,374**	**35,549**	**35,687**	**34,891**	**33,135**	**31,336**
Do Minimum								
APC								
- Births	6,115	6,375	2,201	6,397	6,616	6,740	6,868	7,001
- Other Spells	15,923	4,759	12,151	4,127	4,232	4,340	4,451	4,565
Total	**22,038**	**11,133**	**14,352**	**10,524**	**10,849**	**11,080**	**11,319**	**11,566**
Outpatients								
- New	8,140	17,375	9,589	18,220	18,573	18,752	18,752	18,752
- Review	17,982	17,451	22,785	17,329	17,113	16,139	14,383	12,584
Total	**26,122**	**34,826**	**32,374**	**35,549**	**35,687**	**34,891**	**33,135**	**31,336**
Option 1								
APC								
- Births	6,115	6,375	2,201	6,397	6,616	6,348	6,676	7,009
- Other Spells	15,923	4,759	12,151	4,127	4,232	4,102	4,332	4,565
Total	**22,038**	**11,133**	**14,352**	**10,524**	**10,849**	**10,449**	**11,008**	**11,574**
Outpatients								
- New	8,140	17,375	9,589	18,220	18,573	18,231	18,510	18,794
- Review	17,982	17,451	22,785	17,329	17,113	15,547	14,109	12,622
Total	**26,122**	**34,826**	**32,374**	**35,549**	**35,687**	**33,778**	**32,618**	**31,416**
Option 2								
APC								
- Births	6,115	6,375	2,201	6,397	6,616	6,348	6,676	7,009
- Other Spells	15,923	4,759	12,151	4,127	4,232	4,102	4,332	4,565
Total	**22,038**	**11,133**	**14,352**	**10,524**	**10,849**	**10,449**	**11,008**	**11,574**
Outpatients								
- New	8,140	17,375	9,589	18,220	18,573	18,231	18,510	18,794
- Review	17,982	17,451	22,785	17,329	17,113	15,547	14,109	12,622
Total	**26,122**	**34,826**	**32,374**	**35,549**	**35,687**	**33,778**	**32,618**	**31,416**
Option 3								
APC								
- Births	6,115	6,375	2,201	2,648	6,616	6,348	6,836	7,409
- Other Spells	15,923	4,759	12,151	1,585	4,232	4,102	4,332	4,565
Total	**22,038**	**11,133**	**14,352**	**4,232**	**10,849**	**10,449**	**11,168**	**11,974**
Outpatients								
- New	8,140	17,375	9,589	18,220	18,573	18,231	18,510	18,794
- Review	17,982	17,451	22,785	17,329	17,113	15,547	14,109	12,622
Total	**26,122**	**34,826**	**32,374**	**35,549**	**35,687**	**33,778**	**32,618**	**31,416**

APPENDIX 7

Sandwell and West Birmingham NHS Trust Clinical Risks for Medium Term Options

Version 1 new format November 2009

J Dunn redesign Director,G GAdd-service redesign Manager,E Newell Head of Midwifery, P Bosio Lead Clinician, S Murray Divisional Manager

Risk Area			Risk Assessment				Risk Owner			Risk Management	Risk Commentary			Post Mitigation Risk Assessment			
OPTION	Category	Description	Impact	Likelihood	Overall	Risk Level	Organisation	Officer	Advisor	Indicators for Crystallisation	Action to Mitigate	Date for Review	Notes	Impact	Likelihood	Overall	Risk Level
		NO CHANGE TO CURRENT SERVICE MODEL															
0a	1	Risk of continuing to practice under the present medical model	4	2	8	medium				inappropriate medical intervention including induction of labour and caesarian section with associated risks. Lack of choice for place of birth. Lack of facility for midwifery led care	All midwives to receive normality training programme as established by regional leads. Designated rooms within the labour suite for low risk birth. Continued review of activity and poor outcomes.			3	2	6	medium
0b	1	Inability to work towards 60hr Consultant Labour ward cover for 4000 births at City Hospital as defined by NHSLA	3	4	12	high				women receive substandard or delayed out of hours consultant care resulting in poor clinical outcomes	Business cases submitted for additional consultants - unlikely to be supported			3	4	12	high
0c	1	Inability to change entrenched cultures and responsiveness of maternity services across the two sites	4	4	16	high				difficulty in promoting continuity of care and generic standards across both maternity units. Lack of leadership and willingness to change practice	Site based in service matrons, working in close collaboration to ensure consistency in standards and communication across sites. Joint meetings such as Risk and educational meetings promotes consistency in case management and shared learning. Lead obstetrician appointed for Sandwell who will work closely with CD / Lead obstetrician for City site			3	3	9	medium
0d	1	Lack of continued presence across two sites of Head of Midwifery and Lead Clinician	3	4	12	high				difficulty in promoting continuity of care and generic standards across both maternity units. Lack of leadership and willingness to change practice	as above			3	3	9	medium
0e	1	Inability to promote choice for midwifery led care due to lack of facilities	2	2	4	low				Risk of continuing to practice under the present medical model	as above			2	2	4	low
0f	1	Destabilisation of City site (High Risk) service with on-going mitigation at Sandwell	4	3	12	RED				Increase inn Adverse Clinical Outcomes	Medium term review of services being undertaken			4	3	12	red
0g	1	Public confidence in clinical care for maternity services will remain low due to perceived lack of change	3	4	12	high				Women will choose a medical model of care and be at risk of increased intervention. Continued loss of reputation for service with potential loss of income	Work with Comms team to raise profile of service / promotion of positive developments as they occur.			3	2	6	medium
0h	1	Continued difficulty with recruitment of staff due to poor reputation and lack of facilities/ career development opportunities	3	5	15	high				Lack of highly skilled staff. Inability to provide strong clinical leadership.Difficulty in retaining high calibre staff.	Continued high profile recruitment campaigns have been undertaken over recent months with some success			3	4	12	high
0i	1	Inadequate provision of care for women with complex clinical conditions	4	4	16	high				Continiuity of care for high risk women is reduced. Some complex care servces may not be provided due to resource constraints	Provision of a limited number of specialised clinics on 1 site.			4	3	12	high
0j	1	Unplanned urgent transfer of high risk women in labour remains high	3	4	12	high				women and babies receive substandard or delayed care. Continuity of care is compromised for high risk women	Trust guidelines and transfer policy in place.Cant mitigate this any more than we currently do			3	4	12	high
0k	1	Delivery and urgent transfer of baby at under 34 weeks gestation	4	2	8	medium				women and babies receive substandard or delayed care. Continuity of care is compromised for high risk women	Trust guidelines and transfer policy in place.Cant mitigate this any more than we currently do			4	2	8	medium
0l	1	Skills and competencies can not be maximised across two sites	3	4	12	high				ineffective use of skills competences and resources. Inability to provide optimum standards of care	Implement rotation of staff across sites in order to maximise exposure to all aspects of care. (Note this may adversely impact on recruitment and retention)			3	3	9	medium
		OPTION 1= NO BIRTHS OR INPATIENT CARE AT SANDWELL. ALL BIRTHS AND CONSULTANT LED CLINICS AT CITY															
1a		Increased DNAs for hospital appointments resulting in lack of appropriate antenatal assessment	2	3	6	medium				Poor continuity of care. Lack of appropriate assessent and booking for delivery.	Careful planning with local transport networks to ensure that appropriate transport links in place. Positive promotion of service reconfiguration to ensure women are aware of benefits of service. Clear information provided to women (all languages) regarding services available. Promotion of community based midwifery services			2	1	2	low
1b		Sandwell women may percieve there is a lack of choice and delay accessing appropriate antenatal care	2	2	4	low				Lack of appropriate antenatal assessment. Increased number of high risk women not identified early in pregnancy	as above			2	2	4	low
1c		Women may arrive at Sandwell in labour and need urgent transfer to City	2	3	6	medium				Women receive delayed or substandard care	as above			2	2	4	low
1d		Increased numbers of birth before arrival	3	3	9	medium				Babies delivered in an inappropriate environment with lack of appropriate support.	As above. Ensure local ambulance Trust engaged in consultation. Ensure robust BBA policy			2	1	3	low
1e		Loss of staff who do not wish to transfer to|City	3	3	9	medium				Midwife to birth ratio is reduced. Difficulty in providing continuity of care. Need to recruit midwives	Ensure staff fully engaged in consultation process. Regular staff updates re planning of any service changes. Introduce rotation programme so that staff are familiarised with environment. Maintain transport service between sites for staff redeployed. Set up early discussions with HR and staff side representatives. Establish proactive recruitment strategy			3	2	6	medium
1f		Inappropriate home births	3	2	6	medium				Women refuse to be booked for City Hospital delivery	Consult with users extensively and prepare patient information which promotes maternity services at City site. Engage community midwives in planning in order that they are able to effectively inform women.			3	1	3	low

APPENDIX 7

Sandwell and West Birmingham NHS Trust Clinical Risks for Medium Term Options

Version 1 new format November 2009

J Dunn redesign Director,G GAdd-service redesign Manager,E Newell Head of Midwifery, P Bosio Lead Clinician, S Murray Divisional Manager

Risk Area			Risk Assessment				Risk Owner			Risk Management	Risk Commentary			Post Mitigation Risk Assessment			
OPTION	Category	Description	Impact	Likelihood	Overall	Risk Level	Organisation	Officer	Advisor	Indicators for Crystallisation	Action to Mitigate	Date for Review	Notes	Impact	Likelihood	Overall	Risk Level
1g		Lack of appropriate public transport infrastructure for women living close to Sandwell- delay in accessing antenatal services	2	3	6	medium				Delay in women receiving timely intervention and cincreased clinical risks asscociated with this situation	Careful planning with local transport networks to ensure that appropriate transport links in place. Positive promotion of service reconfiguration to ensure women are aware of benefits of service. Clear information provided to women (all languages) regarding planned changes.			2	3	6	medium
		OPTION 2= SAME AS FOR OPTION 1 BUT SOME CONSULTANT LED CLINICS AT SANDWELL															
2a		Increased DNAs for hospital appointments resulting in lack of appropriate antenatal assessment	2	2	4	low				Poor continuity of care. Lack of appropriate assessent and booking for delivery.	Careful planning with local transport networks to ensure that appropriate transport links in place. Positive promotion of service reconfiguration to ensure women are aware of benefits of service. Clear information provided to women (all languages) regarding services available. Promotion of community based midwifery services			2	1	2	low
2b		Sandwell women may perceive there is a lack of choice and delay accessing appropriate ante natal assesment	2	2	4	low				Poor continuity of care. Lack of appropriate assessent and booking for delivery.	as above			2	2	4	low
2c		Women may arrive at Sandwell in labour and need urgent transfer to City	2	4	8	medium				Women receive delayed or substandard care	As above. Ensure A & E dept included in consultation plans			2	2	4	low
2d		Increased numbers of birth before arrival	3	3	9	medium				Babies delivered in an inappropriate environment with lack of appropriate suppo	As above. Ensure local ambulance Trust engaged in consultation. Ensure robust BBA policy			2	1	3	low
2e		Loss of staff who do not wish to transfer to City	3	3	9	medium				Midwife to birth ratio is reduced. Difficulty in providing continuity of care. Need to recruit midwives	Ensure staff fully engaged in consultation process. Regular staff updates re planning of any service changes. Introduce rotation programme so that staff are familiarised with environment. Maintain transport service between sites for staff redeployed. Set up early discussions with HR and staff side representatives. Establish proactive recruitment strategy			3	2	6	medium
2f		Inappropriate home births	3	2	6	medium				Women refuse to be booked for City Hospital delivery	Consult with users extensively and prepare patient information which promotes maternity services at City site. Engage community midwives in planning in order that they are able to effectively inform women.			3	1	3	low
2g		Lack of appropriate public transport infrastructure for women living close to Sandwell- delay in accessing antenatal service	2	2	4	low				Delay in women receiving timely intervention and cincreased clinical risks asscociated with this situation	Careful planning with local transport networks to ensure that appropriate transport links in place. Positive promotion of service reconfiguration to ensure women are aware of benefits of service. Clear information provided to women (all languages) regarding planned changes.			2	3	6	medium
		OPTION 3= TRANSFER ALL BIRTHS AND CONSULTANT LED CARE TO CITY AND THEN DEVELOP A STAND-ALONE BIRTH CENTRE IN SANDWELL BUT NOT ON HOSPITAL SITE															
3a		Increased DNAs for hospital appointments resulting in lack of appropriate antenatal assessment	2	3	6	medium				Women receive delayed or substandard care	Ensure wide public consultation and information campaign to reduce the likehood of this occuring. Liaiase with Local Ambulance Trust to promote appropriate pathway/urgent transfers			2	2	4	low
3b		Sandwell women may percieve there is a lack of choice and delay accessing appropriate antenatal care	2	2	4	low				Poor continuity of care. Lack of appropriate assessent and booking for delivery.	Careful planning with local transport networks to ensure that appropriate transport links in place. Positive promotion of service reconfiguration to ensure women are aware of benefits of service. Clear information provided to women (all languages) regarding services available. Promotion of community based midwifery services. Future development of stand alone MLU in Sandwell.			2	1	3	low
3c		Loss of staff who do not wish to transfer to City	3	3	9	medium				Midwife to birth ratio is reduced. Difficulty in providing continuity of care. Need to recruit midwives	Ensure staff fully engaged in consultation process. Regular staff updates re planning of any service changes. Introduce rotation programme so that staff are familiarised with environment. Maintain transport service between sites for staff redeployed. Set up early discussions with HR and staff side representatives. Establish proactive recruitment strategy			3	2	6	medium
3d		Women may arrive at Sandwell in labour and need urgent transfer to City	2	3	6	medium				Women receive delayed or substandard care	As above. Ensure A & E dept included in consultation plans			2	3	6	medium
3e		inappropriate home births	3	2	6	medium								3	1	3	low
3g		Lack of appropriate public transport infrastructure for women living close to Sandwell- delay in accessing antenatal care	2	3	6	medium				increased clinical risk to mother and baby	As above. Ensure A & E dept included in consultation plans			4	1	4	low

APPENDIX 7

Sandwell and West Birmingham NHS Trust Clinical Risks for Medium Term Options

Version 1 new format November 2009

J Dunn redesign Director,G GAdd-service redesign Manager,E Newell Head of Midwifery, P Bosio Lead Clinician, S Murray Divisional Manager

Risk Area			Risk Assessment				Risk Owner			Risk Management	Risk Commentary			Post Mitigation Risk Assessment			
OPTION	Category	Description	Impact	Likelihood	Overall	Risk Level	Organisation	Officer	Advisor	Indicators for Crystallisation	Action to Mitigate	Date for Review	Notes	Impact	Likelihood	Overall	Risk Level
3h		Insufficient experience and skills within the mi	4	3	12	high				Delay in women receiving timely intervention and increased clinical risks asscociated with this situation	Careful planning with local transport networks to ensure that appropriate transport links in place. Positive promotion of service reconfiguration to ensure women are aware of benefits of service. Clear information provided to women (all languages) regarding planned changes.Recruitment and training of midwifery workforce			4	2	8	medium
3i		Unfoseen emergency in labour at MLU with need for transfer	4	4	16	high				inappropriate home delivery with clinical risks associated with this situation	Community Midwives to developand communicate robust clinical pathway.			2	2	4	low
3j		Increased workload for community midwives	4	4	16	high				insufficient community midwives to manage workload and shift in care.	Devolp robust clinical pathways. Ensure new ways of working and appropriate new roles and clinical support. Develop rotation posts and develop new JDs to support process			4	2	8	medium
3k		risk of complications in labour during transfer	4	3	12	high								3	3	9	medium
3l		women may arrive at MLU without being planned and require transfer to City	2	3	6	medium				women lack understanding of fstand alne facility and expect full delivery suite to be available. Increases transfers with adverse clinical outcomes	Community Midwives to develop and communicate robust clinical pathway. Wide promotion and communication of facilities and function of the unit. Ongoing robust assessment			2	1	3	low
3m		Women may be inappropriately booked for MLU	4	2	8	medium				High risk women ae planned for mlu	Devolp robust clinical pathways. Robust inclusion and exclusion criteria			4	1	4	low

Category	Narrative
1.	*current service*
2.	*implementation 0-6 months*
3.	*implementation 6-9 months*
4.	*implementation 9-18 months*
5.	*implementation 18-24 months*
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	

Organisation	Narrative
TRUST	*SWBH NHS Trust*
PCTS	*PCTs within Community*
PCT	*HoBt/Sandwell PCTs*
COUNCIL	*Local Auhtorities within Community*

Officer	Narrative
Head of Midwifery lead Clinician Divisional manager Community Midwife	

Likelihood	Narrative	Possible Quantification
1	Very unlikely to occur	*May occur only in exceptional circumstances*
2	Unlikely to occur	*Could occur at some time*
3	As likely to occur as not	*Might occur at some time*
4	Likely to occur	*Will probably occur at some time*
5	Very likely to occur	*Is expected to occur in most circumstances*

Impact	Narrative	Possible Quantification
1	Minimal Impact	*Revenue impact <£20,000; Capital impact <£0.5m; Delay <1 month. Clinical service is maintained. Negative publicity or litigation not expected.*
2	Low Impact	*Revenue impact >£20k <£100k; Capital impact >£0.5m <£1.0m; Delay >1 month <3 months. Mild disruption to clinical services without clinical risk to women.Local adverse publicity or litigation unlikely*
3	Medium Impact	*Revenue impact >£100k <£500k; Capital impact >£1.0m <£3.0m; Delay >3 months <9 months.disruption to clinical services likely. Local adverse publicity possible.*
4	High Impact	*Revenue impact >£500k <£2.0m; Capital impact >£3.0m <£6.0m; Delay >9 months <24 months.Adverse impact on clinical services likely. Negative publicity across the region and/or litigation likely*
5	Very High Impact	*Revenue impact >£2.0m; Capital impact >£6.0m; Delay >24 months. Adverse impact on clinical services or safety for women and babies. Litigation expected. Negative National publicity expected.*

Risk Level	Definition	Action Plan
1 - 4	**GREEN**	No need for specific action plan
5 - 10	**AMBER**	Prepare outline action plan
12 - 25	**RED**	Detailed action plan required

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	IFC: Infection Control Policy SWBH\COI\001
SPONSORING DIRECTOR:	Rachel Overfield – Chief Nurse
AUTHOR:	Dr Beryl Oppenheim – Director of Infection Prevention and Control Rebecca Evans – Head of Infection Control nursing services
DATE OF MEETING:	25 February 2010

SUMMARY OF KEY POINTS:

The Infection Control Policy revised and updated:

- All staff within the organisation are responsible for ensuring the prevention and control of infection.
- All staff are responsible for ensuring they adhere to the correct policies and procedures.
- It is the responsibility of staff to ensure patients are risk assessed and warded appropriately dependent on type of organism and transmissibility

The policy is one of those identified as needing Trust board approval within the Policy on the Development, Management and Approval of policies.

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to approve the revised policy.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Part of the Trust Infection Control Programme 2010
Annual priorities	
NHS LA standards	2.4.9 – Infection Control
Core Standards	C1 & C9
Auditors' Local Evaluation	

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

Financial		
Business and market share		
Clinical	**X**	
Workforce		
Environmental		
Legal & Policy	**X**	
Equality and Diversity		
Patient Experience	**X**	
Communications & Media	**X**	
Risks		Failure to approve policy may result in an incorrect/ poor practice, misunderstanding of role responsibility and media attention.

PREVIOUS CONSIDERATION:

- Infection Control Service
- Consultation via;-
    - Infection Control Operational Committee
    - Health and Safety

Governance Board approved the policy at its meeting on 5 February 2010.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

INFECTION CONTROL POLICY

Reference	SWBH\COI\001
Category	*Assigned by Trust policy co-ordinator*
Date Approved	DD-MM-YYYY
Date of Next Review	

POLICY PROFILE	
Overview	
Key overall purpose of policy	• To meet the statutory requirements as set out in 'The Health and Social Care Act 2008'.- *Code of Practice for health and adult social care on the prevention and control of infections and related guidance*'. • To provide an efficient, cost effective infection control service for the Trust • To utilise, develop and promote infection control practices which are cost effective, safe and efficient, minimising the risk of patients acquiring infections during or as a result of their stay in the hospital. • To implement the annual Programme and polices and to be responsible for providing advice to the Trust or hospital staff on a 24 hour basis.
Principal target audience	All Staff [to include:- agency, locum and contractors], patients and visitors
Application	All Staff [to include:- agency, locum and contractors], patients and visitors
Accountable Executive Director	Chief Nurse
Author(s)	Dr. Beryl Oppenheim. Director of Infection Prevention and Control.
	Ms. Rebecca Evans. Head of Infection Control Nursing Services
Impact Assessment	
Resource implications	None – updated policy.
Training implications	None
Communications implications	None
Date of initial equality impact assessment	02.02.2010
Date of full equality impact assessment (if appropriate)	02.02.2010
NHSLA risk management standards/ CQC core standards	Core Standards - C1- & C9 NHS LA Risk Assessment - 2.4.9 – Infection Control
Consultation and referencing	
Key stakeholders consulted/involved in the development of the policy	• Infection Control Service • Consultation via;- o Infection Control Operational Committee o Health and Safety o Trust Management Board.
Complementary Trust documents for cross reference	Infection Control policies to include:- Hand Hygiene Policy, Induction, Statutory and Mandatory Training Policy, Waste Policy, Occupational Health policies. Antibiotic Policy
Approvals and monitoring	
Approving body	Infection Control Operational Committee, Governance Board and Trust Broad
Date of implementation	
Monitoring and audit	• Infection Control – through day to day practices and audit. • Ward/Departmental managers, Matrons, Clinical directors, Divisional Managers are responsible for ensuring compliance against policy is met.

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.
5				

Contents page

1.0 Introduction

1.1 NHS Trusts are accountable for the provision and range of infection control services they provide In line with 'The Health and Social Care Act 2008'.- *Code of Practice for health and adult social care on the prevention and control of infections and related guidance*'. This includes the provision of Infection Control Policies, staff training and surveillance programmes. Within the Trust, the Infection Control Service (ICS) has prime responsibility for infection control.

1.2 The Infection Control Committees are responsible to the Chief Executive and to the Trust Board.

1.3 This policy outlines the roles and responsibilities of the Trust Board, Executive Directors, Infection Control Service and healthcare workers in relation to infection, prevention and control and is supported by a comprehensive range of infection control policies aimed at specific target organisms, transmissibility and national guidance which relate to the safe provision of infection control for patients, staff and visitors.

1.4 Due to the diversity of specialities and clinical practices within the Trust, it is recognised that specific procedures and guidelines may be required within individual areas. As part of any policy/guideline development infection control should be incorporated as a core element. If Infection Control Guidelines are developed within departments, Infection Control should be consulted.

2.0 Objectives

2.1 To meet the statutory requirements as set out in 'The Health and Social Care Act 2008'.- *Code of Practice for health and adult social care on the prevention and control of infections and related guidance*'.

2.2 To provide an efficient, cost effective infection control service for the Trust

2.3 To utilise, develop and promote infection control practices which are cost effective, safe and efficient, minimising the risk of patients acquiring infections during or as a result of their stay in the hospital.

2.4 To implement the annual Programme and polices and to be responsible for providing advice to the Trust or hospital staff on a 24 hour basis.

3.0 Scope

3.1 This policy applies to all Trust staff in all locations including temporary employees, locums, agency staff, contractors and visiting clinicians.

4.0 Definitions

Designation	**Abbreviation**
Director of Infection, Prevention and Control	DIPC
Infection Control Doctor	ICD
Head of Infection Control Nursing Service	HICNS
Healthcare Economy Group for Infection Control	HEGIC
Infection Control Nurse Advisor	ICNA

Infection Control Surveillance Nurse	ICSN
Infection Control Operational Committee	ICOC
Infection Control Service	ICS
Infection Control Executive Group	ICEG

5.0 Roles and responsibilities

5.1 Chief Executive

It is the responsibility of the Chief Executive and the Trust Board to ensure adequate arrangements are made to control hospital infection. These arrangements include the implementation of an Infection Control Operational Committee (ICOC) and the appointment of a Director of Infection, Prevention and Control (DIPC) with adequate Infection Control Nurse (ICN) cover.

5.2 Executive Lead for Infection Control

The Chief Nurse will have delegated responsibility for leading infection control arrangements within the Trust. This will include liaising with the Director of Infection Prevention and Control, Head of Infection Control Nursing Services and relevant managers as appropriate and overseeing the delivery and monitoring of the Assurance Framework for infection control

5.3 Trust Board

It is the responsibility of the Trust Board

a) To ensure the implementation of infection control policies and guidelines
b) To receive regular reports from the Director of Infection Prevention and Control
c) To ensure adequate resources for the prevention and control of health care associated infection are in place
d) To ensure that infection control is embedded into performance management
e) To ensure that processes are in place to assess risks from infection and to take appropriate measures to manage these risks
f) To monitor and receive regular reports on key infection rates and comparative information over time and between organisations
g) To take account of infection control issues when making policy and investment decisions

5.4 Medical Director

It is the responsibility of the Medical Director to ensure all infection control policies and guidelines are communicated to all Medical staff (to include Medical Students) and ensure infection control principles are incorporated as part of day-to-day clinical practices.

5.5 Infection Control Service (ICS)

The Infection Control Service is responsible for the day-to-day management of the prevention of cross infection and the provision of advice on the implementation of infection control measures required.

a) To provide clinical advice and support for all Health Care Personnel.
b) To provide advice on the care and management of patients with known or suspected infections.
c) To prevent, monitor and control Hospital acquired infections.
d) To monitor, identify and investigate outbreaks or potentially hazardous or ineffective procedures.
e) To undertake surveillance of infection and monitor methods of control.
f) To provide, monitor and evaluate policies for the prevention of infection and its spread.
g) To monitor the risk of cross infection through audit and surveillance.
h) To provide support to all departments in the evaluation of new methods and products of the prevention and control of infection.
i) To provide advice on the purchasing and decontamination of equipment.
j) To provide infection control advice to all health care personnel.
k) To provide a comprehensive infection control education programme to Trust employees both clinical and non-clinical.

5.5.1 Director of Infection Prevention and Control (DIPC)

The Director of Infection, Prevention and Control has overall responsibility and provides leadership for the Infection Control Service (ICS) and is responsible to the Chief Executive for its work, within the framework and resources provided by the Chief Executive. The DIPC works closely with the Head of Infection Control Nursing Service and is supported by Consultant Microbiologists providing 24 hour cover for infection control related issues.

5.4.2 Infection Control Doctors (ICD)

The Infection Control Doctor/s is/are responsible for the day-to-day infection control activities. The ICDs work closely with the Infection Control Nursing Service which is supported by the Consultant Microbiologists/ICDs providing 24 hour cover for infection control related issues.

5.4.3 Head of Infection Control Nursing Services (HICNS)

The Head of Infection Control Nursing Services (HICNS) will manage the Infection Control Nurse Advisors, Infection Control Surveillance Nurses and Decontamination Manager and will play a strategic role as a member of the Infection Control Service in developing and maintaining the prevention, surveillance, investigation and monitoring of Control of Infection across the Trust.

5.4.4 Infection Control Nurse Advisors (ICNA)

The Infection Control Nurse Advisors (ICNA), under the direction of the HICNS, is responsible for the day to day management of infection control within the Trust. As part of the team, they will contribute to the formulation and delivery of policies, procedures and protocols designed to prevent and control episodes of infection. The ICNAs are key members of the team responsible for delivering education and training across the Trust.

5.4.5 Infection Control Surveillance Nurse (ICSN)

The ICSN, under the direction of the HICN, is responsible for the collation and analysis of specified microbiological data which has an impact on patient care and the reduction/prevention of healthcare associated infections. In addition the ICSN undertakes specific audits and training to ensure best practice is understood and applied.

5.4.6 Decontamination Manager.

a) Responsible for providing decontamination advices, support and information to multidisciplinary staff within the Trust through education, training and working with staff in clinical and non clinical areas.

b) Responsible for auditing, implementing, co-ordinating and monitoring the Trusts decontamination strategy to meet the recommendations of local and National guidelines.

c) Responsible for developing, implementing and monitoring the decontamination programme.

d) Responsible for reporting to and updating the Infection Control Operational Committee.

5.5 Managers

a) To ensure staff are aware of and have access to infection control policies and guidelines

b) To ensure staff have understood the relevant policies and guidelines and are compliant with them

c) To ensure all staff have undertaken a Local Infection Control Induction Programme which outlines infection control policies and procedures within individual areas to include; hand hygiene, sharps awareness, decontamination, care and management of patients with communicable infections where appropriate.

5.6 Divisions

It is the responsibility of the Divisional managers to ensure infection control policies, procedures and guidelines are implemented and monitored within each division.

5.7 Matrons

Matrons play a key role within the organisation and are responsible for ensuring adherence to infection control practices to include; cleanliness of the environment; adherence to infection control practices; audit and surveillance of key target mirco-organisms (to include *C.difficile*, MRSA bacteraemias) within their clinical area; compliance to 'Saving Lives' and hand hygiene audit tools and appropriate internal reporting including to the Chief Nurse and Trust Board.

5.8 Ward/Departmental Managers/ Senior Nursing staff are responsible for:

5.8.1 Ensuring the dissemination of this policy within their areas of responsibility.

5.8.2 Notifying the Infection Control Service (ICS) of patients with known or suspected communicable infections.

5.8.3 Ensuring appropriate isolation in line with infection control guidelines.

5.8.4 Providing full information on communicable infections to patients and their relatives (as appropriate). This must be documented in their health care notes and supported with written (patient) information where applicable.

5.8.5 Monitoring and enforcing infection control guidelines amongst staff, patients and visitors including the appropriate use of PPE.

5.8.6 Responsible for ensuring both the environment and equipment are clean and fit for purpose.

5.8.7 Providing information on diagnosis and infection control requirements if the patient is transferred to another institution

5.9 Medical Staff are responsible for:

5.9.1 Undertaking a risk assessment for all patients admitted with known or suspected communicable infections.

5.9.2 Notifying the Infection Control Service (ICS) of patients with known or suspected communicable infections. .

5.9.3 Ensuring all patients with known or suspected communicable infections are isolated appropriately.

5.9.4 Commencing appropriate and prompt treatment.

5.9.5 Providing information on diagnosis and infection control requirements if the patient is transferred to another institution.

5.9.6 Ensuring patients are given adequate information regarding their clinical condition and the reasons behind isolation requirements.

5.10 The Infection Control Operational Committee

The Infection Control Operational Committee (ICOC) represents the main forum for discussion between the ICS and other Senior Trust employees to ensure that there is support from the Trust for infection control policies, procedures and guidelines, for the control and prevention of infection.

a) To advise and support the Infection Control Service
b) To advise relevant personnel to include the Medical Director and Chief Operating Officer or designated Deputy on any infection control related issues
c) To review the annual infection control programme and seek approval by the Trust Board.
d) To approve the annual report produced by the Infection Control Service
e) To assist and advise the Trust in the management of outbreaks, discuss and endorse any outbreak management strategy and monitor its effectiveness
f) To advise and approve infection control policies and guidelines and evaluate their implementation.
g) To monitor the Infection Control action plan and escalate any issues of concern to the Infection Control Executive Committee
h) To offer advice on the most appropriate use of resources available to facilitate the implementation of the infection control programme and endorse any contingency requirements.

i) To circulate minutes of the Infection Control Operational Committee meetings to the Chief Executive, Medical Director, Chief Operating Officer or designated Deputy, CCDC and other personnel as appropriate.
j) To promote and facilitate education to all Health Care Workers as appropriate
k) To provide a link between the ICOC and ward/departments to ensure infection control issues are addressed
l) To ensure infection control issues are identified via Risk Management and Health, Safety and Welfare Council as appropriate

5.11 Executive Infection Control Group

The Executive Infection Control Group (EICG) represents a forum to provide added impetus to the implementation of improvements of infection control across the organisation The EICG links directly with the ICC and Trust Board. Members of the EICG consist of the following;

- Chief Executive
- Director of Infection, Prevention and Control
- Chief Nurse
- Deputy Director of Nursing, Midwifery and Therapies
- Director of Finance
- Director of Facilities
- Chief Operating Officer or designated Deputy
- Deputy Director of Facilities
- Head of Infection Control Nursing Service

5.11.1 Role of the Executive Infection Control Group

a) To monitor progress against the actions in the Assurance Framework and take appropriate measures where necessary.
b) To update the Assurance Framework on a regular basis, maintaining an auditable documentation trail.
c) To review any external documents, guidance and requirements, and to ensure an appropriate Trust response.
d) To identify possible funding sources where funding is required to progress actions.
e) To provide assurance to the Governance Board and Trust Board that appropriate measure are in place to manage the risk of infection.
f) To remove obstacles and bring challenges to the rest of the Trust on issues related to infection control and prevention

5.12 Healthcare Economy Group for Infection Control

- Director of Infection, Prevention and Control (Chair)
- Head of Infection Control Nursing Services, SWBH
- Chief Nurse, SWBH
- DIPC & Infection Control Lead – HOB & Sandwell PCTs
- Consultants in Communicable Disease Control (Birmingham & Sandwell)
- DIPC/Infection Control Lead – Mental Health Trust

5.12.1 Role of the Healthcare Economy Group for Infection Control

Functions of the Healthcare Economy Group for Infection Control

- Promote a better understanding of Healthcare Associated Infections (HCAI) agenda across the wider healthcare economy.
- Review new developments and policies which may impact on the wider economy.
- Promote cooperation across primary/secondary care.
- Develop joint policies/protocols.
- Review reporting and monitoring arrangements

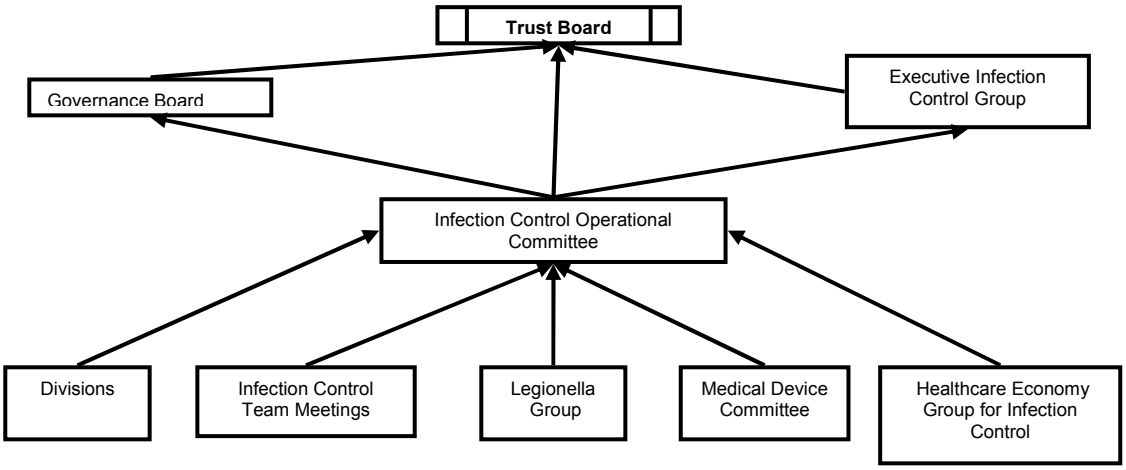
6.0 Infection Control Assurance Framework

6.1 Compliance with national and regional policies, guidelines, initiatives and targets is ensured through a clear internal structure (see 6.3.1 and 6.3.2 below), linked with a strategic assurance framework.

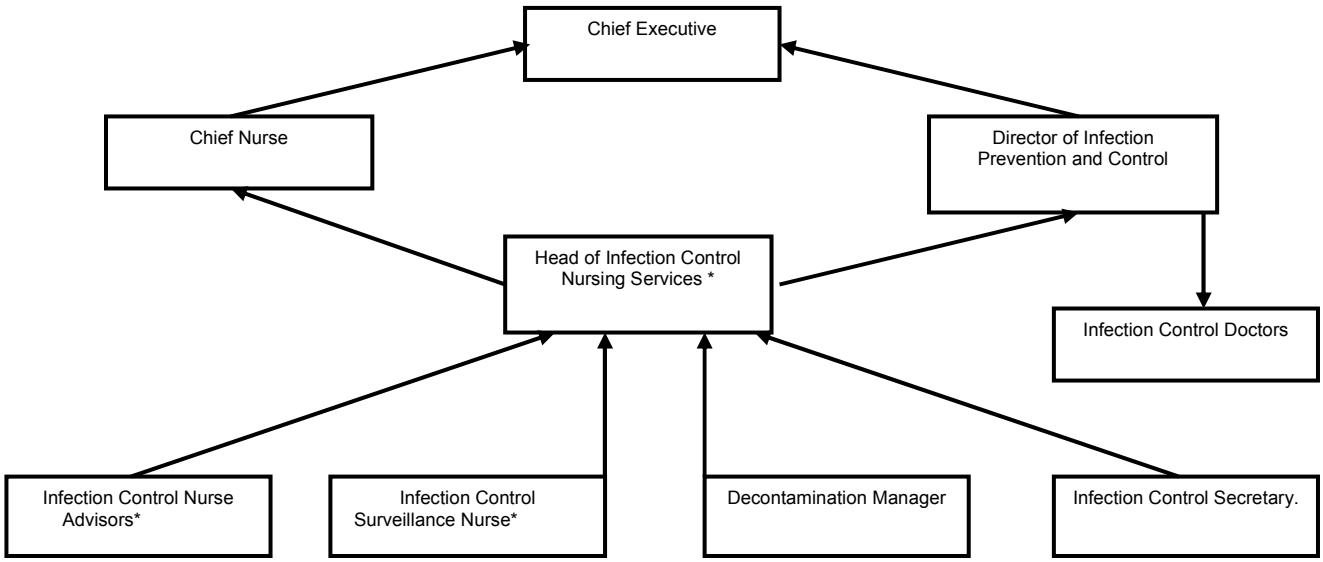
6.2 This assurance framework is a living document which forms an action plan to ensure compliance with key targets and indicators. The Infection Control and Cleanliness Action Plan will be reviewed not less than quarterly by the Trust's Infection Control Operational Committee. This is reviewed by exception by the Infection Control Executive Committee, Governance and Risk Management Committee and Trust Board.

6.3 Accountability Structure for Infection Control

6.3.1 Corporate Accountability Structure for Infection Control



6.3.2. Lines of Accountability for Members of the Infection Control Team



* Professionally accountable to the Chief Nurse

** Infection Control Doctor = Consultant Microbiologist on clinical duty will be responsible for the day-to-day running of their respective sites

7.0 Associated Core Clinical Care Protocols

The Trust has a comprehensive range of policies which cover all of the criteria as outlined in the Health and Social Care Act 2008. All policies are available on the hospital intranet. Key policies include:-

a. Standard infection prevention and control precautions (Infection Control Policies - SWBH/COI/001-038)
b. Aseptic technique (SWBH/COI/025 & clinically incorporated into all clinical procedures)
c. Outbreaks of communicable infection (Outbreak Plan SWBH/COI/004 & incorporated into all relevant policies)
d. Isolation of service users with an infection (SWBH/COI/12-13 and incorporated into specific policies)
e. Control of outbreaks and infections associated with specific alert organisms (Outbreak plan – SWBH/COI/004 and other related policies - SWBH/COI/012-038)
f. Waste Management policy – SWBH/ORG/038
g. Uniform and dress code
h. Immunisation of service users

8.0 Information for Patients and the Public

8.1 It is important that staff ensure that patients and the public are informed of the processes within the Trust for preventing and controlling health care acquired infections. The Trust has developed patient information which covers management of a wide range of infections. Key information leaflets have been printed and are accessible for all staff via the hospital intranet. Patients and visitors can access relevant policies from wards and departments and via PALS.

8.2 Information Includes:

- Helping to reduce the risk of cross infection.
- MRSA
- MRSA Screening – Emergency Patients
- MRSA Screening - Elective Patients.
- ESBL
- Clostridium difficile
- TB
- Hepatitis B
- Hepatitis C
- Human Immunodeficiency Virus

9.0 Education and Training

9.1 Education and training is integral to all infection control policies. Specific element training i.e. hand hygiene compliance is outlined in the Hand Hygiene Policy.

9.2 Levels of training required by each staff group are identified within the Trust Induction and Mandatory Training Policy. Staff must attend mandatory training, in line with the Training Needs Analysis contained within the Trust Induction, Statutory and Mandatory Training Policy.

9.3 It is the responsibility of Managers to ensure all staff have received appropriate training in infection prevention and control and can demonstrate an understanding of the principles and guidelines outlined in the infection control policies/guidelines.

9.4 Managers are responsible for ensuring all staff have undertaken the Infection Control Induction and mandatory training programme.

9.5 Learning and Development is responsible for maintaining an audit trail of all staff that have undergone the Infection Control Induction and mandatory training and following up staff who have not attended training.

10.0 Equality and Diversity

The Trust recognises the diversity of the local community and those in its employ. 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 Equality initial screening toolkit, the results for which are monitored centrally.

11.0 Policy Review

This policy will be reviewed in 2 years time. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance

12.0 Monitoring Effectiveness

12.1 The Trust monitors performance against a number of key infection control indicators through the action plan to its infection control assurance framework.

12.2 ICS monitor compliance of policies through the audit programme and surveillance of target organisms.

12.3 Areas of good practice and areas for improvement are highlighted by the ICS and reported at ICC and Divisional meetings.

13.0 References

- Health and Social Care Act 2008
- Trust Hand Hygiene Policy

14.0 Appendices

Whilst there are no specific appendices to the Infection Control Policy it should be read in conjunction with the Infection Control Manual, which sets out details for management of specific infection control issues.

15.0 Further enquiries

Questions about this policy should be directed to the Infection Control Service

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Initial Equalities Screening Checklist

POLICY TITLE/SERVICE:	**IFC: Infection Control Policy**
ACCOUNTABLE DIRECTOR:	**Rachel Overfield – Chief Nurse.**
MANAGER RESPONSIBLE FOR COMPLETION:	**Dr. Beryl Oppenheim, DIPC**
DATE:	**01.02.2010**

Public service organisations are required to take concerted action to identify and eliminate inequality. Undertaking equality impact assessment in relation to all relevant policies provides the means for doing this.

This checklist should be completed to determine if the proposed policy is relevant to the Trust's General Duty under race, gender and disability equality.

CHECKLIST

Step 1 – What is the purpose of the policy/service proposal?

- To meet the statutory requirements as set out in 'The Health and Social Care Act 2008'.- *Code of Practice for health and adult social care on the prevention and control of infections and related guidance*'.
- To provide an efficient, cost effective infection control service for the Trust
- To utilise, develop and promote infection control practices which are cost effective, safe and efficient, minimising the risk of patients acquiring infections during or as a result of their stay in the hospital.
- To implement the annual Programme and polices and to be responsible for providing advice to the Trust or hospital staff on a 24 hour basis

How will the outcomes be measured?

- Infection Control – through day to day practices and audit.
- Ward/Departmental managers, Matrons, Clinical directors, Divisional Managers are responsible for ensuring compliance against policy is met

Who are the key stakeholders? All clinical and non clinical areas

Step 2 – Gather information and data (evidence)	YES	NO
Will the proposed policy/service involve or have consequences for the patients or staff of the Trust on racial grounds in the context of their gender, disability, sexuality, age, religion and language? • If yes, please explain, identifying those likely to be affected and detailing evidence sources.		No
Is there any reason to believe that people from the different equality strands, taking into account of interaction between strands, could be affected differently, by the proposed policy/service • If yes, please state reason and those likely to be affected and evidence sources...		No
Is there evidence to suggest that any part of the proposed policy/service could discriminate unlawfully, directly or indirectly? • If yes, please specify • If no, please explain		No
Is there any evidence that some people may have different expectations of the policy/service in question due to their race, gender, disability, sexuality, age, religion and language? • If yes, please specify • If no, please explain		No
Is the proposed policy/service likely to affect relations between some		No

people due to their race, gender, disability, sexuality, age, religion and language, for example if is seen as favouring a particular group or denying opportunities for another? • If yes, please state reason/evidence and information on those likely to be affected.	

Step 3 – Impact of the Policy, process or service

If any of the questions are answered 'yes' then the proposed policy/service is likely to be relevant to the Trust's legal duties in relation to race, gender and disability. The relevant manage should proceed to complete a full Equalities Impact Assessment (see appendix 2).

A copy of the completed form must accompany the policy/service when it is presented to the relevant body for approval.

This initial quality impact assessment checklist has been completed by (*please sign below):*

Name of EIA Lead : __ _Dr Beryl Oppenheim
Date: _1st February 2010
Signed: _____

Appendix 5

Sandwell and West Birmingham Hospitals NHS
NHS Trust

POLICY IMPLEMENTATION PLAN

POLICY TITLE:	IFC: Infection Control Policy
ACCOUNTABLE DIRECTOR:	Rachel Overfield – Chief Nurse.
POLICY AUTHOR:	Dr Beryl Oppenheim – Director of Infection Prevention and Control Rebecca Evans – Head of Infection Control nursing services
APPROVED BY:	
DATE OF APPROVAL:	

An implementation plan must be developed for all policies. This will ensure that a systemic 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.

KEY ACTIVITIY	ACTIONS PLANNED TO DELIVER ACTIVITY	PLANNED COMPLETION DATE
Coordination of Plan		
Identify an individual to oversee the implementation plan-	• The plan is already in existence as the existing policy has been updated. • The Director of Infection Prevention and control is responsible for overseeing implementation plan. • IFC team are responsible for promoting principles and issuing guidance throughout the trust • Ward/Departmental managers, Matrons, Clinical directors, Divisional Managers are responsible for ensuring compliance against policy is met	March 2010.
Communication and Engagement	• All clinical staff are affected by the policy. The policy has been developed through work with staff across all sites so the most influential staff have been involved. • Infection Control has a high profile within the Trust and it is not considered there are specific issues in engaging staff. • There are a number of action plans in place to drive forward the infection control programme	March 2010.
Identify the key messages to communicate to the different stakeholder	• All staff within the organisation are responsible for ensuring the prevention and control of infection. • All staff are responsible for ensuring they adhere to the correct policies and procedures. • It is the responsibility of staff to ensure patients are risk assessed and warded appropriately dependent on type of organism and transmissibility.	March 2010.
Consider how these messages will be disseminated	• Policy to be distributed via team brief • Desseminated through relevant committees i.e o Infection Control Operational Committee o Senior Nurse Forum.	March 2010.

	• To be placed on Intranet	
Identify which groups of service users are affected by the policy, either directly or indirectly	All Staff [to include:- agency, locum and contractors], patients and visitors	March 2010
Update or produce new patient information regarding the policy	Not applicable	
Identify any service users who could contribute to the implementation of the policy	Not applicable	
Arrange an appropriate engagement exercise where appropriate	Not appropriate	
Training		
Identify the training needs arising from the implementation of the policy	• There are no specific training needs as a result of the new policy – infection control training is already mandatory within the Trust • Issues to be picked up through existing infection control training • Any specific training needs should be identified to Infection Control by ward/departmental managers.	March 2010
Identify the skills and knowledge needed to deliver training	Users need to have an understanding of infection control policies and the correct application to clinical practice.	
Ensure that the corporate induction and other mandatory training programmes incorporate any changes required as a result of implementing the policy	Corporate induction and local induction have been updated to engage staff prior to release of policy.	March 2010
Resources		
Determine the financial impacts of any changes arising from the introduction of the policy	There are no resource implications from the introduction of the policy	March 2010
Identify any other resource implications arising from the implementation of the policy	There are no resource implications from the implementation of the policy	March 2010
Monitoring and Evaluating		
Determine the main changes you would expect to see once the policy is embedded	• Infection Control – through day to day practices and audit. • Ward/Departmental managers, Matrons, Clinical directors, Divisional Managers are responsible for ensuring compliance against policy is met	March 2010

KEY ACTIVITIY	**ACTIONS PLANNED TO DELIVER ACTIVITY**	**PLANNED COMPLETION DATE**
Devise a means of confirming that the changes expected have occurred	IFC audit programme	March 2010
Devise a means of evaluating the effectiveness of the changes resulting from the policy introduction	IFC audit programme Clinical management of patients with infections. National infection control targets to include:- • C.difficile rates • MRSA bacteraemia rates • MRSA screening rates • Compliance against national cleaning standards	March 2010
Arrange for an evaluation of the policy introduction to be presented to an appropriate monitoring body after the latest activity completion date	Infection Control Operational Committee	March 2010
Consider how lesions learned from the implementation of the policy may be fed back into the organisation	Lessons learned will be raised Infection Control team Meeting, Infection Control Operational Committee and Senior Nurse Forum.	March 2010

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Consent Policy
SPONSORING DIRECTOR:	Mr Donal O'Donoghue, Medical Director
AUTHOR:	Ruth Gibson, Head of Risk Management
DATE OF MEETING:	25 February 2010

SUMMARY OF KEY POINTS:

The Consent Policy has been updated and is appended for approval, together with a full equality impact assessment and implementation plan.

The Consent Policy has been revised to incorporate the changes in the law around capacity and to set out a revised process around delegated consent.

Key features of the delegated consent process for medial trainees include:

- the requirement that each specialty agree a list of key procedures for which consent is delegated
- the identification of delegated consent training needs at local induction
- establishment of a competency database within the Education Centres to capture delegated consent training (replacing the previous registers)
- replacement of the training packs with a training checklist

The policy is one of those identified as needing Trust board approval within the Policy on the Development, Management and Approval of policies.

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Board is recommended to APPROVE the policy.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High quality of care
Annual priorities	
NHS LA standards	Standard 4 'Clinical Care'
Core Standards	SfBH Core Standards and CQC Regulation 18
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Policy reviewed at Consent Group and was approved at the Governance Board at its meeting held on 5 February 2010

1 Introduction

1.1 Why consent is crucial

Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is therefore absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery. Seeking consent is also a matter of common courtesy between health professionals and patients.

1.2 This policy

The Department of Health has issued a range of guidance documents on consent, and these should be consulted for details of the law and good practice requirements on consent. This policy sets out the standards and procedures in this Trust, which aim to ensure that health professionals are able to comply with the guidance. While this document is primarily concerned with healthcare, social care colleagues should also be aware of their obligations to obtain consent before providing certain forms of social care, such as those that involve touching the patient or client.

One of the foundation stones of this policy is that the consultant responsible for a patient is responsible for ensuring that a valid consent is taken and that the patient's wishes are respected throughout.

1.3 What consent is – and isn't

"***Consent***" is a patent's agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be ***valid***, the patient must:

- Have capacity to take the particular decision;
- Have received sufficient information to take it; and
- Not be acting under duress.

The context of consent can take many different forms, ranging from the active request by a patient of a particular treatment (which may or may not be appropriate or available) to the passive acceptance of a health professional's advice. In some cases, the health professional will suggest a particular form of treatment or investigation and after discussion the patient may agree to accept it. In others, there may be a number of ways of treating a condition, and the health professional will help the patient to decide between them. Some patients, especially those with chronic conditions, become very well informed about their illness and may actively request particular treatments. In many cases, 'seeking consent' is better described as 'joint decision-making': the patient and health professional should come to an agreement on the best way forward, based on the patient's values and preferences and the health professional's clinical knowledge.

Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, no-one else can give consent on their behalf unless they have been given the authority to do so under a Lasting Power of Attorney or as a court appointed deputy. However, treatment may be given if it is in their best interests, as long as it has not been refused in advance in a valid and applicable advance directive. For further details on advance directives see the

Department of Health's REFERENCE GUIDE TO CONSENT FOR EXAMINATION OR TREATMENT (Second edition, Chapter 1, paragraph 47).

1.4 Guidance on consent

The Department of Health has issued a number of guidance documents on consent, and these should be consulted for advice on the current law and good practice requirements in seeking consent. Health professionals must also be aware of any guidance on consent issued by their own regulatory bodies.

REFERENCE GUIDE TO CONSENT FOR EXAMINATION OR TREATMENT, SECOND EDITION 2009 provides a comprehensive summary of the current law on consent, and includes requirements of regulatory bodies such as the General Medical Council where these are more stringent. Copies are available from the Risk Management Department and may also be accessed on the internet at www.doh.gov.uk/consent.

Specific guidance, incorporating both the law and good practice advice, is available for health professionals working with children, with people with learning disabilities and with older people. Copies of these booklets are available via the Department of Health link on the Trust Homepage or direct via the internet at www.doh.gov.uk/consent.

2 Objectives

1. To ensure that agreed procedures/processes are in place to obtain valid Consent.
2. To ensure effective processes for recording of consent.
3. To ensure staff who are not capable of performing the procedure but are authorised to obtain consent receive suitable and sufficient training to take valid consent
4. To identify and deliver training requirements for staff in relation to consent.
5. To identify procedure specific training on consent for staff taking consent and who are not capable of performing the procedure
6. To monitor the effectiveness of the Consent to Treatment Policy implementation
7. To ensure robust consent documentation is kept in the patient records
8. To ensure auditing of the consent process takes place on a regular basis, at least annually.

3 Scope

1. This policy applies to all staff involved in the consent process
2. This document relates to trust wide taking of consent including delegated consent and consent taken in the patient's best interests or where mental capacity issues are identified.
3. This policy covers processes for procedure specific training on consent for obtaining consent via delegated methods.

4 Definitions

Consent

Consent is the voluntary and continuing permission of the person to the intervention in question, based on an adequate knowledge of the purpose, likely effects and risks of that intervention,

including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent.

For consent to be valid the patient must:

- Have capacity to make a particular decision
- Have received sufficient information to consider and make the decision
- Not be acting or making a decision under duress

Where possible consent should be taken in advance of the procedure (ie in a pre-operative assessment clinic) so the patient has time to consider the options given and make an informed decision.

Vicarious Liability

Vicarious liability is a legal concept that means a party may be held responsible for injury or damage when in reality they were not actively involved in the incident. Parties that may be charged with vicarious liability are generally in a supervisory role over the person or parties personally responsible for the injury/damage. Vicarious liability implies that the employer is responsible for the acts of its employees, where employees are acting within the Trust's terms and conditions/policies).

Best Interests

An act done or decision made, under the Mental Capacity Act 2005, for, or on behalf of, a person who lacks capacity or made in his/her best interests. Best interests are wider than medical interests and include the patient's wishes, beliefs of the patient when competent, including general, spiritual and religious wellbeing. Healthcare professionals must consider all the relevant circumstances relating to the decision in question; these are listed in the Reference Guide to consent for examination or treatment, second edition.

Mental Capacity

The Mental Capacity Act 2005 defines a person who lacks capacity as a person who is unable to make a decision for themselves because of an impairment or disturbance of the functioning of the mind or brain. A person must be assumed to have capacity unless it is established that they lack capacity: if there is doubt, the health professional must assess the capacity of the patient to take the decision in question, recording the assessment and conclusions drawn from it in the patient's notes.

Delegated Consent

Valid consent to treatment involves a patient agreement to the intervention following a discussion and understanding of the risks and benefits of the procedure that is being undertaken. The Consultant carrying out the procedure is ultimately responsible for ensuring that the patient is genuinely consenting to what is proposed.

Guidance from the Department of Health stipulates that consent is sought by a professional competent to do so because they either carry out the procedure themselves or have received specialist training in advising about the procedure, have been assessed by the organisation and are aware of their own knowledge limitations and are subject to audit. The taking of consent may therefore be delegated to a member of staff who is not capable of performing the procedure but is

authorised to obtain consent. Such authority is generally gained through training and assessment in line with this policy. This means the staff member will be able successfully to explain the risks and benefits of and alternatives to the procedure being undertaken. This staff member may be a junior doctor or other health care professional.

Advance Decisions

Patients may have a 'living will' or 'advance directive' specifying how they would like to be treated in the case of future incapacity. Professionals cannot be required by such directives to provide particular treatments (which might be inappropriate). An advance refusal of treatment will be legally binding for a patient who now lacks capacity if made voluntarily by an appropriately informed person with capacity when made. An advance decision to refuse potentially life-saving treatment must be in writing and be witnessed.

5 Roles and Responsibilities

5.1 Medical Director

The Medical Director is responsible for ensuring a robust system for the taking of consent and for monitoring the effectiveness of the system is in place across the Trust.

The Medical Director is required, under the conditions of vicarious liability for the Trust, to be satisfied that where health care professionals either take consent or take on new roles or tasks such as delegated consent that the process is robust and staff are competent to carry out their roles.

The Medical Director will ensure the policy is enforced in respect of any failures in compliance which are escalated to him/her.

5.2 Consultant

The Consultant carrying out the procedure is ultimately responsible for ensuring that the patient is genuinely consenting to what is being done. It is they who will be held responsible in law if they are challenged later. (GOOD PRACTICE IN CONSENT IMPLEMENTATION GUIDE: CONSENT TO EXAMINATION OR TREATMENT DOH NOVEMBER 2001). Where delegated consent is undertaken the Consultant(s) remain responsible for the consent processes.

The Consultant will take part in identifying the training, supervision and review of staff taking part in the delegated consent process. (see Appendix G1).

The Consultant must ensure that anyone taking delegated consent for a patient under their care:

- Follows the processes in this policy for taking and recording consent
- Has sufficient knowledge of the investigation or procedure and has an understanding of the risks involved,
- Has the ability verbally to provide information that the patient asks about or needs to know about their condition, its treatment and prognosis, including any future effects on the patient's lifestyle,
- Has knowledge about alternatives to the proposed treatment, frequency of adverse effects, their seriousness and effectiveness compared to the treatment being proposed,

- Has the ability to communicate satisfactorily to patients in a way that is understood,
- Has the ability to satisfy the patient's concerns so that he/she is able to understand what is being proposed and asked to consent to.
- Is aware that the consent process is dynamic and that consent, once given, can be withdrawn or become potentially invalid due to a change in circumstances (ie medical condition changes)
- Provides the patient with adequate written information and other support (ie access to interpreters, IMCAs) so that the decision made is informed.

The Consultant must agree the criteria for the type of patient which the health care professional with responsibility for delegated consent may actually take consent from. The Health Care Professional should not take delegated consent from patients where there is an issue regarding their capacity to consent, e.g. learning disability, dementia.

The Consultant must ensure that they complete an approval record for each approved procedure for any medical trainees for whom they are Educational Supervisors and for any other healthcare professionals that they are asked to train. (see Appendix G2)

The Consultant is responsible for ensuring accurate, timely and complete information relating to consent is documented in the patient record.

The Consultant has a duty to ensure each patient consenting to treatment has capacity to consent. Assessment of Capacity to consent is part of that duty

5.3 Clinical Director

The Clinical Director is responsible for ensuring Trust approved systems for consent are operational and working effectively within the directorate.

Where consent is delegated the Clinical Director must ensure that:

- a list of applicable procedures is maintained within the directorate
- details provided to the Education Centres and Clinical Effectiveness
- training is carried out promptly and escalated incidents are managed promptly.

The Clinical Director must have an overview of what procedures have been delegated and ensure annual audits of consent are undertaken and reported.

5.4 Divisional Director

In the event that the Clinical Director is the Educational Supervisor of a medical trainee and fails to undertake delegated consent training promptly the Divisional Director must follow this up promptly.

5.5 Healthcare Professional undertaking delegated consent

Teamwork is a crucial part of the way the NHS operates and where written consent is being sought, it may be appropriate for other members of the team to participate in the process of seeking consent.

The Healthcare Professional taking delegated consent must ensure that:

- They only take consent for a procedure which they are competent to perform or for which they have had specific training in taking consent
- They make the patient aware of the implications of the treatment including pre-peri-and post-operative effects and consequences.
- They give the patient adequate literature describing the procedure, its benefits and risks any alternatives.
- They make an appropriate record of the consent on the correct consent forms and/or in the patient record.
- The patient has proper access to the delegating clinician so that any problems or queries which cannot be answered by the person explaining the treatment can be easily and speedily addressed.

The healthcare professional who has delegated consent approval may only take consent for those procedures/treatments which they have been trained and registered for at this Trust.

5.6 Medical Staffing

The Medical Staffing Department is responsible for ensuring all new junior doctors are provided with local induction documentation to allow assessment of delegated consent competency to be undertaken

The Head of Medical Staffing will follow up instances where Basic Skills Competency Forms have not been returned.

5.7 Education Centres

The Education Centres are responsible for:

Collecting completed local induction consent competency documents in a timely way

Escalating where documentation is not received to ClinicalDirectors and to the Head of Medical Staffing

Ensuring details of competency are logged and kept up to date

Ensuring reports of competency provided to directorates/divisions and Clinical Effectiveness as required

5.8 Assistant Director of Nursing responsible for Quality

The Assistant Director of Nursing responsible for Quality will ensure an up to date register (appendix G3) of all healthcare professionals who are not medically trained but who take consent, together with details of their training, is maintained and make this available for audit/review as required.

6 Documentation (Process for recording consent)

For ***significant*** procedures, it is essential for health professionals to document clearly both a patient's agreement to the intervention and the discussions which led up to that agreement. This may be done

either through the use of a consent form (with further detail in the patient's notes if necessary), or through documenting in the patient's notes that they have given oral consent.

Written consent

Consent is often wrongly equated with a patient's signature on a consent form. A signature on a form is *evidence* that the patient has given consent, but is not *proof* of valid consent. If a patient is rushed into signing a form, on the basis of too little information, the consent may not be valid, despite the signature. Similarly, if a patient has given valid verbal consent, the fact that they are physically unable to sign the form is no bar to treatment. Patients may, if they wish, withdraw consent after they have signed a form: the signature is evidence of the process of consent-giving, not a binding contract.

It is rarely a legal requirement to seek written consent, but it is good practice to do so if any of the following circumstances apply;

- The treatment or procedure is complex, or involves significant risks (the term 'risk' is used throughout to refer to any adverse outcome, including those which some health professionals would describe as 'side-effects' or 'complications')
- The procedure involves general/regional anaesthesia or sedation
- Providing clinical care is not the primary purpose of the procedure
- There may be significant consequences for the patient's employment, social or personal life
- The treatment is part of a project or programme of research approved by the Trust

Written consent should be recorded on the Trust's approved consent forms (see sections 6.2 and 9.1 and Appendix A)

Completed forms should be kept with the patient's notes. Any changes to a form, made after the form has been signed by the patient, should be initialed and dated by both patient and health professional.

It will not usually be necessary to document a patient's consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if you have any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient (for example if they have declined, or become very distressed about, similar care in the past); it would be prudent to do so.

The MENTAL HEALTH ACT 1983 and the HUMAN FERTILISATION AND EMBRYOLOGY ACT 1990 require written consent in certain circumstances.

6.1 Procedure to follow when patients lack capacity to give or without consent

Where an adult patient does not have the capacity to give or withhold consent to a significant intervention, this fact should be documented in form 4 (form for adults who are unable to consent to investigation or treatment), along with the assessment of the patient's capacity, why the health professional believes the treatment to be in the patient's best interests, and the involvement of people close to the patient. The standard consent forms should never be used for adult patients

unable to consent for themselves. For more significant interventions, this information should be entered in the patient's notes.

An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity. You should involve appropriate colleagues in making such assessments of incapacity, such as specialist learning disability teams and speech and language therapists, unless the urgency of the patient's situation prevents this. External agencies should also be involved if appropriate to ensure the patient has an advocate (ie IMCA). If at all possible, the patient should be assisted to make and communicate their own decision, for example by providing information in non-verbal ways where appropriate.

Occasionally, there will not be a consensus on whether a particular treatment is in an incapacitated adult's best interests. Where the consequences of having, or not having, the treatment are potentially serious, a court declaration may be sought. See Appendix E for details of how to do this.

6.2 Consent forms

Standard consent forms and forms for adults who are unable to consent for themselves are reproduced in Appendix A and are available to order using the normal stationery order system. There are three versions of the standard consent form (ie for patients with capacity):

Form 1 for adults or children with capacity,

Form 2 for parental consent for a child or young person and form 3 for cases where it is envisaged that the patient will remain alert throughout the procedure and no anaesthetist will be involved in their care.

Form 3 : The use of Form 3 is optional but may be thought more appropriate than Form 1 in situations where patients do not need to be made aware of issues surrounding general or regional anaesthesia and do not need to make any advance decisions about additional procedures because they will be in a position to make any such decisions at the time if necessary.

Form 4: this is for use with adult patients who lack capacity

7 Process for Obtaining Consent

When a patient formally gives their consent to a particular intervention, this is only the *endpoint* of the consent process. It is helpful to see the whole process of information provision, discussion and decision-making as part of 'seeking consent'. This process may take place at one time, or over a series of meetings and discussions, depending on the seriousness of what is proposed and the urgency of the patient's condition.

7.1 When should consent be sought?

7.1.1 Single stage process

In many cases, it will be appropriate for a health professional to initiate a procedure immediately after discussing it with the patient. For example, during an ongoing episode of care a physiotherapist may suggest a particular manipulative technique to be used, they will then give their consent and the procedure can go ahead immediately. In many such cases, consent will be given orally.

If a proposed procedure carries significant risks, it will be appropriate to seek written consent, and health professionals must take into consideration whether the patient has had sufficient chance to absorb the information necessary for them to make their decision. As long as it is clear that the patient understands and consents, the health professional may then proceed.

7.1.2 Two or more stage process

In most cases where *written* consent is being sought, treatment options will generally be discussed well in advance of the actual procedure being carried out. This may be on just one occasion (either within primary care or in a hospital out-patient clinic), or it might be over a whole series of consultations with a number of different health professionals. The consent process will therefore have at least two stages: the first being the provision of information, discussion of options and initial (oral) decision, and the second being confirmation that the patient still wants to go ahead. The consent form should be used as a means of documenting the information stage(s) as well as the confirmation stage.

Patients receiving elective treatment or investigations for which written consent is appropriate should be familiar with the contents of their consent form before they arrive for the actual procedure, and should have received a copy of the page documenting the decision-making process. They may be invited to sign the form, confirming that they wish treatment to go ahead, at any appropriate point before the procedure: in out-patients, at a pre-admission clinic, or when they arrive for treatment. If a form is signed before patients arrive for treatment, however, a member of the healthcare team must check with the patient at this point whether they have any further concerns and whether their condition has changed. This is particularly important where there has been a significant lapse of time between the form being signed and the procedure. When confirming the patient's consent and understanding, it is advisable to use a form of words which requires more than a yes/no answer from the patient: for example beginning with "tell me what you're expecting to happen", rather than "is everything all right"?

While administrative arrangements will vary, it should always be remembered that for consent to be valid, the patient must feel that it would have been possible for them to refuse, or change their mind. It will rarely be appropriate to ask a patient to sign a consent form after they have begun to be prepared for treatment (for example, by changing into a hospital gown), unless this is unavoidable because of the urgency of the patent's condition.

7.2 Seeking consent for anaesthesia

Where an anaesthetist is involved in a patent's care, it is their responsibility (not that of a surgeon) to seek consent for anaesthesia, having discussed the benefits and risks and alternatives. In elective treatment the patient should receive information about anaesthesia before their pre-operative visit from the anaesthetist: if no information is provided until such a late stage the patient will not be in a position genuinely to make a decision about whether or not to undergo anaesthesia. Patients should therefore either receive a general leaflet about anaesthesia in out-patients, or have the opportunity to discuss anaesthesia in a pre-assessment clinic.

The Anaesthetist should ensure that the discussion with the patient and their consent is documented in the anaesthetic record, in the patient's notes and on the consent form. Where the clinician providing the care is personally responsible for anaesthesia (e.g. where local anaesthesia or sedation is being used), then he or she will also be responsible for ensuring that the patient has given consent to that form of anaesthesia.

In addition, where general anaesthesia or sedation is being provided as part of dental treatment, the General Dental Council currently holds dentists responsible for ensuring that the patient has all the necessary information. In such cases, the anaesthetist and dentist will therefore share that responsibility.

7.3 Emergencies

Clearly in emergencies, the two stages (discussion of options and confirmation that the patient wishes to go ahead) will follow straight on from each other, and it may often be appropriate to use the patient's notes to document any discussion and the patient's consent, rather than using a form. The urgency of the patient's situation may limit the quantity of information that they can be given, but should not affect its quality.

7.4 Treatment of babies, children and young people

When babies or young children are being cared for in hospital, it will not usually seem practicable to seek their parents' consent on every occasion for every routine intervention such as blood or urine tests or X-rays. However, in law, such consent is required. Where a child is admitted, you should therefore discuss with their parent(s) what routine procedures will be necessary, and ensure that you have their consent for these interventions in advance. If parents specify that they wish to be asked before particular procedures are initiated, you must do so, unless the delay involved in contacting them would put the child's health at risk.

Only people with '***parental responsibility***' are entitled to give consent on behalf of their children. You must be aware that not all parents have parental responsibility for their children (for example, unmarried fathers do not automatically have such responsibility although they can acquire it). If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check before proceeding. Further advice is available from the Named Nurse for Child Protection, ext 2753 or on mobile phone via switchboard.

Young people under 16 yrs of age may consent to treatment where they are assessed as having the required capacity to consent to treatment in their own right. A proforma for aiding the assessment of capacity to consent is available to assist clinicians in the decision and documentation of whether a child has the relevant capacity (see Appendix C).

Although a young person may consent, parents with parental responsibility still retain a right to consent on the young person's behalf for treatment where refusal would result in injury or damage to the young person.

7.5 Treatment of Neonates

The Trust has adopted the guidelines produced by the British Association for Perinatal Medicine (BAPM) in their document 'GOOD PRACTICE FRAMEWORK FOR CONSENT IN NEONATAL CARE'. A copy can be found on the Consent webpage

8 Provision of information

The provision of information is central to the consent process. Before patients can come to a decision about treatment, they need comprehensible information about their condition and about possible treatment/investigations and their risks and benefits (including the risks/benefits of doing nothing). They also need to know whether additional procedures are likely to be necessary as part of the procedure, for example a blood transfusion, or the removal of particular tissue. Once a decision to have a particular treatment/investigation has been made, patients need information about what will happen: where to go, how long they will be in hospital, how they will feel afterwards and so on.

Patients and those close to them will vary in how much information they want: from those who want as much detail as possible, including details of rare risks, to those who ask health professionals to make decisions for them. There will always be an element of clinical judgement in determining what information should be given. However, the *presumption* must be that the patient wishes to be well informed about the risks and benefits of the various options. Where the patient makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented.

The following sources of patient information are available in this Trust:

EIDO patient information library *(reference)*

PALS Department (ext.5836 – City site and ext.3928 – Sandwell site)

Additional information may be viewed via the Trust web links:

NHS Direct – http://www.nhsdirect.nhs.uk/

National electronic Library for Health (NeLH) – http://www.nelh.nhs.uk/

Patient information is developed locally with divisions. New patient information must be agreed through the Clinical Governance arrangements within the Division.

Provisions for patients whose first language is not English and/or those with sensory impairment or loss.

This Trust is committed to ensuring that patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare staff. It is not appropriate to use children, family members or friends to interpret for patients who do not speak English. (see Patient Communication policy). Additional advice is available via the PALS Department ext. 5386 – City site and ext. 3829 – Sandwell site. Interpreters may be booked via the Cultural Liaison Office ext. 5019.

Following identification of a patient's language and communication need via the 'pick and point card' booked appointments are recorded by Trust PAS and retrieved daily by Centralised Booking. Emergency and walk-ins booking forms may be sent via email, faxed, posted or arrangements made by telephone.

8.1.1 Access to more detailed or specialist information.

Patients may sometimes request more detailed information about their condition or about a proposed treatment that provided in general leaflets. This Trust will encourage the Divisions to develop communication systems to assist this process.

The PALS Department will facilitate communication of specific patient queries to the clinical staff involved, for example the Consultant responsible for a patient's care, a Clinical Nurse Specialist or Therapist.

8.1.2 Access to health professionals between formal appointments

After an appointment with a health professional in primary care or in out-patients, patients will often think of further questions which they would like answered before they take their decision. Where possible, it will be much quicker and easier for the patient to contact the healthcare team by telephone than to make another appointment or to wait until the date of an elective procedure (by which time it is too late for the information genuinely to affect the patient's choice). Where possible the clinical team should provide contact details or refer patients to the PALS Department.

8.1.3 Open access clinics

Where patients access clinics directly, it should not be assumed that their presence at the clinic implies consent to particular treatment. You should ensure that they have the information they need before proceeding with an investigation or treatment. Where possible the consent form and any information should be sent to the patient's home, so that they have time to read the information prior to the procedure or ensure that Primary Care relay information prior to attendance at clinic.

9 Who is responsible for seeking consent?

The health professional carrying out the procedure is ultimately responsible for ensuring that the patient is genuinely consenting to what is being done: it is they who will be held responsible in law if this is challenged later.

Where oral or non-verbal consent is being sought at the point the procedure will be carried out, this will naturally be done by the health professional responsible. However, team work is a crucial part of the way the NHS operates, and where written consent is being sought it may be appropriate for other members of the team to participate in the process of seeking consent.

9.1 Completing consent forms (also see section 6)

The standard consent form provides space for a health professional to provide information to patients and to sign confirming that they have done so. The health professional providing the information must be competent to do so: either because they themselves carry out the procedure, or because they have received specialist training in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations and are subject to audit.

If the patient signs the form in advance of the procedure (for example in out-patients or at a pre-assessment clinic), a health professional involved in their care on the day should sign the form to confirm that the patient still wishes to go ahead and has had any further questions answered. It will be appropriate for any member of the healthcare team (for example a nurse admitting the patient for an elective procedure) to provide the second signature as long as they have access to appropriate colleagues to answer questions they cannot handle themselves.

Staff who are providing information to patients on behalf of the practitioner capable of performing the procedure, must have undergone the formal training programme for delegated consent, which has been agreed by the Divisional Governance arrangements.

Staff who are responsible for confirming consent must have direct access to the person performing the procedure at the time of signing. Access may be via the Trust paging service or contact using Trust mobile telephone.

9.2 Responsibility of health professionals

It is a health professional's own responsibility:

- To ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent to do so; and
- To work within their own competence and not to agree to perform tasks which exceed that competence.
- Where a communication need is identified e.g. interpreter \ communication aid the patient must be offered this service. Should the patient refuse this, this should be recorded in the notes and a disclaimer form completed (see Patient communication policy).

N.B. If staff feel under pressure to seek consent while not feeling competent to do so, they should contact the Divisional General Manager or the Clinical/ ***Divisional Director locally in the first instance, where there remains an unresolved situation the advice of the Medical Director or Director of Nursing and Therapies must be sought. An incident form must be completed.***

10 Refusal of treatment

If the process of seeking consent is to be a meaningful one, refusal must be one of the patient's options. An adult patient with capacity is entitled to refuse any treatment, except in circumstances governed by the MENTAL HEALTH ACT 1983. The situation for children is more complex: see the Department of Health's SEEKING CONSENT: WORKING WITH CHILDREN for more detail. The following paragraphs apply primarily to adults.

If, after discussion of possible treatment options, a patient refuses all treatment, this fact should be clearly documented in their notes. If the patient has already signed a consent form, but then changes their mind, the practitioner (and where possible the patient) should note this on the form. It is still useful to complete the relevant consent form with the benefits of the treatment, the risks of the treatment, alternatives to treatment and ask the patient to sign for refusal of consent.

Where a patient has refused a particular intervention, you must ensure that you continue to provide any other appropriate care to which they have consented. You should also ensure that the patient realises they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.

If a patient consents to a particular procedure but refuses certain aspects of the intervention, you must explain to the patient the possible consequences of their partial refusal. If you genuinely believe that the procedure cannot be safely carried out under the patient's stipulated conditions, you are not obliged to perform it. You must, however, continue to provide any other appropriate care. Where another health professional believes that the treatment can be safely carried out under the conditions specified by the patient, you must on request be prepared to transfer the patient's care to that health professional.

11 Mental Capacity

The MENTAL CAPACITY ACT 2005 (Code of Practice Chapter 2) outlines 5 core principles. These are;

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because they make an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's right and freedom of action.

The MCA is specifically designed to cover situations where someone is unable to make a decision because their mind or brain is affected, for instance, by illness or disability, or the effects of drugs or alcohol. The type of decisions that are covered range from day-to-day decisions such as what to wear or eat, through to serious decisions about where to live, having an operation or what to do with a person's finances and property. It may be the case that the person lacks capacity to make a particular decision at a particular time but this does not mean that a person lacks all capacity to make any decisions at all. It is important that staff are aware that lack of capacity may not be permanent and assessments of capacity should be time and decision specific.

When a patient needs to make a decision, it must be assumed that the person has capacity to make the decision in question (Principle 1). Every effort should be made to encourage and support the person to make the decision themselves (Principle 2) and consideration of a number of factors to assist in that decision making.

These could include:

- Does the person have all the relevant information needed to make the decision? If there is a choice, has information been given on the alternatives?
- Could the information be explained or presented in a way that is easier for the person to understand? For example, a person with a learning disability might find it easier to communicate using pictures, photographs, videos, tapes or sign language.
- Are there particular times of the day when a person's understanding is better or is there a particular place where they feel more at ease and able to make a decision?
- Can anyone else help or support the person to understand information or make a choice? For example, a relative, friend or independent advocate.

It must be remembered that if a person makes a decision which is thought to be eccentric or unwise, this does not necessarily mean that the person lacks capacity to make the decision.

When there is reason to believe that a person lacks capacity to make a decision the following points must be considered;

- Has everything been done to help and support the person to make a decision?

- Does this decision need to be made without delay?
- If not, is it possible to wait until the person does have the capacity to make the decision for him or herself?

If the person's ability to make a decision still seems questionable then an assessment of capacity must be made.

11.1.1 Assessing Capacity

The MCA makes clear that any assessment of a person's capacity must be 'decision-specific'. This means that:

- The assessment of capacity must be about the particular decision that has to be made at a particular time and is not about a range of decisions.
- If someone cannot make complex decisions, that does not mean that they cannot make simple decisions.
- A decision cannot be made that someone lacks capacity based upon their age, appearance, condition or behaviour alone.

The ***Functional Test of Capacity*** required documentation should be completed (see Appendix D)

In order to decide whether an individual has the mental capacity to make a particular decision, a capacity assessment should be made:

1. Decide whether there is an impairment of, or disturbance in, the functioning of the person's mind or brain (it does not matter if this is permanent or temporary).
2. Does the impairment or disturbance make the person unable to make the particular decision?
3. The person will be unable to make the particular decision if after all appropriate help and support to make the decision has been given to them (Principle 2) they cannot:

    - Understand the information relevant to that decision
    - Retain that information
    - Use or weigh that information as part of the process of making the decision.
    - Communicate their decision (whether by talking, using sign language or another means)

Every effort should be made to find ways of communicating with someone before deciding that they lack the capacity to make a decision based solely on their inability to communicate. Very few people will lack capacity on this ground alone. An assessment must be made on the balance of probabilities – is it more likely than not that the person lacks capacity? You should be able to show in your records why you have come to the conclusion that the person lacks capacity to make the particular decision.

An assessment of capacity should not be made without involving family, friends and/or carers or an Independent Mental Capacity Advocate (IMCA) if one has been appointed. This will depend on the situation and the decision that needs to be made.

11.1.2 Independent Mental Capacity Advocate (IMCA) Service

In most situations, people who lack capacity will have a network of support from family members or friends who take an interest in their welfare, or from a deputy or an attorney appointment under a

Lasting Power of Attorney. However, some people who lack capacity may have no-one to support them (other than paid staff) with major, potentially life-changing decisions. The Act created an Independent Mental Capacity Advocate (IMCA) who will represent and support these patients. An IMCA is a specific type of advocate that must be involved if there is no other appropriate person who can be consulted. An IMCA will not be the decision-maker, but the decision-maker will have a duty to take into account the information given by the IMCA.

An Independent Mental Capacity Advocate will only be involved if:

- the decision is about serious medical treatment provided by the NHS
- it is proposed that the person be moved into long-term care of more than 28 days in a hospital or 8 weeks in a care home
- a long-term move (8 weeks or more) to different accommodation is being considered, for example, to a different hospital or care home
- in England, local authorities and the NHS have been given powers to extend the IMCA service to specific situations if they are satisfied that an IMCA would provide particular benefit, these are care reviews about accommodation and decisions about protection issues.

The duties of an Independent Mental Capacity Advocate are to:

- support the person who lacks capacity and represent their views and interests to the decision-maker
- obtain and evaluate information – an IMCA can talk to the patient in private and examine, and where appropriate, take copies of health and social care records such as clinical records, card plans or social care assessment documents
- as far as possible, ascertain the person's wishes and feelings, beliefs and values
- ascertain alternative courses of action
- obtain a further medical opinion, if necessary
- prepare a report for the person who instructed them. If an IMCA disagrees with the decision made, they can also challenge the decision-maker

IMCA contact details:

City - Advocacy Matters (IMCA), 198 Boldmere Road, Sutton Coldfield, B73 5UE
Tele: 0121 321 2377Fax No: 0121 321 2396

Sandwell - POhWER IMCA, iBIC Holt Court South, Jennens Road Aston Science Park, B7 4EJ
Tele No: 0845 233 0438 Fax No: 0845 337 3052

Further advice can be obtained from the Trust Vulnerable Adults lead in working hours and from the Night Practitioners out of hours.

12 Tissue

The legal position regarding the use of human tissue (including blood samples and other bodily fluids provided for testing) raises some difficult issues and is currently under review. Such tissue can be very valuable in education and research, and its use may lead to developments in medical knowledge

and hence improvements in healthcare for all. At present, this Trust requires that patients should be given the opportunity to refuse permission for tissue taken from them during surgery or other procedure to be used for education or research purposes. Where patients refuse permission for tissue taken from them during surgery to be used for education or research purposes, a record will be documented on the consent form and on the form accompanying the tissue sample being sent to the laboratory for analysis. (For consent regarding tissues removed during post mortem, please refer to the POLICY FOR CONSENT FOR HOSPITAL POST MORTEMS, RETENTION, AND THE RESPECTFUL DISPOSAL OF HUMAN TISSUES.

Explicit consent is not necessary for public health surveillance using the unlinked anonymous method, but a well-publicised opt-out policy must be in place in accordance with Pathology Standard Operating Procedures.

Pending the outcome of the review of the law governing the use of human organs and tissue, the Department of Health believes that tissue samples may be used for quality assurance purposes without requiring specific patient consent ***provided*** there is an active policy of informing patients of such use. This is essential to ensure the high quality of service, which all patients have the right to expect. Wherever possible, samples of tissue used in this way should be anonymised or pseudonymised.

13 Clinical photography and conventional or digital video recordings

Photographic and video recordings made for clinical purposes form part of a patient's record. Although consent to certain recordings, such as x-rays, is implicit in the patient's consent to the procedure, health professionals should always ensure that they make clear in advance if any photographic or video recording will result from that procedure. (See PHOTOGRAPHIC & VIDEO RECORDING CONSENT AND CONFIDENTIALITY POLICY).

Photographic and video recordings which are made for treating or assessing a patient must not be used for any purpose other than the patient's care or the audit of that care, without the express consent of the patient or a person with parental responsibility for the patient. The one exception to this principle is set out in paragraph 3 below. If you wish to use a recording for education, publication or research purposes, you must seek consent in writing, ensuring that the person giving consent is fully aware of the possible uses of the material. In particular, the person must be made aware that you may not be able to control future use of the material once it has been placed in the public domain. If a child is not willing for a recording to be used, you must not use it, even if a person with parental responsibility consents.

Photographic and video recordings made for treating or assessing a patient and from which there is no possibility that the patient might be recognised, may be used within the clinical setting for education or research purposes without express consent from the patient, as long as this policy is well publicised. However, express consent must be sought for any form of publication.

If you wish to make a photographic or video recording of a patient specifically for education, publication or research purposes, you must first seek their written consent (or where appropriate that of a person with parental responsibility) to make the recording, and then seek their consent to use it (See Appendix B for REQUEST/CONSENT FORM FOR CLINICAL PHOTOGRAPHY from the PHOTOGRAPHIC & VIDEO RECORDING CONSENT AND CONFIDENTIALITY POLICY). Patients must know that they are free to

stop the recording at any time and that they are entitled to view it if they wish, before deciding whether to give consent to its use. If the patient decides that they are not happy for any recording to be used, it must be destroyed. As with recordings made with therapeutic intent, patients must receive full information on the possible future uses of the recording, including the fact that it may not be possible to withdraw it once it is in the public domain.

The situation may sometimes arise where you wish to make a recording specifically for education, publication or research purposes, but the patient is temporarily unable to give or withhold consent because, for example, they are unconscious. In such cases, you may make such a recording, but you must seek consent as soon as the patient regains capacity. You must not use the recording until you have received consent for its use, and if the patient does not consent to any form of use, the recording must be destroyed.

If the patient is likely to be permanently unable to give or withhold consent for a recording to be made, you should seek the agreement of some-one close to the patient. You must not make any use of the recording which might be against the interests of the patient. You should also not make, or use, any such recording if the purpose of the recording could equally well be met by recording patients who are able to give or withhold consent.

14 Delegated Consent

Delegated consent involves staff who are not capable of performing the procedure but are authorised to obtain consent from a patient due to undergo that procedure. Valid consent to treatment involves a patient's agreement to the intervention following a discussion and understanding of the risks and benefits of the procedure that is being undertaken. The Consultant is ultimately responsible for ensuring that the patient is genuinely consenting to what is being done.

15 Delegated consent

The Trust expects that consent will generally only be taken by Consultants or other professionals capable of carrying out the proposed procedure. Consent should not be delegated to the most junior doctors in training (ie FY1s)

For consent to be valid, the decision to proceed must be made by a patient who has been fully informed of the intended benefits and the significant, unavoidable or frequently occurring risks. Healthcare professionals who do not carry out the procedure themselves cannot be assumed to have the necessary knowledge to explain the risks and benefits without specific training. This section describes the procedures which **must** be followed where Consultants wish to delegate the taking of consent to doctors in training and other healthcare professionals. Compliance with this requirement will be subject to audit.

Requirements for Delegated Consent

The consultant in charge of the patient's care understands that they remain responsible and will need to be involved in the training and supervision of the professionals taking delegated consent.

The consultant, or group of consultants in a specialty, must identify which specific treatments/procedures they will be allowing delegated consent for. This list should be agreed with the Clinical Director who should ensure that a record is kept of this list for that specialty and provide a copy to the Education Centres and to Clinical Effectiveness.

The Consultant(s) delegating consent must ensure that the health professional:

- has sufficient knowledge of the investigation or procedure and has an understanding of the risks involved
- is able to provide the information needed or requested by the patient in connection with their condition, its treatment and prognosis, including any future effects on the patient's lifestyle
- knows about the alternatives to the proposed treatment, frequency and severity of adverse effects and the effectiveness of the alternatives compared to the proposed treatment.
- is able to communicate satisfactorily with patients and understands the need to use professional interpreters rather than family members for translation whenever feasible.
- is able to answer the patient's concerns so that they are able to understand what is proposed and what they are being asked to consent to

The taking of consent should **not** be delegated for patients who

- lack capacity
- are undergoing novel procedures
- are undergoing high-risk surgery, either because of their co-existing medical conditions or because the operation is inherently high-risk.

The patient should be given printed information relevant to their procedure in line with the Patient Information Policy.

15.1 Identifying professionals who need delegated consent training

Medical Trainees

All medical trainees are required to complete a Basic Skills Competency Form with their Educational Supervisor on arrival at the Trust or on rotation into a new post. This includes questions which will establish the procedures for which the trainee may take delegated consent at this Trust and their training status for each. The completed forms are returned to the Education Centres within 1 month and responses entered on the competency database. Forms which are not received within 1 month will be followed up by email by the Education Centres. If the form is not received within a week of follow up this will be escalated to the Head of Medical Staffing, with a copy to the College Tutor. If the Head of Medical Staffing is unable to obtain a response this will be escalated to the Clinical Tutor.

If the completed form identifies a training need the medical trainee's Educational Supervisor is responsible for ensuring training is provided prior to delegated consent being taken by the trainee.

The training should allow the medical trainee to

- understand the legal implications of taking consent
- have sufficient knowledge of risks, benefits and alternatives for the procedures for which

consent will be sought
- understand their scope of practice
- be clear about when and how to access additional information
- understand the criteria for competency and on-going monitoring of individual delegated consent, including the delegation information required on the consent forms.

Once the Education Centres receive a form identifying a training need they will forward the Delegated Consent Approval Form (appendixG2) to the Educational Supervisor, with a copy to the trainee, explaining training must be provided and the signed form returned within 2 weeks. If the form is not returned the Education Centres will escalate this to the Clinical Director (or Divisional Director if the Educational Supervisor is the Clinical Director). If the form is still not returned this will be escalated to the Medical Director.

Details from the completed forms will be added to the competency database by the Education Centres. Reports of compliance will be forwarded from the database on a quarterly basis to the Educational Advisory Committees and the Consent Group.

Other Healthcare Professionals wishing to take consent

If it is identified that it may be appropriate to their role for a healthcare professional to take consent for a procedure they should contact the Clinical Director for the relevant specialty. The Clinical Director will consider whether it is appropriate for this individual (or a group of staff) to take consent, will ensure training is provided and a Delegated Consent Approval Form signed off.

The completed form will be sent to the Assistant Director of Nursing responsible for quality who will maintain a corporate register of such individuals.

15.2 Documentation

All discussions with the patient must be recorded in the patient record and the consent form. A copy of the consent form must be given to the patient.

The Health Care Professional with responsibility for delegated consent must ensure that audit of their consent documentation takes place annually as a minimum. Live registration will not be maintained unless audit has been carried out and satisfactory results obtained. Review of the audit process and outcomes is the responsibility of the manager. The Divisional General Manager must be aware of all procedures where delegated consent is applied and provide an overview to the Divisional Director of where the process is being delegated and or what procedure.

16 Training

Workshop style training will be run throughout the year for all levels of clinical staff. Induction programmes for clinical staff will include the Consent Policy and forms in use.

Training provision for consent:

Junior Doctors will receive consent training as part of the programme under protected learning time

All other doctors in training/including consultants (including doctors in training) will receive consent training on induction to the trust.

Staff undertaking delegated consent will undertake training specific to the procedures they are consenting the patient to. Those staff will also be expected to compete the EIDO consent training (be informed: The medical legal resource on consent to treatment). The EIDO Consent basic user guide is accessed via the Intranet in Clinical Governance/Clinical Risk/Education & Training or found at http://swbhweb/server.php?show=conClinicalGuideline.9137

All staff will be encouraged to undertake self assessment training programme using the EIDO consent training purchased by the Trust.

Delegated consent training packages have been developed for procedure-specific consent training. These training packages must be used for the purpose of training staff who are not capable of performing the procedure to take consent.

17 Audit and monitoring

17.1 Audit

1. A corporate consent audit to measure compliance with the CONSENT FOR EXAMINATION OR TREATMENT POLICY will be carried out on an annual basis
2. Divisional/speciality leads for the consent audit will be identified in the speciality clinical audit forward plans
3. Roles and responsibilities for the consent audit will be:

    - The Clinical/Divisional Director is responsible for ensuring that annual audits of the delegated consented procedures and treatments are undertaken and reported
    - Healthcare professionals taking consent must participate in annual audits of consent
    - The Clinical Effectiveness Department will co-ordinate the annual corporate audit of consent in conjunction with the Trust Consent for Treatment Group who will approve the data collection tool.
    - Results from the annual consent audit will be presented to the Trust Consent for Treatment Group and the Governance Board.

The consent audit will review compliance with the following standards:

- Patients receive a copy of the consent form
- The appropriate consent form is used
- All sections of the consent form are completed appropriately
- Risk, benefits and alternatives of the proposed procedure are discussed with the patient and are documented by the clinician.
- Consent is taken by:
    - A Consultant
    - A Healthcare professional capable of performing the procedure
    - A Healthcare professional who has received specialist training
- Patient consent is confirmed in cases where the consent form has not been signed on the day of the procedure

17.2 Awareness of policy

This policy will be posted on the intranet, highlighted at team brief when reviewed and will be raised at induction and subsequent training sessions.

17.3 Breach of policy

Breach of policy will be investigated and may be reviewed under the incident reporting arrangements.

18 Equality

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

The Trust recognises the equality impacts on all aspects of its day-to-day operations and has produced an Equality Statement Policy to reflect this. All policies are assessed in accordance with the equality initial screening toolkit, the results for which are monitored centrally.

19 Policy Review

This policy will be reviewed every three years. Earlier review may be required in exceptional circumstances, organizational change or relevant changes in legislation or guidance.

20 References

- POLICY FOR CONSENT FOR HOSPITAL POST MORTEMS, RETENTION AND THE RESPECTFUL DISPOSAL OF HUMAN TISSUES.
- DNACPR POLICY
- POLICY FOR ASSESSING MENTAL CAPACITY AND COMPLYING WITH THE MENTAL CAPACITY ACT 2005
- PHOTOGRAPHIC & VIDEO RECORDING CONSENT & CONFIDENTIALITY POLICY
- The NHS Constitution (DH, 2009)
- Reference guide to consent for examination or treatment (DH, 2001)
- Good practice in consent: achieving the NHS plan commitment to patient centred consent practice (Health Service Circular HSC 2001/023)
- Seeking Consent: working with children (DH, 2001)
- Research governance framework for health and social care: Second edition (DH, 2005)

- Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (DH)

- Relevant guidance and codes of conduct relating to consent published by professional registration councils such as the General Medical Council, Nursing & Midwifery Council, General Social Care Council and the Health Professions Council

- Mental Health Act Code of Practice (2007)

- Mental Capacity Act Code of Practice (2008)

Appendices

1 Appendix A

1.1 Consent forms in use in this organization

Consent forms will be printed on A3 size carbonless copy paper, so that the patient can have a copy.

These are national consent forms which contain mandatory information. The Trust has limited ability to add contents and change layout but ***cannot*** remove any information from the forms.

Form 1. Patient Agreement form

Form 2. Parental Agreement form for treatment for a child or young person

Form 3. Agreement form for procedures \ drug treatment that don't require anaesthetic but carry significant risk.

Form 4. Form for adults who lack capacity.

Each consent form includes guidance notes, printed on the reverse side of the gold copy. After completion of the form, the gold copy should be filed in the patient's notes and the white copy offered to the patient or their parent / advocate / carer.

Appendix A: Consent Form 1 – Left side

Sandwell and West Birmingham Hospitals NHS Trust

Consent Form 1

Patient Agreement to Investigation or Treatment

Patient details (or pre-printed label)

NHS Organisation ..... Patient's first names .....

Patient's Surname/Family name ..... Responsible health professional .....

Date of birth ..... Job title .....

NHS number (or other identifier) ..... Special requirements .....

☐ Male ☐ Female *(e.g. other language / other communication method)*

Name of proposed procedure or course of treatment (include brief explanation if medical term not clear) .....

.....

.....

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained:

The intended benefits .....

.....

.....

Significant, unavoidable or frequently occurring risks .....

.....

.....

Any extra procedures which may become necessary during the procedure.

☐ blood transfusion .....

☐ other procedure (please specify) .....

.....

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

I am taking responsibility for this patient's consent because:

☐ I am competent to carry out the procedure.

☐ I have been trained in consent for the procedure in accordance with the delegated consent process.

If you cannot tick either of the boxes then you must find someone competent to take consent.

Information provision.

☐ The following leaflet/tape has been provided .....

This procedure will involve:

☐ general and/or regional anaesthesia ☐ local anaesthesia ☐ sedation

Signed ..... Date .....

Name (PRINT)..... Job title .....

Contact details (if patient wishes to discuss options later) .....

Copy accepted by patient: yes / no (please ring)

GOLD COPY: CASE NOTES WHITE COPY: PATIENT

Appendix A: Consent Form 1 – Right side

Patient Identifier/label

Statement of patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy, which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia.)

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures which **I do not wish to be carried out** without further discussion.

.....

.....

.....

Patient's signature ..... Date .....

Name (PRINT) .....

A witness should sign below if the patient is unable to sign but has indicated his or her consent. Young people / competent children may also like a parent to sign here (see notes).

Signed ..... Date .....

Name (PRINT) .....

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance.

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signed ..... Date .....

Name (PRINT) ..... Job Title .....

Important notes: (tick if applicable)

☐ See also advance directive/living will (e.g. Jehovah's Witness form)

☐ Patient has withdrawn consent (ask patient to sign/date here) .....

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.

Signed .....

Name (PRINT) ..... Job title .....

☐ Trust staff Name of Agency ..... Other

Appendix A: Consent Form 1 – Guidance notes

What a consent form is for

This form documents the patient's agreement to go ahead with the investigation or treatment you have proposed. It is not a legal waiver - if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients are also entitled to change their mind after signing the form, if they retain capacity to do so. The form should act as an aide-memoire to health professionals and patients, by providing a check-list of the kind of information patients should be offered, and by enabling the patient to have a written record of the main points discussed. In no way, however, should the written information provided for the patient be regarded as a substitute for face-to-face discussions with the patient.

The law on consent

See the Department of Health's REFERENCE GUIDE TO CONSENT FOR EXAMINATION OR TREATMENT, SECOND EDITION, for a comprehensive summary of the law on consent (also available at www.doh.gov.uk/consent).

Who can give consent

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed", then he or she will be competent to give consent for himself or herself. Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign this form for themselves, but may like a parent to countersign as well. If the child is not able to give consent for himself or herself, some-one with parental responsibility may do so on their behalf and a separate form is available for this purpose. Even where a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child's care, unless the child specifically asks you not to do so. If a patient is mentally competent to give consent but is physically unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

When NOT to use this form

If the patient is 18 or over and lacks the capacity to give consent, you should use form 4 (Form for adults who lack the capacity to consent to investigation or treatment) instead of this form. A patient lacks capacity if they have an impairment of the mind or brain or disturbance affecting the way their mind or brain works and they cannot:

- understand information about the decision to be made
- retain that information in their mind
- use or weigh that information as part of the decision-making process, or
- communicate their decision (by talking, using sign language or any other means)

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so. Relatives **cannot** be asked to sign this form on behalf of an adult who lacks capacity to consent for themselves, unless they have been given the authority to do so under a Lasting Power of Attorney or as a court appointed deputy.

Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about 'serious or frequently occurring' risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. In *Chester v Afshar*, a majority of the House of Lords held that a neurosurgeon who failed to warn a patient of the small risk of injury inherent in spinal surgery, even if properly performed, was liable to the patient when the risk materialised, even though the risk was not increased by the failure to warn and the patient had not shown that she would never have had an operation carrying the same risk.

You should always answer questions honestly. Sometimes, patients may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this on the consent form or in the patient's notes.

Appendix A: Consent Form 2 – Left side

Sandwell and West Birmingham Hospitals NHS Trust

Consent Form 2

Parental Agreement to investigation or treatment for a child or young person

Patient details (or pre-printed label)

NHS Organisation .....
Patient's first names .....
Patient's Surname/Family name .....
Responsible health professional .....
Date of birth .....
Job title .....
NHS number (or other identifier) .....
Special requirements .....
☐ Male ☐ Female
(e.g. other language / other communication method)

Name of proposed procedure or course of treatment (include brief explanation if medical term not clear) .....
.....
.....

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)
I have explained the procedure to the patient. In particular, I have explained:
The intended benefits .....
.....
.....
Significant, unavoidable or frequently occurring risks .....
.....
.....
Any extra procedures which may become necessary during the procedure.
☐ blood transfusion .....
☐ other procedure (please specify) .....
.....
I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

I am taking responsibility for this patient's consent because:
☐ I am competent to carry out the procedure.
☐ I have been trained in consent for the procedure in accordance with the delegated consent process.
If you cannot tick either of the boxes then you should not be taking consent.

Information provision.
☐ The following leaflet/tape has been provided .....

This procedure will involve:
☐ general and/or regional anaesthesia ☐ local anaesthesia ☐ sedation

Signed ..... Date .....
Name (PRINT)..... Job title .....
Contact details (if patient wishes to discuss options later) .....

Statement of interpreter (where appropriate)
I have interpreted the information above to the child and his or her parents to the best of my ability and in a way in which I believe s/he can understand.
Signed .....
Name (PRINT) ..... Job title .....

☐ Trust staff Name of Agency ..... Other

Copy accepted by patient: yes / no (please ring)

GOLD COPY: CASE NOTES WHITE COPY: PATIENT

Appendix A: Consent Form 2 – Right side

Patient Identifier/label

Statement of parent/guardian

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy, which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I confirm that I have 'parental responsibility' for this child.

I **agree** to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that my child and I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to children having general or regional anaesthesia.)

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save the life of my child or to prevent serious harm to his or her health.

I have been told about additional procedures which may become necessary during my child's treatment. I have listed below any procedures which **I do not wish to be carried out** without further discussion.

.....

.....

.....

Parent/guardian's signature ..... Date .....

Name (PRINT) .....

Tissue (Including blood samples and other bodily fluids)

I do / do not give permission for this child's Tissue to be used by the Trust for the purpose of quality control and assurance of laboratory services and education. I understand such samples will be anonymised.

I do / do not give permission for this child's Tissue to be used by the Trust for the purpose of approved research and development and acknowledge that patient details will need to be retained.

Parent/guardian's signature ..... Date .....

Name (PRINT) .....

Child's agreement to treatment (if child wishes to sign)

I agree to the treatment I have been told about.

Name ..... Signature .....

Date .....

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the parent/child has signed the form in advance.

On behalf of the team treating the patient, I have confirmed with the child and his or her parent(s) that they has no further questions and wish the procedure to go ahead.

Signed ..... Date .....

Name (PRINT) ..... Job Title .....

Important notes: (tick if applicable)

☐ See also advance directive/living will (e.g. Jehovah's Witness form)

☐ Parent has withdrawn consent (ask parent to sign/date here) .....

Appendix A: Consent Form 2 – Guidance notes

Guidance to health professionals (to be read in conjunction with consent policy)

This form

This form should be used to document consent to a child's treatment, where that consent is being given by a person with parental responsibility for the child. The term 'parent' has been used in this form as shorthand for 'person with parental responsibility'. Where children have capacity to consent for themselves (see below), they may sign the standard 'adult' consent form (form 1). There is space on that form for a parent to countersign if a child with capacity wishes them to do so.

Who can give consent?

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. The courts have stated that if a child under the age of 16 has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed", then he or she will be competent to give consent for himself or herself. If children are not able to give consent for themselves, some-one with parental responsibility may do so on their behalf.

Although children acquire rights to give consent for themselves as they grow older, people with 'parental responsibility' for a child retain the right to give consent on the child's behalf until the child reaches the age of 18. Therefore, for a number of years, both the child and a person with parental responsibility have the right to give consent to the child's treatment. In law, health professionals only need the consent of one appropriate person before providing treatment. This means that in theory it is lawful to provide treatment to a child under 18 which a person with parental responsibility has authorised, even if the child refuses. As a matter of good practice, however, you should always seek a competent child's consent before providing treatment unless any delay involved in doing so would put the child's life or health at risk. Younger children should also be as involved as possible in decisions about their healthcare. Further advice is given in the Department's guidance SEEKING CONSENT: WORKING WITH CHILDREN. Any differences of opinion between the child and their parents, or between parents, should be clearly documented in the patient's notes.

Where a young person of 16 or 17, or a Gillick competent child under 16, refuses treatment it is possible that such a refusal could be overruled if it would in all probability lead to the death of the child or to severe permanent injury. It would be prudent to obtain a court declaration or decision if faced with a competent child or young person who is refusing to consent to treatment, to determine whether it is lawful to treat the child.

Parental responsibility

The person(s) with parental responsibility will usually, but not invariably, be the child's birth parents. People with parental responsibility for a child include: the child's mother; the child's father if married to the mother at the child's conception, birth or later; a legally

appointed guardian; the local authority if the child is on a care order; or a person named in a residence order in respect of the child. Fathers who have never been married to the child's mother will only have parental responsibility if they have acquired it through a court order or parental responsibility agreement (although this may change in the future).

Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for children and their parents when making up their minds about treatment. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about 'serious or frequently occurring' risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly.

Guidance on the law on consent

See the Department of Health publications Reference guide to consent for examination or treatment and Seeking consent: working with children for a comprehensive summary of the law on consent (also available at www.doh.gov.uk/consent).

Appendix A: Consent Form 3 (A4)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Consent Form 3

Patient/parental agreement to Investigation or Treatment

(procedures where consciousness not impaired)

Patient details (or pre-printed label)

NHS Organisation ..... Patient's first names .....

Patient's Surname/Family name ..... Responsible health professional .....

Date of birth ..... Job title .....

NHS number (or other identifier) ..... Special requirements .....

☐ Male ☐ Female *(e.g. other language / other communication method)*

Name of procedure (include brief explanation if medical term not clear)

.....

.....

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained:

The intended benefits .....

.....

Significant, unavoidable or frequently occurring risks .....

.....

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

I am taking responsibility for this patient's consent because:

☐ I am competent to carry out the procedure.

☐ I have been trained in consent for the procedure in accordance with the delegated consent process.

If you cannot tick either of the boxes then you must find someone competent to take consent.

Information provision.

☐ The following leaflet/tape has been provided .....

Signed ..... Date .....

Name (PRINT)..... Job title .....

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.

Signed .....

Name (PRINT) ..... Job title .....

☐ Trust staff Name of Agency ..... Other

Statement of patient/person with parental responsibility for patient

I agree to the procedure described above.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience

Signed ..... Date .....

Name (PRINT)..... Relationship to patient.....

Tissue (including blood samples and other bodily fluids)

I **do/do not give permission** for my Tissue to be used by the Trust for the purpose of quality control and assurance of laboratory services and education. I understand that such samples will be anonymised.

I do/do not give permission for my Tissue to be utilised by the Trust for the purposes of approved research and development and acknowledge that patient details will need to be retained

Patient's signature ..... Date .....

Name (PRINT).....

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient/parent has signed the form in advance)I have confirmed that the patient/parent has no further questions and wishes the procedure to go ahead.

Signed ..... Date .....

Name (PRINT)..... Job title .....

Form 3 guidance

Guidance to health professionals (to be read in conjunction with consent policy)

This form

This form documents the patient's agreement (or that of a person with parental responsibility for the patient) to go ahead with the investigation or treatment you have proposed. **It is only designed for procedures where the patient is expected to remain alert throughout and where an anaesthetist is not involved in their care: for example for drug therapy where written consent is deemed appropriate**. In other circumstances you should use either form 1 (for adults/ children who have capacity) or form 2 (parental consent for children/young people) as appropriate.

Consent forms are not legal waivers - if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients also have every right to change their mind after signing the form.

Who can give consent?

Everyone aged 16 or more is presumed to have capacity to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed", then he or she will have capacity to give consent for himself or herself. Young people aged 16 and 17, and younger children who have been assessed as having capacity, may therefore sign this form for themselves, if they wish. If the child is not able to give consent for himself or herself, some-one with parental responsibility may do so on their behalf. Even where a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child's care, unless the child specifically asks you not to do so. If a patient has capacity to give consent but is physically unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

When NOT to use this form (see also 'This form' above)

If the patient is 18 or over and lacks capacity to give consent, you should use form 4 (Form for adults who are unable to consent to investigation or treatment) instead of this form. A patient will not have capacity to give consent if:

- they are unable to comprehend and retain information material to the decision and/or
- they are unable to weigh and use this information in coming to a decision and/or
- they are unable to communicate their decision

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so. Relatives cannot be asked to sign this form on behalf of an adult who lacks capacity to consent for himself or herself unless they have acquired the right to do so under a Lasting Power of Attorney or as a Court-appointed Deputy.

Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds about treatment. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but following the Chester v Afshar judgement, patients should be informed about significant, unavoidable or frequently occurring risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes, patients may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this overleaf or in the patient's notes.

The law on consent

See the Department of Health's Reference guide to consent for examination or treatment for a comprehensive summary of the law on consent (also available at www.doh.gov.uk/consent).

Appendix A: Consent Form 4 – Left half

Sandwell and West Birmingham Hospitals NHS Trust

Consent Form 4

Form for Adults who lack the capacity to consent to investigation or treatment

Patient details (or pre-printed label)

NHS Organisation .....
Patient's first names .....
Patient's Surname/Family name .....
Responsible health professional .....
Date of birth .....
Job title .....
NHS number (or other identifier) .....
Special requirements .....
☐ Male ☐ Female
(e.g. other language / other communication method)

All sections to be completed by health professional proposing the procedure.

A Details of procedure or course of treatment proposed

.....
.....
.....

(NB see guidance to health professionals overleaf for details of situations where court approval must first be sought)

B Assessment of patient's capacity (in accordance with the Mental Capacity Act)

I confirm that the patient lacks capacity to give or withhold consent to this procedure or course of treatment because of an impairment of the mind or brain or disturbance affecting the way that their mind or brain works (for example, a disability, condition or trauma, or the effect of drugs or alcohol) and they cannot do one or more of the following:

☐ understand information about the procedure or course of treatment
☐ retain that information in their mind
☐ use or weigh that information as part of the decision-making process, or
☐ communicate their decision (by talking, using sign language or any other means)

Further details: for example how above judgements reached; which colleagues consulted; what attempts made to assist the patient to make his or her own decision and why these were not successful;

.....
.....
.....

C Assessment of the patient's best interests

I am satisfied that the patient has not refused this procedure in a valid advance decision. As far as is reasonably possible, I have considered the person's past and present wishes and feelings (in particular if they have been written down), any beliefs and values that would be likely to influence the decision in question. As far as possible, I have consulted other people (those involved in caring for the patient, interested in their welfare, or those the patient has said should be consulted) as appropriate. I have considered the patient's best interests in accordance with the requirements of the Mental Capacity Act and believe the procedure to be in their best interests because:

.....
.....
.....
.....

If the lack of capacity is likely to be temporary, the treatment cannot wait until the patient recovers capacity because;

.....
.....

Copy accepted by patient/family/advocate: yes / no (please ring)

GOLD COPY: CASE NOTES WHITE COPY: PATIENT/FAMILY/ADVOCATE

Appendix A: Consent Form 4 – Right half

Patient Identifier/label

D Involvement of the patient's family and others close to the patient

Unless the patient has an attorney or a court-appointed deputy with responsibility for health related decisions, the final responsibility for determining whether a procedure is in the best interests of a person who lacks capacity lies with the health professional performing the procedure. However the health professional must consult with those close to the patient (e.g. spouse/partner, family and friends, carer, supporter or advocate) as far as is practicable and as appropriate.

Independent Mental Capacity Advocate (IMCA)

For decisions about serious medical treatment, where there is no-one appropriate to consult other than paid staff, has an Independent Mental Capacity Advocate (IMCA) been consulted?

☐ Yes ☐ No

Details:.....

.....

Signature.....Date.....

To be signed by a person or persons close to the patient if they wish:

I / We have been involved in a discussion with the relevant health professionals over the treatment of .....(patient's name).

I / We understand he/she is unable to give his/her own consent, based on the criteria set out on this form, and that treatment may lawfully be provided if it is in his/her best interests to receive it. Any other comments (including any concerns about the decision)

.....

.....

Name..... Relationship to patient .....

Address (if different to patient) .....

.....

.....

Signature .....Date.....

E The patient has an attorney or deputy

Where the patient has authorised an attorney to make decisions about the procedure in question under a Lasting Power of Attorney or a court appointed deputy has been authorised to make decisions about the procedure in question, the attorney or deputy will have the final responsibility for determining whether a procedure is in the patient's best interests.

Statement of attorney or deputy

I have been authorised to make decisions about the procedure in question under a Lasting Power of Attorney / as a court appointed deputy (delete as appropriate) I have considered the relevant circumstances relating to the decision in question (see section C) and believe the procedure to be in the patient's best interests.

Comments: .....

Signature..... Date .....

Signature of health professional proposing treatment

The above procedure is, in my clinical judgement, in the best interests of the patient, who lacks capacity to consent for himself or herself. Where possible and appropriate I have discussed the patient's condition with others close to him or her, and taken their knowledge of the patient's views and beliefs into account in determining his or her best interests.

I have / have not sought a second opinion.

Signed ..... Date .....

Name (PRINT) ..... Job Title .....

Where second opinion sought (s)he should sign to confirm agreement:

Signed ..... Date .....

Name (PRINT) ..... Job Title .....

Appendix A: Consent Form 4 – Guidance notes

Guidance to health professionals (to be read in conjunction with consent policy)

This form should only be used where it would be usual to seek written consent but an adult patient (16 or over) lacks capacity to give or withhold consent to treatment. If an adult **has** capacity to accept or refuse treatment, you should use the standard consent form and respect any refusal. Where treatment is very urgent (for example if the patient is critically ill), it may not be feasible to fill in a form at the time, but you should document your clinical decisions appropriately afterwards. If treatment is being provided under the authority of Part IV of *the Mental Health Act 1983*, different legal provisions apply and you are required to fill in more specialised forms (although in some circumstances you may find it helpful to use this form as well). If the adult now lacks capacity, but has clearly refused particular treatment in advance of their loss of capacity (for example in an advance directive or 'living will'), then you must abide by that refusal if it was validly made and is applicable to the circumstances. For further information, see the Department of Health's REFERENCE GUIDE TO CONSENT FOR EXAMINATION OR TREATMENT, SECOND EDITION 2009, for a comprehensive summary of the law on consent (also available at www.doh.gov.uk/consent)

When treatment can be given to a patient who lacks capacity to consent

All decisions made on behalf of a patient who lacks capacity must be made in accordance with the Mental Caoacity Act 2005. More information about the Act is given in the Code of Practice, available from www.publicguardian.gov.uk. Treatment can be given to a patient who is unable to consent, only if:

- the patient lacks the capacity to give or withhold consent to this procedure AND
- the procedure is in the patient's best interests.

Capacity

A person lacks capacity if they have an impairment or disturbance (for example, a disability, condition or trauma, or the effect of drugs or alcohol) that affects the way their mind or brain works which means that they are unable to make a specific decision at the time it needs to be made. It does not matter if the impairment or disturbance is permanent or temporary. A person is unable to make a decision if they cannot do one or more of the following things:

- understand the information given to them that is relevant to the decision.
- retain that information long enough to be able to make the decision
- use or weigh up the information as part of the decision making process
- communicate their decision – this could be by talking or using sign language and includes simple muscle movements such as blinking an eye or squeezing a hand.

You must take all steps reasonable in the circumstances to assist the patient in making their own decisions. This may involve explaining what is involved in very simple language, using pictures and communication and decision aids as appropriate. People close to the patient (spouse/partner, family, friends and carers) may often be able to help, as may specialist colleagues such as speech and language therapists or learning disability teams, and independent advocates (as distinct from an IMCA as set out below) or supporters. Sometimes it may be necessary for a formal assessment to be carried out by a suitably qualified professional.

Capacity is 'decision-specific': a patient may lack capacity to take a particular complex decision, but be quite able to take other more straight-forward decisions or parts of decisions. Capacity can also fluctuate over time and you should consider whether the person is likely to regain capacity and if so whether the decision can wait until they regain capacity.

Best interests

The Mental Capacity Act requires that a health professional must consider all the relevant circumstances relating to the decision in question including, as far as possible, considering:

- the person's past and present wishes and feelings (in particular if they have been written down)
- any beliefs and values (e.g. religious, cultural or moral) that would be likely to influence the decision in question and any other relevant factors
- the other factors that the person would be likely to consider if they were able to do so

When determining what is in a person's best interests, a health professional must not make assumptions about someone's best interests merely on the basis of the person's age or appearance, condition or any aspect of their behaviour. If the decision concerns the provision or withdrawal of life-sustaining treatment the health professional must not be motivated by a desire to bring about the person's death.

The Act also requires that, as far as possible, health professionals must consult other people if it is appropriate to do so and take into account their views as to what would be in the best interests of the person lacking capacity. It is particularly important to consult anyone previously named by the patient as someone to be consulted, their family, friends and any carers.

Independent Mental Capacity Advocate (IMCA)

The Mental Capacity Act introduced a duty on the NHS to instruct an independent mental capacity advocate (IMCA) in serious medical treatment decisions when a person who lacks capacity to make a decision has no one who can speak for them, other than paid staff. IMCAs are not decision makers for the person who lacks capcacity. They are there to support and represent that person and to ensure that decision making for people who lack capacity is done appropriately and in accordance with the Act.

Lasting Power of Attorney and court-appointed deputy

A person over the age of 18 can appoint an attorney to look after their health and welfare decisions if they lack the capacity to make such decisions in the future. Under a Lasting Power of Attorney (LPA), the Attorney can make decisions that are as valid as those made by the person themselves. The LPA may specify limits to the Attorney's authority and the LPA must specify whether or not the Attorney has the authority to make decisions about life-sustaining treatment. The Attorney can only, therefore, make decisions as authoirsed in the LPA and must make decisions in the person's best interests.

The Court of Protection can appoint a deputy to make decisions on behalf of a person who lacks capacity. Deputies for personal welfare decisions will only be required in the most difficult cases where important and necessary actions cannot be carried out without the Court's authority or where there is no other way of settling the matter in the best interests of the person who lacks capacity. If a deputy has been appointed to make treatment decisions on behalf of a person who lacks capacity then it it the deputy rather than the health professional who makes the treatment decision and the the deputy must make decisions in the patient's best interests.

Second opinions and court involvement

Where treatment is complex and/or people close to the patient express doubts about the proposed treatment, a second opinion should be sought, unless the urgency of the patient's condition prevents this. The Court of Protection deals with serious decisions affecting personal welfare matters, including healthcare, which were previously dealt with by the High Court. Cases involving:

- decisions about the proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from patients in a permanent vegetative state (PVS)
- cases involving organ, bone marrow or peripheral blood stem cell (PBSC) donation by an adult who lacks capacity to consent
- cases involving the proposed non-therapeutic sterilisation of a person who lacks capacity to consent to this (e.g. for contraceptive purposes)
- all other cases where there is a doubt or dispute about whether a particular treatment will be in a persons' best interests (including cases involving ethical dilemmas in untested areas)

should be referred to the Court for approval. The Court can be asked to make a decision in cases where there are doubts about the patient's capacity and also about the validity or applicability of an advance decision to refuse treatment.

Appendix B Clinical Photography

Department of Medical Illustration

Request/Consent for Clinical Photography
(please complete form in block capitals)

Sandwell and West Birmingham Hospitals NHS Trust

Med Ill Job no.

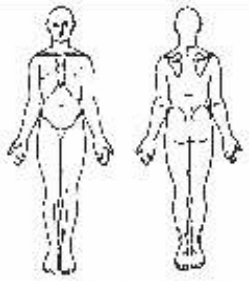
Media		Purpose			
Digital	☐	Patient notes	☐	Thesis	☐
Prints	☐	Teaching	☐	Research	☐
Video	☐	Publication	☐	Medico/Legal	☐

Requested by .....

Surname			Reg no
Forename		Sex	Date of birth
Address			Cons
			Ward/Dept
			Hosp

Diagnosis

To show



Eye patient use only

FFA	☐	Consultant/SR only	
ICG	☐	Consultant/SR only	
Colours	☐		
R only	☐	R > L	☐
L only	☐	L > R	☐

This patient may be dilated with (Please Delete where applicable)

TROPICAMIDE ..... % Right Eye

PHENYLEPHRINE ..... % Left Eye

All images taken by all staff must be given to Medical Illustration for management and security purposes

Consent Type 1: Open Publication

I understand that illustrations revealing my face or identity are required for reproduction in a journal, textbook or medical publication. They may be published as part of a display or information leaflet or on an open access web site, which may be seen by members of the general public as well as medical professionals. To this I give my consent.

Signature : ..... Date : ..... Patient/Parent/Guardian

Consent Type 2: Restricted Educational Use

I also understand that the illustrations requested here may be useful for the purposes of medical teaching and research and in view of the explanation given to me, I agree that the illustrations may be shown to appropriate professional staff. (Images that are supplied in electronic format for educational use may be used for that purpose only).

Signature : ..... Date : ..... Patient/Parent/Guardian

Consent Type 3: Patient Record

I understand that the illustrations requested here, to which I have agreed, will form part of my confidential treatment records.

Signature : ..... Date : ..... Patient/Parent/Guardian

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient/parent/guardian to the best of my ability in a way in which I believe she/he/they can understand.

Name : ..... Agency name/other .....

Signature : ..... Trust Staff ☐ Date : .....

Consent obtained by

Name : ..... Job title : .....

Signature : ..... Date : .....

Appendix C

Sandwell and West Birmingham Hospitals NHS Trust

Assessment of Capacity for Young People under 16 years of Age

Nb this is NOT a consent form

Insert Sticky Label

Patient's Name …….

Hospital Number ……..

Patient's Age ……

Prior to taking verbal or written consent form a person under 16 years of age it is your responsibility (as the person taking consent) to follow the current Trust guidelines. If you have assessed that this is not an emergency situation and every effort has been made to contact a person with parental responsibility it is essential to complete this document.

Recent legislation means that children and young people have a choice and may consent to treatment in their own right, further legislation has also added that where there are life threatening issues people with parental responsibility (or the courts) may override refusal of consent.

The person taking the consent must be assured that the child or young person wants to give consent, has received sufficient information to come to a decision and can retain information. The child or young person must demonstrate to the person taking consent that they are able to use and weigh up the information in the decision making process and arrive at a decision.

An information booklet is available and it is recognized as good practice to allow the young person time to read this booklet prior to giving consent. (**CONSENT – WHAT YOU HAVE A RIGHT TO EXPECT, A GUIDE FOR YOUNG CHILDREN DOH JULY 2001**)

Assessment of Capacity for Young People under 16 years of age.

Questions for the child or young person to answer

1. What language do you speak?

2. Can you speak and write in English or do you need an interpreter?

3. What is the procedure/treatment you are being asked to consent to?

4. What are the benefits of the treatment/procedure do, how will it help you?

5. What are the chances of you getting such benefits?

6. Are there any alternatives?

7. What do you think about the risks and benefits, are they big or small?

8. What may happen if you do not have the procedure/treatment?

9. Do you need more information or time to help you to make a decision?

10. Would you like to talk to someone else about the procedure/treatment before you make a decision?

11. What is your decision?

The Clinician assessing capacity to complete:

It is my clinical judgment that ……..…..(write in patient's name) **does not have** the capacity to consent ☐

Has the capacity to give consent to (the procedure or course of treatment) ☐
because……
……
……

Information regarding the procedure has been given in language appropriate to his/her age and understanding (*please state what aids were used in communication e.g. interpreter)*

The following communication aids were used

DOH information booklet given ☐

Verbal discussion ☐

Audio tape ☐

Interpreter ☐

The young person is able to comprehend and retain the relevant information and demonstrate he/she is able to use this information in the decision making process through:

Reiterating the main points of the procedure to me. ☐

Asking questions about the procedure/treatment to clarify what they have understood ☐

Showing an understanding of the consequence of not consenting to the procedure /treatment ☐

Completing the question sheet regarding consent. ☐

The patient is able to outline the **consequences** of having the intervention in question by ..

Listing the benefits of the procedure/treatment. ☐

Listing the potential risks of the procedure/treatment ☐

The young person does not have a morbid underlying condition affecting his/her judgment on consent such as a needle phobia/anorexia nervosa

The young person is deemed competent only if these 4 criteria are met

Signature of health professional assessing capacity

Signature …… Date ……

Name (print)…….. Job title ……..

Telephone number and bleep ……..

Valid Consent:

For consent to be valid, it must be given voluntarily by an appropriately informed person who has the capacity to consent to the intervention in question. Acquiescence where the person does not know what the intervention entails is not 'consent' or an indication of capacity.

Although a child or young person may have the capacity to give consent, valid consent must be given voluntarily. This requirement must be considered carefully. Children and young people may be subject to undue influence by their parents, other carers or a potential sexual partner, and it is important to establish that the decision is that of the individual him or herself.

Young People aged 16-17

By virtue of section 8 of the *Family Law Reform Act 1969*, young people aged 16 or 17 are entitled to consent to their own medical treatment, and any ancillary procedures involved in that treatment, such as anaesthetic. However, unlike adults, the refusal of a competent person aged 16-17 may in certain circumstances be over-ridden by either a person with parental responsibility or a court.

If the requirements for a valid consent are met, it is not legally necessary to obtain consent from a person with parental responsibility for the young person in addition to that of the young person. It is, however, good practice to involve the young person's family in the decision making process, unless the young person specifically wishes to exclude them.

Young People under 16 years

Following the case of *Gillick vs. West Norfolk & Wisbech AHA (1986)* the courts held that children who have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention will also have the capacity to consent to that intervention. This '*Gillick*' competence may also apply to consent for treatment, research or tissue donation. As the understanding required for different interventions will vary considerably, a child under 16 may therefore have the capacity to consent to some interventions but not others. Therefore this form is only applicable to a single intervention or procedure, and should be subject to regular review.

The concept of '*Gillick*' competence is said to reflect the child's increasing development to maturity. In some cases, for example because of a mental disorder, a child's mental state may fluctuate significantly so that on occasions the child appears Gillick competent in respect of a particular decision and on other occasions does not. In cases such as these, careful consideration should be given to whether the child is truly '*Gillick*' competent at any time to take this decision.

If the child is '*Gillick*' competent and is able to give consent after receiving appropriate information, that consent will be valid and additional consent by a person with parental responsibility will not be required. However it is good practice to involve the young person's family in the decision making process, especially where the decision will have on-going implications, unless the young person specifically wishes to exclude them or it would not be in the child's best interests to do so.

Child or Young Person With Capacity Refusing Treatment

Where a young person of 16 or 17 who could consent to treatment in accordance with section 8 of the *Family Law Reform Act*, or a child under 16 but 'Gillick' competent, refuses treatment, such a refusal can be over-ruled by either a person with parental responsibility for the child or by the court.

This power to over-rule must be exercised on the basis that the welfare of the child/young person is paramount. As with the concept of best interests, 'welfare' does not just mean physical health. The psychological effect of having the decision over-ruled must also be considered. While no definitive guidance has been given as to when it is appropriate to over-rule a competent young person's refusal, it has been suggested that t should be restricted to occasions where the child is a risk of suffering 'grave and irreversible mental or physical harm'

Further guidance is available from:

REFERENCE GUIDE TO CONSENT FOR EXAMINATION OR TREATMENT, SECOND EDITION 2009, (available at www.doh.gov.uk/consent)

Appendix D

Assessment of Mental Capacity

Functional Test of Capacity

Is there an impairment of, or disturbance in, the functioning of the person's mind or brain (it does not matter if this is permanent or temporary)?	yes\no
Record of decision to be made:	
Does the impairment or disturbance make the person unable to make the particular decision?	yes\no
Can the person: 1) Understand the information relevant to that decision?	yes\no If no please state reason:
2) Retain that information?	yes\no If no please state reason:
3) Use or weigh that information as part of the process of making the decision?	yes\no If no please state reason:
4) Communicate their decision (whether by talking, using sign language or any other means)?	yes\no If no please state reason:
Record actions taken:	
Name of member of staff……	Designation……..
Signature……Date…….	Ward\Department……

Mental Capacity Useful contact details

Named Nurse for adult safeguarding

Diane Rhoden

Tel:

Debbie Dunn

Head of Litigation and Complaints

Sandwell and West Birmingham Hospitals NHS Trust

Tel. 0121 507 5679

Email Debbie.Dunn@swbh.nhs.uk

Dr A.Mackenzie

Consultant Anaesthetist

Lead Consultant Clinical Risk

Sandwell and West Birmingham Hospitals NHS Trust

Tel. 0121 507 4343

Email Angus.Mackenzie@swbh.nhs.uk

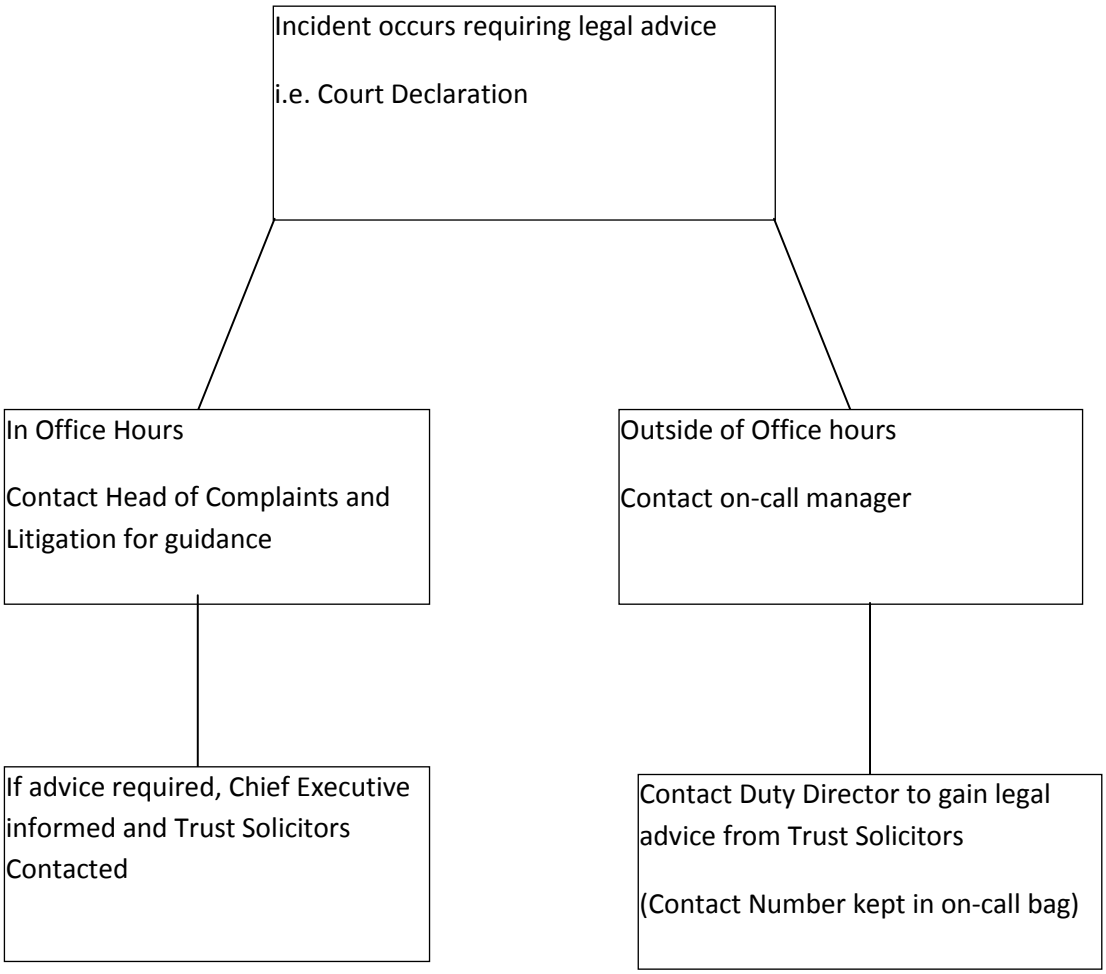
Patient Advice and liaison Service

Tel. 0121 607 3369 (Sandwell)

Tel. 0121 507 5836 (City)

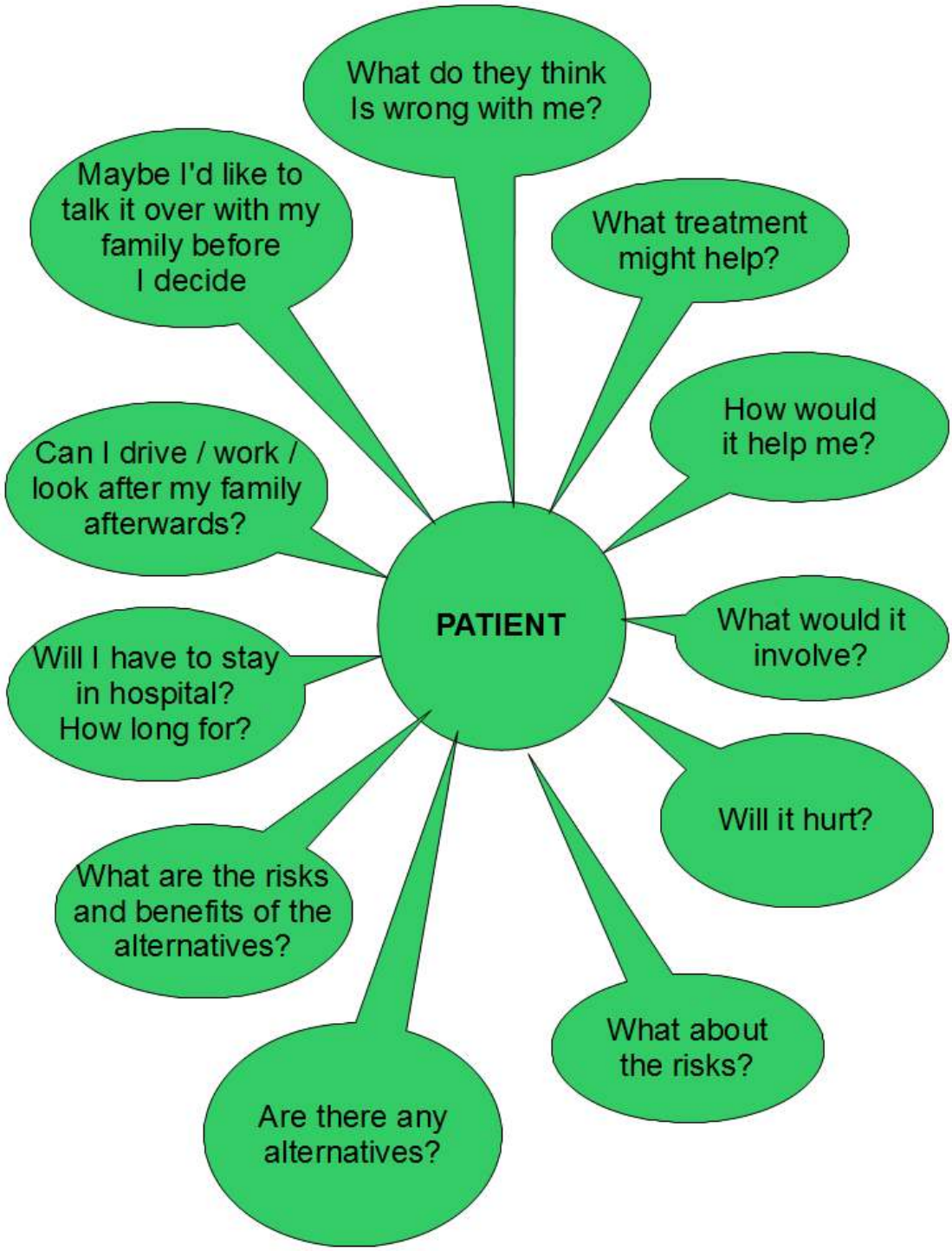
Appendix E

How to seek a court declaration



Appendix F

1.2 **Seeking consent: remembering the patient's perspective**

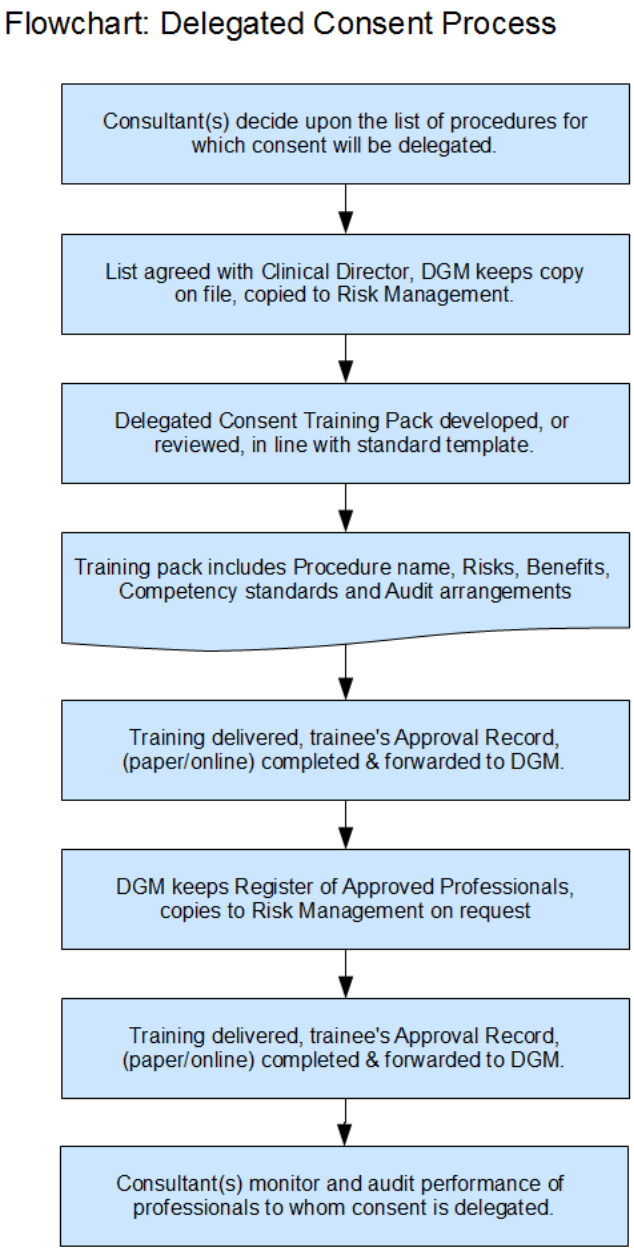


Appendix G

THE DELEGATION OF CONSENT PROCESS

Appendix G1

FLOW CHART FOR DELEGATION OF CONSENT



Appendix G2

Delegated Consent Approval Record

Name of Person taking delegated consent	
Procedure(s)	
Consultant carrying out procedure	
Consultant method of carrying out procedure	
Risks / side effects	
Benefits	
Treatment options	
Date practitioner approved to take delegated consent	
Date for Review of Competency	
Signature of Consultant who will be carrying out procedures/treatments	
Signature of Health Care Practitioner taking delegated Consent	

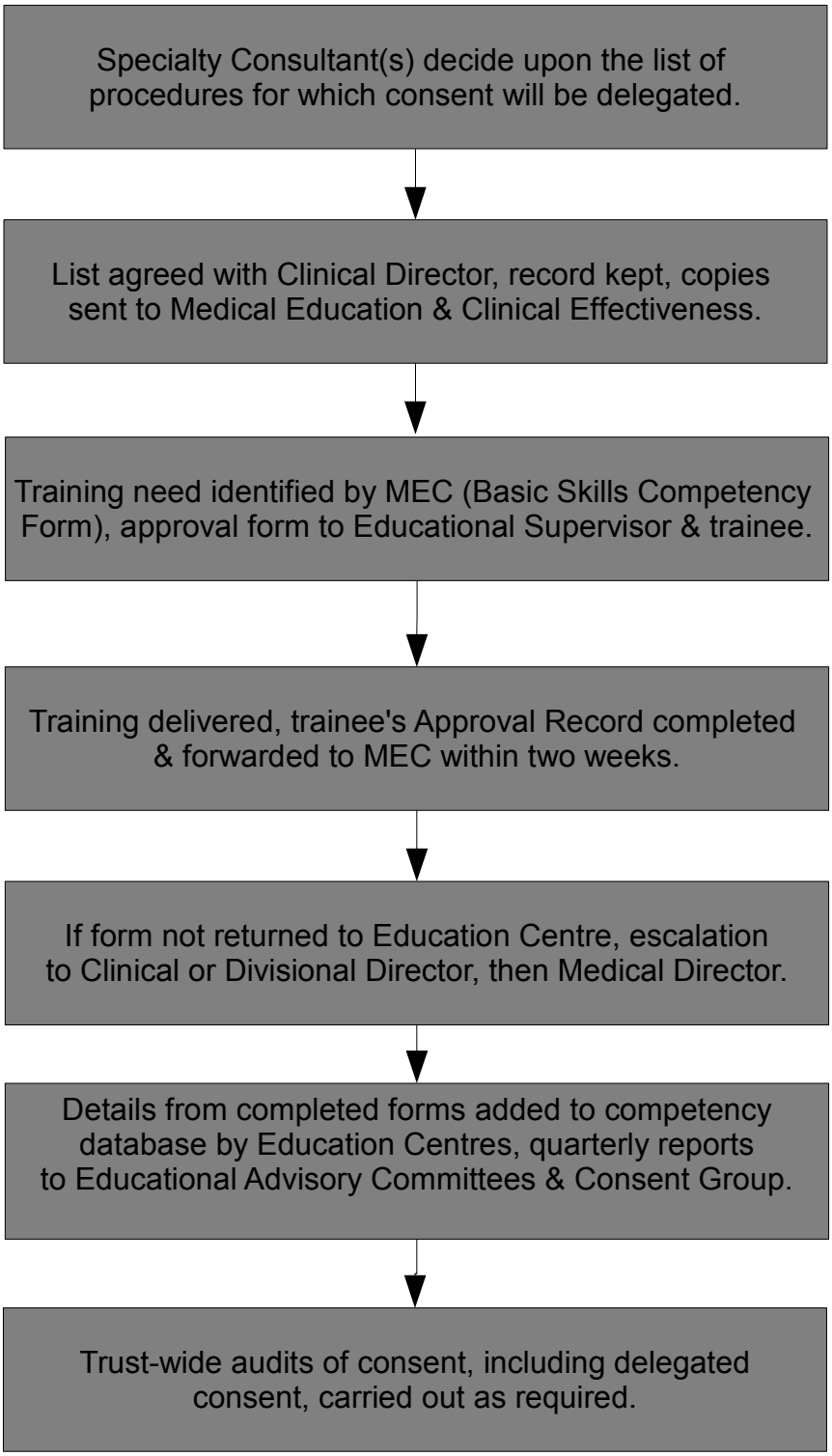
*Each healthcare professional taking delegated consent to have this delegated consent approval record completed with the Consultant prior to undertaking delegated consent. A copy is to be kept in the individual's personal file and a copy sent to the Education Centre to be logged

Appendix G3

Trust Register of Approved Non-Medical Healthcare Practitioners for delegated Consent

Name	Procedure / treatment	Department	Training delivered & competency assessed	Approval date	

Flowchart: Delegated Consent Process



***Note**: If other Healthcare Professionals should take consent as part of their role, this should be discussed with the Clinical Director, who will arrange for training and completion of a Delegated Consent Approval Form. This should be forwarded to the Assistant Director of Nursing responsible for Quality, who will maintain a corporate register of such individuals.*

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Equality Impact Assessment

Toolkit

A guide for staff who need to complete Equality Impact Assessments

Equality & Diversity Team

Content

Introduction

The equalities duties provide a framework for the Trust to carry out its functions more effectively and to tackle discrimination in a proactive way, ensuring that equality considerations are consistently integrated into its day-to-day business through equality impact assessment. This will not only engender legal compliance, but also help to ensure that Trust services best support the healthcare needs of the local population.

As a manager or someone who is involved in a service, policy, or function development, you are required to complete an Equality Impact Assessment [EIA] using this toolkit.

Policy - A written statement of intent describing the broad approach or course of action the Trust is taking with a particular issue.
Service – A system or organisation that provides for a public need.
Function – Any of a group of related actions contributing to a larger action i.e. signage, enabling equitable access to hospital buildings and services.

What is the Equality Impact Assessment (EIA) Toolkit all about?
The equality impact assessment toolkit aims to make the process of equality impact assessing easier to understand and implement. It is designed to make it simpler for you to complete your equality impact assessment and make the process and outcomes meaningful for you and others involved. It is also intended to engender a sensible and proportionate approach that ensures the Trust gives due regard to the requirements to promote equality alongside other competing requirements.

What is an EIA?
EIA is a way of examining your services, functions and policies to see if it could have an adverse or the potential for an adverse impact on any of the equality groups;

- Ethnic communities (Race)
- Age
- Gender (including transgender)
- Religion
- People of varying sexual orientations (heterosexual, homosexual, bisexual)
- Disabled people

Equality Group	Definition	Legislation
Ethnicity (Race)	A shared history, sense of identity, geography and cultural roots.	The Race Relations Act 1976 Race Relations Amendment Act 2000. Equality Act 2006.
Disability	Physical or mental impairment which has a substantial long-term adverse effect on the ability to carry out normal day to day activities.	Disability Discrimination Act 1995 and 2005 The Disability Equality Duty 2006

Age	The time that a person has existed since birth.	The Equal Pay Act 1970 The Equality Act 2006 Employment Equality (Age) Regulations 2006
Sexual Orientation	Attraction you feel towards people of the opposite sex, same sex or both.	The Employment Equality (sexual orientation) Regulations 2003 Civil Partnership 2005
Gender	An individual's self-conception as being male or female or transgender.	The Gender Act 2004 The Gender Recognition Act April 2005 Gender Duty 2007
Religion and Belief	A clear belief system, a profound belief affecting the way of life or view of the world	The Employment Equality (Religion or Belief) Regulations 2003

Aims

Why should I carry out an EIA?

First and foremost an EIA allows you to find out whether your policy or service has an adverse or potential adverse impact on different equality groups. The EIA process allows you to assess whether your services, policies or functions are discriminating directly or indirectly.

Very importantly EIAs allow the Trust to establish excellent outcomes for its diverse communities and address existing or potential inequalities which may result from its services, policies or functions.

- **Indirect discrimination:** Having policies or practices in place that applies to all employees however they could disadvantage people.
- **Direct discrimination:** treating staff or workers or job applicants less favourably than others because they belong to a particular equality group.

When should an impact assessment be undertaken?

Equality impact assessment should start at the same time as the process of a review of an existing or proposal for new service, policy or function commences: i.e. when considering the aims, objectives and implementation.

Once the policy, service or function requiring an equality impact assessment has been approved and implemented, it should be monitored to ensure the intended outcome is being achieved. Any concerns about the way it is working can then be addressed.

For existing policies, functions and service, an equality impact assessment should be undertaken when the policy, etc, is formally reviewed. An assessment should be carried out on all policies every three years.

What are the main aims of an EIA?

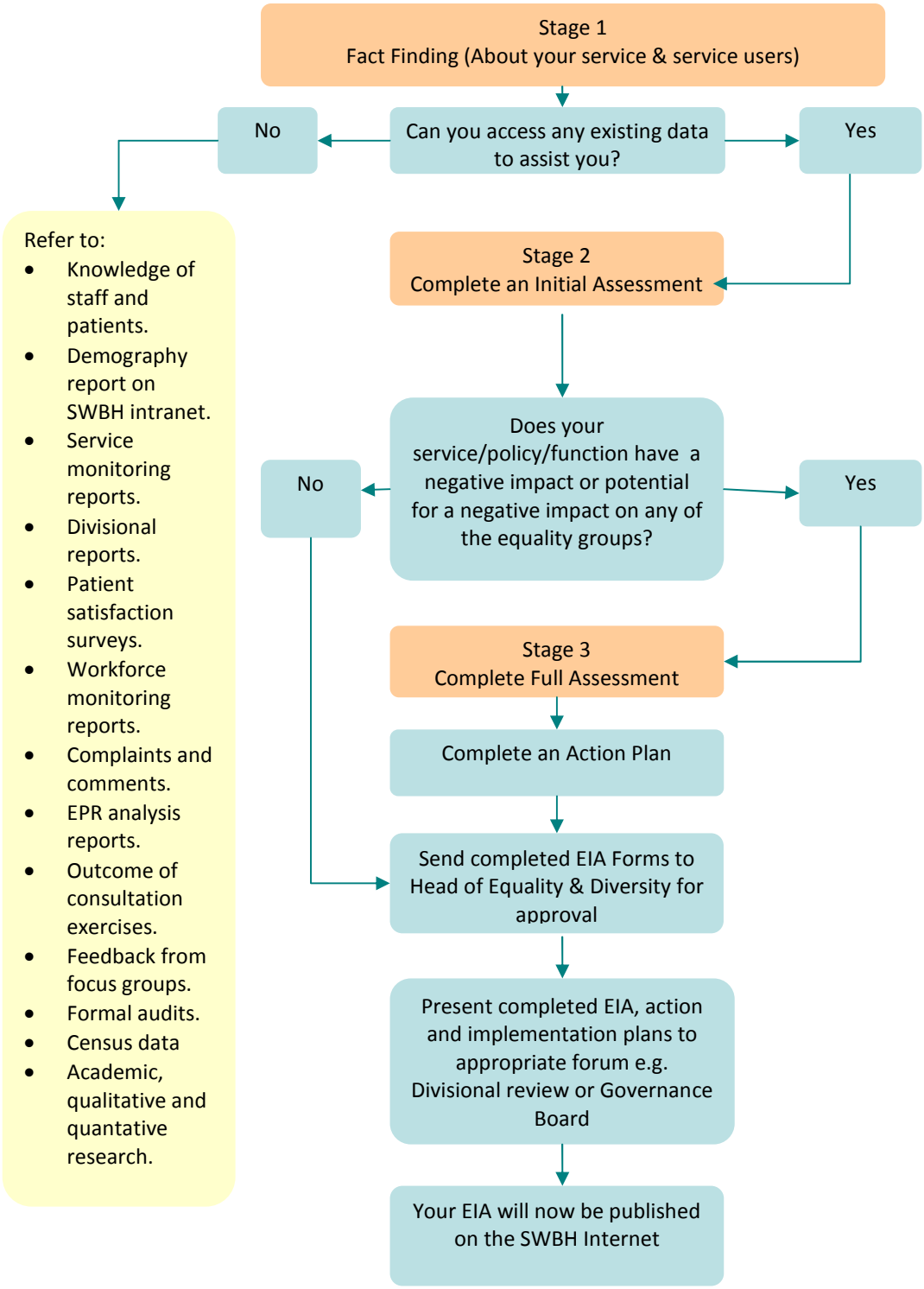
The main aim of an EIA is to:

- Take account of the needs and services of the Trust and those affected by what it does.
- Consider other ways of achieving the aims of the service, function or policy.
- Allow you to have more contact with the diverse groups in our community.
- Change the way you think about your work and the decisions you make.
- Help you to think more about the needs of the community we serve.
- To remove any negative impact there may be on equality groups.

How will the information collected be used?

- Stop direct and indirect discrimination from happening now and in the future.
- Make sure that your services are accessible to everyone in the local community.
- Help improve the way you treat staff and patients.
- As a reminder that the process is not the most important thing - it's the outcome that matter.
- Help us to recognise the fact that we don't all have an equal chance in life, and find ways to address this through our work.

EIA Process Flowchart



How do I begin my EIA?

There are three stages to our EIA process:

Stage 1
This is the fact finding stage where you gather as much information about the service, policy or function you intend to Equality Impact Assess. Who will be using the service, policy or function and the outcomes you want to achieve. It is important to make sure that your service, policy or function has clear aims and objectives.

Stage 2
This stage allows you to identify whether your Policy, Service or Function has an adverse or potential adverse impact on different equality groups. In some cases an Initial Equality Assessment Screening (Appendix A) is all you will need to establish whether you are providing equal outcomes for staff and/or patients belonging to the equality groups. On discovering an adverse or the potential for an adverse impact you will need to undertake a Full Equality Impact Assessment.

Stage 3
This stage involves questioning aspects of a proposed/existing service, policy or function and forecasting the likely effect on different groups using the Full EIA Form (see Appendix B).

The answers to the questions contained in the Full EIA Form will require time and research in order for you to answer them sufficiently. The Trust can provide you with some of the data you require. Although the sources of information will vary depending on the nature of the service, policy or function, they may include the following:

Source Material:-

- EPR analysis (ethnic monitoring collection and analysis)
- The knowledge and experience of the people assisting in the service.
- SWBH demography http://swbhweb/server.php?show=nav.00000200o002
- Service monitoring reports / Divisional reports
- Patient satisfaction surveys
- Workforce monitoring reports
- Complaints and comments
- Outcome of consultation exercises
- Feedback from focus groups
- Feedback from organisations representing the interests of key target groups
- National and local statistics and audits
- Census data
- Academic, qualitative and quantative research

Remember, it is vital to concentrate on the main objectives of the EIA and not lose sight of the goals, know when to stop! Look for practical outcomes and focus on identifying gaps

in the current provision. If it is not possible for you to get data easily or immediately, this should be highlighted in your final action plan.

Action Planning

The real value of completing an EIA comes from the actions that will take place and the positive changes that will emerge through conducting the assessment. To ensure that the action plan is more than just a list of proposals and good intentions, the following should be included:

- Each action be attributed to a key person who is responsible for its completion
- An achievable timescale that is also at the same time reasonable
- Relevant and appropriate activities and progress milestones
- Any cost implications and how these will be addressed.

It is necessary that the action plan feeds into service and team plans and links to the Trusts Single Equalities Scheme (SES), which can be found on the Trusts intranet/internet sites Equality and Diversity.

The action plan should only include the main actions or activities likely to have the greatest impact. This should not be a comprehensive list of all the possible things that might help. It is unlikely that any implementation plan will have less than four activities, but an implementation plan that rolls over to six pages is unlikely to be providing sufficient focus for most activities.

Submission of completed EIA and related documents

The Equality and Diversity staff will provide advice and support throughout the process of EIAs. Once you have completed your Equality Impact Assessment Screening (Appendix A) and the Full Impact Assessment (Appendix B), your Action and Implementation plans, you must submit these documents to the Equality and Diversity department to be signed off by the Head of Equality and Diversity before they are presented for ratification at the appropriate meeting – Divisional Review or Governance Board.

Frequently asked Questions

How will EIAs help me improve my service?

EIAs will help you deliver excellent services that are accessible and which meet the varied needs of their staff, patients and service users. In its simplest form the EIA process can be seen as a foundation tool for measuring the effect of the service, function or policy on people and should encourage greater transparency about decision making. Assessing a service, function or policy will help to identify if it has the potential to impact on certain groups differently and give you the opportunity to adapt it as necessary. It will also alert you to whether any groups may have particular needs.

What are the benefits of EIAs?

The EIA process will help to avoid claims of unlawful discrimination as it provides a framework that ensures the Trust meets its legislative duties. The process helps the Trust to anticipate problems and make informed and open decisions. This process will guide The Trust from where we are now to where we want to be.

Can a negative impact ever be justified?

Although unlawful discrimination can never be justified, there may be occasions where it is appropriate that an activity impacts less favourably on some equality groups. For example, the Trust may be targeting services to a particular part of the population that have been historically referred to as 'hard-to-reach' or 'traditionally disadvantaged'. Increasing involvement levels for that community but not for some others who are traditionally easier to engage this is acceptable. It will be necessary to consider whether the potential for less favourable impact on one or more communities can be justified.

Can I build the EIAs into my existing systems and processes?

Yes. It's important that the process starts at the point where the aims and objectives are being decided. Time needs to be factored into the development of any policy, function or service for undertaking an impact assessment. This will ensure that the potential for impact on the equality groups is considered from the outset.

Do I have to impact assess existing functions as well as new functions and policies?

Yes. As well as impact assessing new services, functions and policies the Trust also has existing arrangements which will need to be assessed. All current services and policies must be continuously monitored and checked for their impact. The difference between assessing present policies and assessing future policies is that existing information about the implementation of a present policy should indicate any adverse impact.

Appendix A

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 equality groups.
    - Opportunity to promote equality for the equality groups
    - 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:	**Medical Director**
Is it a Service, Policy or Function:	**Policy**
Lead officer:	**Head of Risk Management**
Title of policy, function or service:	Consent Policy

Existing: x☐

New/proposed: ☐

Changed: ☐

Q1) What is the aim of your policy/service/function?

To ensure consent is informed and appropriate for all patients

Q2) Who is the policy/service/function going to benefit?

All patients and all staff involved in taking consent

Q3) Do you have any feedback data that influences, affects or shapes this policy, function or service?

Yes	No
x☐ Please complete comments below.	☐ Please go to question 5

What is your source of feedback?

- ☐x Previous EIAs
- ☐x National Reports
- ☐x Internal Audits
- ☐x Patient Surveys
- ☐x Complaints
- ☐ Focus Groups
- ☐ Equality & Diversity Training
- ☐ Equality & Diversity Team

What does this source of feedback reveal?

This policy has potential to impact adversely on some patient groups

Q4) Thinking about each group below does or could the policy, function, or service have a negative impact on members of the equality groups below?

Group	Yes (negative)	No (positive)	Unclear
Age	x☐	☐	☐
Disability	x☐	☐	☐
Ethnicity	x☐	☐	☐
Gender	☐	x☐	☐
Transgender	☐	x☐	☐
Sexual orientation	☐	x☐	☐
Religion or belief	☐	x☐	☐
Other socially excluded groups	☐	☐	x☐

If the answer is “yes” or “Unclear” consider doing a full EIA

Q5) Who was involved in the EIA, and how?

Who:

x☐ Staff members
x☐ Consultants
☐ Doctors
☐ Nurses
☐ Local patient/user groups

x☐ Other Please specify: Risk Team, Complaints and Litigation, Clinical Effectiveness, Consent Group

How were they involved?

☐ Surveys
x☐ Team Meeting
☐ Via the Single Equality Scheme
☐ Divisional Review

x☐ Other Please specify:
Consent Group, audit, hot spot meetings

Q6) Have you identified an adverse/potential adverse impact (direct /indirect discrimination)?

No	☐	yes	☐x

Q6a) If 'No' Explain why you have made this decision?

Q6b) If 'yes' explain adverse impact – you may need to complete a full EIA

Patients in the groups identified may be less able to engage with the consent process without further support

If adverse impact has been identified please continue to Stage 3. If no adverse impact has been identified please submit your Initial Equality Impact Assessment to the Head of Equality and Diversity (pauline.richards@swbh.nhs.uk) or 0121 507 5169 for approval.

Please note: Issues relating to either interpreting/translating or ensuring single-sex accommodation have been identified as corporate issues, therefore if the adverse impact you have identified falls within these categories a full impact assessment is not required.

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 an adverse impact, you are agreeing that the organisation has not

discriminated against any of the equality groups. 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: Please Print	Designation:
Date:	
Contact number:	

This EIA has been approved by the Divisional General Manager/Clinical Lead

Name: Please Print	Designation:
Date:	
Contact number:	

This EIA has been signed off by the Head of Equality & Diversity

Name: Please Print	Designation:
Date:	
Contact number:	

All EIA and related documents must be submitted to the Divisional Review or Governance Board for approval prior to being recorded on the Trust central EIA register.

Appendix B

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 adverse 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?

You may want to mention the environment, privacy and dignity, language, transport, access, signage, local demography…

There is a possibility patients may not be fully involved in the consent process and may not give a fully informed consent to a procedure due to a failure to provide adequate information in a way they can access

1a Identify the Equality group(s) that will be affected by the adverse Impact:

Ethnicity	Gender	Transgender	Age	Disability	Religion or belief	Sexual Orientation	**Other**
☐x	☐	☐	☐ x	☐x	☐	☐	☐

1b Think about other socially excluded groups or communities e.g. rural community, carers, areas of deprivation, low literacy skills.

The main barriers to engaging in the process are not understanding the process (due to youth/old age, disability, language barriers). This may affect some patients within these groups but belonging to these groups would not be an issue per se.

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?

The main barriers to engaging in the consent process are not understanding the process (due to youth/old age, disability, language barriers.

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?

Consent Group, Hot Spot Group membership, Governance Board membership.

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)

Further consultation of staff groups

Step 4) Make a decision (based on Initial Screening outcome and questions 1 – 3!

4a Why have you decided to carry out this Full Equality Impact Assessment?

Full EIA carried out when the policy was reviewed last time

4b There is insufficient evidence to judge whether there is differential impact – state why?

no

4c The EIA shows that the service, policy or function has a differential impact which is not adverse – State why?

no

4d The EIA reveals a differential impact which also amounts to adverse impact – Outline what actions will be taken to address adverse impact**.**

The policy provides mechanisms for mitigating the adverse impact (ie access to IMCAs, amended to cover incapacity, processes to cover adversely impacted groups). These will be monitored by audit and at the Consent Group.

Those for whom English is not a first language may potentially be disadvantaged if the full implications of the planned procedure cannot be discussed with them, giving rise to a risk that consent may not be informed. The policy makes provision for these by requiring that interpreters are available to cover for this situation.

Older patients, or those under a disability, may not have sufficient capacity to give consent. The policy provides for this by setting out a process to manage consent for those without capacity and for ensuring that patients who have difficulty speaking are assisted by, for example, speech therapists. The policy also deals with the provisions of the Mental Capacity Act

Children may not have sufficient capacity. The policy provides for this by requiring consent by a suitable person on their behalf or an assessment of the child's capacity.

Where there is any doubt the policy also makes provision for legal advice to be sought.

A detailed assessment will be completed to assess whether any of these groups have been disadvantaged as a result of the policy.

The Trust has a Consent Committee, which is chaired by the Clinical Risk Lead Clinician which will monitor data sources including incidents, complaints, claims, audit, PALS, patient survey to identify any future adverse impact and ensure this is managed appropriately.

4e What will be the main effects and benefits?

See 4d

Step 5) Plan to address Adverse Impact

1. It is now time to complete your action plan using the table below. Please detail how you are going to address the adverse impact, stating the immediate, medium and long-term goals as required.

	Adverse Impact	Action Required	Expected Outcome	Lead	Timescale
1.	Identified groups may not be able to engage with consent process	Implement policy in line with implementation plan	Policy embedded across Trust	Medical Director	ongoing

	effectively				
2.		Audit policy on annual basis	Areas of non-compliance identified and addressed via action plans	Head of Clinical Effectiveness	annual
3.		Review data around the consent process from incidents, complaints and claims	Adverse impacts identified and followed up	Consent Committee Chair	Quarterly
4.					
5.					

NB: As a requirement of the Divisional Review process, please ensure that you include the above actions within your Implementation Plan.

5a How are you going to monitor the policy, function or service, please state how often and who will be responsible?

Through Consent Committee on a quarterly basis

Step 6) Congratulations you have made it.

Completed by:

Name: Ruth Gibson	Designation: Head of Risk Management
Date:	2/2/10
Contact number:	4974
Head of Service:	

This EIA has been approved by the Divisional General Manager/Clinical Lead

Name: Please Print	Designation: Director of Governance

Date:	
Contact number:	

This EIA has been signed off by the Head of Equality & Diversity

Name:	Designation:
Date:	
Contact number:	

Step 7) Now we need to publish your results.

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

- Pauline Richards (Head of Equality & Diversity) pauline.richards@swbh.nhs.uk 0121 507 5169
- Belinder Virk (Equality & Diversity Advisor) belinder.virk@swbh.nhs.uk 0121 507 5561
- Estelle Hickman (Equality & Diversity Advisor) estelle.hickman@swbh.nhs.uk 012 507 5561

Equality & Diversity Team
Arden House
City Hospital
Birmingham B18 7QH

Sandwell and West Birmingham Hospitals NHS
NHS Trust

POLICY IMPLEMENTATION PLAN

POLICY TITLE:	Consent
ACCOUNTABLE DIRECTOR:	Medical Director
POLICY AUTHOR:	Head of Clinical Risk
APPROVED BY:	
DATE OF APPROVAL	

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 checklist to be used as a starting point for thinking about implementation in a systematic manner.

KEY TASKS	ISSUES IDENTIFIED	ACTION TAKEN/PLANNED	LEAD	TIMESCALE
Co-ordination of implementation • How will the implementation plan be co-ordinated and by whom? *Clear co-ordination is essential to monitor and sustain progress against the implementation plan and resolve and issues that may arise.*	Director of Governance and DGMs	Regular review of implementation of policy at 1-1 with Head of Risk Management by Director of Governance Development	Director of Governance	March 10
Engaging staff • Who is affected directly or indirectly by the policy? • Are the most influential staff involved in the implementation? *Engaging staff and developing strong working relationships will provide a solid foundation for changes to be made.*	This policy affects clinical staff, in particular medical staff and surgical areas, although all clinical staff are potentially affected. The Clinical Risk Lead will be involved in implementation which will assist secure buy in from the medical body of staff.	Clinical Risk Lead provides induction to junior doctors which will raise awareness.	Clinical Risk Lead	Ongoing
Involving service users and carers • Is there a need to provide information to service users and carers regarding this policy? • Are there service users, carers, representatives or local organisations who could contribute to the implementation? *Involving service users and carers will ensure that any actions taken are in the best interests of the service users and carers and that they are better informed about their care.*	No.	Consent is discussed with patients on a case by case basis. Any complaints, incidents or claims will be identified and reviewed at the Consent Committee to ensure effective implementation of the policy	Consent Committee	Ongoing
Communication • What are the key messages to communicate to the different stakeholders? • How will these messages be	The key messages relate to the new Mental Capacity Act and to the need to ensure staff are communicating fully with patients who may have difficulty communicating.	- Awareness to be raised in the Staff bulletin and in Heartbeat - Mental Capacity Act training being provided to staff - Awareness raising sessions to be	Head of Risk Management	March 2008

KEY TASKS	ISSUES IDENTIFIED	ACTION TAKEN/PLANNED	LEAD	TIMESCALE
communicated? *Effective communication will ensure that all those affected by the policy are kept informed thus smoothing the way for any changes. Promoting achievements can also provide encouragement to those involved.*		held demonstrating the services for patients with communication difficulties		
Training • What are the training needs related to this policy? • Are the people available with the skills to deliver the training? *All stakeholders need time to reflect on what the policy means to their current practice and key groups may need specific training to be able to deliver specific requirements.*	General consent training – ongoing Staff/skills shortages Delegated consent training provided at a local level – department based training	Director of Governance Development to lead review of consent training availability and training programme within the Risk Department to ensure appropriate coverage for training needs 2 new staff to start in January 2008 to assist with training. Use of Eido consent training computer package to be reviewed.	Director of Governance Development	March 10
Resources • Have the financial impacts of any changes been established? • Are other resources required to enable the implementation of the policy e.g. new documentation, increased staffing? *Identification of resource impacts is essential at the start of the process to ensure action can be taken to address issues that may arise at a later stage.*	There may be a small resource requirement for training of staff to provide consent training.	To be reviewed by the Director of Governance Development as part of the review of the provision of consent training	Director of Governance Development	March 10

KEY TASKS	ISSUES IDENTIFIED	ACTION TAKEN/PLANNED	LEAD	TIMESCALE
Securing and sustaining change • Have the likely barriers to change and realistic ways to overcome them been identified? • Who needs to change and how do you plan to approach them? • Have arrangements been made with service managers to enable staff to attend briefing and training sessions? • Are arrangements in place to ensure the induction of new staff reflects the policy? *Initial barriers to implementation need to be addressed as well as those that may affect the on-going success of the policy.*	No significant barriers have been identified – medical staff are keen to ensure consent is properly obtained.	Monitor practices in relation to consent via the Consent committee and ensure training is provided as above	Consent Committee	ongoing
Evaluation • What are the main changes in practice that should be seen from the policy? • How might these be evaluated? • How will lessons learned from implementation of this policy be fed into the organisation? *Evaluating and demonstrating the benefits of new policy is essential to promote the achievements of those involved and justify changes that have been made.*	Reduction in numbers of incidents / reduction in severity of incidents which do occur	To be evaluated via the Consent Committee to ensure the policy is not adversely impacting on any patient groups	Consent Committee	Ongoing
Other consideration •				

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Transfer of Agreement from Olympus UK Ltd. to Haemonetics Ltd.
SPONSORING DIRECTOR:	Richard Kirby, Chief Operating Officer
AUTHOR:	Robert Ashley, Divisional Manager for Pathology
DATE OF MEETING:	25 February 2010

SUMMARY OF KEY POINTS:

A blood tracking system is currently being implemented into the Trust, which is supplied by Olympus UK Ltd.

Notification has been received that Olympus has entered into a transfer agreement, whereby it has agreed to transfer its blood tracking business to Haemonetics.

A deed of novation has therefore been received, affecting the transfer of the Trust's contractual arrangements from Olympus to Haemonetics. The transfer will not affect the terms of the customer agreement.

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

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

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	None specifically
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

Financial		
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy	**X**	Adherence to the Trust's SOs/SFIs and SoD
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		

PREVIOUS CONSIDERATION: Not previously considered.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

REPORT TITLE:	Quarterly Infection Prevention and Control Report – October - December 2009
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Dr Beryl Oppenheim Director of Infection Prevention and Control
DATE OF MEETING:	25 February 2010

KEY POINTS:

EXECUTIVE SUMMARY

- Working across the healthcare economy continues to progress well and there will be an emphasis on joint working to reduce numbers of cases of *MRSA* and *Clostridium difficile* infections (CDI).

- Numbers of *MRSA* bloodstream infections and *CDI* remain well within our threshold levels. Recently published data on Trust attributable cases of *MRSA* bacteraemias show SWBH to be within the best performing quartile across the region.

PURPOSE OF THE REPORT:

☐ **Approval** ☉ **Noting** ☐ **Discussion**

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to receive and note the Quarterly Report for October - December 2009.

ALIGNMENT TO TRUST ANNUAL OBJECTIVES:

Ensure continued improvement in infection control and achievement of national and local targets

IMPACT ASSESSMENT:

FINANCIAL	☐	
ALE	☐	
CLINICAL	☑	
WORKFORCE	☐	
LEGAL	☐	
EQUALITY & DIVERSITY	☐	
COMMUNICATIONS	☐	
PPI	☐	
RISKS		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUARTERLY INFECTION PREVENTION AND CONTROL REPORT
October to December 2009

Management and Organisation

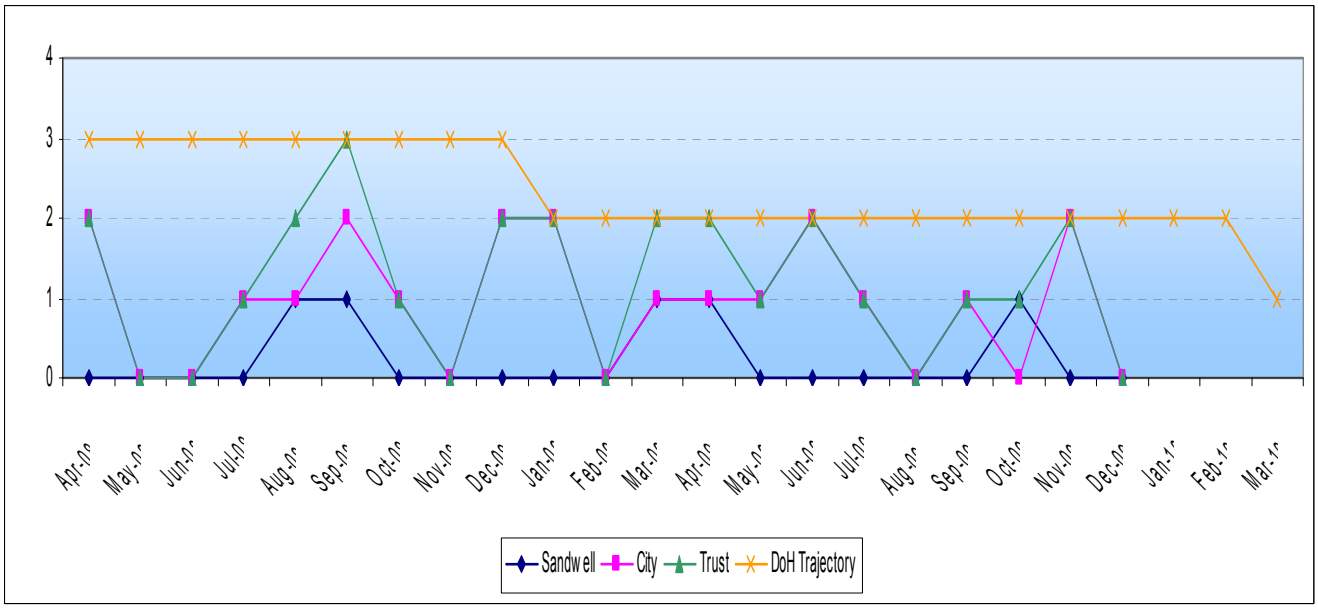
Working arrangements both within the Trust and with community partners continue to work well. A decision has been made to strengthen the role of the Infection Control Operational Committee by devolving to it the role of monitoring of the Infection Control and Cleanliness Action Plan and this will be kept under careful review. Within the wider healthcare economy current priorities include joint working to gain a better understanding of the patient characteristics and risk factors for cases of *Clostridium difficile* infection (CDI) diagnosed in the community or within 48 hours of admission to hospital and to ensure that all general practitioners providing services across the economy are familiar with important information regarding antibiotic prescribing and diagnosis and management of CDI.

MRSA

Mandatory reporting of MRSA bloodstream infections

There were a total of 3 MRSA bacteraemias during this quarter (Figure 1) with our threshold for that period being 6. This brings a total of 10 cases in 9 patients for the first 9 months of the year, of which 4 were diagnosed more than 48 hours after admission and the remaining 6 were in samples taken within the first 2 days of admission from patients originating from 3 different Primary Care Trusts.

Figure 1. Total MRSA bacteraemias



Sandwell and West Birmingham Hospitals NHS
NHS Trust

From 2010/11 MRSA bloodstream infections will be reported differently, with those diagnosed within 48 hours of admission being attributed to the Primary Care Trust of origin, and only those diagnosed after 48 hours being attributed to the acute Trust. To facilitate the setting of baselines, comparative data from all organisations for the 12 month period October 2008 to September 2009 has been published, and the information for acute Trusts in the West Midlands is shown in Table 1. As can be seen, SWBH is in the best performing quartile.

Table 1. Acute Trusts in the West Midlands

Name of NHS Trust	Post 48 hour cases October 2008 to September 2009	MRSA bacteraemia per 100,000 bed days
Birmingham Children's Hospital NHS Foundation Trust	2	2.47
Birmingham Women's NHS Foundation Trust	0	0
Burton Hospitals NHS Foundation Trust	7	5.16
George Eliot Hospital NHS Trust	3	2.72
Heart of England NHS Foundation Trust	17	3.01
Hereford Hospitals NHS Trust	2	2.22
Mid Staffordshire NHS Foundation Trust	3	2.21
Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust	0	0
Sandwell and West Birmingham Hospitals NHS Trust	6	1.68
Shrewsbury and Telford Hospital NHS Trust	7	2.53
South Warwickshire General Hospitals NHS Trust	4	2.69
The Dudley Group of Hospitals NHS Foundation Trust	2	0.78
The Royal Orthopaedic Hospital NHS Foundation Trust	0	0
The Royal Wolverhampton Hospitals NHS Trust	5	2.17
University Hospital Birmingham NHS Foundation Trust	17	4.62
University Hospital of North Staffordshire NHS Trust	17	4.67
University Hospitals Coventry and Warwickshire NHS Trust	9	2.49
Walsall Hospitals NHS Trust	7	3.86

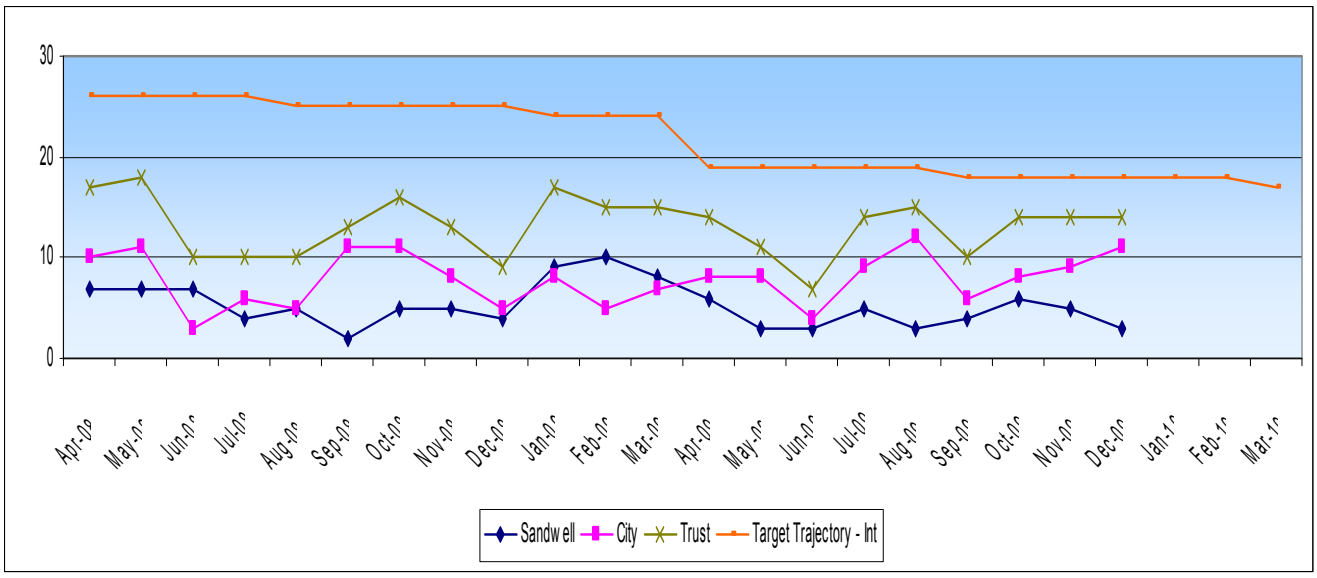
Worcestershire Acute Hospitals NHS Trust	5	1.63

Median rate	2.87
Best quartile rate	1.92

Clostridium difficile **Infections (CDI)**

There were 59 cases of CDI in patients admitted to the Trust during the period October to December 2009, of which 42 were diagnosed after 48 hours and are attributable to our trajectory (Figure 2). This is well within our threshold of 54 cases for that quarter.

Figure 2. *Clostridium difficile* cases >48 hours

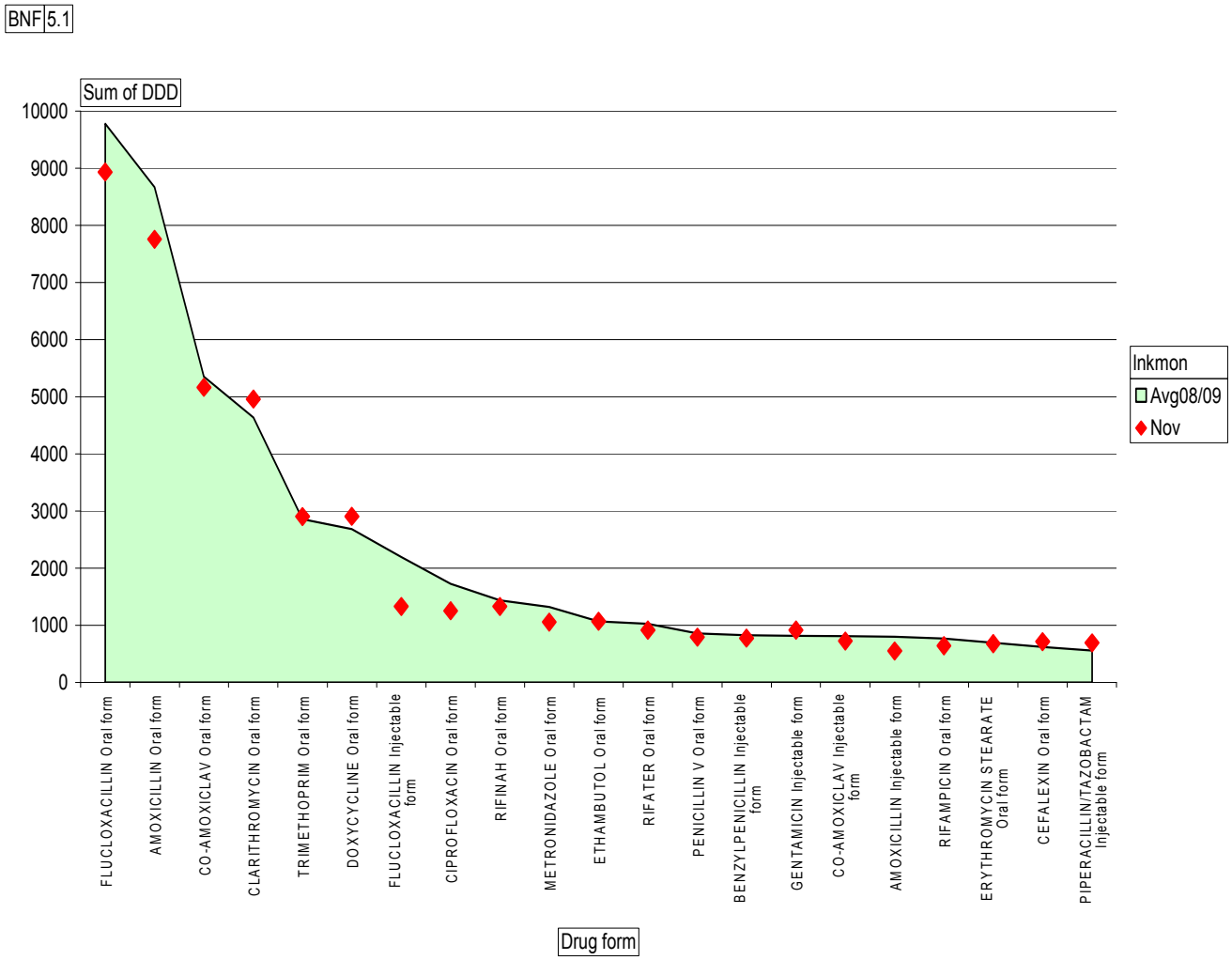


Antibiotic Stewardship

This has been another productive period for the Antibiotic Management Team. It saw the launch of the revised Trust guideline for the management of commonly encountered infections which for the first time gives a range of different options for vulnerable elderly patients who are likely to receive repeated courses of antibiotics and are particularly at risk of developing infections due to antibiotic resistant bacteria or CDI. The compliance with this new guidance is currently being audited and a report should be available in the near future.

At a time when recommendations for antibiotic usage are changing, it is particularly important to be able to rapidly review the impact of these changes on prescribing patterns, and the figure shows an example of the reports now being compiled monthly which gives a simple visual indication of the previous month's prescribing compared to the average usage over the previous year. Of course this type of data requires interpretation of any changes in the light of what might be expected e.g. an increase in the antibiotics predominantly used for chest infections during the winter months, or increases in agents which are being encouraged through various guidelines.

Figure 3. Previous month's prescribing compared to the average usage over the previous months



Outbreaks

The winter period is always challenging because of the potential for outbreaks of viral infections. Fortunately influenza remained uncommon with only a very small number of cases being diagnosed. The third quarter did see the start of the norovirus season. Seven wards were closed because of possible outbreaks of norovirus; however, two were able to be re-opened within 24 hours as testing showed no evidence of the infection. Norovirus outbreaks in the community and hospitals has continued to prove extremely challenging during the final quarter of the year. We believe that the particular strength of our service is the ability for local, rapid and accurate testing for influenza and norovirus, which allows for infection control actions to be based on the most up to date and accurate information.

Audit and Training

This has been a period of a major focus on mandatory training and the excellent uptake of training on infection control during the two sessions specifically designated for consultants was particularly pleasing.

A wide range of regular and one-off audits have been undertaken and any relevant findings that require further action will now be added to the infection control action plan to ensure a consistent approach to monitoring and review.

Infection Control programme

Review of the infection control programme shows that it remains on target to deliver all actions planned for this year. The final quarter of 2009/10 will be devoted to planning the programme for the next financial year. This will need to take into account planning for what are likely to be extremely challenging targets for reductions in numbers of infections, and also our plans for reporting on a range of hospital acquired infections other than MRSA and CDI.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Infection Control Assurance Framework
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Rachel Overfield, Chief Nurse
DATE OF MEETING:	25 February 2010

SUMMARY OF KEY POINTS:

The Infection Control Assurance Framework was produced in response to the 2006 Health Act – Code of Practice for the Prevention and Control of HCAI.

The Trust Board are asked to note the Infection Control and Cleanliness Assurance Framework which seeks to provide assurance to the Trust Board on progress and compliance against 'The Health and Social Care Act – Code of Practice for the NHS on the prevention and control of healthcare associated infections'.

There is only one amber for the Board to note – 2e. This relates to the maintenance of buildings. The nature and age of the Trust's estate make this specific standard difficult to achieve in full.

The Trust Board are also asked to note that a revised version of the code has been issued with slightly revised criteria. The assurance framework will be adjusted to reflect this for the next Trust Board report.

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

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

The Trust Board is also asked to note that a revised version of the code has been issued with slightly revised criteria.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Ensure continued improvement in infection control and achievement of national and local targets
Annual priorities	
NHS LA standards	2.4.9 - Infection control
Core Standards	C4a - the risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in MRSA;
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Usual quarterly report to Trust Board

Sandwell and West Birmingham Hospitals NHS
NHS Trust

25th February 2010

Infection Control and Cleanliness Trust Board Assurance Framework – Version 12

The following provides a framework in which assurance can be gained that the Trust understands the risks associated with infection control and cleanliness: has actions in place or planned to mitigate risk: assigned individuals and expected outcomes from each action and appropriate monitoring structures.

The document takes into account standards from the following key documents:

- Health Act 2008 – Code of Practice for the prevention and control of healthcare associated infections.

The document is overseen by the Executive Infection Control Committee and owned by the Trust Executive Lead, Chief Nurse.

Status	
Green	Complete/compliant
Light Green	On track/compliant
Amber	Some delay/partial compliance
Red	Significant delay/non compliance

Compliance Criteria		Outcome required	Action required/to have in place	Who By/Exec Lead	Status
1 *Have in place and operate effective management systems for the prevention and control of HCAI which are informed by risk assessments and analysis of infection incidents* Overall Status: 'MEETS'	1a	A Board level agreement outlining the boards collective responsibility for minimizing the risks of infection and the general means by when it prevents and controls such risks.	• Board level agreement • Risk assessment and incorporation of risks into the Trust Risk Register • System of risk and incident reporting and investigation • Appropriate structures in place for managing risk.	Chief Nurse	Green
	1b	The designation of an individual as Director of Infection Prevention and Control, accountable to the Chief Executive and the Board.	• Appoint a DIPC • Provide system for reporting to TB	Chief Executive	Green
	1c	A mechanism that ensures sufficient resources are available to secure the effective prevention and control of HCAIs.	• Trust Assurance Framework • Infection Control Action Plan • Infection Control Programme • Infection Control team and information infrastructure • Infection Control Operational Committee and Executive Committee	Chief Nurse	Green
	1d	Ensuring that relevant staff, contractors and others who are directly or indirectly concerned with patient care receive suitable and sufficient information on infection prevention and control.	• Training programmes for all staff and evidence of attendance. • Specific induction for contractors.	Director of Workforce	Green
	1e	A programme of audit to ensure key policies and practices are being implemented appropriately.	• Develop a programme of audit against all key policies • Identify resources and timescales • Identify reporting cycle	DIPC	Green
	1f	A policy addressing the admission, discharge, transfer and movement of patients between departments and health care facilities.	• Develop an all encompassing bed management policy • Develop and deliver relevant training and awareness raising	Chief Operating Officer	Green

	1g	Designation of Decontamination Lead	• Appoint a Decontamination Lead	Chief Nurse	Green
2 *Provide and maintain a clean and appropriate environment which facilitates the prevention and control of HCAI.* Overall Status: 'PARTLY MEETS'	2a	The Trust has policies for the environment that make provision for liaison between members of the ICT and facilities management.	• Senior Nurse Forum and Facilities • Chief Nurse role • PEAT visits • Infection Control Operational Committee and Executive Committee	Chief Nurse	Green
	2b	The Trust designates lead managers for cleaning and decontamination of equipment.	• Appoint Decontamination Manager • Establish a Decontamination Committee • Regular reports against a work plan	Director of Estates	Green
	2c	Chief Nurse, Matrons and ICT involve in all aspects of cleaning	• Chief Nurse role to include facilities management • Joint Forums • PEAT • Infection Control Operational Committee • Executive Infection Control Committee	Chief Nurse	Green
	2d	Matrons have personal responsibility for delivering safe and clean care environment and the nurse in charge of a shift is responsible for standards throughout the shift.	• Job Descriptions for Matrons and shift leaders • Matrons report • PEAT visits • Environment audits • Cleaning audits • Cleaning matrix	Chief Nurse	Green
	2e	All parts of the premises in which the Trust provides care are suitable for purpose, clean and well maintained	• Cleaning standards • Maintenance programme • PEAT • Cleaning audits • Environmental audit • TB reports	Chief Nurse and Director of Estates	Amber
	2f	Cleaning arrangements detail the standards of cleanliness required in each part of the premises	• Cleaning schedules detailing the frequency of cleans • Cleaning audits • Cleanliness TB report	Chief Nurse	Green
	2g	There is adequate provision of suitable hand-washing facilities and antibacterial handrubs	• Handwash facilities at entrance to the wards • Sufficient handwash facilities throughout the wards • Handwash facilities in sluices	Chief Nurse and Director of Estates	Green

			• Handwash facilities in siderooms • Hand gel at entrance to the wards and siderooms • Hand gel at the end of beds • Appropriate policies		
	2h	There are effective arrangements for the decontamination of instruments and other equipment.	• Decontamination and disinfectant policy • Decontamination work plan • Decontamination Committee	Director of Estates	Green
	2i	The supply and provision of linen and laundry reflects the HSG (95) 18	• Linen and laundry contract compliant with the HSG standards • Report to Executive Infection Control Committee quarterly. • Linen and laundry policy in place	Chief Nurse	Green
	2j	Uniform policies ensure that clothing worn by staff is clean and fit for purpose.	• Uniform policy in place • Uniform audits take place twice a year • Included in PEAT	Chief Nurse	Green
3 *Provide suitable and sufficient information on HCAI to the patient, the public and other service providers when patients move between health and social care providers* Overall status: 'MEETS'	3a	Provides information on prevention and control of HCAI and key asopects of the providers policy on infection prevention and control.	• Infection control policy widely published • Various leaflets available • Posters and signage • Visitors Policy	DIPC	Green
	3b	Information on the role and responsiblities of individuals in the prevention and control of HCAI to support them when visiting patients.	• As per 3a	DIPC	Green
	3c	Information to support vigilance in patients.	• As per 3a	DIPC	Green
	3d	Information to stress the importance of compliance by visitors with hand hygiene and visiting restrictions.	• As per 3a	Chief Nurse	Green
	3e	Information on how to report breeches in hygiene and cleanliness	• As per 3a	Chief Nurse	Green
	3f	Information re incident/outbreak management	• Policy widely available • As per 3a	DIPC	Green
	3g	Feedback that is focused on the patient pathway.	• Bed Management Policy • Divisional reports • Ward review process	Chief Nurse	Green
	3h	Information is provided across boundaries	• Health economy wide committee • Screening action plan	DIPC	Green
4		Prevention and control of HCAI should be	• Job descriptions of all staff include control	Chief Nurse	Green

Ensure that patients presenting with an infection or who acquire an infection during care are indentified promptly and receive appropriate management and treatment to reduce the risk of transmission. Overall Status: 'MEETS'		such as to demonstrate responsibility is devolved to: • All professional groups • All specialties	and prevention of infection • Division performance reviews • Division governance groups • Division reports to Infection Control Operational Committee • Ward reviews • Incidence reports by Division • Saving Lives/Hand Hygiene audits by ward		
5 *Gain the co-operation of staff, contractors and others involved in the prevention and control of infection.* Overall Status: 'MEETS'		Providers should ensure that staff, contractors and others co-operate to meet obligations under this code.	• PDR's • Performance reviews • Infection Control and Prevention included in SLA's and contracts with others	Chief Nurse	Green
6 *Provide or secure adequate isolation facilities.* Overall Status: 'MEETS'		Providers should ensure that adequate isolation facilities are provided including facilities for day care. Policies should be in place for risk assessment and allocation of isolation facilities. Sufficient staff should be available to care for patients in isolation.	• Review of facilities • Facilities in 'control' of Infection Control team • Isolation policy and risk assessment tools in place • Staffing assessments undertaken	DIPC	Green
7 *Secure adequate access to laboratory support.* Overall Status: 'MEETS'		Providers should ensure that laboratories used to provide microbiology services have in place appropriate protocols and that they operate according to the required accreditation standards – CPA (UK) Ltd.	• Labs are CPA accredited	DIPC	Green

8 *Have and adhere to appropriate policies and protocols for the prevention and control of HCAI.* Overall Status: 'MEETS'		Providers have a list of core policies in place (List ref Act 2008 p15)	• All listed policies are in place • An audit programme exists to audit compliance • Policies are widely available • Policies are included in staff training	DIPC	Green
9 *Ensure as far as practicable that healthcare workers are free of and protected from exposure to infections during the course of their work and that all staff are suitably educated in the prevention and control of infection.* Overall Status: 'MEETS'	9a	All staff can access relevant occupational health services	• Manual of services • Service advertised widely • Referral system	Director of Workforce	Green
	9b	Policies are in place for prevention and management of communicable diseases including immunisations.	• Policy documents	Director of Workforce	Green
	9c	Prevention and control of infection is included in the induction programme for new staff and in training programmes for all staff.	• Training prospectus • Registers • Training packages • Report to Executive Infection Control Committee	Director of Workforce	Green
	9d	There is a programme of ongoing education for existing staff	As per 9c	Director of Workforce	Green
	9e	There is a record of relevant immunisations	• Records are in place • Report to Executive Infection Control Committee	Director of Workforce	Green
	9f	There is a record of training and updates for all staff.	As per 9e	Director of Workforce	Green
	9g	The responsibilities of each member of staff for the prevention and control of infection is reflected in their job descriptions and in PDRs.	• All job descriptions reflect this • Audit of Job descriptions • Audit of PDRs • Report to Executive Infection Control Committee	Director of Workforce	Green

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Cleanliness/PEAT report
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Steve Clarke, Deputy Director of Facilities
DATE OF MEETING:	25 February 2009

SUMMARY OF KEY POINTS:

The report is provided to inform the Board the results from the National Standards of Cleanliness and PEAT audits and give an update on the PEAT inspections for 2009 and 2010 to date.

The report provides an overview of the:

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

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

To receive and note the quarterly report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Continue to reduce hospital infection rates, and achievement of national and local targets
Annual priorities	
NHS LA standards	2.4.9 Infection Control
Core Standards	C21 - Health care 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.
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Usual quarterly report

SWBTB (2/10) 027 (a)

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

TRUST BOARD REPORT

CLEANLINESS & PEAT (PATIENT FOOD)

25TH FEBRUARY 2010

NATIONAL STANDARDS OF CLEANLINESS (NSoC)

National Standards of Cleanliness Audits

The NSoC audit returns are still producing very good results in all of the critical areas. The audit process has been reinforced and they are now checked and 'signed off' by both the Hotel Services line management and the relevant Ward/Departmental Manager/Representative.

The audits will also be subject to scrutiny by the introduction of a Quality Assurance check every month. The Quality Assurance results will be reported in the cleanliness report for the May Trust Board.

	Aug-09		Sep-09		Oct-09		Nov-09		Dec-09		Jan-10	
	V High	High	V High	High	V High	High	V High	High	V High	High	V High	High
	%		%		%		%		%		%	
City	96	95	97	98	97	94	96	94	96	95	97	94
Sandwell	98	97	98	97	95	96	94	98	94	97	95	96
Rowley	N/A	95	N/A	97	N/A	96	N/A	98	N/A	98	N/A	98
BTC	98	98	98	97	98	95	98	96	98	98	98	97
Target	**98**	**95**	**98**	**95**	**98**	**95**	**98**	**95**	**98**	**95**	**98**	**95**
Overall Average	**97**	**96**	**98**	**97**	**97**	**95**	**96**	**97**	**96**	**97**	**97**	**96**

National Standards of Cleanliness – C4C

A hand-held data capture system has been purchased for the NSoC audits. The current room data and cleaning schedules are being transferred onto the system, training is in progress, the revised audit schedule will commence in March 2010.

PEAT

- **Main PEAT Audits (External)**
  The 2010 Patient Environment Action Team (PEAT) national programme has commenced from the 4th January 2010. There are some changes to the detail in the assessment form; this is based on a review carried out from the last inspection 2009.

  Midlands & Eastern and Southern Strategic Health Authorities assessments started on 11th January 2010, the reports need to be submitted by the 5th March 2010.

  The dates for the SWBH NHS Trust self-assessment audits are indicated below:

  Tuesday 23rd February 2010 @ 10.30am – City Hospital & Eye Hospital (2 teams)
  Wednesday 24th February 2010 @ 10.30am – Sandwell Hospital (2 teams)
  Friday 26th February 2010 @ 11.00am – Rowley Regis Hospital (1 team)

- **PEAT Expenditure 2009/10**

  The PEAT expenditure to date is 506k; the main reason for the overspend is that two agency painters have to be retained to ensure the public areas are maintained and meet the required standards, public expectation and audit reviews.

(£000's)	Funding	Expenditure
Extra Maintenance Staff (Agency)	0	244
Patient Equipment/Optimal/LIA	0	60
PEAT Expenditure		
PEAT Funding	480	202
Total	**480**	**506**

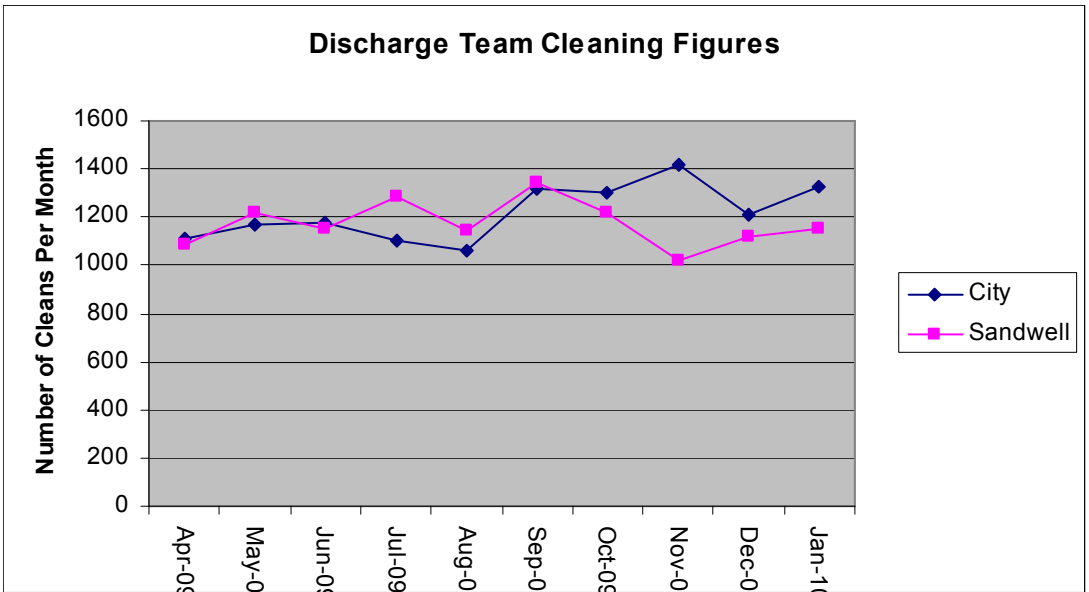
CAPITAL EXPENDITURE

- **Decontamination**
  - City bed store complete (Acute Spine, Basement).
  - Sandwell decontamination/bed store, work due to commence asap, completion by the end of March.

- **Accommodation (Sandwell)**
  The accommodation rooms in the old Human Resources block, first floor, are being changed to office accommodation, this will release valuable space on all wards, the work will be complete by March 2010.

DISCHARGE CLEANING TEAMS

The discharge team continues to provide a service that not only generates the required clinically clean bed area following discharge but generates patient satisfaction and also releases valuable time for ward staff to concentrate on patient care.



CATERING

The patient catering (A La Carte) continues to receive good reviews and positive feedback from patients and user groups.

- **Environmental Health Inspections:**

Site	Last Inspection Date	Issues fro EHO reports/action plans
City	27.8.09	No outstanding issues. Next inspection due in April 2010.
Sandwell	3.3.09	No outstanding issues. Next inspection due in February/March 2010.
Rowley	4.11.09	No outstanding issues. However Trust IC audit has identified a requirement for a hand wash basin in the sealing room.

- **Kitchen Audits:**

Site	Number	Issues/Actions
City	2	All outstanding issues actioned. Currently developing a RAG rating system for kitchen audits.
Sandwell	1	
Rowley	1	
Prince of Wales	0	
WRVS	0	

- **Food Sampling (Rowley):**

Site	Number	Issues/Actions
Number of products samples sent for testing.	10	No action required.
- No. of negative samples	10	
- No. of positive samples	0	

CLEANLINESS GENERAL/INITIATIVES

- **Wheelchairs**
  Audit undertaken January/February 2010. Number of dirty wheelchairs found. A formal cleaning system is in place at Rowley Regis Hospital but an overall review of the cleaning/recording system is required at City and Sandwell, as the current system is not effective in terms of consistency and control.

- **Patient Dignity**
  Concerns have been raised both locally and nationally in regard to the standard of hospital nightwear; the Trust is currently exploring options with our linen supplier and working with the National Design Council.

- **Ipsos MORI Report**

SWBTB (2/10) 027 (a)

A study was commissioned by NHS West Midlands and undertaken by Ipsos MORI. The aim was to explore the issues which drive the perceptions of the general public on hospital cleanliness and therefore identify what would improve this perception and what actions need to follow to achieve this. A report and action plan will be presented to the Infection Control Committee meeting in March.

STEVE CLARKE
DEPUTY DIRECTOR - FACILITIES

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	ALE Process 2009/2010
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Tony Wharram, Deputy Director of Finance
DATE OF MEETING:	25 February 2010

SUMMARY OF KEY POINTS:

For 2009/2010, the ALE process will change to be based on an assessment of compliance with trigger events for each theme. The Trust expects to be able to provide evidence in all cases that no triggers points have been breached and this evidence will then be subject to review by external auditors.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

To note the report and changes to the ALE process.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	Changes to the process by which compliance is assessed.

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

Financial	**X**	
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy	**X**	
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		Potential impact on ALE score if new assessments are not met.

PREVIOUS CONSIDERATION:

Prior year reports on ALE assessment.
The ALE process is also considered in detail by the Governance and Risk Management Committee and by the Audit Committee.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

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

Thursday 25th February 2010

ALE PROCESS 2009/2010

1. Introduction

The Audit Commission has advised that the approach to the ALE assessment for 2009/10 is to be more risk-based and is designed to alleviate some of the burden at the better performing Trusts. To this end, where a Trust has scored a level 3 or 4 in any individual theme in 2008/09, auditors will not reassess this again in 2009/10, but will carry forward the score.

Trusts will be able to request a reassessment where it believes that the performance has improved from level 3 to 4.

Auditors will automatically review any theme scoring level 1 or 2 in 2008/09.

2. Trigger Events

As part of the new approach to the ALE assessment, performance in each of the ALE themes will initially be self assessed against the trigger points shown in the table below. The Trust will need to provide evidence to its auditors that none of the trigger points have occurred. This evidence will then be reviewed by the Trust's auditor and an assessment made of what additional work needs to be carried out to be satisfied that performance has not deteriorated. This is unlikely to be a KLOE by KLOE review.

Theme	Triggers
Financial reporting	• a material error in the financial accounts or late submission of the accounts for audit.
Financial management	• a significant shift in performance from the forecast financial plan; or • the medium term financial plan has not been reviewed to take account of the impact of having to make significant efficiency savings in the light of pressure on public spending.

Theme	Triggers
Financial standing	• the Trust forecasts a deficit for the year from the beginning of quarter three or four.
Internal control	• a significant adverse event or external report suggesting that internal controls were not operating adequately; or • the board has not reviewed its arrangements against the board checklist and general findings in the Audit Commission report Taking it on Trust and has developed an action plan accordingly.
Value for money	• evidence that performance on key operational targets has materially deteriorated; or • the Trust is not implementing key actions from the NHS Carbon Reduction Strategy 2009.

ALE assessment will, as normal, be undertaken in two stages with the financial management, internal control and value for money standards being assessed during the interim audit (commenced 1st February) and the remaining two standards during the statutory accounts audit (commencing 10th May).

3. Trust Evidence

The Trust expects to be able to provide evidence in all cases that no triggers points have been breached. This is consistent with achieving ALE scores in each of the themes of at least 3 during the 2008/2009 assessment. Key areas of evidence for the three themes to be assessed during interim audit are outlined in the following table.

Theme	Trigger	Key Evidence
Financial Management	Shift in forecast from financial plan	• Stability in planned and forecast statutory targets • Internal FPC/Board Reports and forecasts • DoH FIMS returns
	Review of medium term financial plan	• Development of 3 year CIP/QuEP programme • RCRH and associated planning work • Initial 10/11 and beyond financial plans
Internal Control	Adverse events or external reports	• Reports to Governance and Audit Committees
	Taking It On Trust review	• Presentation to and outcome from Governance Committee and Trust Board
Value for Money	No material deterioration on key targets	• Routine performance monitoring reports to FPC/TMB and Trust Board
	Implementing key actions from NHS Carbon Reduction Strategy	• Report from Director of Estates at Trust Board meetings, e.g. sustainability agenda

Discussions are taking place with the Auditor to ensure that compliance requirements are clear based on emerging audit commission guidance. Directors have been briefed on the need for a self assessment against the evidence submitted previously and a determination of whether performance has deteriorated in any areas. Those responsible for certain KLOEs are aware that testing may arise where the Auditor requires additional assurances over and above the evidence provided to prove a negative return against trigger points. The precise submission date is to be confirmed, but it is anticipated to be in the latter part of February in keeping with previous years.

4. Recommendations

The Trust Board is recommended to:

4.1 NOTE the contents of the report.

R White
Director of Finance

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Right Care Right Here Progress Report
SPONSORING DIRECTOR:	Richard Kirby, Chief Operating Officer
AUTHOR:	Jayne Dunn, Redesign Director – Right Care Right Here
DATE OF MEETING:	25 February 2010

SUMMARY OF KEY POINTS:

The paper provides a progress report on the work of the *Right Care Right Here* Programme as at the end of January 2010 and includes a copy of the *Right Care Right Here* Programme Director's report to the Right Care Right Here Partnership.

It covers:

- Progress of the Programme including performance data for exemplar projects against targets for April – November 2010.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Care Closer to Home: Ensure full Trust participation in the delivery of Right Care, Right Here programme exemplars project
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION: Usual monthly update to Trust Board

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

RIGHT CARE RIGHT HERE PROGRAMME: PROGRESS REPORT FEBRUARY 2010

INTRODUCTION

The Right Care Right Here Programme is the partnership of S&WBH, HoB tPCT, Sandwell PCT and Birmingham and Sandwell local authorities leading the development of health services within Sandwell and Western Birmingham. This brief paper provides a progress report for the Trust Board on the work of the Programme as at the end of January 2010.

This report is in three sections:

a) Overview of the work of the Right Care Right Here Programme
b) Programme Director's report as presented to the Right Care Right Here Partnership and the Boards of Sandwell and HoB PCTs (Appendix 1)
c) Right Care Right Here Exemplar Project Performance for April – November 2010 (Appendix 2 – summary of the performance & Appendix 3 - separate spreadsheet with performance data)

OVERVIEW

This section provides an overview of the work of the Right Care Right Here Programme. This work is set out in more detail in the Programme Director's report in Appendix 1. The work of the Right Care Right Here Programme and involvement of the Trust in this is also discussed on a monthly basis at the Right Care Right Here Implementation Board meetings. The most significant issues arising this month are as follows:

Project Performance – Appendix 3 shows the performance of exemplar projects (first and second wave) for the period April – November 2010 whilst Appendix 2 provides some more detailed explanation around the performance.

There are five projects with 'Green' status – Rehab Beds - Sheldon, Urgent Care – Sandwell, Respiratory, Dermatology and ENT, Diabetes all of which are exceeding targets.

The following five the projects are rated as 'Amber' :

- *Urgent Care, HoB*: activity 7% below target. The plan is for this service to cease on 31/3/10 and be re-provided by Assura from Summerfield Health Centre from mid-February 2010.
- *Gynaecology:* October and November performance data unavailable.
- *Rehab Beds, Rowley*: Data for the STAR service is provided on a quarterly basis with the last set of data showing activity 8% below target. The Step Up bed provision is not being fully utilized by GPs.
- *Musculoskeletal*: there are areas of underperformance for Community Orthopaedics and Pain Management and no primary care data for GP led Rheumatology.
- *Respiratory:* The Project Lead post has become vacant owing to maternity leave, and whilst information has been provided by different sources it does not reconcile with the previous performance reports submitted. Programme working with service leads and the SWBH support Project Lead to resolve.

Two projects remain rated as 'Red':

- *Ophthalmology*: Year to date performance is 13% below target and no data provided for November 2009.
- *Cardiology*: The partial actual activity data to the end of September is below target and the data submitted from Sandwell PCT for October and November needs to be validated. The RCRH Programme Manager will meet with Sandwell PCT Information lead to seek resolution.

Issues relating to data collection and reporting continue to be discussed at Programme Delivery Group and actions agreed/undertaken with some improvement.

Service Redesign Activity :

The Strategic Model Of Care Steering (SMOCS) Groups continue to present their three key deliverables (Clinical Strategy, Overall Model of Care and Priorities for Service Redesign) to the Clinical Group. The current position with regard to these is:

- Approved: Maternity and Newborn, Planned Care, Dementia, Long Term Conditions, End of Life, Children's Services. Staying Healthy, Acute Care

- For approval in March after amendments: Mental Health

Within the Trust the approved SMOCS are being considered by the RCRH Implementation Board and also circulated to members of the Clinical Management Executive. They will then be added to the Trust's intranet.

Exemplar Projects – Final Review: The final review process for the exemplar projects has been completed with a clear outcome for each project having been identified and approved by the RCRH Strategy Group along with a set of recommended actions to deliver the agreed outcome i.e. project closure and/or transfer into the new workstreams or Care Pathway Review . The Programme Delivery Group is monitoring these actions.

New Service Redesign Workstreams: These are being established. An initial meeting of the Urgent and Emergency Care Workstream took place on 21st December 2009. A Workshop on Intermediate Care took place on 25th January 2010 following which the Intermediate Care Workstream is being established. The RCRH Programme Manager met with John Adler at the end of January to initiate the work of the Demand Management – Referrals/Outpatient workstream.

Review of the Programme – Work continues on the revised Overall Programme Plan. The Programme will present the outcomes of the review to the Joint Health Overview and Scrutiny Committee in February.

Affordability and Activity and Capacity Model Update: Considerable and significant work has been undertaken in the last few weeks on the issue of securing agreement to a projected level of affordability and activity to 2017/18 and the impact on the financial position of the two PCTs and SWBH. In developing this, the emphasis has been on trying to achieve a balanced position for each organisation, without rendering them incapable of delivering services because of substantial cuts in infrastructure or staffing. It has been a complex and difficult process of modelling, forecasting and negotiation.

Members of the finance and capacity group met with Chief Executives in January and agreed an approach including a set of changes to Version 5.0 of the Activity and Capacity Model that will then move this to Version 5.1 of the model which will be the framework within which future redesign will be undertaken. This will provide the basis for a highly efficient acute hospital, operating at national best practice levels. The main changes include:

- The levels of historical growth will be moderated in the model to take account of the expected impact of improved healthy lifestyle services.
- Confirmed planning assumption that by 2013/14, the quantum reduction assigned to decommissioning procedures of limited value will be achieved, either through implementing the changes or by alternatives.
- All organisations will review the proposed catchment population changes to identify areas and volumes which could remain as part of the SWBH catchment. The rationale for this is that the adoption of better management of long term conditions in primary care would result in more patients being maintained in the local health economy and therefore less likely to access care elsewhere.

In terms of affordability the following approach has been agreed:

- Use of the World Class Commissioning assumptions on allocations and tariff as issued by the SHA and Centre for the period ending in 2013/14.
- Remodelling the affordability of the agreed activity from 2014/15 to 2017/18 based on agreed assumptions to provide two scenarios.
- The Trust will review infrastructure cost reductions related to design, to include 24/7 medical cover and 23 hour surgery
- PCTs will identify within the re-modelled financial projections opportunities to invest in community services which will require expansion
- PCTs will articulate their proposals to achieve cost reductions in more detail in their World Class Commissioning submissions

It was further agreed that the Finance Directors will meet to agree the effect of these assumptions and ensure alignment and consistency within the Long Term Sustainability Models and in anticipation of the refresh of the New Hospital Outline Business Case. This will constitute the 'sense check' that all the elements work together.

It will be important to discuss with the SHA the acceptability of the assumptions we are making from 2014/15 onwards and the potential for our Local Health Economy to receive more than our fair share of transition funding to assist in ensuring this major strategic change.

Review of Commissioning Arrangements in Birmingham – The three Birmingham PCTs have developed their recommendation to the SHA on the future arrangements. The report was submitted on 4th January 2010 to the SHA and a response is expected from the SHA in February.

The Boards of the three Birmingham PCTs have put forward the recommended option of one commissioning organisation for the NHS in Birmingham, on the basis that the detail and evidence is further developed for this option. In addition they recommended that this option is developed in line with a proposed set of principles.

The need to ensure continued partnership working with Sandwell PCT and the continued viability and sustainability of the RCRH Partnership is acknowledged although not expressed as a formal principle.

The RCRH Programme is developing a programme of activities to maintain a high profile for the RCRH Programme in Birmingham.

RECOMMENDATIONS

The Trust Board is recommended to:

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

Jayne Dunn
Redesign Director – Right Care Right Here
15th February 2010

APPENDIX 1

Sandwell and the Heart of Birmingham Health and Social Care Community

RIGHT CARE, RIGHT HERE PROGRAMME

Report to:	**Right Care, Right Here Partnership Board**
Report of:	**Les Williams, Programme Director**
Subject:	**Programme Director's Report**
Date:	**Monday, 25th January, 2010**

1. Summary and Recommendation

This paper summarises the main issues and developments in the Programme since the previous report. There are no items for decision.

The Partnership Board is recommended to:

- Note the content of the report

2. Service Redesign Activity

2.1 SMOCS Update

Owing to the cancellation of the Clinical Group in January, approval of the revised Acute Care and Staying Healthy SMOCS documents is being pursued by email. The majority of members have confirmed their approval of the documents, with one amendment to the Staying Healthy document and two suggested changes to the Acute Care SMOCS being progressed. It is anticipated that the final version of the document will be agreed by the end of January 2010.

A meeting is being organised to enable the commissioning issues raised in relation to the Mental Health SMOCS to be understood and changes to the document agreed. It is likely that this document will be re-presented to the Clinical Group in March for final sign off.

The current status, detailed below, remains unchanged:

Approved:
Maternity and Newborn, Planned Care, Dementia, Long Term Conditions, End of Life, Children's Services

For approval in January after amendments:
Staying Healthy, Acute Care

For approval in March after amendments:
Mental Health

It was agreed to present the SMOCS reports to Sandwell and HoBt PCT PECs to note and sign up, the schedule for which is as follows:

SMOCS	Sandwell PEC	HoBt PEC
Children's Services	10/12/09	17/12/09
Planned Care	10/12/09	17/12/09
Maternity and Newborn	10/12/09	17/12/09
Dementia	12/01/10	18/02/10
Long Term Conditions	12/01/10	17/12/09
End of Life	12/01/10	21/01/10
Acute Care	16/02/10	18/02/10
Staying Healthy	16/02/10	18/02/10
Mental Health	16/03/10	18/03/10

The schedule setting out when each SMOCS report is being presented to SWBH's Right Care, Right Here Implementation Board has been requested and the agreed wider distribution to partner organisations underway.

2.2 First and Second Wave Projects Final Review Process

The process is underway to enact the recommendations, with the Programme Delivery Group monitoring that the actions required to enable project closure and/or transfer into the new workstreams or Care Pathway Review.

The evaluation report from the Rehabilitation Beds – Rowley Project Steering Group was presented to the Programme Delivery Group on 18th January 2010, and a recommendation made for approval by the Strategy Group.

In response to the questionnaire sent to Project Boards to identify key learning to transfer to the process supporting the new Programme Workstreams and identify ideas to improve clinician engagement in service redesign work, 17 respondents have completed the document. The results will be collated and analysed for report to Workstream Lead Directors by the first week in February to inform project organisation and delivery.

2.3 Map of Medicine

Members of the Programme Team have received the initial training required to enable the tool to be used. A comprehensive action plan covering the governance framework, pathway review process, IM and T requirements and stakeholder engagement and communications is being developed. The Project Initiation Document required for submission to Sue Hindle, Care Pathways and Knowledge Manager at WMSHA, is near completion. Clinical champions within primary and secondary care are being identified.

3. Review of Programme

3.1 Establishment of New Workstreams

An initial meeting of the Urgent and Emergency Care Workstream took place on 21st December 2009 at which membership, key information inputs, workstream organisation and the transfer of the Urgent Care – Sandwell project were discussed and actions agreed.

It has been agreed by Sandy Bradbrook and the Assistant Programme Manager, Anu Sandhu, that the Intermediate Care Workstream will commence after the workshop scheduled for 25th January 2010. Angela Poulton is meeting with John Adler to initiate the work of the Demand Management – Referrals/Outpatient workstream on 22nd January 2010.

Nominations for membership of all three workstreams are still being pursued.

3.2 Affordability and Activity and Capacity Model Update

Considerable and significant work has been undertaken in the last few weeks on this issue of securing agreement to a projected level of affordability and activity to 2017/18 and the impact on the financial position of the two PCTs and Sandwell and West Birmingham Hospitals. In developing this, the emphasis has been on trying to achieve a balanced position for each organisation, without rendering them incapable of delivering services because of substantial cuts in infrastructure or staffing. It has been a complex and difficult process of modelling, forecasting and negotiation.

On Monday, 18th January, members of the finance and capacity group met with Chief executives to reach an agreement. The agreed approach has the following features:

- The 5th January iteration of Version 5.0 of the Activity and Capacity Model to be the basis for activity projections, with modifications to take account of potential catchment area changes and the impact on reducing emergency admissions of better management of long term conditions. This will then provide Version 5.1 of the model which will be the framework within which future redesign will be undertaken.
- This provides the basis for a highly efficient acute hospital, operating at national best practice levels
- Use of the World Class Commissioning assumptions on allocations and tariff as issued by the SHA and Centre for the period ending in 2013/14
- Remodelling the affordability of the agreed activity from 2014/15 to 2017/18 based on the following assumptions:
  - LHE base case to set allocation growth at 2.5%+, not 1.5% (precise percentage to be defined)
  - SHA base case to set allocation growth at 2.0%+, not 1.5% (precise percentage to be defined)
- SWBH will review infrastructure cost reductions related to design, to include 24/7 medical cover and 23 hour surgery
- Confirmed planning assumption that by 2013/14, the quantum reduction assigned to decommissioning procedures of limited value will be achieved, either through implementing the changes or by alternatives. It was noted that further debate was required on the assumed level of reduction in 2010/11 and the proposed trajectory. It was further agreed that the three Finance Directors would raise the possibility of transitional funding for this with the SHA.
- All organisations will review the proposed catchment population changes to identify areas and volumes which could remain as part of the SWBH catchment. The rationale for this is that the adoption of better management of long term conditions in primary care would result in more patients being maintained in the local health economy and therefore less likely to access care elsewhere. In Sandwell, this is being pursued through the Pathfinder pilot project.
- While there is insufficient data available to be able to identify with any certainty the impact of improved healthy lifestyle services, it was agreed that it is reasonable to assert that the expected impact would mitigate the levels of historical growth which had already been moderated in the model. HoB indicated their view that applying these services in the context of already comparatively low levels of elective admissions would lead to elective interventions at an earlier stage, resulting in less volume and less acuity of emergency admissions
- PCTs will identify within the re-modelled financial projections opportunities to invest in community services which will require expansion
- PCTs will articulate their proposals to achieve cost reductions in more detail in their WCC submissions

In terms of further action, it was agreed that the Finance Directors would meet to agree the effect of these assumptions and ensure alignment and consistency within the Long Term Sustainability Models and in anticipation of the refresh of the New Hospital Outline Business Case. This would constitute the 'sense check' that all the elements work together.
It will be important to discuss with the SHA the acceptability of the assumptions we are making from 2014/15 onwards and the potential for our LHE to receive more than our fair share of transition funding to assist in ensuring this major strategic change.

This agreement now enables the Partnership to make progress on developing its plans in more detail.

3.3 Joint Overview and Scrutiny Committee Meeting

As reported last month, the date for this presentation, which commences the Programme Stakeholder Engagement Plan, has been agreed as 9th February 2010. The presentation to be used will include the objectives and principles of the Programme, the reasons for the Review, the individual PCTs' capital infrastructure reviews and their outcomes, the updated position on developing the New Acute Hospital and the purchase of the land at Grove Lane, the updated shape of the programme with planned timeframes, and the process for taking forward redesign of services, with clinical engagement and involvement of stakeholders and the public.

4. Review of Commissioning Arrangements in Birmingham

As reported at the last meeting, the three Birmingham PCTs have developed their recommendation to the SHA on the future arrangements. The report was submitted on 4th January 2010 to the SHA and is given at Appendix 1. The recommendation is:

'The Boards of the three Birmingham PCTs recommend that:

- The recommended option is for one commissioning organisation for the NHS in Birmingham. On the basis that the detail and evidence is further developed for this option.
- This option is developed in line with the proposed principles set out in section 8 of this document.'

Section 8 identifies the principles to be followed, which are:

1. A single PCT will be a new organisation and not a merger. The PCTs must move forward as quickly as is realistically possible to determine collectively a process to design a new organisation and to implement necessary changes.
2. A strategy for the city is required, considering the interface with neighbouring organisations, responsiveness to local need and opportunities for a single approach across health and social care. This should provide a framework for the design of the new organisation.
3. **New arrangements must be lean and efficient** and show a significant reduction in management costs and improved productivity. They must make the most effective use of management talent across existing organisations.
4. Risks need to be recognised and managed appropriately. Existing organisations still need to sustain and improve performance during the period of change.
5. An agreed system of interim governance should be implemented that respects the statutory responsibilities of each PCT and which builds alignment of strategy and approach, minimises on-costs and makes best use of current resources.
6. The process should maximise the opportunities for the even-handed involvement of all key stakeholders, including patients and the public and clinical constituencies. In supporting effective partnership and promoting collaborative behaviours, a priority is building the relationship with Birmingham City Council (BCC).
7. The window of opportunity provided by the 2010 NHS Operating Framework should be used to develop a provider programme that enables South Birmingham to rapidly deliver NHS Trust status and to identify future arrangements for provision of the rest of £100m plus Community Health Services in the city, in discussion with BCC and other stakeholders.
8. To make early and full use of the role of the SHA as system managers and the guardian of proper and effective change processes.'

While there is no reference to Right Care Right Here in these recommendations, the Programme is referenced in Section 4, in the sub-section on collaborative working and commissioning. This states:

'Collaborative working and commissioning
There is good practice in place that can be built on with regard to collaborative working and commissioning in Birmingham. An example of an existing formal collaborative arrangement between the three PCTs is the West Midlands Ambulance Service (WMAS) contract. Formalised arrangements have the advantage of providing clear accountability and allowing the PCTs to act effectively across organisational boundaries.

The PCTs acknowledge that there is room for further strengthening of their strategic alignment to improve coordination; streamline processes, governance and decision making; and to enhance delivery. In its report, the National Support Team drew attention to the lack of transparency of leadership arrangements in the existing organisations and the absence of a process to ensure cross-thematic working. It also needs to be ensured that collaborative commissioning is focused on areas where it is in the best interests of quality and efficiency.

With regard to neighbouring PCTs, any change in commissioning arrangements in Birmingham will have implications for neighbouring organisations and on Solihull Care Trust and Sandwell PCT in particular. A strengthened strategic perspective could, on the one hand, reduce the number of organisations these neighbours relate with and so should streamline joint working. On the other hand a stronger strategic view would need to continue the specific partnerships between the existing PCTs. In particular important initiatives such as the *Right Care Right Here* partnership should continue to be given a high priority to ensure its continued viability and sustainability. Appendix 3 summarises the *Right Care Right Here* partnership. On balance then, collaborative working between the PCTs in Birmingham and their neighbours would be improved through a stronger strategic approach.'

Appendix 3 states:

'Right Care Right Here is a major programme in Sandwell and Heart of Birmingham tPCT focused on providing specialist medical care and social services closer to home, making health services more accessible and enhancing the quality of estates to be fit for the future.
It entails extensive service redesigns and new developments including the building of a new hospital and the development of community hospitals, town centre healthcare facilities, primary health centres, outpatient and diagnostic facilities, intermediate care facilities and urgent care centres.
The key objectives of the programme are to improve health outcomes and to ensure that people have the opportunity to benefit from healthier lifestyles and are able to live independent lives.'

The report also recommends that there should be a review of acute hospital capacity and Sandy Bradbrook informs me that he has indicated that I will be invited to take part in this from the Programme's perspective.

The response from the SHA is expected in early February.

Following the last meeting, the Strategy Group met with Communications Leads to develop a programme of activities to maintain a high profile for the Programme in Birmingham. General principles have been agreed and the full programme will be brought to the next Partnership Board meeting.

5. Recommendation

The Partnership Board is recommended to:

- Note the content of the report

Les Williams
Programme Director

2010-01-18 – prog dir report - lnw

APPENDIX 2

Sandwell and the Heart of Birmingham Health and Social Care Community

RIGHT CARE, RIGHT HERE PROGRAMME

Report to:	**Right Care, Right Here Partnership Board**
Report of:	**Angela Poulton, Programme Manager**
Subject:	**Performance Report**
Date:	**Monday, 25th January 2010**

6. Summary and Recommendation

This paper summarises the performance of first and second wave projects. There are no items for decision.

The Partnership Board is recommended to:

- Note the content of the report

7. Project Performance

7.1 April to November 2009

Given at Appendix 1 is the Project Performance report for April to November 2009.

In summary, the RAG status assigned to the projects (with reasons) and signed off by the Programme Delivery Group is as follows:

- **Red (2/12 Projects)**

  Ophthalmology
  Year to date performance is 13% below target and no data provided for November 2009.

  Cardiology
  The partial actual performance information to September is below target. It was previously reported that information provided by Sandwell PCT Information Department requires validation as not consistent with previously reported consultant led activity and non consultant led activity not identified, and this situation remains unchanged. Programme Manager to meet with Sandwell PCT Information lead to seek resolution.

- **Amber (5/12 Projects)**

  Urgent Care – Heart of Birmingham
  The level of underperformance against year to date target has increased from 5% to 7% between October and November. The plan for this service to cease on 31/3/10 and be re-provided by Assura from Summerfield Health Centre from mid-February 2010.

  Rehabilitation Beds - Rowley
  Step-up capacity not being fully utilized by GPs. STAR data previously below target by 8% with no data provided by the Local Authority to the interim Project Lead for November.

  Musculoskeletal
  It has previously been reported that there are areas of underperformance that persist and no primary care date for GP-led Rheumatology. The Project Lead has been unable to provide the actual performance data for November 2009 despite requesting from SWBH Information Department.

Respiratory
The Project Lead post has become vacant owing to maternity leave, and whilst information has been provided by different sources it does not reconcile with the previous performance reports submitted. Programme working with service leads and the SWBH support Project Lead to resolve.

Gynaecology
October and November performance data unavailable

- **Green (5/12 projects)**

  Urgent Care – Sandwell
  Rehabilitation Beds - Sheldon
  Dermatology
  ENT
  Diabetes

Whilst the performance status overall has remain unchanged, the Diabetes project has been assigned green status this month owing to complete performance data being provided showing the year to date target being exceeded and the Respiratory project has been assigned amber status pending validation of the November data submissions.

8. Recommendation

The Partnership Board is recommended to:

- Note the content of the report

Angela Poulton
Programme Manager

RIGHT CARE, RIGHT HERE PROGRAMME

Project Performance Report April-November 09/10

Key: **CL OPs** Consultant Led Outpatients **NCL Ops** Non Consultant Led Outpatients

PROJECT	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	% Over/ Under YTD	2008/09 Yearend Target	Status	PROJECT LEAD	Comments
	MONTH (2009/10)																	
URGENT CARE - SANDWELL																		
Target (Attendances)	976	976	976	976	976	976	976	975	0	0	0	0	7,807		11,710		Gill Gadd	Activity exceeding target
Actual	865	927	1,008	865	905	1,143	1,392	1,243	0	0	0	0	8,348				SWBH	
Variance													**541**	**7**				
URGENT CARE - HoB																		
Targets (Attendances):																		
City	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	0	0	0	0	20,000		30,000		Mark Curran	Activity continues to be below target. Project closure agreed and service to cease at City
Actual	2,424	2,433	2,113	3,176	2,233	2,014	2,157	1,993	0	0	0	0	18,543				HOB PCT	hospital 31/03/10.
Variance													**-1,457**	**-7**				
Primary Care	0	0	0	0	0	0	0	0	0	0	0	0	0		13,000			
Actual	0	0	0	0	0	0	0	0	0	0	0	0	0					
Variance													**0**	**n/a**				
REHAB BEDS - SHELDON																		
Targets:																		
Community - D43 (OBDs)	647	647	646	646	647	647	647	646	0	0	0	0	5,173		7,760		Angela Young	Project exceeding targets overall. Project has closed, with on-going performance
Actual	638	783	631	643	643	584	693	716	0	0	0	0	5,331				HOB PCT	monitoring arrangements agreed i.e. data provision from HoB tPCT Business Intelligence Unit
Variance													**158**	**3**				
Care Centres (OBDs)	571	571	571	570	571	571	571	570	0	0	0	0	4,566		6,850			
Actual	595	657	592	662	606	625	652	650	0	0	0	0	**5,039**					
Variance													**473**	**10**				
Comm. Alternatives Sub-Acute D47 (?)	0	0	0	0	0	0	0	0	0	0	0	0	0		2625*			
Actual	0	0	0	0	0	0	0	0	0	0	0	0	0					
Variance													**0**	**n/a**				
Comm. Alternatives Rehabilitation (Patient Package)	292	292	292	291	291	292	292	291	0	0	0	0	2,333		3,500			
Actual	836	977	1,045	1,132	943	974	935	1,110	0	0	0	0	**7,952**					
Variance													**5,619**	**241**				
	Note: Target for Community Alternatives Sub-Acute D47 is HoBPCT only - Sandwell target to be agreed.																	
REHAB BEDS - ROWLEY																		
Targets:																		
Community Step Up - ET Ward (OBDs)	317	317	317	316	316	317	317	316	0	0	0	0	2,533		3,800		Chris Gibbs	Significant overperformance for step-down activity and undeperformance for step-up
Actual	48	231	246	285	300	266	279	312	0	0	0	0	1,967				(interim)	continues. STAR data provided quarterly from LA but is anticipated to continue to be below
Variance													**-566**	**-22**			SPCT	target. Project evaluation report submitted for review by Programme Delivery Group.
Community Step Down - Mc Ward (OBDs)	642	642	642	641	641	642	642	641	0	0	0	0	5,133		7,700			
Actual	1,526	1,663	1,611	1,627	1,588	1,611	1,654	1,598	0	0	0	0	12,878					
Variance													**7,745**	**151**				
STAR (Av Admits)	83	83	84	83	83	84	83	0	0	0	0	0	583		1,000			
Actual	60	77	75	91	62	86	88	n/a	0	0	0	0	539					
Variance													**-44**	**-8**				
MUSCULOSKELETAL (includes Orthopaedic beds & outpatients, Rheumatology outpatients & Pain Management																		
Targets:																		
HoB Orthopaedics Triage (NCL OPs)	545	545	545	545	543	543	546	0	0	0	0	0	3,812		6,535		Paul Hazle	Project lead has not submitted report - awaiting data from Information Department.
Actual	530	520	883	874	721	918	1,019	n/a	0	0	0	0	5,465				SWBH	
Variance													**1,653**	**43**				
Sandwell Orthopaedics Triage (NCL OPs)	574	574	574	574	573	574	573	0	0	0	0	0	4,016		6,885			
Actual	585	520	623	669	490	626	661	n/a	0	0	0	0	4,174					
Variance													**158**	**4**				
Community Rheumatology (CL OPs)	381	381	381	381	378	380	380	0	0	0	0	0	2,662		4,564			
Actual	387	397	453	496	404	468	512	n/a	0	0	0	0	3,117					
Variance													**455**	**17**				
Primary Care Rheumatology (CL OPs)	0	0	0	0	0	0	0	0	0	0	0	0	0		140			
Actual	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0					
Variance													**0**	**n/a**				
Community Orthopaedics (CL OPs)	74	74	74	74	74	75	74	0	0	0	0	0	519		889			
Actual	50	4	43	47	72	56	29	n/a	0	0	0	0	301					
Variance													**-218**	**-42**				
Community Pain Management (CL OPs)	59	59	59	59	59	56	59	0	0	0	0	0	410		702			
Actual	11	13	15	20	20	35	26	n/a	0	0	0	0	140					
Variance													**-270**	**-66**				
	Note; Community Pain Management actual activity only includes Lyng activity																	

RIGHT CARE, RIGHT HERE PROGRAMME

Project Performance Report April-November 09/10

PROJECT	MONTH (2009/10) April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	% Over/ Under YTD	2008/09 Yearend Target	Status	PROJECT LEAD	Comments
OPHTHALMOLOGY																		
Target (CL OPs)	1,273	1,273	1,273	1,272	1,273	1,273	1,273	0	0	0	0	0	8,910		15,274		Vacant	No report submitted.
Actual	1,162	971	1,169	1,183	1,004	1,267	968	n/a	0	0	0	0	7,724				SPCT	
Variance													**-1,186**	**-13**				
	Note: Rowley Regis MC actual activity not available for Aug-Oct																	
DERMATOLOGY																		
Targets:																		
Community (CL OPs)	267	267	267	265	266	267	266	267	0	0	0	0	2,132		3,198		Vacant	Project exceeding target overall.
Actual	219	250	246	268	138	221	205	137	0	0	0	0	1,684				HOB PCT	
Variance													**-448**	**-21**				
Community - GPwSI (OPs)	134	134	134	132	134	133	134	133	0	0	0	0	1,068		1,602			
Actual	178	187	260	275	188	288	290	258	0	0	0	0	1,924					
Variance													**857**	**80**				
RESPIRATORY																		
Targets:																		
Community - Nurse-led (OPs)	80	80	90	100	100	100	100		0	0	0	0	650		1,034		Vacant	Data submitted by support Project Lead and service lead - can not reconcile to previous
Actual	276	281	258	248	208	163	193	n/a	0	0	0	0	1,627				SPCT	submissions - Programme Manager to pursue.
Variance													**977**	**150**				
Primary Care - GP/Nurse/GPwSI (OPs)	0	0	0	0	0	0	0	0	0	0	0	0	0		432			
Actual	0	0	0	0	0	0	0	0	0	0	0	0	0					
Variance													**0**	**n/a**				
ENT																		
Target (CL Outpatients)	822	822	822	821	821	822	822	821	0	0	0	0	6,573		9,860		Jane Clark	Actual activity exceeding target, the position representing 58% of total activity occurring in the
Actual	852	883	978	991	739	900	999	740	0	0	0	0	7,082				SWBH	community. Service specification for Community Ear Care service is complete and being
Variance													**509**	**8**				presented to next ENT Project Board.
CARDIOLOGY																		
Targets:																		
Community (CL OPs)	65	65	65	65	65	66	0	0	0	0	0	0	391		782			Partial year-to-date information. Data provided by Andrew Wilson to be validated as
Actual - Rowley & Neptune	61	61	54	79	37	80	n/a	n/a	0	0	0	0	372				Vacant	no consistent with previous months' data provided by SWBH - Programme Manager to meet
Variance													**-19**	**-5**			SPCT	Andrew Wilson to resolve.
Community (NCL OPs)	0	0	0	0	0	0	0	0	0	0	0	0	0		1,867			
Actual	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0					
Variance													**0**	**n/a**				
GYNAECOLOGY																		
Target (CL OPs)	88	88	88	88	87	87	0	0	0	0	0	0	526		1,053		Therese	Project lead has submitted narrative report but no performance data for 2 months.
Actual	89	100	88	91	79	82	n/a	n/a	0	0	0	0	529				McMahon	
Variance													**3**	**1**			HOB PCT	
DIABETES																		
Targets:																		
Community (CL OPs)	486	487	486	486	487	486	486	486	0	0	0	0	3,890		5,835		Olivia Amartey	Activity has exceeded target. Project to close subject to joint service specification being
Actual	379	463	631	605	371	518	454	562	0	0	0	0	3,983				HOB PCT	agreed.
Variance													**93**	**2**				
Primary Care (NCL OPs)	0	0	0	0	0	0	0	0	0	0	0	0	0		361			
Actual	n/a	0	0	0	0	0	0	0	0	0	0	0	0					
Variance													**0**	**n/a**				

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	RCRH Acute Hospital Development: Project Director's Report
SPONSORING DIRECTOR:	New Hospital Project Director
AUTHOR:	Andrea Bigmore, New Hospital Project Manager Graham Seager, Director of Estates and New Hospital Project
DATE OF MEETING:	25 February 2010

SUMMARY OF KEY POINTS:

The Project Director's report includes reference to the following for discussion:

- Progress with the Compulsory Purchase Order
- Review of the impact of revised activity assumptions
- Outcome of a meeting with the Department of Health
- Programme planning and the approvals required by Trust Board
- Outcome of a regeneration workshop held in January

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to receive the report for information.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	21st Century Facilities
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

Financial	**X**	
Business and market share	**X**	
Clinical	**X**	
Workforce	**X**	
Environmental	**X**	
Legal & Policy	**X**	
Equality and Diversity	**X**	
Patient Experience	**X**	
Communications & Media	**X**	
Risks		Risks identified in project risk register and where appropriate included in Trust risk register

PREVIOUS CONSIDERATION:

Usual monthly report

Sandwell and West Birmingham Hospitals NHS
NHS Trust

right care
right here

RIGHT CARE, RIGHT HERE PROGRAMME
ACUTE HOSPITAL DEVELOPMENT

Report to:	**Trust Board**
Report of:	**Andrea Bigmore / Graham Seager**
Subject:	**Acute Hospital Development Progress Report**
Date:	**February 2010**

1. Compulsory Purchase Order (CPO)

Work continues on the CPO process with the issue of the Statement of Case. The Trust is waiting to be notified of the dates for CPO Inquiry. The team is also pursuing voluntary acquisitions of land.

2. Activity Review

To reflect the change in public sector financial planning assumptions the Right Care, Right Here (RCRH) Programme review has resulted in some changes to the activity model which informs the financial and estates modelling for the acute hospital.

A significant exercise has now commenced to ensure that the scheme continues to be affordable and best value for money for the revised activity planning assumptions.

The Trust Board will be updated on the progress of this work as it develops.

3. Meeting with the Department of Health

Representatives of the Trust have met with the Department of Health (DH) and the Private Finance Unit (PFU) earlier this month. The aim of this meeting was to agree next steps and a timetable to initiation of the procurement process.

The meeting was very positive, which reflects the high profile of the New Hospital Development nationally. Their confidence in us is based on the strong partnership working that continues to be the central driving principle of the project.

The DH was happy to agree to our aim of achieving approval to initiate the procurement in December 2010. This is subject to us achieving the following by this date:

- A clear path to land title
- Approval of an updated Outline Business Case (OBC)
- Approval of our procurement documentation

With the revised activity / affordability modelling to be undertaken these targets are challenging, but we will be working closely with the SHA, DH and PFU to ensure that we can deliver to timescale.

4. Programme Planning

Subsequent to the meeting with the DH the Project Team is now planning the work of the workstreams to update the OBC and to complete work already started on the procurement documents.

The Trust Board will need to approve submission of the updated OBC in November 2010. The PFU will approve the procurement documents in steps agreed with them in advance as part of the planning process.

The culmination of the plan will be for the Trust to post an OJEU (Official Journal of the European Union) notice to initiate the procurement.

5. Regeneration

The Project Board invited a range of stakeholders to a regeneration workshop at the end of January. This event was well attended and provided an opportunity to share information about the New Hospital Development and the regeneration programmes being planned adjacent to the scheme. It was really encouraging to hear about the range of good work being done to ensure that the Windmill Eye area of Sandwell and the Ladyport area of Birmingham will be developed and improved.

All present at the workshop agreed that the New Hospital Development is a catalyst for change and that joint working across council borders and between sectors would be required to maximise the benefits for the local area. It was agreed that joint governance arrangements will be established to raise the profile of the cross boundary regeneration plans with our New Hospital Development at centre stage.

A draft action plan has been formed to ensure that focus on delivery is maintained. Update on how these early plans will be taken forward will be presented later in the year.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	IM&T Strategic Update
SPONSORING DIRECTOR:	Richard Kirby, Chief Operating Officer
AUTHOR:	Sue Wilson, Deputy Director of Elective Access & EPR
DATE OF MEETING:	25 February 2010

SUMMARY OF KEY POINTS:

The Trust has an IM&T strategy for the period 2009 – 2013 designed to ensure that we make progress towards the IM&T infrastructure needed to support the new acute hospital and the provision of care closer to home. The paper presents an annual review of this strategy including:

- the impact of the recent review of the National Programme for IT on the delivery of the planned electronic patient record (Lornenzo);
- projects being pursued by IM&T to support the Quality and Efficiency Programme;
- other key IM&T developments.

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

Approval	Receipt and Noting	Discussion
		X

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Board is asked to:

- Note the annual IM&T strategic update and progress made and the new plans regarding supporting QuEP.
- Note the risks raised in association with the delivery of Lorenzo Regional Care from CSC and the NPfIT Programme.
- Note the actions that are being taken to manage these risks solutions to mitigate them.
- Note that the Trust has met the IG Statement of Compliance by achieving level 2 and above across the core 25 standards.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	An Effective NHS Foundation Trust
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

IM & T strategy considered annually by the Trust Board

Sandwell and West Birmingham Hospitals NHS
NHS Trust

IM&T Strategic Direction – Annual Update to Trust Board

1. Introduction

The purpose of this report is to provide the annual update on the Trust's IM&T strategic direction and any major risks with the approach. In 2008 a 5 year IM&T strategy (2008-2013) was produced to steer the Trust towards the opening of the new hospital and the associated plans to have a state-of-the-art hospital enabled by the latest technology, with clinical professionals delivering their services in a totally paperless environment. The strategy was subject to annual review.

2. Current IM&T Strategy - 2008-2013

Decisions were made back in 2004, due to the announcement of the National Programme for IT (NPfIT), that the Trust would implement the new solutions for Electronic Patient Records supplied by NHS Connecting for Health (CfH) and Computer Sciences Corporation (CSC), the Local Service Provider (LSP). This would include a fully integrated solution across the Local Health Economy (LHE). These solutions were free to the Trust, during CSC's contractual lifetime with CfH to deliver the Lorenzo solution set.

Originally back in 2004, the systems had to be fully delivered by 2010, but a number of delays have occurred and the delivery timeframe has changed several times. The solutions were designed to operate within a Data Centre provided by CSC, which removed the need for management of the systems and associated hardware e.g. servers by local IM&T departments.

The Trust had planned to start moving to Lorenzo in late 2010 or early 2011. This would give sufficient time to implement EPR functionality to support a paperless hospital in 2016.

Lorenzo Regional Care comprises of 4 major releases to make up a single integrated clinical solution across the LHE, and broadly comprises of the following:

- Release 1 – Clinic documents, assessments and results reporting
- Release 2 – Requesting of tests and investigations, replacing PAS, outpatient prescribing, Care Plans and TTO/Discharge process.
- Release 3 – Theatres, Maternity, Inpatient Prescribing and Medicines Administration, Advanced Bed Management, Multi-Resource Scheduling and integration with social care messaging.

- Release 4 – Protocols, Integrated Care pathways, Interactive Charting, Tray/Instrument Management, Stock Management, Surveillance and Screening, Document Management screening, Non-Patient Requests and mobile device integration.

Taking into account the delays with Lorenzo delivery in 2008, our strategy for 2008-2013 identified a need to continue with our current electronic patient record (iCM) as an interim solution, whilst ensuring a migration path to Lorenzo in 2009-2011.

3. Latest position on Delivery of Lorenzo Regional Care from CSC/NPfIT

The National Programme for IT (NPfIT) continues to remain a high profile and widely discussed programme. It has been announced recently that NPfIT would find £600m in savings within the programme as part of the wider drive to improve efficiency in the Department of Health and NHS.

Following a review of NPfIT nationally, there will be a scaling back in the amount of functionality and releases to be delivered in Lorenzo Regional Care. Discussions are still ongoing at a national level to agree the final deliverables and the implications to local Trusts of the functionality they will not receive. The CIO for West Midlands has called a meeting on the 25th February, where we will be advised of the latest position and possibly the final agreement.

Timeframes of early 2011, can be achieved to commence implementation of Release 1 and 2 of Lorenzo, but no timeframes have as yet been agreed for Release 3 until the renegotiation of the contracts have been concluded with CSC.

4. Risks to the Trust of delays with Lorenzo Regional Care

The delays in the delivery of Lorenzo will create the following list of risks to the Trust, which we will need to mitigate.

- If Lorenzo Regional Care is scaled back on functionality to a level which will mean we do not have a joined up integrated record, then there would be risks attached to taking even the first 2 releases. However, the alternatives, which would need to be fully explored, could require the Trust to invest in a different solution which would be very difficult in view of the expected future financial climate.

- If the Trust decided to move to Lorenzo Releases 1 and 2, it is likely that it could be an early adopter for Release 3, but restricted functionality as discussed above. To enable the fully integrated EPR to be achieved, we may have to procure from CSC the missing functionality we require.

- The new hospital which will open in 2016 is at this time considered to be supported by a fully electronic patient record. Any further delays in rolling out functionality to

support this paperless goal, will compromise this being achieved. This will mean that the Trust may have to address the need for a Medical Records Library in the new Trust or invest fully in document management systems to scan in the paper record. At this time this represents a risk due to the timeframe to finalise the new hospital build and the OBC.

5. Option Appraisal to determine Strategic Way Forward

There are several options which will need to be explored over the next 2-3 months in order that a final decision can be made on the way forward with indicative costs for each option. This will also need to be supported by a clinical stakeholder group to input to final decision.

- Move to Lorenzo releases 1 and 2, request early adopter for Release 3 and procure remaining functionality if required when content of these releases if confirmed.

- Continue with iCM and local solutions and progress to Lorenzo directly with iSoft rather than through NPfIT.

- Explore with SHA whether we can choose to take other NPfIT solutions than Lorenzo (although this may be unlikely);

- Procure an alternative electronic patient record.

6. Quality and Efficiency Programme (QuEP)

To support the Trust's Quality and Efficiency Programme an IM&T workstream is being formed to support the other QuEP workstream outcomes, as well as explore other benefits IT may bring through new technologies. Some of the projects below will require investment to deliver returns and business cases will need to be assessed. In addition, some of the benefits may be "breaking new ground" in their identification due to the lack of published research. The projects include, but are not exclusive to:

- Digital dictation
- NHS Mail
- Electronic Bed Management system including nursing and medical handover reports
- ePrescribing – linked to Lorenzo Regional Care timeframes
- Ophthalmology system to support BMEC
- Improved specification for PCs, extending mobile devices, single sign-on and patient in context software – designed to give the technical illusion of an integrated system and avoid multiple sign-ons.
- Automatic dialling re: clinical reminders to reduce DNA rate
- Planning for paperLite/paperless hospital
- Digital pens – aim for system in which no-one has to transcribe data simply for input purpose
- Single A&E system across the Trust – options under discussion.

- Rotawatch scheduling tools

7. Other IT projects in progress or completed

In 2009-10 there have been several notable achievements with delivery of clinical systems to support the Trust:

- Upgrade of the iPM PAS system to be 18 week compliant

- Implementation of the eVolution Maternity system in the acute Trust and piloting in the Community settings. The Community setting has proved very challenging with issues primarily concerned with the hand-held record and how to produce that electronically.

- Support to the Hospital at Night project with an electronic handover reporting system

- Trust-wide implementation of electronic requesting of tests and investigations

- Revision of the TTO/Discharge letter and roll-out now commenced to Sandwell GPs, as City GPs already receive the electronic discharge summary.

- Electronic referral to support smoking cessation

- Alerts by SMS and texting to alert MRSA, C-Diff, EBSL, TB etc.

- Historical load of all clinical letters at Sandwell to support paperless in the outpatient setting potentially within 18 months.

- Expansion of the locally developed Clinical Data Archive (CDA) to support the creation of a passive Electronic Patient Record which can be viewed. The CDA now includes all Pathology, Radiology, some Cardiology Results, Endoscopy reports, ECG reports, alerts, clinical letters, TTO/Discharge summaries.

8. Information Governance

An Information Governance (IG) update will be presented to the next Trust Board meeting. Our key target for this year is that by March 31st, 2010, we must meet compliance by achieving the appropriate level on the Information Governance toolkit which is an assurance tool.

Compliance has been obtained for the **IG Statement of Compliance** by achieving level 2 and above across the core 25 standards.

9. Conclusion and Recommendations

The Board is recommended to:

- Note the annual IM&T strategic update and progress made and the new plans regarding supporting QuEP.

- Note the risks raised in association with the delivery of Lorenzo Regional Care from CSC and the NPfIT Programme

- Note the actions are being taken to manage these risks and find solutions to mitigate them.

- Note that the Trust has met the IG Statement of Compliance by achieving level 2 and above across the core 25 standards,

Sue Wilson,

Deputy Director of Elective access & EPR

18th February 2010

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Research and Development Strategy 2009-2011
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Professor Carl Clarke, Director of Research and Development
DATE OF MEETING:	25 February 2010

SUMMARY OF KEY POINTS:

The Trust's Research and Development strategy is presented for information.

The strategy identifies the key objectives to be achieved in 2009 - 2011 to fulfil the vision for research and development within the Trust.

This strategy document will outline the organisational structures and processes required to support this vision and the changes required to achieve the strategic objectives.

The strategy will be reviewed in 2011 to adapt further to the rapidly changing research environment in the NHS.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

To review the strategy.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	None specifically
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Considered by the Trust Management Board at its meeting on 16 February 2010.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Research and Development Strategy (2009-2011)

CONTENTS

Contents

1. INTRODUCTION

1.1 Effective research and development is essential in the NHS to improve both the "health and wealth of the nation".[1] In a series of landmark reports in the mid-2000s, the Department of Health outlined its mission to: "to create a health research system in which the NHS supports outstanding individuals, working in world-class facilities, conducting leading-edge research, focused on the needs of patients and the public."[1,2]

1.2 These Government objectives have lead to radical changes in the organisation and funding of research and development within the NHS. The creation of the National Institute for Health Research (NIHR) has resulted in the replacement of the traditional capitation method of funding through the Culyer stream with a more transparent system lead by the Comprehensive Local Research Networks (CLRN) and Topic Specific Research Networks (TSRN).

1.3 These dramatic changes have been compounded by changes in research governance procedures with the introduction of the European Clinical Trials Directive.[3] The Directive aims to improve the conduct and monitoring of non-commercial NHS research to the standard of commercial clinical trials. This has increased the burden on both clinical researchers and the governance systems of individual trust research and development (R & D) departments.

1.4 This rapidly changing research environment presents NHS trusts with a series of challenges. As the transitional funding from the old Culyer system is withdrawn to be replaced by CLRN and TSRN funding, trusts face a significant financial threat. The new funding is allocated directly for staff and other service support costs on the basis of the number of patients recruited into clinical trials and few trusts have financial systems which can cope with such transparent funding. Trust R & D departments will require additional support to perform their statutory governance role in monitoring clinical trial procedures.

1.5 With this backdrop of a rapidly changing research framework in the NHS, it is of crucial importance that SWBH Trust reviews and adapts its R & D strategy to this changing environment.

2. THE VISION

2.1 The vision is to improve the health of the population supported by Sandwell and West Birmingham Hospitals NHS Trust.

2.2 We will achieve this by affirming the Trust as an international centre of research excellence.

2.3 We will increase the quantity and quality of research and innovation at the Trust in co-operation with our partner organisations including local Universities and industries.

2.4 We will continue to attract, develop and retain the best research professionals to conduct clinically-based research within the NHS. This will include the encouragement of NHS consultants who wish to perform clinical trials as part of the NIHR Clinical Research Network Portfolio.

2.5 We will re-organise the financial framework for research in the Trust to allow the transparent flow of funds to those who are performing and supporting research.

2.6 We will strengthen and streamline systems within the Research and Development Department at the Trust which will support the more rigorous governance requirements.

2.7 We will encourage the recruitment of more patients to NIHR Portfolio trials, including commercial studies, by a variety of methods including the development of a Trust-wide network of research nurses and other administrative staff.

2.8 We will introduce mandatory training programmes for all staff involved in research to ensure that all research undertaken in the Trust is conducted to the highest standard.

2.9 These innovations will lead to the Trust R & D department evolving into a 'Research Support Service' as required by the NIHR Implementation Plan 4.1g.[4]

3. PURPOSE AND SCOPE

3.1 The strategy identifies the key objectives to be achieved in 2009 - 2011 to fulfil the vision for research and development within the Trust.

3.2 This strategy document will outline the organisational structures and processes required to support this vision and the changes required to achieve the strategic objectives.

3.3 The strategy will be reviewed in 2011 to adapt further to the rapidly changing research environment in the NHS.

4. BACKGROUND AND CONTEXT

4.1 New National Health Research Strategy

4.1.1 The government launched its new national health research strategy in 2006 under the heading "Best Research for Best Health".[1] The vision of this strategy is to "improve the health and wealth of the nation through research". Improving the nations "wealth" refers to the support in the NHS for commercial research, thereby supporting the UK's pharmaceutical and biotechnology industries.

4.1.2 This strategy has lead to the development of the virtual National Institute for Health Research (see figure). The NIHR supports high quality trainees, investigators and senior investigators in its virtual 'faculty' and will be funding a number of research centres and units. The NIHR supports existing research funding streams including the Health Technology Assessment (HTA) Programme and the clinical trials of the Medical Research Council (MRC). It has also introduced new streams such as Programme Grants for Applied Research and the Research for Patient Benefit (RfPB) programme.

4.1.3 The NIHR has followed the successful lead of the National Cancer Research Network in developing a series of Topic Specific Research Networks such as the Dementias and Neurodegenerative Diseases Research Network (DeNDRoN) to provide practical and financial support for research in particular areas. Research fields not covered by the topic specific networks receive support via Comprehensive Local Research Networks (CLRN).

4.1.4 Another declared aim of the new NHS research strategy is the rationalisation of regulatory and governance procedures involved with clinical research in the NHS, or so-called "bureaucracy busting".[4] This will involve unifying and streamlining administrative procedures, whilst promoting research governance processes that are proportionate to risk. This will feed into the ongoing changes to the research ethics system co-ordinated through the National Research Ethics Service (NRES) . The net effect will be transformation of R & D departments into 'Research Support Services'.

4.1.5 It will be clear from the outline of the new national research strategy above that this is an ambitious and far ranging plan which will lead to large scale changes in clinical research at national and local levels. This will lead to challenges for all primary and secondary care trusts.

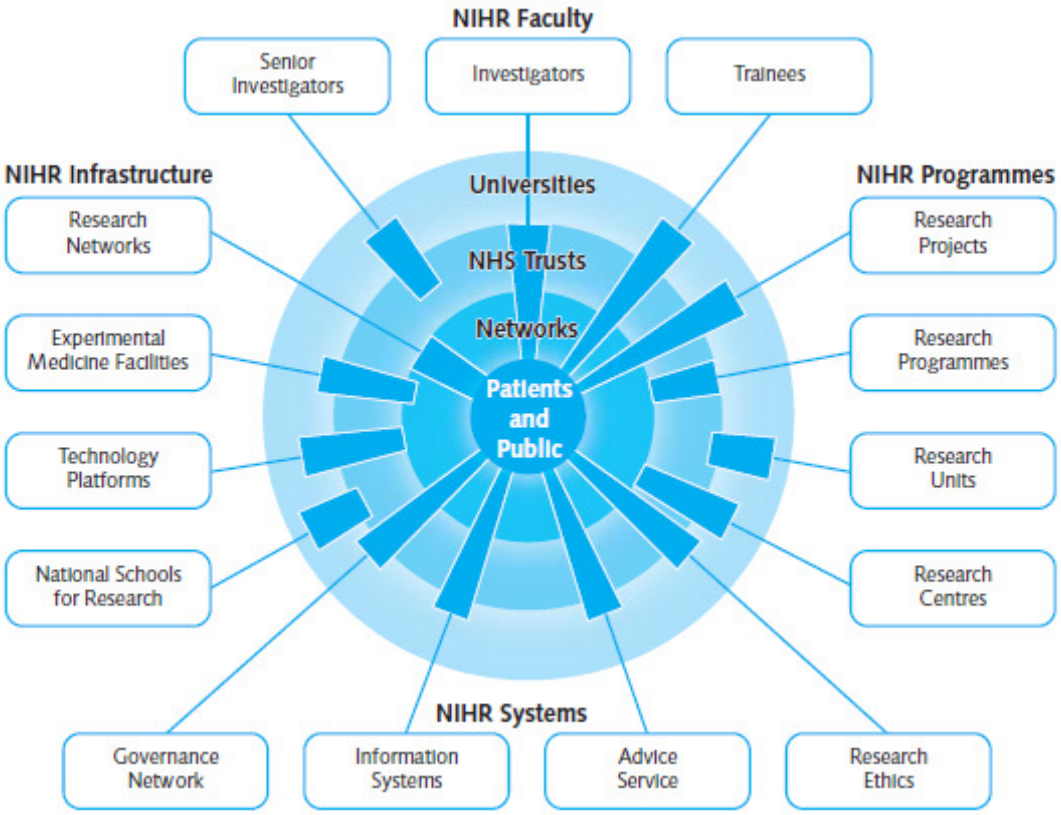


Figure Structure of National Institute for Health Research[1]

4.2 Existing Research Structures at SWBH Trust

4.2.1 SWBH Trust has a long history of clinical research and medical education. The strength of the Trust's research continues to be based around the availability of large well characterised clinical cohorts in the fields of Cancer, Cardiology, Rheumatology, Ophthalmology, and Neurology. This is supported by the broad ethnic mix of the Birmingham and Sandwell populations.

4.2.2 The Trust contributes large numbers of patients to NIHR Portfolio clinical trials every year. It supports commercially funded clinical trials in many fields including Cancer, Cardiology and Neurology and provides the opportunity for both undergraduate and postgraduate students to undertake educational research.

4.2.3 This Trust research is supported by the Research and Development Department which is based on the City Hospital site. Traditionally, the Department consisted of:

- Director (0.2 WTE), clinically qualified, to oversee the research done in the Trust
- R&D Manager (0.7 WTE) to supervise the R & D Department and its workload
- Auditing & Monitoring Officer (1.0 WTE) to monitor and audit research governance at the Trust
- Administrator (1.0 WTE) to process the applications for Site Specific and R & D approvals
- Secretarial support (0.6 WTE)

4.2.4 Through much of 2007 to summer 2009, most of these posts were vacant as suitable appointees could not be found. This corresponded to a time of considerable change, as the impact of the new national research strategy took effect. In spite of considerable

effort by those remaining in the R & D office, the Trust was not able to respond to the new national strategy without external assistance. As a result, Research Management and Governance (RM&G) duties, introduced in 2008, were contracted to Heart of England Foundation Trust (HEFT).

4.2.5 The Trust adopted an R & D Policy in June 2007 which is due for review in October 2009 by the Governance Board.

4.2.6 Research and development are monitored by quarterly meetings of the R & D Committee. The Constitution of the Committee was last reviewed in August 2006.

4.3 Key drivers influencing change in the Trust R & D strategy

4.3.1 The central driver for change in the Trust's R & D strategy is the government's new national health research strategy.[1] The Trust needs to embrace the central ethos of this strategy of improving the health and wealth of the nation by improving the Trust's research base.

4.3.2 The recent staff shortages in the R & D Department have demonstrated very clearly that the Department cannot function without the required workforce being in post and remaining stable to develop expertise and institute change.

4.3.3 Historically, research finances at the Trust have been distributed as part of the baseline income and have not been directly related to research activity. With the new funding streams from the NIHR via the CLRNs, such financial arrangements are no longer tenable. The Trust must develop transparent systems with income going directly to departments to cover the costs of medical and nursing time and other research costs. Without these fundamental changes, the Trust risks losing funding in the region of £1 million per annum.

4.3.4 The key break on research nationwide is the availability of staff time. This includes medical staff, through the lack of availability of local Principal Investigator (PI) time, and a shortage of research nurses and other research support staff. Funding for both PI and other research staff time is now being made available by the CLRNs, but the Trust's existing financial arrangements are not allowing this funding to stimulate new research as it should. The new national funding streams should be encouraging the Trust's PIs to apply for more support to do more research, but the lack of any guarantee that the funds will reach them is deterring many from applying.

4.3.5 With the reality of the new hospital build in 2015 incorporating a purpose built clinical research and education facility, SWBH Trust is at a key turning point for the promotion of research. The new research facility will provide the opportunity to bring many of its existing research teams together in one structure which will generate more research collaborations. The Trust should also be planning to expand its research base by the appointment of new clinical academics in collaboration with the University of Birmingham ahead of the new build.

4.3.6 Novel NIHR funding streams are generating new external collaborations for the Trust which must be supported:

- Relationships with the Birmingham & Black Country (BBC) CLRN and the TSRN's have already been discussed.
- The Trust is part of a successful bid to develop a NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC).[5] Only nine CLAHRCs have been established. These will undertake high-quality applied health research focused on the needs of patients and will support the translation of research evidence into practice in the NHS. CLAHRCs are collaborative partnerships between a university and the surrounding NHS organisations, focused on improving patient outcomes through the conduct and application of applied health research. They will create and embed approaches to research and its dissemination that are specifically designed to take

account of the way that health care is increasingly delivered across sectors and a wide geographical area. The new Collaborations will focus on the "second gap in translation" identified in the Cooksey Report.[2]

- SWBH is one of a number of local secondary care trusts who are applying to become part of a Health Innovation and Education Cluster (HIEC).[6] These are partnerships between NHS organisations (primary, secondary and tertiary care), the higher education sector (universities and colleges), industry (healthcare and non-healthcare industries) and other public and private sector organisations. Their purpose is to enable high quality patient care and services by quickly bringing the benefits of research and innovation directly to patients, and by strengthening the co-ordination of education and training so that it has the breadth and depth to support excellence.

4.3.7 CLRNs have been instructed by the NIHR to monitor trust's governance procedures and practises. The BBC CLRN will be keen to see that SWBH Trust re-establishes RM&G services at the Trust and ensures that all clinical research is consistently being performed to the highest standards.

5. TRUST RESPONSE TO KEY DRIVERS

The Trust has already begun to address these key drivers for change with the appointment of a new R & D Director and an R & D Manager. The Trust Board's approval is now sought for a new R & D strategy to take these changes further over the next 3 years.

6. LOCAL IMPLEMENTATION FRAMEWORK

6.1 R & D Department Staffing

6.1.1 The Trust will appoint a full time RM&G Manager. Following suitable training, the Trust will commence full RM&G duties again, thereby replacing the HEFT service it currently receives.

6.1.2 The Trust will continue to support the secretarial service which has recently been re-introduced into the Department.

6.1.3 The Trust will expand its support to the R & D Department from the Finance Department as required to institute new working arrangements.

6.1.4 The trust will support the R&D Department to develop a pool of Research Nurses, Allied Health Professionals and other research support staff within the Corporate Team set-up to provide researchers with high quality assistance to deliver projects.

6.1.5 There will be an on-going commitment to provide all members of the R & D staff with appropriate training to ensure that they are working to highest standard and delivering the most up to date advice to researchers in the Trust.

6.1.6 These changes will allow the R & D Department to be transformed into a more proactive 'Research Support Service'.

6.2 R & D Financial Systems

6.2.1 The Trust will develop transparent arrangements for the financing of R & D across the organisation. This will involve research income from external sources, including the CLRN and commercial organisations, flowing to the new clinical directorates. Similarly, each directorate will be responsible for the research costs it incurs, including those involving pharmacy, pathology and imaging. The new system will be in place for the beginning of the financial year 2010-2011.

6.3 Investigator support

6.3.1 The R&D Department will develop and instigate a support system to assist CI's and PI's with regulatory applications for new and existing clinical trial applications.

6.3.2 In future job planning rounds, the Trust will encourage PIs to identify time spent in research and whether funding for this has been arranged through the CLRN/TCRN.

6.3.3 The Trust will encourage existing and potential new PIs to apply to the CLRN and TCRN's in their two annual rounds for funding for research sessions. Such applications will be administered and supported by the R & D Department (Research Support Service).

6.3.4 The Trust will support PIs who apply for academic clinical fellows and academic foundation scheme junior posts to work in their departments.

6.3.5 The Trust will encourage its PIs to apply for large clinical studies grants from NIHR, MRC, Wellcome Foundation, etc and charities. The Trust will provide support for PI time to make such applications from the CLRN provided Flexibility and Sustainability Funding stream.

6.4 Trust wide network of research nurses and other research support staff

6.4.1 The Trust will develop a network of well trained research support staff which will include tenured research nurses, allied health professionals research scientists and administrative staff.

6.4.2 The new network of research support staff will be expanded by new tenured research nurse appointments. In 2009-2010, the funding for these appointments will be pump primed with funds secured from the Trust's charitable sources, but in subsequent years expansion in NIHR Portfolio trial recruitment will generate the additional income required.

6.5 Research management and governance

6.5.1 Following the appointment of an RM&G Manager and the return of RM&G responsibilities to the Trust, audit of SWBH projects by the R & D Department will re-commence.

6.5.2 The RM&G Manager and R&D Administrator will be trained in the use of the Co-ordinated System for Gaining NHS Permissions (CSP) and the responsibility for processing new Portfolio study approvals via this system will be transferred from HEFT to SWBHT.

6.5.3 The R&D Department will continue to collaborate with the Human Resources Department to develop a policy for the implementation of the Research Passport scheme to streamline the system to allow researchers from outside organisations to access researcher resources within SWBHT by the end of 2009.

6.5.4 The requirement that all researchers are trained in the principles of Good Clinical Practice (GCP) will be promoted by the R&D Department. This will be achieved by

ensuring that all research active staff have appropriate GCP training during 2010 and undertake regular updates thereafter.

6.5.5 Consideration will be given to quarterly courses on GCP to be held on Trust premises.

6.6 New build clinical research and education facility

6.6.1 The Trust will continue to support an integrated clinical research and education facility on the new hospital site.

6.6.2 The Trust will continue to work with the University of Birmingham and other local higher education institutions to develop new clinical academic posts based in the existing and the new hospitals.

6.7 External contacts

6.7.1 The Trust will support the new Birmingham CLAHRC and the potential HIEC and will develop further links with external bodies as required to further its research portfolio.

6.8 Promotion of research

6.8.1 Once the new R&D Department staffing arrangements have been instituted, promotion of research will re-commence through regular newsletters to staff and the R&D website.

6.8.2 The Trust will hold a half-day celebration of its research history and current work in early 2010. This will include talks by senior clinical researchers at the Trust, along with the annual junior research prize competition (Evans and Gaisford Award).

6.8.3 Throughout 2010, the Trust will have a policy of actively promoting its research strategy to staff and encouraging them to develop research interests.

6.9 Trust annual grant round

6.9.1 The Trust will re-institute its annual grant round in 2010 with funding from charitable sources.

6.9.2 The number and size of the grants will be reviewed and the methods by which this competitive process will be managed will also be reviewed.

7. STRATEGIC OBJECTIVES FOR RESEARCH AND DEVELOPMENT FOR 2009 – 2011

7.1 Development and adoption by SWBH Trust of a research and development strategy. Progress will be monitored monthly by the two responsible executive directors and by quarterly presentations to the Trust Board.

7.2 Staffing in the R&D Department will be restored and expanded to support clinical research.

7.3 Transparent financial systems for research will be introduced to the Trust. This will require additional support by the Finance Department.

7.4 Junior and senior clinicians will be supported in terms of time for research and preparing grant applications, along with providing logistical support for research.

7.5 A network of well trained research support staff will be developed which will include tenured research nurses, research scientists and administrative staff.

7.6 Plans will be developed for an integrated clinical research and education facility on the new hospital site.

7.7 Support will be given to the new Birmingham CLAHRC and the potential HIEC. The Trust will develop further links with external bodies as necessary.

7.8 There will be sustained promotion of research and development in the Trust throughout 2010.

7.9 The culture of Good Clinical Practice in clinical research will be highlighted in 2010 and a rolling programme of GCP educational events will be instituted.

8. KEY DOCUMENTS

Research and Development Policy June 2007

Research and Development Committee Constitution August 2006

9. REFERENCES

1. **Department of Health** (2006) Best research for best health.
2. **Department of Health** (2006) A review of UK health research funding.
3. **Council of the European Union** (2001) Directive 2001/20/EC of the European Parliament and of the Council.
4. **Department of Health** (2009) Best research for best health. Implementation Plan 4.1g. Bureaucracy busting: NIHR research support services.
5. **Department of Health** (2009) Best research for best health. Implementation Plan 5.8. NIHR collaborations for leadership in applied health research and care (CLAHRCs).
6. **Department of Health** (2009) Breakthrough to real change in local healthcare. A guide for applications to create Health Innovation and Education Clusters (HIECs).

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance – Month 10
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Robert White/Tony Wharram
DATE OF MEETING:	25 February 2010

SUMMARY OF KEY POINTS:

The report is provided to update the Board on financial performance for the ten months to 31st January 2010.

In-month surplus is £258k against a target surplus of £231k; £27k above plan.

Year to date surplus is £2,119k against a plan of £2,163k, £44k below plan.

In-month WTEs are 112 below plan, excluding the effect of agency staff.

Cash balance is approximately £1.8m greater than the revised plan at 31st January.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

- To receive and note the monthly finance report.
- To endorse any actions taken to ensure that the Trust remains on target to achieve its planned financial position.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Deliver the financial plan including achieving a financial surplus of £2.269m and a CIP of £15m.
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	Reporting and management of financial position.

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

Financial		Potential to fail to meet statutory financial targets.
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		Potential to fail to meet statutory financial targets.

PREVIOUS CONSIDERATION:

Financial Management Board and Trust Management Board on 16 February 2010 and the Finance and Performance Committee on 18 February 2010.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – January 2010

EXECUTIVE SUMMARY

• In the period 1st April 2009 to 31st January 2010, the Trust delivered an overall I&E surplus of £2,119,000 which is £44,000 below the planned position. During the month of January, a net surplus of £258,000 was generated exceeding the planned surplus by £27,000. This continues the steady progress made since July 2009 where each monthly budget position has gradually reduced the deficit built up in the first quarter.

• Fully coded and priced activity information is available for December and patient related SLA income included within this report is based on this position.

• At month end, WTE's (whole time equivalents) excluding the impact of agency staff were almost 112 below plan. Total pay expenditure, including agency costs for the month was £336,000 above plan. Although the pay position remains above plan owing to the costs of undertaking additional activity, it is an improvement on the picture reported for the last few months. The pay position includes agency expenditure of £616,000 during January which is an increase on the December position and is reflective of winter pressures.

• The month-end cash balance is approximately £1.8m above the revised cash profile.

• Performance continues to reflect higher than planned levels of activity and income with similar higher levels of expenditure particularly on more variable costs such as bank and agency pay and medical consumables.

Financial Performance Indicators

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	27	-44	> Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	34	16	> Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	-336	-2,920	< Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	-452	-2,901	< Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	112	70	< Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	1,817	1,817	> = Plan	> = 95% of plan	< 95% of plan
CIP Actual v Plan £000	-8	-68	> 97½% of Plan	> = 92½% of plan	< 92½% 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	2,163	2,119
Capital Resource Limit	9,754	7,776
External Financing Limit	---	15,331
Return on Assets Employed	3.50%	3.50%

2009/2010 Summary Income & Expenditure Performance at January 2010	Annual Plan £000's	CP Plan £000's	CP Actual £000's	CP Variance £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's	Forecast Outturn £000's
Income from Activities	332,103	27,928	28,910	982	276,999	282,814	5,815	339,358
Other Income	38,579	3,431	3,271	(160)	31,797	31,819	22	38,201
Operating Expenses	(341,565)	(28,892)	(29,680)	(788)	(284,330)	(290,151)	(5,821)	(349,085)
EBITDA	29,117	2,467	2,501	34	24,466	24,482	16	28,474
Interest Receivable	150	13	6	(7)	125	65	(60)	75
Depreciation & Amortisation	(16,444)	(1,370)	(1,370)	0	(13,636)	(13,636)	0	(16,444)
PDC Dividend	(8,374)	(698)	(698)	0	(6,977)	(6,977)	0	(7,656)
Interest Payable	(2,180)	(181)	(181)	0	(1,815)	(1,815)	0	(2,180)
Net Surplus/(Deficit)	**2,269**	**231**	**258**	**27**	**2,163**	**2,119**	**(44)**	**2,269**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

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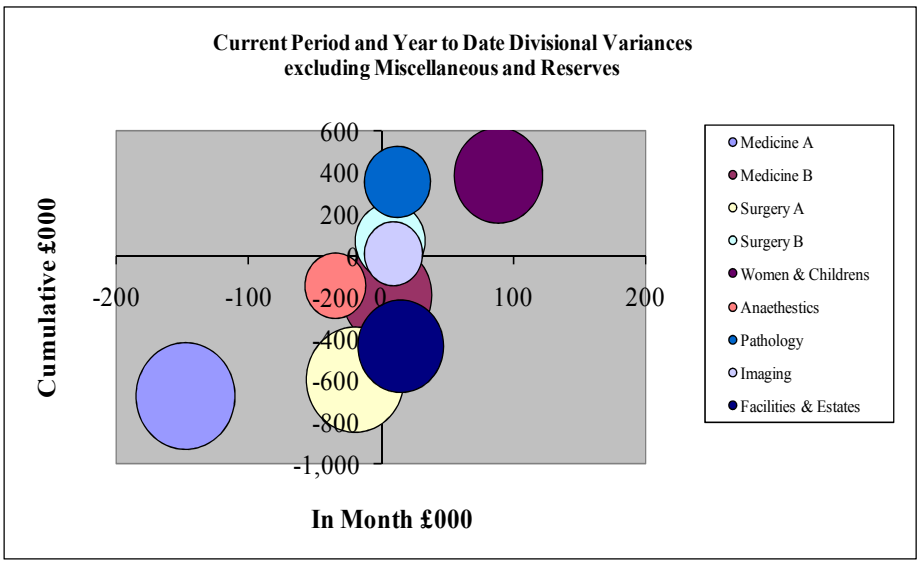
Divisional Performance

• Since the first quarter, the Trust has experienced a slow improvement in financial performance with the cumulative I&E shortfall being steadily reduced to its current level of £44k. This has primarily been driven by higher than planned activity levels generating higher patient related income and increased costs in delivering this activity including the opening of additional capacity and meeting national and local targets.

• Pay costs remain significantly above plan now reaching £2,920k for the year to date with a further movement away from plan of £336k during the month. This position does however represent an improvement against performance in November and December. WTE numbers, excluding the impact of agency staff, are approximately 112 below plan although when agency staff numbers are taken into account, this rises to 21 above plan. This is again an improvement on the position reported in November and December. The non pay position also continues to be significantly higher than plan. Generally, this has occurred in areas most closely related to patient activity levels although in January there has also been some increased expenditure on printing & stationery, minor works and clinical waste.

• In month, Medicine A, Anaesthetics and Surgery A have generated deficits, although in the case of the latter two divisions these deficits are relatively small. Generally, the ongoing strong income position is reflected in improved performance across many divisions, even those which remain in deficit. However, many operational divisions continue to experience significant pressures on both pay and non pay, particularly on bank and agency costs and patient related consumables although in some cases these are balanced by over achievement of income.

• The performance for the Trust overall continues to be assisted by favourable budget positions within corporate divisions with a year to date performance of £619,000 better than plan.



The tables adjacent and overleaf show a mixed position across divisions. The performance of Medicine A, Anaesthetics & critical Care and Surgery A worsened in month while Medicine B, Women & Childrens Services and Diagnostic Services improved. Medicine A, Medicine B, Surgery A, Anaesthetics & Critical Care and Facilities all continue to report sizeable year to date net deficit positions.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

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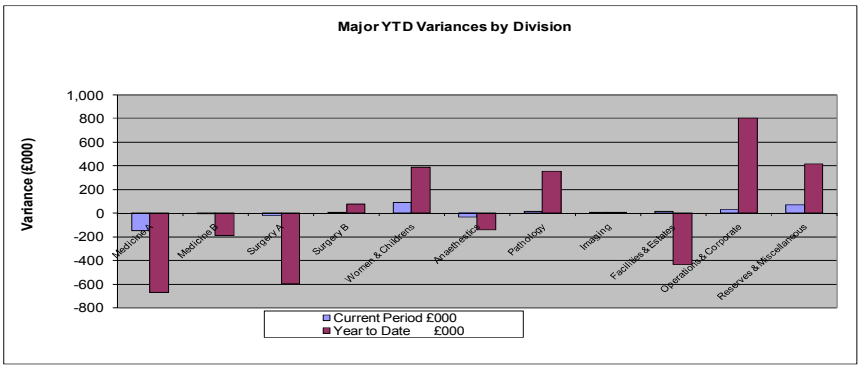
Divisional Variances from Plan

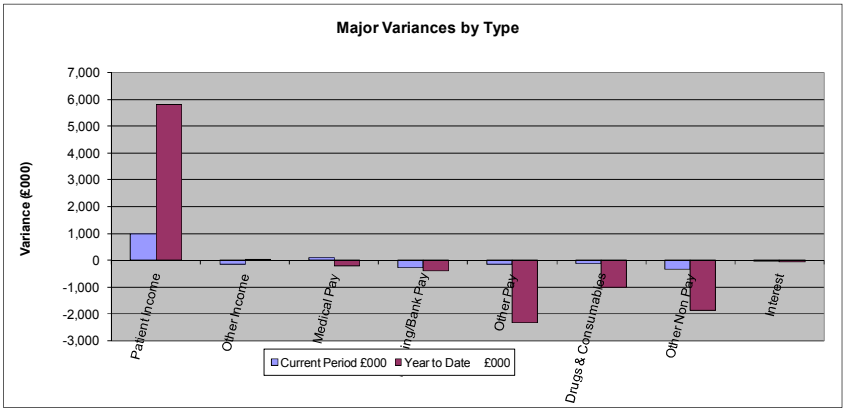
	Current Period £000	Year to Date £000
Medicine A	-148	-671
Medicine B	4	-189
Surgery A	-19	-596
Surgery B	7	75
Women & Childrens	89	388
Anaethestics	-35	-141
Pathology	12	356
Imaging	9	11
Facilities & Estates	15	-433
Operations & Corporate	29	801
Reserves & Miscellaneous	70	414



The tables below illustrate that overall, income continues to perform better than plan for the month and year to date, primarily driven by higher levels of patient related SLA (service level agreement) activity. Overall pay expenditure remains significantly above plan and expenditure on bank and agency remains high although performance against plan has improved when compared with November and December particularly in relation to substantive pay groups. In month, non pay expenditure remains in excess of plan, a combination of continuing spend on patient related consumables and increased expenditure on printing, waste management and minor building works.

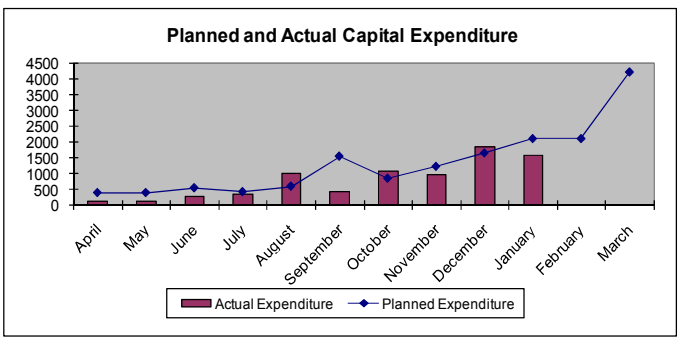
Variance From Plan by Expenditure Type

	Current Period £000	Year to Date £000
Patient Income	982	5,815
Other Income	-160	22
Medical Pay	87	-221
Nursing/Bank Pay	-275	-380
Other Pay	-148	-2,319
Drugs & Consumables	-124	-1,021
Other Non Pay	-328	-1,880
Interest	-7	-60



Capital Expenditure

• Planned and actual capital expenditure by month is summarised in the adjacent graph. Expenditure of £1,593,000 was incurred in January mainly relating to medical equipment, telecoms and statutory standards. This brings total capital expenditure for the year to date up to £7,776,000.



Sandwell and West Birmingham Hospitals NHS
NHS Trust

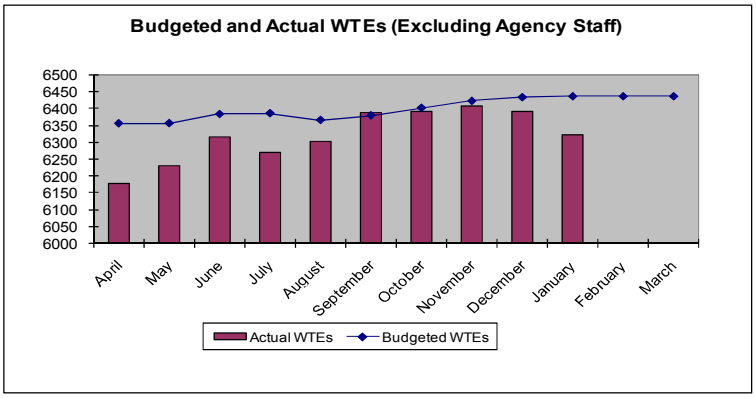
Financial Performance Report – January 2010

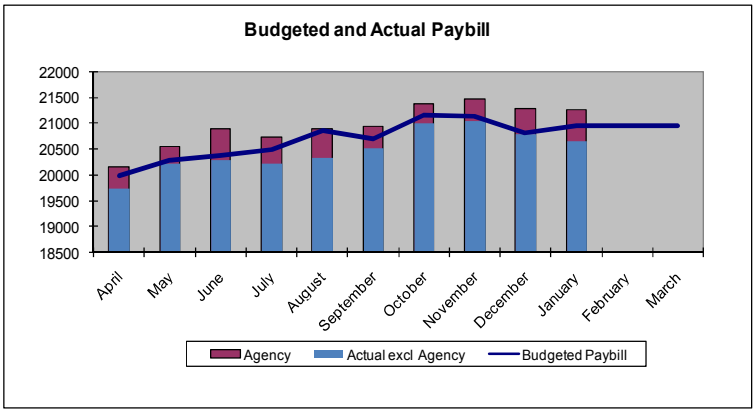
Paybill & Workforce

• Workforce numbers, excluding agency staff are approximately 112 wtes below plan for January. After adding agency numbers, this becomes an adverse position of 21 wtes. There has been a fall of approximately 78 wtes in substantive pay groups (i.e. excluding bank and agency which can vary significantly from one month to another). With the exception of medical staff, this fall is spread over all pay groups.

•Paybill (including agency staff) is £336,000 above budgeted levels for the month and £2,920,000 for the year to date. Although this still remains an issue in terms of managing expenditure, it does represent a significant improvement over performance in November and December and reflects the fall in wte numbers.

•In month expenditure on agency staff was £616,000, an increase of over £100,000 against expenditure in December.





Pay Variance by Pay Group

• The table below provides an analysis of all pay costs by major staff category by removing both bank and agency costs and allocating these into the appropriate main pay group.

• The table demonstrates that the major areas of pay overspend continue to lie within medical staffing and healthcare assistants and support staff, the latter group being broken down primarily into two sub groups: healthcare assistants in clinical divisions and support staff (primarily domestics) within Facilities.

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Analysis of Total Pay Costs by Staff Group

	Year to Date to January					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	61,135	61,181		1,779	62,960	-1,825
Management	11,386	10,668		0	10,668	718
Administration & Estates	23,378	22,721		979	23,700	-322
Healthcare Assistants & Support Staff	10,225	10,070	1,635	1,022	12,727	-2,502
Nursing and Midwifery	72,496	67,595	3,575	914	72,084	412
Scientific, Therapeutic & Technical	28,013	27,295		147	27,442	571
Other Pay	43	15			15	28
Total Pay Costs	206,676	199,545	5,210	4,841	209,596	-2,920

Balance Sheet

• The opening Statement of Financial Position (balance sheet) for the year at 1st April reflects the IFRS based audited accounts for 2008/2009.

• Cash balances at 31st January are approximately £1.8m higher than the revised plan, an increase of approximately £0.5m against the position at 31st December The Trust has now received confirmation of its final External Financing limit for 31st March 2010 which is -£568k i.e. a net repayment of PDC. To achieve this target, the Trust's cash balance at the year end will need to be £8,852k. The year end cash forecast and the revised plan have been amended to reflect this figure. Although other updates have been made to the forecast movements, no further changes have been made to the revised plan as the overall effect of the changes is not material.

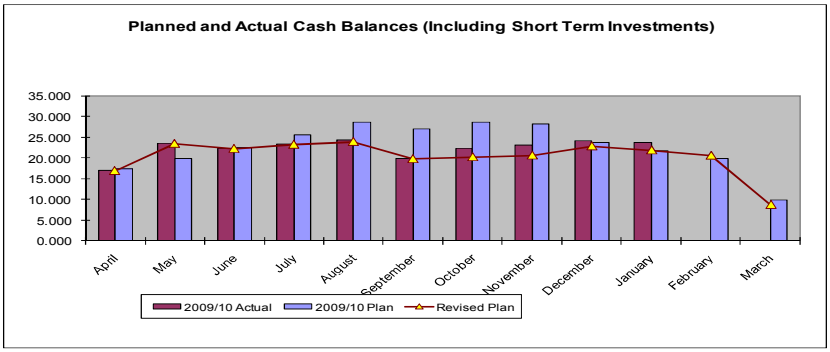
Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION

		Opening Balance as at March 2009 £000	Balance as at January 2010 £000	Forecast at March 2010 £000
Non Current Assets	Intangible Assets	547	460	522
	Tangible Assets	277,912	272,052	257,371
	Investments	0	0	0
	Receivables	1,158	1,140	1,200
Current Assets	Inventories	3,295	3,276	3,300
	Receivables and Accrued Income	19,138	23,547	19,500
	Investments	0	0	0
	Cash	8,752	23,719	8,852
Current Liabilities	Payables and Accrued Expenditure	(28,516)	(44,575)	(32,806)
	Loans	0	0	0
	Borrowings	(1,885)	(1,880)	(1,880)
	Provisions	(5,440)	(2,059)	(2,200)
Non Current Liabilities	Payables and Accrued Expenditure	0	0	0
	Loans	0	0	0
	Borrowings	(33,627)	(32,227)	(31,127)
	Provisions	(2,193)	(2,193)	(1,943)
		239,141	241,260	220,789
Financed By				
Taxpayers Equity	Public Dividend Capital	160,231	160,231	159,663
	Revaluation Reserve	60,699	60,699	40,966
	Donated Asset Reserve	2,531	2,531	2,391
	Government Grant Reserve	1,985	1,985	1,805
	Other Reserves	9,058	9,058	9,058
	Income and Expenditure Reserve	4,637	6,756	6,906
		239,141	241,260	220,789

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – January 2010



Cash Flow

• The table below shows cash receipts and payments for January 2010 and a forecast of expected flows for the following 12 months. This will be updated as part of the budget setting and financial planning process for 2010/11.

Sandwell & West Birmingham Hospitals NHS Trust
CASH FLOW

12 MONTH ROLLING FORECAST AT JANUARY 2010

ACTUAL/FORECAST	Jan-10 £000s	Feb-10 £000s	March-10 £000s	April-10 £000s	May-10 £000s	Jun-10 £000s	Jul-10 £000s	Aug-10 £000s	Sep-10 £000s	Oct-10 £000s	Nov-10 £000s	Dec-10 £000s	Jan-11 £000s
Receipts													
SLAs: Sandwell PCT	**13,013**	13,013	13,013	13,208	13,208	13,208	13,208	13,208	13,208	13,208	13,208	13,208	13,208
HoB PCT	**7,195**	7,195	7,195	7,303	7,303	7,303	7,303	7,303	7,303	7,303	7,303	7,303	7,303
South Birmingham PCT	**1,263**	1,263	1,263	1,282	1,282	1,282	1,282	1,282	1,282	1,282	1,282	1,282	1,282
BEN PCT	**1,733**	1,733	1,733	1,759	1,759	1,759	1,759	1,759	1,759	1,759	1,759	1,759	1,759
Pan Birmingham LSCG	**1,213**	1,213	1,213	1,231	1,231	1,231	1,231	1,231	1,231	1,231	1,231	1,231	1,231
Other PCTs	**2,617**	2,450	2,450	2,487	2,487	2,487	2,487	2,487	2,487	2,487	2,487	2,487	2,487
Over Performance Payments	**1,236**	0	0	1,000									
Education & Training	**1,330**	1,400	1,400	1,421	1,421	1,421	1,421	1,421	1,421	1,421	1,421	1,421	1,421
Loans	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Interest	**6**	7	6	11	8	8	8	8	8	8	8	8	8
Other Receipts	**3,734**	3,200	3,200	2,300	2,300	2,300	2,300	2,300	2,300	2,300	2,300	2,300	2,300
Total Receipts	33,340	31,474	31,473	32,002	30,999	30,999	30,999	30,999	30,999	30,999	30,999	30,999	30,999
Payments													
Payroll	**12,243**	12,450	12,450	12,603	12,603	12,603	12,603	12,603	12,603	12,603	12,603	12,603	12,603
Tax, NI and Pensions	**7,911**	8,550	11,050	8,655	8,655	8,655	8,655	8,655	8,655	8,655	8,655	8,655	8,655
Non Pay - NHS	**3,454**	2,465	3,096	2,440	2,440	2,440	2,440	2,440	2,440	2,440	2,440	2,440	2,440
Non Pay - Trade	**7,731**	6,785	9,463	5,880	5,940	5,940	6,250	6,200	6,200	6,200	6,200	6,200	6,200
Non Pay - Capital	**2,053**	2,158	4,932	500	500	500	501	501	501	501	501	501	501
PDC Dividend	**0**	0	3,027	0	0	0	0	0	3,300	0	0	0	0
Repayment of PDC	**0**	0	568										
Repayment of Loans	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Interest	**0**	0	0	0	0	0	0	0	0	0	0	0	0
BTC Unitary Charge	**362**	360	360	371	371	371	371	371	371	371	371	371	371
Other Payments	**50**	50	50	355	355	356	357	358	359	360	361	362	362
Total Payments	**33,804**	32,818	44,996	30,804	30,864	30,865	31,177	31,128	34,429	31,130	31,131	31,132	31,132
Cash Brought Forward	**24,183**	23,719	22,375	8,852	10,050	10,185	10,319	10,141	10,012	6,582	6,451	6,319	6,186
Net Receipts/(Payments)	**(464)**	(1,344)	(13,523)	1,198	135	134	(178)	(129)	(3,430)	(131)	(132)	(133)	(133)
Cash Carried Forward	**23,719**	22,375	8,852	10,050	10,185	10,319	10,141	10,012	6,582	6,451	6,319	6,186	6,054

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

Sandwell and West Birmingham Hospitals NHS
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SLA Performance

•The table below shows a summary of both activity and financial performance for major patient types across the Trust's SLA's. This demonstrates that the majority of the financial gain is the result of higher than planned levels of out-patient activity. Final SLA performance remains subject to data processing rules generated via the CBSA. The Trust has challenged the interpretation of activity performance levels by the CBSA and PCT and is working collaboratively in resolving these.

Year to Date Key Performance Against SLA

PERFORMANCE UP TO NOVEMBER	Activity			Finance		
	Planned	Actual	Variance	Planned £000	Actual £000	Variance £000
Accident & Emergency	239,241	172,631	(612)	12,679	13,172	492
Admitted Patient Care - Elective	46,638	49,060	2,422	42,264	44,407	2,125
Admitted Patient Care - Non Elective	43,939	47,270	3,331	69,677	68,919	(758)
Excess Bed Days	27,412	27,722	310	5,674	5,590	(84)
Other	122	633	113	57,554	59,024	1,470
Out-Patients First Attendance	118,853	120,180	1,327	19,997	20,034	37
Out-Patients Follow Up	282,163	304,176	22,013	24,469	26,834	2,366
Out-Patients With Procedure	5,706	18,230	12,524	1,187	3,895	2,709
Unbundled Activity	11,233	44,134	32,901	8,400	9,019	618
Total	**775,307**	**784,036**	**74,329**	**241,901**	**250,894**	**8,975**

Note: This analysis does not cover all services provided under SLAs

SLA Performance by Commissioner

• The table adjacent shows overall financial performance by commissioner for the Trust's major commissioners. This demonstrates that over performance is spread over a large number of commissioners including specialised service agencies.

Year to Date SLA Performance by Commissioner

PERFORMANCE UP TO NOVEMBER	Finance		
	Planned £000	Actual £000	Variance £000
SANDWELL PCT	116,810	118,555	1,738
HEART OF BIRMINGHAM TEACHING PCT	64,863	66,584	1,716
BIRMINGHAM EAST & NORTH PCT	15,597	15,778	179
SOUTH BIRMINGHAM PCT	11,392	12,921	1,528
PAN BIRMINGHAM LSCG	10,935	12,776	1,842
WALSALL PCT	4,843	4,941	98
WEST MIDLANDS SCT	3,941	3,988	47
DUDLEY PCT	3,395	3,908	510
WORCESTERSHIRE PCT	2,020	2,320	300
SOLIHULL CARE TRUST	1,763	1,978	215
OTHERS	6,343	7,146	803
TOTAL	**241,901**	**250,894**	**8,975**

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – January 2010

SLA Performance by Specialty

• The table adjacent shows overall financial performance by specialty or service area for those services making the largest contribution to the Trust's net over performance. This is a summary of all types of activity within any given specialty or service area and includes both admitted patient care and out-patients. It therefore needs to be considered only as a broad indication of performance within each area as there may be different issues affecting various patient types within a service.

Year to Date SLA Performance: Variances From Plan

PERFORMANCE UP TO NOVEMBER	Finance		
	Planned £000	Actual £000	Variance £000
Gastroenterology	3,423	6,004	2,576
Cardiology	7,703	9,958	2,255
Elderly	14,722	16,134	1,412
Respiratory Medicine	1,910	3,092	1,181
Clinical Haematology	3,028	4,181	1,154
Urology	5,247	6,386	1,139
Ophthalmology	17,364	18,332	968
ENT	3,862	4,603	739
Oncology	9,880	10,554	674
Neurology	1,506	2,161	655
Direct Access	3,842	4,467	624
Paediatrics	7,572	8,176	604
Maternity	18,617	19,179	562
Vascular Surgery	1,803	2,323	520
Dermatology	3,531	3,965	435
Oral Surgery	755	1,165	410
Plastic Surgery	2,503	2,874	370
Gynaecological Oncology	1,771	2,095	324
Rehabilitation	0	258	258
Diabetes	942	1,164	222
Nephrology	121	322	201
Clinical Immunology	301	475	174
Trauma & Orthopaedics	19,378	18,926	(452)
A&E	15,293	14,380	(913)
General Surgery	15,507	14,586	(928)
General Medicine	28,551	20,619	(7,933)
Others	52,770	54,512	1,742
TOTAL	**241,901**	**250,894**	**8,975**

Note: the performance of general medicine needs to be viewed alongside other medical specialties with planned general medicine activity actually delivered within medical sub specialties.

Risk Ratings

Measure	Description	Value	Score
EBITDA Margin	Excess of income over operational costs	8.4%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	100.1%	5
Return on Assets	Surplus before dividends over average assets employed	4.1%	3
I&E Surplus Margin	I&E Surplus as % of total income	0.7%	2
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	3.4	1
Overall Rating			**2.5**

Risk Ratings

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

•The only significantly weak area remains liquidity which will only be substantially corrected with the introduction of a working capital facility.

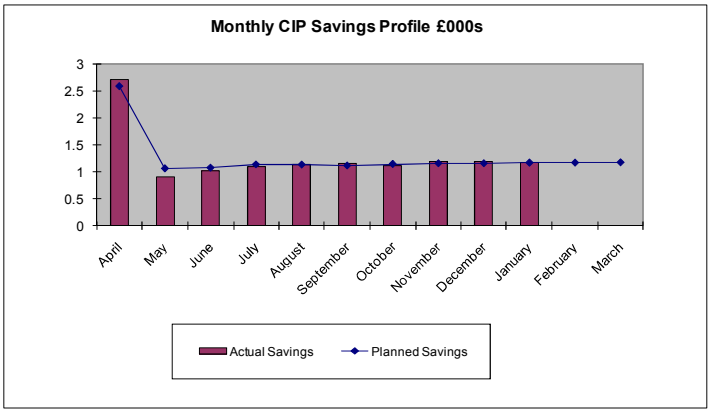
Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – January 2010

Cost improvement Programme

•The adjacent graph shows the monthly profile of the Trust's cost improvement programme and actuals achieved up to January.

•As at January, there is a shortfall against planned levels of £58k or 0.5% which represents an improvement against the position reported for December.



External Focus and Forward Look

• Performance against Service Level Agreements with PCTs showed another significant increase in December and early figures for January suggest that this trend is continuing. This is consistent with operational pressures being experienced for example, within A&E coupled with the need to open additional capacity. Pursuing additional capacity has been a challenge owing to infection control measures (e.g. responding to norovirus) which in turn creates operational pressures. The rise in activity above start of year plans gives rise to additional costs for commissioners and negotiations are ongoing with Sandwell PCT as the co-ordinating commissioner to agree a year end position and therefore generate some financial stability for both the Trust and the PCTs themselves.

• Both Sandwell and Heart of Birmingham PCTs continue to report significant over performance both for Sandwell and West Birmingham Hospitals and for other providers. Although this over performance is causing financial pressures for the PCTs, they are expecting to achieve overall financial plans at the year end.

• Work on the 2010/11 LDP is continuing in the context of the Right Care, Right Here programme. Considerable work is needed by all partners in an effort to bridge the transition period especially 2010/11 in terms of moving towards activity plans for the overall programme. This is vital to ensure financial stability for the Trust in the short to medium term and to ensure the Health Economy overall can reach long term financial planning targets. Developments in the financial planning process are dealt with as a separate item.

• Clearly, if the Trust is to meet its Income and Expenditure target at the end of the year, it is imperative that an acceptable agreement is reached with Sandwell PCT which protects the Trust's income levels while, at the same time, ensures that expenditure is managed within these constraints.

• Given the expectation of a very tight financial settlement, particularly from 2011/2012 onwards, it is essential that the Trust is in the best possible financial position to move forward over the next few years. Part of this process will need to be to ensure that underlying financial performance is sound, especially the control of pay expenditure as evidenced by the effective and efficient delivery of high quality healthcare.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – January 2010

Conclusions

• For the year to 31st January 2010, the Trust has generated an overall income and expenditure surplus of £2,119,000 which is £44,000 below plan. For the current month, the actual surplus of £258,000 was £27,000 better than plan.

• Capital expenditure in January continued at the higher levels witnessed over the last couple of months, primarily driven by the purchase of medical equipment, telecoms and statutory standards work. However, the programme remains below profile for the year and there is still some considerable way to go to deliver the current programme by the year end.

•At 31st January, cash balances are approximately £1.8m higher than the revised cash plan.

• Medicine A, Anaesthetics & Critical Care and Surgery A have all generated in month deficits and these, along with Medicine B and Facilities, continue to show year to date deficits. As in previous months, this continues to be balanced by better than planned performance in other divisions and, in particular, within corporate services.

• Expenditure against pay budgets continues to worsen in month with a further deterioration of £336k, although this is an improvement on performance in November and December. Excluding agency staff, actual numbers of whole time equivalents (wtes) in post has decreased by 70 in month, primarily accounted for by reductions in substantive staff numbers rather than bank staff. Taking into account an estimated effect on wtes of agency staff, wte numbers are 21 greater than planned.

• Existing controls on pay and wte numbers will continue to be rigorously applied, particularly as the Trust moves towards the new financial year and an expectation of a significantly tighter economic environment although pressures from high activity levels and the ongoing need to ensure national and local targets are met will continue to place substantial pressure on both pay and non pay expenditure over the remainder of the financial year.

Recommendations

The Trust Board is asked to:

i. NOTE the contents of the report; and

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

Robert White

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Monthly Performance Monitoring Report
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of planning & Performance Management
DATE OF MEETING:	25 February 2010

SUMMARY OF KEY POINTS:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April 2009 – January 2010.

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

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Financial Management Board, Trust Management Board and Finance and Performance Management Committee.

SANDWELL AND WEST BIRMINGHAM HOSPITALS PERFORMANCE MONITORING REPORT - JANUARY 2010

SWBTB (2/10) 044(a)

EXECUTIVE SUMMARY

<table>
<tr><th>Note</th><th>Comments</th></tr>
<tr><td>a</td><td>The percentage of Cancelled Operations increased to 1.0% overall during the month of January, with numerical increases seen in a number of specialties.</td></tr>
<tr><td>b</td><td>Delayed Transfers of Care reduced on both sites, and overall, to 2.6%. This compares with 3.9% for the previous month.</td></tr>
<tr><td>c</td><td>Stroke Care - the proportion of patients spending at least 90% of their hospital stay on a Stroke Unit improved during the months of December and January to 64.0% and 69.8% respectively. Actions to facilitate the transfer to Stroke patients to a bed on a Stroke Unit as soon as practicable, and the on-going validation of data have now been implemented.</td></tr>
<tr><td>d</td><td>Accident & Emergency 4-hour waits - performance improved on both sites improved during the month, increasing performance overall for the month to 97.8%, marginally short of the 98.0% operational threshold. Performance for the year to date is 98.41%.</td></tr>
<tr><td>e</td><td>The overall number of cases of C Diff reported across the Trust during the month of January increased to 17. Of these, 14 were attributable to the City site. There was one case of MRSA Bacteraemia reported during the month. The Trust continues to meet National and Local performance trajectories.</td></tr>
<tr><td>f</td><td>Overall Referral to Treatment Time targets for Admitted Care (=>90%) and Non-Admitted Care (=>95%) were both met during the month of January, although the percentage of Non-Admitted patients in Trauma & Orthopaedics whose treatment commenced within 18 weeks of referral is reported as 79.27%.</td></tr>
<tr><td rowspan="7">g</td><td>CQUIN:</td></tr>
<tr><td>Outpatient source of Referral - Performance remains well within the trajectory set for this target.</td></tr>
<tr><td>Caesarean Section Rate - The rate for the month increased to 25.8%. The rate for the year to date is 23.4%, within the trajectory for the period.</td></tr>
<tr><td>Brain Imaging - Throughout the most recent 5 months the proportion of patients admitted as an emergency following a stroke who received a brain scan within 24 hours of admission has remained in excess of 80%. With performance to date reported as 80.1%.</td></tr>
<tr><td>Hip Fracture - Performance during January fell slightly to 83.9%, with performance year to date 84.2%.</td></tr>
<tr><td>Smoking Cessation Referrals - The number of referrals made to PCT smoking cessation services of patients specifically prior to listing for Elective Surgery for the month of January improved significantly, with indications of continued improvement into February. Year to date referrals now total 639.</td></tr>
<tr><td>Inpatient Patient Satisfaction Survey - The second survey has been concluded with at least 50 responses received to the questionnaire per ward.</td></tr>
<tr><td>h</td><td>Detailed analysis of Financial Performance is contained within a separate paper to this meeting.</td></tr>
<tr><td>i</td><td>Activity (trust-wide) to date is compared with the contracted activity plan for 2009 / 2010 - Month and Year to Date.
<table>
<tr><th></th><th colspan="4">Month</th></tr>
<tr><th></th><th>Actual</th><th>Plan</th><th>Variance</th><th>%</th></tr>
<tr><td>IP Elective</td><td>1117</td><td>1138</td><td>-21</td><td>-1.8</td></tr>
<tr><td>Day case</td><td>4130</td><td>4318</td><td>-188</td><td>-4.4</td></tr>
<tr><td>IPE plus DC</td><td>5247</td><td>5456</td><td>-209</td><td>-3.8</td></tr>
<tr><td>IP Non-Elective</td><td>5248</td><td>5311</td><td>-63</td><td>-1.2</td></tr>
<tr><td>OP New</td><td>12372</td><td>13699</td><td>-1327</td><td>-9.7</td></tr>
<tr><td>OP Review</td><td>33730</td><td>34210</td><td>-480</td><td>-1.4</td></tr>
</table>
<table>
<tr><th colspan="4">Year to Date</th></tr>
<tr><th>Actual</th><th>Plan</th><th>Variance</th><th>%</th></tr>
<tr><td>11431</td><td>10874</td><td>557</td><td>5.1</td></tr>
<tr><td>43437</td><td>41272</td><td>2165</td><td>5.2</td></tr>
<tr><td>54868</td><td>52146</td><td>2722</td><td>5.2</td></tr>
<tr><td>55491</td><td>54869</td><td>622</td><td>1.1</td></tr>
<tr><td>135276</td><td>137152</td><td>-1876</td><td>-1.4</td></tr>
<tr><td>347412</td><td>324974</td><td>22438</td><td>6.9</td></tr>
</table>
Activity to date is compared with 2008 / 09 for the corresponding period
<table>
<tr><th></th><th>2008 / 09</th><th>2009 / 10</th><th>Variance</th><th>%</th></tr>
<tr><td>IP Elective</td><td>10938</td><td>11431</td><td>493</td><td>4.5</td></tr>
<tr><td>Day case</td><td>42332</td><td>43437</td><td>1105</td><td>2.6</td></tr>
<tr><td>IPE plus DC</td><td>53270</td><td>54868</td><td>1598</td><td>3.0</td></tr>
<tr><td>IP Non-Elective</td><td>55061</td><td>55491</td><td>430</td><td>0.8</td></tr>
<tr><td>OP New</td><td>129075</td><td>135276</td><td>6201</td><td>4.8</td></tr>
<tr><td>OP Review</td><td>310939</td><td>347412</td><td>36473</td><td>11.7</td></tr>
</table></td></tr>
<tr><td>j</td><td>Bank and Agency - The Nurse Bank Fill Rate improved to 84.1%. Overall Nurse Bank and Nurse Agency shifts worked and costs increased during the month. Overall Medical Agency and Medical Locum costs during January were similar to those incurred during December. The spend on Agency staff during the month was 2.90% of the total pay spend.</td></tr>
<tr><td>k</td><td>Overall Sickness Absence increased to 5.39% during the month of January, the highest level for any month during the year to date. An increase is seen in both short-term and long-term absence. Rates by Division for the month range from 0.0% - 8.0%.</td></tr>
<tr><td>l</td><td>Overall compliance with Mandatory Training modules is reported as 60.7% at the end of January. The number of PDRs reported as completed improved during January, increasing numbers year to date to 4016, representing an overall compliance of 90%.</td></tr>
</table>

SANDWELL AND WEST BIRMINGHAM HOSPITALS CORPORATE QUALITY AND PERFORMANCE MONITORING REPORT - JANUARY 2010

Exec Lead	NATIONAL AND LOCAL PRIORITY INDICATORS			September	October	November	December			January			To Date	TARGET		Exec Summary Note	THRESHOLDS			06/07 Outturn	07/08 Outturn	08/09 Outturn
				Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	09/10							
RW	Net Income & Expenditure (Surplus / Deficit (-))		£000s	257 ▲	251 ▲	135 ▼	→		160 ▲	→		258 ▼	2119	2163	2269		0%	0 - 1%	>1%	3399	6547	2535
RK	Cancer	2 weeks	%	92.8 ■	94.5 ■	96.1 ▲	→		93.6 ▼	→			93.8	=>93	=>93		No variation		Any variation	100	97.1	98.6
		31 Days	%	100 ▲	99.4 ▼	99.4 ■	→		100 ▲	→			99.7	=>96	=>96		No variation		Any variation	99.9	99.9	100
		62 Days	%	94.0 ▲	89.2 ▼	89.9 ▲	→		89.1 ▼	→			89.7	=>85	=>85		No variation		Any variation	99.3	99.7	98.6
RK	Cancelled Operations	Elective Admissions Cancelled at last minute for non-clinical reasons	%	0.5 ▲	0.6 ▼	1.0 ■	0.4 ▲	1.0 ■	0.7 ■	1.0 ■	1.1 ■	1.0 ■	0.8	<0.8	<0.8	a	<0.8	0.8 - 1.0	>1.0	0.9	0.9	1.0
		28 day breaches	No.	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	0	0	0		3 or less	4 - 6	>6	4	0	0
	Delayed Transfers of Care	Total	%	2.6 ▼	3.6 ■	2.6 ■	3.8 ■	4.1 ■	3.9 ■	2.6 ■	2.6 ■	2.6 ■	2.8	<3.0	<3.0	b	<3.0	3.0 - 4.0	>4.0	4.0	2.7	3.1
RK	Coronary Heart Disease	Primary Angioplasty (<90 mins)	%	85 ▲	79 ■	64 ■	56 ▲	75 ■	62 ▼				74.8	80	80		>80	75-80	<75	n/a	63.0	70.5
		Primary Angioplasty (<150 mins)		92 ▲	90 ▼	75 ■	71 ▲	50 ■	64 ■				83.5	80	80		>80	75-80	<75	n/a	n/a	83.6
		Rapid Access Chest Pain	%	100 ■	100 ■	100 ■	100 ■	100 ■	100 ■				99.8	=>98	=>98		>99	98 - 99	<98	99.7	99.6	100.0
		Revascularisation >13 weeks	No.	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	0	0	0		0		>0	0	0	0
		Thrombolysis (60 minutes)	%	no pts	no pts	no pts			no pts				no pts	80	80		>80	75-80	<75	57	50	0
DO'D	Stroke Care	>90% stay on Stroke Unit	%	67.4 ■	59.3 ■	51.7 ▼	→		64.0 ▲	→		69.8 ■	59.5	69.5	70	c	+>70	65 - 70	<65	n/a	n/a	36.5
RK	A/E 4 Hour Waits		%	98.6 ▼	99.0 ▲	96.7 ■	96.7 ▲	96.0 ▼	96.2 ▼	98.8 ■	97.2 ▲	97.8 ▲	98.41	=>98	=>98	d	=>98		<98	98.20	98.28	98.16
	GUM 48 Hours	Patients seen within 48 hours	%	88.2 ■	87.0 ▼	86.3 ▼	→		87.5 ▲	→		87.3 ▼	88.0	=>90	=>90		=>90	80-89	<80	n/a	n/a	81.0
		Patients offered app't within 48 hrs	%	100 ■	99.5 ▼	100 ▲	→		100 ■	→		100 ■	99.8	=>98	=>98		=>98	95-98	<95	35.8	80.7	98.3
R0	Infection Control	C. Diff - EXTERNAL (DH) TARGET	No.	10 ▲	14 ▼	14 ■	3 ▲	11 ■	14 ■	3 ■	14 ■	17 ▼	130	222	264	e	No variation		Any variation	n/a	355	163
		C. Diff - INTERNAL (LHE) TARGET	No.	10 ▲	14 ▼	14 ■	3 ▲	11 ■	14 ■	3 ■	14 ▼	17 ▼	130	185	220		No variation		Any variation	n/a	355	163
		MRSA - EXTERNAL (DH) TARGET	No.	1 ▼	1 ■	2 ▼	0 ■	0 ■	0 ▲	1 ▼	0 ■	1 ▼	11	29	33		No variation		Any variation	61	43	15
		MRSA - INTERNAL (LHE) TARGET	No.	1 ▼	1 ■	2 ▼	0 ■	0 ■	0 ▲	1 ▼	0 ■	1 ▼	11	20	23		No variation		Any variation	61	43	15
RK	Data Quality	Valid Coding for Ethnic Category (FCEs)	%	95 ■	95 ■	94 ■	→			→			94	90	90		>/=90	89.0-89.9	<89	90.0	89.0	87.0
		Maternity HES	%				→		5.7 ■	→			5.7	<15	<15		=<15	16-30	>30	n/a	n/a	
RO	Infant Health & Inequalities	Maternal Smoking Status Data Complete	%	99.3 ▼	→	→	→		99.0 ■	→			99.3	=>99.0	=>99.0		=>99	98-99	<98	99.9	99.5	99.9
		Breast Feeding Status Data Complete	%	98.8 ■	→	→	→		99.3 ■	→			99.1	=>99.0	=>99.0		=>99	98-99	<98	98.3	99.8	97.8
		Maternal Smoking Rates	%	11.5 ■	→	→	→		10.9 ▲	→			11.8	<12.0	<12.0		<12.0	12-14	>14.0	13.2	13.1	12.6
		Breast Feeding Initiation Rates	%	62.0 ▼	→	→	→		63.3 ▲	→			62.7	>57.0	>57.0		>57.0	55-57	<55.0	52.5	55.0	54.2
RK	Patient Access	Inpatients >26 weeks	%	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	0.000	0	0		<0.03		>0.03	1	0	0
		Outpatients >13 weeks	%	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	0.001	0	0		<0.03		>0.03	4	0	5
RK	RTT Milestones	Admitted Care (RTT <18 weeks)	%	97.2 ▲	97.6 ▲	93.4 ▼	→		92.8 ▼	→		95.5 ▲	95.5	=>90.0	=>90.0	f	=>90.0		<90.0	52.0	90.6	98.6
		Admitted Care - Data Completeness	%	109.5 ■	108.4 ■	103.5 ■	→		99.8 ■	→		102.8 ■	102.8	90-110	<90 or >110		90-110		<90 or >110	n/a	n/a	100.4
		Non-Admitted Care (RTT <18 weeks)	%	98.0 ■	97.7 ▼	97.3 ▼	→		96.7 ▼	→		98.4 ▲	98.4	=>95.0	=>95.0		=>95.0		=<95.0	n/a	95.5	98.8
		Non-Admitted Care - Data Completeness	%	109.7 ■	108.3 ■	98.4 ■	→		90.9 ■	→		96.3 ■	96.3	90-110	<90 or >110		90-110		<90 or >110	n/a	n/a	98.1
		Audiology Direct Access Waits (<18 wks)	%	100 ■	100 ■	100 ■	→		100 ■	→		100 ■	100	=>95	=>95		=>95		<95	n/a	n/a	99.0
		Audiology Data Completeness	%	97.0 ■	108.0 ■	110.0 ■	→		102.0 ■	→		108.0 ■	108.0	90-110	<90 or >110		90-110		<90 or >110	n/a	n/a	96.0
		Diagnostic Waits greater than 6 weeks	No.	0 ■	0 ■	2 ■	→		1 ▲	→			1	0	0		0		>0	996	25	26
DO'D	Mortality in Hospital	Hospital Standardised Mortality Rate	HSMR	80.5 Jun '09	83.4 JuL '09	82.3 Aug '09	→		97.8 Sept '09	→		90.0 Oct '09	89.2	Rate only	Rate only					96.4	100.9	105.1
		Peer (SHA) HSMR	HSMR	89.1	90.7	91.5	→		85.7	→		90.4	93.4	Rate only	Rate only					108.8	106.0	103.9
RK	CQUIN	OP Source of Referral Information	%	2.02 ▼	1.18 ▲	1.04 ▲	→		1.64 ▼	→		1.13 ▲	1.39	5.0	5.0	g	No variation		Any variation	n/a	n/a	10.0
DO'D		Caesarean Section Rate	%	27.6 ■	23.4 ■	24.2 ▼	23.0 ▲	21.3 ▲	22.0 ▲	24.1 ▼	27.1 ■	25.8 ▼	23.4	26.0	26.0		=<26.0		>26.0	n/a	27.7	27.0
		Brain Imaging for Em. Stroke Admissions	%	84.6 ■	88.0 ▲	82.4 ▼	→		85.2 ▲	→		83.3 ▼	80.1	72.0	72.0		=>72.0		<72.0	n/a	n/a	72.0
		Hip Fracture Op's <48 hours of admission	%	89.5 ▼	84.6 ▼	84.8 ▲	→		89.5 ▲	→		83.9 ■	84.2	86.0	87.0		No Variation	0 - 2% Variation	>2% Variation	63.6	70.1	77.8
		Smoking Cessation Referrals	No.	28 ▼	173 ■	65 ■	→		59 ▼	→		172 ■	639	833	1000		=>83	per month	<83	n/a	n/a	7
RO		IP Patient Satisfaction (Survey Coverage)	%										Completed				=>90		<90	n/a	n/a	n/a

Exec Lead	CLINICAL QUALITY			Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust	To Date	YTD	09/10	Summary Note				06/07 Outturn	07/08 Outturn	08/09 Outturn
RK	Readmission Rates	(Within 28 days of discharge)	%	11.6	11.6	12.3	11.9	11.9	11.9				11.6	No. Only	No. Only					10.1	n/a	11.6
		(Within 14 days of discharge)	%	8.6	8.6	9.0	9.1	8.6	8.8				8.5	No. Only	No. Only					n/a	n/a	7.3
R0	Infection Control	Savings Lives Compliance	%	99	100	99	→		100	→		99	99	>95	>95		< YTD target		> YTD target	n/a	n/a	99.0
		MRSA Screening (Elective)	No.	2242	2305	2192	→		1611	→		2248	19772	No. Only	No. Only		0 - 10%	10 - 15%	>15%	n/a	n/a	6495
		MRSA Screening (Non-Elective)	No.	2209	2133	2125	→		2175	→		2203	14051	No. Only	No. Only		0 - 10%	10 - 15%	>15%	n/a	n/a	n/a
DO'D	Obstetrics	Post Partum Haemorrhage (>2000 ml)	No.	1	2	0	0	0	0	0	0	0	9	36	48		=<2	3 - 4	>4	n/a	n/a	
		Admissions to Neonatal ICU	%	8.2	5.5	4.1	4.7	4.5	4.6	7.5	2.9	5.0	5.7	=<10	=<10		=<10	10.0-12.0	>12.0	n/a	9.6	
		Adjusted Perinatal Mortality Rate	/1000	2.0	9.2	16.6							16.6	<8.0	<8.0		<8	8.1 - 10.0	>10	n/a	n/a	
	FINANCE & FINANCIAL EFFICIENCY																					
RW	Gross Margin		£000s	2462	2493	2377	→		2402	→		2501	24482	24466	29805		0%	0 - 1%	>1%	26429	33250	26436
	CIP		£000s	1126	1079	1151	→		1113	→		1169	12653	12711	15075		0 - 2.5%	2.5 - 7.5%	>7.5%	19679	14027	11084
	In Year Monthly Run Rate		%	12.23	13.06	14.41	→		29.03	→		11.69	-2.03	0	0		NO or a + variation	0 - 5% variation	>5% variation	329	45	1.4
RK	Income / WTE		£s	4892	4960	5001	→		5087	→		5088	4978	5127	5127		No variation	0 - 5% variation	>5% variation	5460	4924	5014
	Income / Open Bed		£s	32353	32496	32048	→		32518	→		30217	32155	31184	31184		No variation	0 - 5% variation	>5% variation	24774	29065	30498
	Income per Spell	Total Income	£s	2853	2762	2892	→		2994	→		3066	2851	2762	2762		No Variation	0 - 4% Variation	>4% Variation	2635	2740	2701
		Clinical Income	£s	2560	2483	2572	→		2695	→		2755	2563	2454	2454		No Variation	0 - 4% Variation	>4% Variation	2317	2449	2400
		Non-Clinical Income	£s	293	279	320	→		299	→		311	288	308	308	h	No Variation	0 - 4% Variation	>4% Variation	318	291	301
	Cost per Spell	Total Cost	£s	2829	2740	2880	→		2980	→		3042	2832	2742	2742		No Variation	0 - 4% Variation	>4% Variation	n/a	2643	2682
		Total Pay Cost	£s	1912	1862	1937	→		1960	→		2027	1899	1825	1825		No Variation	0 - 4% Variation	>4% Variation	1772	1737	1785
		Medical Pay Cost	£s	562	570	580	→		564	→		585	554	544	544		No Variation	0 - 4% Variation	>4% Variation	543	517	532
		Nursing Pay Cost (including Bank)	£s	658	638	671	→		680	→		713	660	639	639		No Variation	0 - 4% Variation	>4% Variation	609	615	625
		Non-Pay Cost	£s	917	877	943	→		1019	→		1015	932	917	917		No Variation	0 - 4% Variation	>4% Variation	n/a	906	897
		Mean Drug Cost / IP Spell	£s	121	123	130	→		134	→		139	121	123	123		No Variation	0 - 4% Variation	>4% Variation	n/a	95	120
		Mean Drug Cost / Occupied Bed Day	£s	51	52	52	→		52	→		50	48	48	48		No Variation	0 - 4% Variation	>4% Variation	n/a	35	47
	PATIENT EXPERIENCE																					
RK	Same Sex Accommodation Breaches	Number of Breaches	No.	→	→	590	→		546	→		771	1907	No. Only	No. Only		To date = since 1 Nov 2009			n/a	n/a	n/a
		Percentage of overall admissions	%	→	→	5.29	→		5.74	→		6.94	6.00	No. Only	No. Only					n/a	n/a	n/a
KD	Complaints	Number Received	No.	216	→	→	→			→			444	No. Only	No. Only					673	697	789
		Response within initial negotiated date	%	65.7	→	→	→			→			70.9	85	85		80%+	70 - 79%	<70%	77.4	81.2	81.1
	Thank You Letters		No.	482	→	→	→			→			893	No. Only	No. Only					6026	3491	2912
RK	Elective Access Contact Centre	Number of Calls Received	No.	12667	no data	no data	→		no data	→		no data	12667	No. Only	No. Only					n/a	n/a	190434
		Average Length of Queue	mins	1.54	no data	no data	→		no data	→		no data	1.54	0.5	0.5		No variation	0 - 10% variation	>10% variation	n/a	n/a	0.44
		Maximum Length of Queue	mins	7.4	no data	no data	→		no data	→		no data	7.4	6.0	6.0		No variation	0 - 10% variation	>10% variation	n/a	n/a	17.4
	Telephone Exchange	Number of Calls Received	No.	81809	86302	86020	→		81214	→			854976	No. Only	No. Only					n/a	1826476	1559688
		Calls Answered	%	88.4	90.7	86.9	→		87.9	→			81.6	No. Only	No. Only					n/a	81.0	82.3
		Answered within 15 seconds	%	44.6	51.9	42.1	→		45.1	→			45.1	No. Only	No. Only					n/a	n/a	39.1
		Answered within 30 seconds	%	60.9	68.5	58.5	→		61.0	→			61.0	No. Only	No. Only					n/a	n/a	55.5
		Average Ring Time	Secs	28.0	23.1	30.7	→		29.5	→			29.5	No. Only	No. Only					n/a	n/a	28.8
		Longest Ring Time	Secs	877	774	1068	→		447	→			447	No. Only	No. Only					n/a	n/a	695
	STRATEGY																					
RK	Referrals	Total By Site	No.	16646	16595	15959	→		14298	→			143852	131950	178070		No Variation	0 - 2% Variation	>2% Variation	138580	151755	178070
		Total GP Referrals	No.	11069	10692	10348	→		9498	→			94402	89383	120138		No Variation	0 - 2% Variation	>2% Variation	98476	95857	120138
		Total Other Referrals	No.	5577	5903	5611	→		4800	→			49450	42567	57932		No Variation	0 - 2% Variation	>2% Variation	40104	55898	57932
		By PCT - Heart of B'ham	No.	4434	4620	4492	→		4015	→			39352	36696	49859		No Variation	0 - 2% Variation	>2% Variation	40394	41628	49859
		By PCT - Sandwell	No.	8447	8213	7798	→		7154	→			71940	65220	87779		No Variation	0 - 2% Variation	>2% Variation	72580	77592	87779
		By PCT - Other	No.	3765	3762	3669	→		3129	→			32560	30034	40453		No Variation	0 - 2% Variation	>2% Variation	25606	32535	40453
		Conversion (all referrals) to New OP Att'd	%	87.2	89.8	87.7	→		88.0	→			85.3	No. Only	No. Only					91.5	87.0	85.9

Exec Lead	ACTIVITY			Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust	To Date	YTD	09/10	Summary Note				06/07 Outturn	07/08 Outturn	08/09 Outturn
RK	Spells	Elective IP	No.	1224 ▼	1200 ■	1163 ■	359 ▼	700 ▼	1059 ▼	336 ▼	781 ▲	1117 ■	11431	10874	13077	i	No Variation	0 - 2% Variation	>2% Variation	13887	13395	13106
		Elective DC	No.	4402 ▼	4616 ▼	4636 ▲	1890 ▼	2291 ▼	4181 ▼	1926 ■	2204 ■	4130 ■	43437	41272	49636		No Variation	0 - 2% Variation	>2% Variation	45831	46304	50873
		Total Elective	No.	5626 ▼	5816 ▼	5799 ▲	2249 ▼	2991 ▼	5240 ▼	2262 ■	2985 ■	5247 ■	54868	52146	62713		No Variation	0 - 2% Variation	>2% Variation	59718	59699	63979
		Non-Elective - Short Stay	No.	1427 ▼	1421 ▼	1079 ■	656 ▲	646 ▲	1302 ■	703 ▲	709 ■	1412 ▲	15539	11527	13745		No Variation	0 - 2% Variation	>2% Variation	12414	11575	12770
		Non-Elective - Other	No.	3903 ▲	4248 ▲	4202 ■	1876 ■	2442 ■	4318 ■	1689 ■	2147 ■	3836 ■	39952	43342	54971		No Variation	0 - 2% Variation	>2% Variation	52662	55163	56226
		Total Non-Elective	No.	5330 ▲	5669 ■	5281 ■	2532 ■	3088 ▲	5620 ■	2392 ▼	2856 ▼	5248 ■	55491	54869	68716		No Variation	0 - 2% Variation	>2% Variation	65076	66738	68996
	Outpatients	New	No.	14517 ▲	14904 ■	13995 ■	4222 ▼	8363 ■	12585 ■	4361 ▼	8011 ■	12372 ▼	135276	137152	163114		No Variation	0 - 2% Variation	>2% Variation	127449	131941	152923
		Review	No.	36396 ▲	37203 ▼	35604 ▲	12063 ▼	21055 ▼	33118 ▼	11790 ■	21940 ▼	33730 ■	347412	324974	385680		No Variation	0 - 2% Variation	>2% Variation	370970	361113	374867
	A/E Attendances	Type I (Sandwell & City Main Units)	No.	15233 ▲	16084 ■	14395 ■	6490 ▼	8675 ▲	15165 ▲	6332 ▲	8080 ▼	14412 ▼	160845	165681	197122		No Variation	0 - 2% Variation	>2% Variation	200561	195093	191141
	A/E Attendances	Type II (BMEC)	No.	3079 ▲	2971 ▼	2448 ■	→	2532 ■	2532 ■	→	2572 ▲	2572 ▲	29014	25845	30749		No Variation	0 - 2% Variation	>2% Variation	31373	29803	30800
	PATIENT ACCESS & EFFICIENCY																					
RK	Length of Stay	Average Length of Stay	Days	4.7 ▼	4.2 ▲	4.5 ▼	4.9 ▼	4.5 ▼	4.7 ▼				4.5	5.0	5.0		No Variation	0 - 5% Variation	>5% Variation	5.7	5.0	5.0
		All Patients with LOS > 14 days	No.	281	298	316	194	150	344	177	148	325	325	No. Only	No. Only					n/a	345	312
		All Patients with LOS > 28 days	No.	142	147	163	85	72	157	90	85	175	175	No. Only	No. Only					190	174	152
		Min. Stay Rate (Electives (IP/DC) <2 days	%	91.39 ▼	92.0 ■	92.2 ▲	94.9 ▲	90.4 ■	92.3 ▲	95.1 ▲	91.0 ▲	92.8 ▲	92.2	92.0	92.0		No Variation	0 - 5% Variation	>5% Variation	88.3	90.5	91.6
	Admissions	Day of Surgery (IP Elective Surgery)	%	84.3 ▼	84.5 ▲	85.8 ▲	89.8 ▼	86.6 ▲	87.7 ▲	87.6 ▼	87.3 ▲	87.4 ▼	85.2	82.0	82.0		No Variation	0 - 5% Variation	>5% Variation	63.2	76.5	79.4
		Day of Surgery (IP Non-Elective Surgery)	%	66.44	63.0	67.9	61.1	64.41	62.7	69.4	70.47	70.0	69.6	No. Only	No. Only					n/a	68.3	70.2
		With no Procedure (Elective Surgery)	%	11.1	9.4	10.4	9.5	6.6	7.5				9.9	No. Only	No. Only					10.6	n/a	10.6
		Per Bed (Elective)	No.	5.07 ▼	6.81 ■	5.18 ■	4.78 ▲	5.92 ■	5.37 ▲	4.42 ▼	5.49 ■	4.97 ▼	5.52	5.90	5.90		No Variation	0 - 5% Variation	>5% Variation	4.66	4.87	5.33
	Discharges	Pt's Social Care Delay	No.	17 ▼	15 ▲	15 ■	15 ■	8 ▼	23 ■	3 ■	6 ▲	9 ■	9	<18	<18	b	No Variation	0 - 10% Variation	>10% Variation			
		Pt.'s NHS & NHS plus S.C. Delay	No.	11 ■	9 ■	9 ■	7 ■	3 ▲	10 ■	1 ■	6 ▼	7 ■	7	<10	<10		No Variation	0 - 10% Variation	>10% Variation			
	Beds	Occupied Bed Days	No.	25898 ▼	27392 ▼	27724 ▼	13120 ▲	15112 ▲	28232 ▲	13405 ▼	15724 ■	29129 ■	276739	287365	342000		No Variation	0 - 5% Variation	>5% Variation	378060	348676	342793
		Occupancy Rate	%	86.1 ■	86.5 ■	90.7 ■	90.9 ■	82.2 ■	86.4 ■	87.5 ■	84.7 ■	86.1 ■	86.1	86.5-89.5	86.5-89.5		86.5 - 89.5	85.5-86.4 or 89.6-90.5	<85.5 or >90.5	88.6	90.8	90.3
		Open at month end (exc Obstetrics)	No.	966 ▼	976 ■	1000 ■	469	531	1000 ■	516	549	1065 ▼	1065	975	975		No Variation	0 - 2% Variation	>2% Variation	1039	1007	975
	Day Case Rates	All Procedures	%	76.1 ▼	78.1 ▲	78.2 ▲	82.1 ▼	74.5 ▼	77.8 ▼	85.2 ▲	73.8 ▼	78.7 ▲	79.2	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation	76.0	76.9	79.0
		BMEC Procedures	%	77.93 ▼	78.81 ▲	80.29 ■	→	77.28 ■	77.3 ■	→	81.17 ■	81.2 ■	79.2	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation	71.5	77.2	79.7
	Non-Admitted Care	New : Review Rate	Ratio	2.50 ▲	2.50 ■	2.54 ▼	2.86 ▼	2.52 ▼	2.63 ▼	2.70 ▲	2.74 ▼	2.73 ▼	2.57	2.30	2.30		No Variation	0 - 5% Variation	>5% Variation	2.91	2.74	2.45
		DNA Rate - New Referrals	%	13.4 ▲	14.0 ▼	12.8 ▲	15.0 ▼	16.4 ▼	15.9 ▼	16.0 ▼	17.3 ▼	16.8 ▼	13.9	9.0	9.0		No Variation	0 - 5% Variation	>5% Variation	10.8	10.9	12.0
		DNA Rate - Reviews	%	12.2 ▲	11.9 ▲	12.2 ▼	14.2 ▼	13.7 ▼	13.9 ▼	17.2 ▼	15.5 ▼	16.1 ▼	12.5	9.0	9.0		No Variation	0 - 5% Variation	>5% Variation	12.8	13.5	13.5
		OP Cancellations - Trust Initiated	No.		2770	2705	→		3259	→			8734	No. Only	No. Only		To date = since 1 Oct 2009			n/a	n/a	n/a
		OP Cancellations - Patient Initiated	No.		3273	3524	→		3587	→			10384	No. Only	No. Only					n/a	n/a	n/a
		OP Cancellations as % OP activity	%		11.6	12.6			15.0				13.0	No. Only	No. Only					n/a	n/a	n/a
	Pathology	Cervical Cytology Turnaround	Weeks	1.8 ▲	1.8 ■	0.8 ▲	→		0.8 ■	→			0.8	<4.0	<4.0		<4.0	4.0-6.0	>6.0	1.7 - 4.0	1.5 - 2.9	2.7
	Ambulance Turnaround	In Excess of 30 minutes	%	n/a	n/a	26.6 ■	23.9 ▲	22.3 ▲	23.0 ▲	20.2 ▲	18.6 ▲	19.3 ▲	19.3	<10.0	<10.0		<10	10 - 12.5	>12.5	n/a	29.1	19.0
		(West Midlands average)	%	n/a	n/a	35.2	→		31.3	→		27.8	27.8	No. Only	No. Only					n/a	31.1	21.0
		In Excess of 60 minutes	No.	n/a	n/a	67 ■	25 ▲	35 ▲	60 ▲	12 ▲	21 ▲	33 ▲	33	0	0		0	1 - 5	>5	n/a	n/a	
	THEATRE UTILISATION																					
RK	Sitrep Declared Late **Cancellations** by Specialty	General Surgery	No.	3 ▼	3 ■	9 ■	3	3	6 ■	6	2	8 ■	70	50	60	a	0-5% variation	5 - 15% variation	>15% variation	n/a	75	104
		Urology	No.	4 ▼	4 ■	3 ▲	0	2	2 ▲	5	6	11 ■	35	40	48		0-5% variation	5 - 15% variation	>15% variation	n/a	67	102
		Vascular Surgery	No.	0 ■	4 ■	0 ■	0	0	0 ■	0	0	0 ■	5	3	3		0-5% variation	5 - 15% variation	>15% variation	n/a	1	7
		Trauma & Orthopaedics	No.	5 ■	8 ■	8 ■	4	2	6 ■	4	7	11 ■	64	60	72		0-5% variation	5 - 15% variation	>15% variation	n/a	100	75
		ENT	No.	1 ▼	3 ■	4 ▼	0	5	5 ▼	0	4	4 ▲	22	10	12		0-5% variation	5 - 15% variation	>15% variation	n/a	19	23
		Ophthalmology	No.	7 ▼	10 ■	20 ■	0	11	11 ■	0	2	2 ■	109	90	108		0-5% variation	5 - 15% variation	>15% variation	n/a	139	153
		Oral Surgery	No.	1 ■	0 ■	4 ■	0	3	3 ▲	0	2	2 ■	22	7	8		0-5% variation	5 - 15% variation	>15% variation	n/a	10	19
		Cardiology	No.	0 ▲	0 ■	2 ▼	0	0	0 ▲	0	0	0 ■	6	18	21		0-5% variation	5 - 15% variation	>15% variation	n/a	28	31
		Gynaecology / Gynae-Oncology	No.	3 ■	4 ▼	4 ■	2	1	3 ▲	6	8	14 ■	52	45	54		0-5% variation	5 - 15% variation	>15% variation	n/a	69	71
		Plastic Surgery	No.	1 ▼	0 ▲	1 ▼	0	0	0 ▲	0	1	1 ▼	10	10	12		0-5% variation	5 - 15% variation	>15% variation	n/a	17	21
		Dermatology	No.	5 ■	0 ■	0 ■	0	2	2 ▼	0	0	0 ▲	18	20	24		0-5% variation	5 - 15% variation	>15% variation	n/a	4	24
		TOTAL	No.	30 ▼	36 ▼	55 ■	9	29	38 ■	21	32	53 ■	413	352	422		0-5% variation	5 - 15% variation	>15% variation	n/a	529	630

Exec Lead	WORKFORCE			Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust	To Date	YTD	09/10	Summary Note				06/07 Outturn	07/08 Outturn	08/09 Outturn
RK	WTE in Post	Total	No.	6388 ■	6394 ■	6408 ▲	→		6393 ▲	→		6324 ▲	6324	6432	6241		No Variatio	0 - 1% Variatio	>1% Variatio	6000	5875	6042
		Medical and Dental	No.	763 ▲	769 ▼	770 ▲	→		759 ▲	→		757 ▲	757	789	761		No Variatio	0 - 1% Variatio	>1% Variatio	822	736	755
		M'ment, Admin. & HCAs	No.	2054 ▲	2038 ▲	2033 ■	→		2025 ▲	→		1992 ■	1992	2015	1952		No Variatio	0 - 1% Variatio	>1% Variatio	1806	1765	1852
		Nursing & Midwifery (excluding Bank)	No.	2360 ▼	2396 ▼	2409 ▼	→		2404 ▲	→		2373 ▲	2373	2600	2547		No Variatio	0 - 1% Variatio	>1% Variatio	2481	2255	2259
		Scientific and Technical	No.	958 ▲	966 ▼	958 ▲	→		973 ▼	→		961 ▲	961	1027	981		No Variatio	0 - 1% Variatio	>1% Variatio	891	869	913
		Bank Staff	No.	253	225	238	→		232	→		241	241	No. Only	No. Only					n/a	250	260
		Gross Salary Bill	£000s	20944 ▼	21389 ▼	21461 ▼	→		21290 ▼	→		21272 ▼	209596	206676	243342		No Variatio	0 - 1% Variatio	>1% Variatio	220244	219667	238674
RK	Bank & Agency	Nurse Bank Fill Rate	%	86.5	86.9	84.8	→		78.6	→		84.1	85.1	No. Only	No. Only	j				n/a	87.6	81.8
		Nurse Bank Shifts covered	No.	4908 ■	4966 ▼	5261 ▼	→		4734 ▲	→		4931 ▼	51075	51530	61836		0 - 2.5%	2.5 - 5.0%	>5.0% Variatio	67330	68707	69675
		Nurse Agency Shifts covered	No.	254 ▲	250 ▲	459 ■	→		715 ▼	→		738 ▼	4235	4143	4972		0 - 5% Variatio	5 - 10% Variatio	>10% Variatio	2879	5524	4765
		Nurse Bank AND Agency Shifts covered	No.	5162 ▲	5216 ▼	5720 ■	→		5449 ■	→		5669 ▼	55310	55673	66808		0 - 2.5%	2.5 - 5.0%	>5.0% Variatio	70209	74231	74440
		Nurse Bank Costs	£000s	522 ▼	509 ▲	544 ▼	→		536 ▲	→		503 ▲	5191	5353	6423		0 - 2.5%	2.5 - 5.0%	>5.0% Variatio	6883	6980	6844
		Nurse Agency Costs	£000s	68 ■	97 ■	72 ■	→		167 ■	→		225 ▼	935	827	992		0 - 5% Variatio	5 - 10% Variatio	>10% Variatio	474	1078	832
KD		Medical Agency Costs	£000s	156 ▲	159 ▼	167 ▼	→		164 ▲	→		199 ▼	1762	993	1192		0 - 5% Variatio	5 - 10% Variatio	>10% Variatio	693	1296	2026
RK		Other Agency Costs	£000s	218 ▲	135 ▲	192 ▼	→		177 ▲	→		192 ▼	2145	1175	1410		0 - 5% Variatio	5 - 10% Variatio	>10% Variatio	1661	2223	3759
KD		Medical Locum Costs	£000s	265 ▼	275 ▼	273 ▲	→		247 ▲	→		210 ▲	2431	1875	2250		0 - 2.5%	2.5 - 5.0%	>5.0% Variatio	2566	2445	2747
RK/KD		Agency Spend cf. Total Pay Spend	%	2.11 ■	1.83 ■	2.01 ■	→		2.39 ▼	→		2.90 ■	2.31	<2.00	<2.00		<2	2 - 2.5	>2.5	1.50	2.15	2.77
CH	Sickness Absence	Long Term	%	3.18 ▲	3.42 ■	3.25 ■	→		3.40 ■	→		3.79 ▼	3.08	<3.00	<3.00	k	<3.0	3.0-3.35	>3.35	2.50	3.52	3.16
		Short Term	%	1.23 ▼	1.59 ■	1.59 ■	→		1.33 ■	→		1.60 ■	1.32	<1.25	<1.25		<1.25	1.25-1.40	>1.40	2.17	1.26	1.22
		Total	%	4.41 ▼	5.00 ■	4.84 ▲	→		4.73 ■	→		5.39 ■	4.40	<4.25	<4.25		<4.25	4.25-4.75	>4.75	4.67	4.78	4.38
	Recruitment & Retention	Permission to Recruit	wte	90	100	61	→		42	→		55	735	No. Only	No. Only					n/a	1143	1124
		New Starters	wte	142	85	50	→		28	→		43	886	No. Only	No. Only					n/a	855	1066
		Leavers	wte	94	73	43	→		65	→		40	741	No. Only	No. Only					n/a	1004	999
		Inductions	No.	87	83	71	→		31	→		52	718	No. Only	No. Only					n/a	442	896
	Learning & Development	PDRs (includes Junior Med staff)	No.	530 ▼	310 ■	194 ▼	→		143 ▼	→		208 ▲	4016	4451	5341	l	0-5% variation	5 - 15% variation	>15% variation	n/a	1963	4518
		Mandatory Training Compliance	%		40.1 ■	41.4 ▲	→		55.7 ▲	→		60.7 ▲	60.7	100	100		=>80	50 - 79	<50	4313 (No.)	2770 (No.)	4044 (No.)

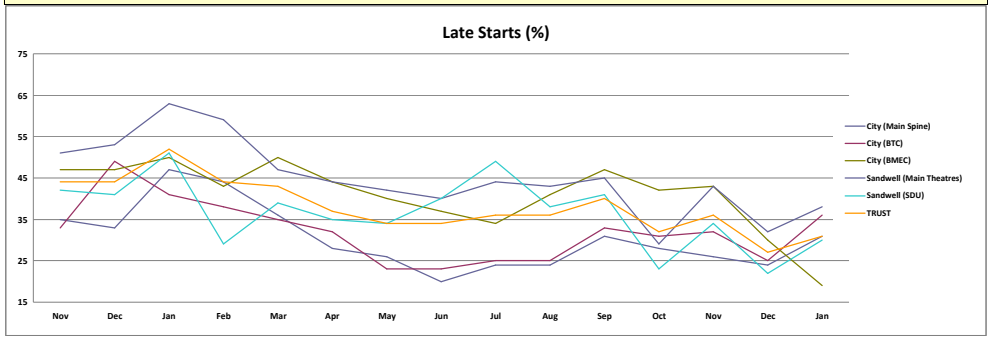
KEY TO PERFORMANCE ASSESSMENT SYMBOLS	
▲	Fully Met - Performance continues to improve
■	Fully Met - Performance Maintained
▼	Met, but performance has deteriorated
▲	Not quite met - performance has improved
■	Not quite met
▼	Not quite met - performance has deteriorated
▲	Not met - performance has improved
■	Not met - performance showing no sign of improvement
▼	Not met - performance shows further deterioration

Please note: Although actual performance within the period may have improved, this may not always be reflected by a symbol which reflects this, if the distance from trajectory has worsened

SUPPLEMENTARY DATA THEATRE UTILISATION

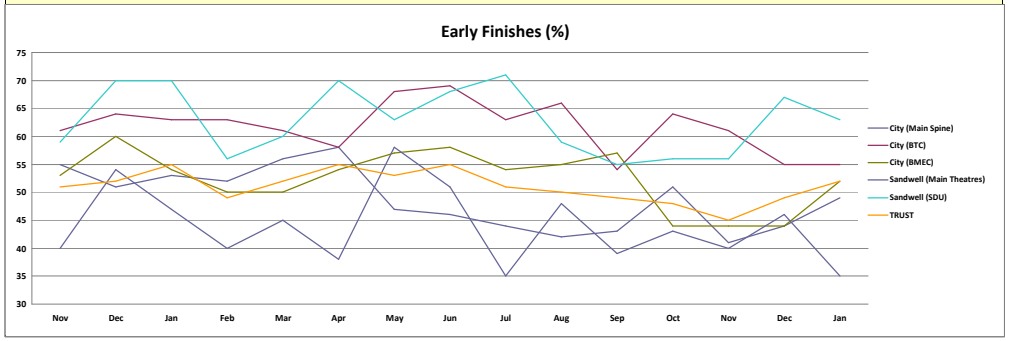
LATE STARTS (%)	2008 / 2009					2009 / 2010											
Theatre Location	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
City (Main Spine)	35	33	47	44	36	28	26	20	24	24	31	28	26	24	31		
City (BTC)	33	49	41	38	35	32	23	23	25	25	33	31	32	25	36		
City (BMEC)	47	47	50	43	50	44	40	37	34	41	47	42	43	30	19		
Sandwell (Main Theatres)	51	53	63	59	47	44	42	40	44	43	45	29	43	32	38		
Sandwell (SDU)	42	41	51	29	39	35	34	40	49	38	41	23	34	22	30		
TRUST	44	44	52	44	43	37	34	34	36	36	40	32	36	27	31		

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



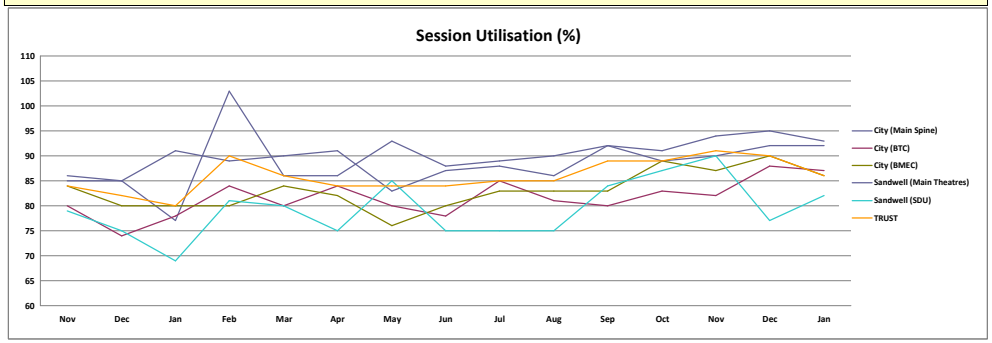
EARLY FINISHES (%)	2008 / 2009					2009 / 2010											
Theatre Location	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
City (Main Spine)	55	51	53	52	56	58	47	46	44	42	43	51	41	44	49		
City (BTC)	61	64	63	63	61	58	68	69	63	66	54	64	61	55	55		
City (BMEC)	53	60	54	50	50	54	57	58	54	55	57	44	44	44	52		
Sandwell (Main Theatres)	40	54	47	40	45	38	58	51	35	48	39	43	40	46	35		
Sandwell (SDU)	59	70	70	56	60	70	63	68	71	59	55	56	56	67	63		
TRUST	51	52	55	49	52	55	53	55	51	50	49	48	45	49	52		

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



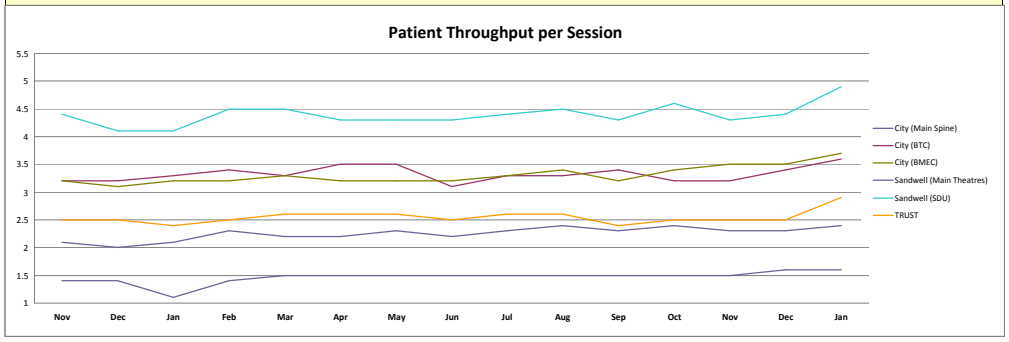
SESSION UTILISATION (%)	2008 / 2009					2009 / 2010											
Theatre Location	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
City (Main Spine)	86	85	77	103	86	86	93	88	89	90	92	91	94	95	93		
City (BTC)	80	74	78	84	80	84	80	78	85	81	80	83	82	88	87		
City (BMEC)	84	80	80	80	84	82	76	80	83	83	83	89	87	90	86		
Sandwell (Main Theatres)	85	85	91	89	90	91	83	87	88	86	92	89	90	92	92		
Sandwell (SDU)	79	75	69	81	80	75	85	75	75	75	84	87	90	77	82		
TRUST	84	82	80	90	86	84	84	84	85	85	89	89	91	90	86		

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



THROUGHPUT / SESSION	2008 / 2009					2009 / 2010											
Theatre Location	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
City (Main Spine)	1.4	1.4	1.1	1.4	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.6	1.6		
City (BTC)	3.2	3.2	3.3	3.4	3.3	3.5	3.5	3.1	3.3	3.3	3.4	3.2	3.2	3.4	3.6		
City (BMEC)	3.2	3.1	3.2	3.2	3.3	3.2	3.2	3.2	3.3	3.4	3.2	3.4	3.5	3.5	3.7		
Sandwell (Main Theatres)	2.1	2.0	2.1	2.3	2.2	2.2	2.3	2.2	2.3	2.4	2.3	2.4	2.3	2.3	2.4		
Sandwell (SDU)	4.4	4.1	4.1	4.5	4.5	4.3	4.3	4.3	4.4	4.5	4.3	4.6	4.3	4.4	4.9		
TRUST	2.5	2.5	2.4	2.5	2.6	2.6	2.6	2.5	2.6	2.6	2.4	2.5	2.5	2.5	2.9		

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



Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	The NHS Performance Framework Monitoring Report and summary performance assessed against the NHS FT Governance Risk Rating (FT Compliance Report)
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of planning & Performance Management and Tony Wharram, Deputy Director of Finance
DATE OF MEETING:	25 February 2010

SUMMARY OF KEY POINTS:

The **NHS Performance Framework Monitoring Report** provides an assessment of the Trust's performance mapped against the indicators which comprise the framework.

There is one area of underperformance in the latest reporting period (January). Performance against the A&E 4-hour wait target was 97.80%, marginally below the 98.0% threshold for achievement.

Foundation Trust Compliance Report – the Trust's Governance Risk Rating remains AMBER due current A/E 4-hour wait performance, and in-year non-compliance with two Care Quality Commission Core Standards.

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

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Finance and Performance Management Committee on 18 February 2010 and Financial Management Board on 16 February 2010.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2009/10

Operational Standards and Targets

Indicator	Weight	Thresholds		2009 / 2010											
		Achieve	Fail	Q1	Score	Weight x Score	Q2	Score	Weight x Score	Q3	Score	Weight x Score	January	Score	Weight x Score
A/E Waits less than 4-hours	1.00	98.00%	97.00%	99.39%	3	3.00	98.90%	3	3.00	97.26%	2	2.00	97.80%	2	2.00
Cancelled Operations - 28 day breaches	1.00	5.0%	15.0%	0	3	3.00	0	3	3.00	0	3	3.00	0	3	3.00
MRSA Bacteraemia	1.00	0	>1.0SD	5	3	3.00	2	3	3.00	3	3	3.00	1	3	3.00
Clostridium Difficile	1.00	0%	>1.0SD	32	3	3.00	39	3	3.00	42	3	3.00	17	3	3.00
18-weeks RTT (Admitted)	1.00	90.0%	85.0%	98.0	3	3.00	>90.0%	3	3.00	>90.0%	3	3.00	>90.0%*	3	3.00
18-weeks RTT (Non-Admitted)	1.00	95.0%	90.0%	98.5	3	3.00	>95.0%	3	3.00	>95.0%	3	3.00	>95.0%*	3	3.00
• Achievement in all specialties (inc. DAA Audiology, exc. Orthopaedics)	0.50	95.0%	90.0%	>95.0%	3	1.50	>95.0%	3	1.50	>95.0%	3	1.50	>95.0%*	3	1.50
• Achievement in Orthopaedics	0.50	95.0%	95.0%	>95.0%	3	1.50	>95.0%	3	1.50	>95.0%	3	1.50	>95.0%*	3	1.50
Cancer - 2 week GP Referral to First Outpatient Appointment	1.00	93.0%	88.0%	93.1%	3	3.00	93.3%	3	3.00	94.7%	3	3.00	>93.0%*	3	3.00
Cancer - 31 day second or subsequent treatment (surgery)	0.33	94.0%	89.0%	100%	3	1.50	99.1%	3	1.50	>94.0%	3	0.99	>94.0%*	3	0.99
Cancer - 31 day second or subsequent treatment (drug)	0.33	98.0%	93.0%							>98.0%	3	0.99	>98.0%*	3	0.99
Cancer - 31 day diagnosis to treatment for all cancers	0.33	96.0%	91.0%	99.8%	3	1.50	99.8%	3	1.50	99.6%	3	0.99	>96.0%*	3	0.99
Cancer - 62 day referral to treatment from screening	0.33	90.0%	85.0%	99.8%	3	0.99	100%	3	0.99	100%	3	0.99	>90.0%*	3	0.99
Cancer - 62 day referral to treatment from hospital specialist	0.33	85.0%	80.0%	66.70%	0	0.00	98.6%	3	0.99	90%	3	0.99	>85.0%*	3	0.99
Cancer - 62 day urgent referral to treatment for all cancers	0.33	85.0%	80.0%	90.6%	3	0.99	89.3%	3	0.99	89.3%	3	0.99	>85.0%*	3	0.99
3-month revascularisation breaches (as % admissions)	1.00	0.1%	0.2%	0.0%	3	3.00	0.0%	3	3.00	0.0%	3	3.00	0.0%*	3	3.00
2-week Rapid Access Chest Pain	1.00	98.0%	95.0%	99.50%	3	3.00	100%	3	3.00	100%	3	3.00	100%*	3	3.00
48-hours GU Medicine Access	1.00	98.0%	95.0%	99.60%	3	3.00	100.00%	3	3.00	99.8%	3	3.00	100%	3	3.00
Delayed Transfers of Care	1.00	3.5%	5.0%	2.60%	3	3.00	2.40%	3	3.00	3.40%	3	3.00	2.6%	3	3.00
Stroke (Stay on Stroke Unit)	1.00	60%	30.0%	53.50%	2	2.00	59.60%	2	2.00	58.0%	2	2.00	69.8%	3	3.00
Outpatient Waits >13 weeks (% of First OP Attendances)	0.50	0.03%	0.15%	0.002%	3	1.50	0.000%	3	1.50	0.000%	3	1.50	0.000%*	3	1.50
Inpatient Waits >26 weeks (% of Elective Admissions)	0.50	0.03%	0.15%	0.000%	3	1.50	0.000%	3	1.50	0.000%	3	1.50	0.000%*	3	1.50
													* Projected		
Sum	**16.00**					**45.98**			**46.97**			**45.94**			**46.94**
Average Score						**2.87**			**2.94**			**2.87**			**2.93**

Scoring:	
Fail	0
Underachieve	2
Achieve	3

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

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING

Financial Indicators				SCORING			2009 / 2010										
Criteria	Metric	Weight (%)		3	2	1	October	Score	Weight x Score	November	Score	Weight x Score	December	Score	Weight x Score	January	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	3	0.15	0	3	0.15	0	3	0.15	0	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	-0.04%	3	0.6	-0.03%	3	0.6	-0.02%	3	0.6	-0.01%	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.	7.80%	3	0.15	7.86%	3	0.15	7.78%	3	0.15	7.78%	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.	7.69%	3	0.15	7.76%	3	0.15	7.73%	3	0.15	7.54%	3	0.15
	Rate of Change in Forecast Surplus or Deficit		15	Still forecasting an operating surplus with a movement equal to or less than 3% of forecast income	Forecasting an operating deficit with a movement less than 2% of forecast income OR an operating surplus movement more than 3% of income.	Forecasting an operating deficit with a movement of greater than 2% of forecast income.	0.00%	3	0.45	0.00%	3	0.45	0.00%	3	0.45	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	0.61%	3	0.15	0.60%	3	0.15	0.60%	3	0.15	0.60%	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	7.69%	3	0.15	7.77%	3	0.15	7.74%	3	0.15	7.55%	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	68.00%	2	0.05	69.00%	2	0.05	70.00%	2	0.05	69.00%	2	0.05
	Better Payment Practice Code Volume (%)		2.5	95% or more of the volume of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the volume of NHS and Non NHS bills are paid within 30days	Less than 60% of the volume of NHS and Non NHS bills are paid within 30 days	57.00%	1	0.025	67.00%	2	0.05	67.00%	2	0.05	62.00%	2	0.05
	Current Ratio		5	Current Ratio is equal to or greater than 1.	Current ratio is anything less than 1 and greater than or equal to 0.5	A current ratio of less than 0.5	1.05	3	0.15	1.05	3	0.15	1.04	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	20.35	3	0.15	21.00	3	0.15	22.10	3	0.15	22.76	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	42.53	2	0.1	44.19	2	0.1	46.80	2	0.1	46.61	2	0.1
						Weighted Overall Score			2.9			2.9			2.9			2.9

*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:	Developing the Executive Team and Operational Management Structure
SPONSORING DIRECTOR:	John Adler, Chief Executive
AUTHOR:	John Adler, Chief Executive and Richard Kirby, Chief Operating Officer
DATE OF MEETING:	25 February 2010

SUMMARY OF KEY POINTS:

The attached report is to update the Trust Board on the outcome of discussions on the future structure of the Executive Team and changes to the Trust's operational and clinical management structure agreed at Trust Management Board in December 2010.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to receive the report for information and note the updated structures.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	None specifically
Annual priorities	
NHS LA standards	
Core Standards	
Auditors' Local Evaluation	

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

Financial		
Business and market share		
Clinical		
Workforce	**X**	The directorate of Workforce will report into the Chief Nurse.
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Considered with Executives affected by the structure changes.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

DEVELOPING THE EXECUTIVE TEAM AND OPERATIONAL MANAGEMENT STRUCTURE

FEBRUARY 2010

INTRODUCTION

The purpose of this paper is to update the Trust Board on the outcome of discussions on the future structure of the Executive Team and changes to the Trust's operational and clinical management structure agreed at Trust Management Board in December 2010

EXECUTIVE TEAM

Members of the Board will recall that during the second half of 2009 it was agreed to implement the following changes to the Executive Team structure

- create a voting Executive Director post of Director of Workforce, following the retirement of the previous Director of Workforce, who was a non-voting director
- create a post of Director of Business Development and Planning, reporting to the Director of Finance and Performance
- disestablish the vacant post of Director of Strategy

In the last quarter of 2009 a recruitment process was undertaken for the new Director of Workforce post but, despite attracting an apparently strong field, no suitable candidate was found. It is felt unlikely that re-advertisement of the post would result in a different outcome in the foreseeable future. An interim Director of Business Development and Planning was appointed but this assignment finished earlier this month.

In the light of the above developments, and the need to reduce executive costs in line with the Cost Improvement Programme, a further review has been undertaken and the following changes have been agreed.

- disestablish the post of Director of Workforce. The Workforce function will now report through the Chief Nurse.
- create a voting Director of Strategy and Organisational Development post
- disestablish the post of Director of Business Development and Planning. The functions envisaged for this post will be shared between other members of the Executive Team, whilst ensuring that there is appropriate co-ordination of this important area of activity.

In summary, the above changes are designed to:

- Ensure that the workforce function retains strong executive leadership, well aligned to operational and strategic priorities

- Increase the strategic capacity of the Trust at a time of substantial change, particularly in the external environment

- Improve the organisational development capabilities of the Trust, ensuring that our many positive initiatives are properly planned and co-ordinated

- Deliver the savings in executive management costs required by the Cost Improvement Programme for 2010/11.

The Chief Nurse will take on responsibility for Workforce from 1 April 2010. The recruitment process for the Director of Strategy and OD will commence as soon as practicable.

OPERATIONAL MANAGEMENT STRUCTURE

There were a set of reasons for considering changes to the operational management structure during the winter including:

- establishment of Clinical Directorates – the need to provide high-quality management support at CD level and the impact on Divisional structures;

- changes in the DGM team - a retirement and the departure of one DGM for a new role in a different trust;

- changes to the structure for IM&T and Elective Access – the existing arrangements had evolved over time under the previous COO;

- the scale of the management agenda going forward – including the need to ensure we are able to improve both quality and productivity and deliver the ambitious Right Care, Right Here agenda and the need to demonstrate the management structure was delivering its contribution to the CIP for 2010/11.

In order to respond to these issues the following changes were agreed at December TMB.

- Merge the two divisions of Medicine and Emergency Care creating a single trust-wide Division of Medicine and Emergency Care. This will:

    - support moves to integrate medical specialities across the trust;

    - provide opportunities to support the development of clinical directorates in medicine;

    - support the increasing integration of emergency care services across the trust.

- Merge the divisions of Surgery A and Anaesthetics and Critical Care creating a single division of Surgery, Anaesthetics and Critical Care.

    - provide greater critical mass than the current small division of Anaesthetics and Critical Care is able to manage;

    - support closer integration of anaesthetics, theatres and surgery thereby supporting improved use of theatres;

    - provide opportunities to support the development of clinical directorates in surgery, anaesthetics and critical care.

- Review the structures in IM&T, Elective Access and Operations including:

    - establishing a single Director of IM&T reporting to the COO to replace the current arrangement of two deputy directors reporting directly to the COO.

    - Transferring responsibility for Elective Access from IM&T to the Deputy COO's portfolio.

It is intended to have these changes operational from 1st April 2010. Significant savings will be generated which are detailed in the relevant sections of the Cost Improvement Programme for 2010/11.

The resulting divisional structure including clinical directorates is set out in appendix A.

CONCLUSION AND RECOMMENDATIONS

This paper has summarised changes to the Trust's Executive Team and operational management structure in light of our current circumstances and future direction of travel.

Trust Board is recommended to

1. NOTE the changes to the Executive Team and the Trust's operational management structure.

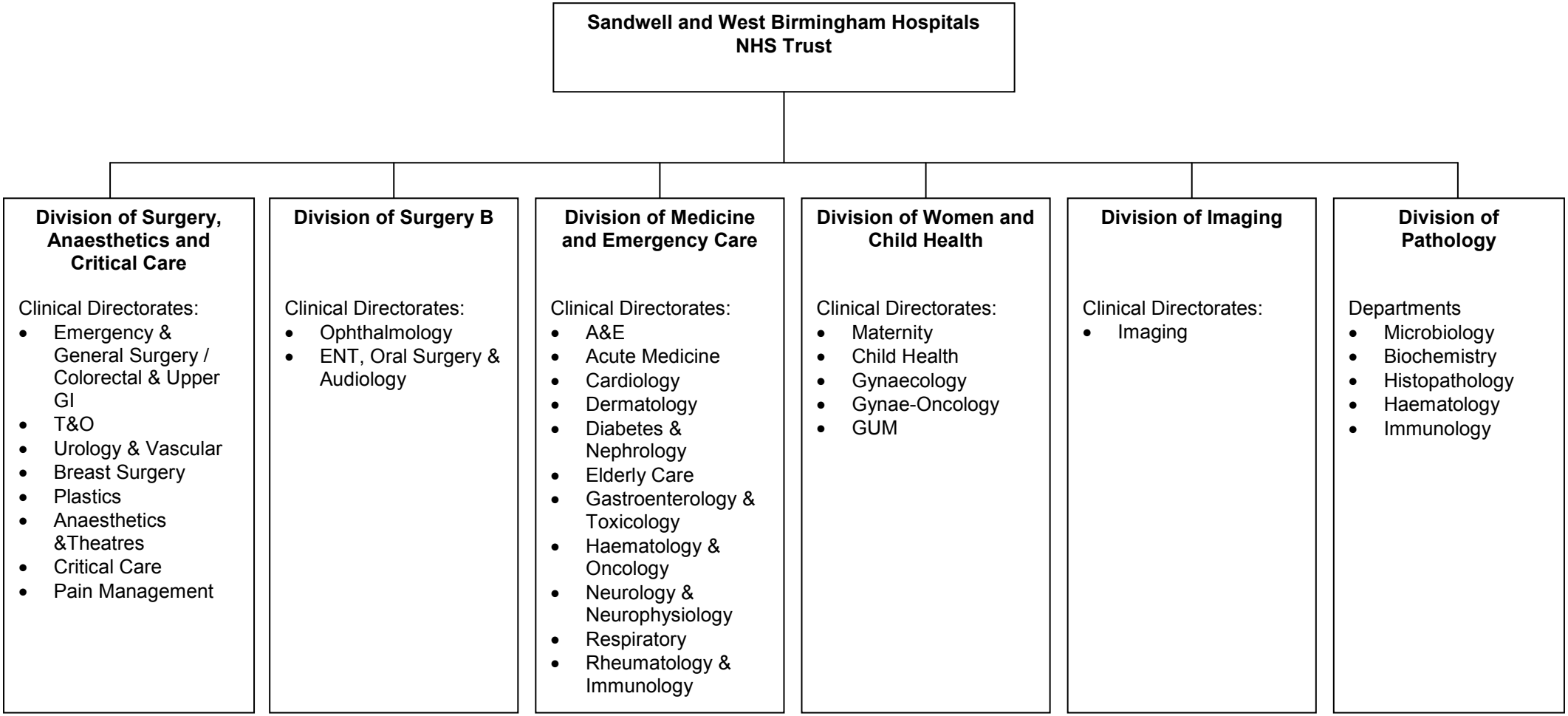
2. NOTE that the savings generated by the changes will contribute to the Cost Improvement Programme for 2010/11.

John Adler
Chief Executive

Richard Kirby
Chief Operating Officer

18th February 2010

Appendix A
Sandwell and West Birmingham Hospitals NHS Trust – Clinical Management Structure from 1st April 2010



Notes

1. The diagram shows the proposed clinical management structure only – it is not intended to be a full representation of the management structure of the Trust
2. The Trust currently has two directorates Elderly Care – one for each site. It is proposed to agree how best these divisions should be brought together on a cross-site basis as part of developing the detailed structure for the new medical division.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Finance and Performance Management Committee – v0.2

Venue Executive Meeting Room, City Hospital **Date** 21 January 2010; 1430h – 1630h

Members Present		In Attendance		Secretariat
Mr R Trotman	[Chair]	Mr T Wharram		Mr S Grainger-Payne
Mrs S Davis		Mr M Harding		
Miss I Bartram				
Mrs G Hunjan		**Guests**		
Dr S Sahota		Mr M Beveridge	[Item 4.1 only]	
Mr J Adler		Dr R Rasanayagam	[Item 4.1 only]	
Mr R White	[Part]	Mrs C Bromley	[Item 4.1 only]	
Mr R Kirby				

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
No apologies for absence were received.	
2 Minutes of the previous meeting – 17 December 2009	**SWBFC (12/09) 229**
The minutes of the previous meeting were accepted as a true and accurate record of discussions held on 17 December 2009.	
AGREEMENT: The minutes of the previous meeting were approved subject to minor amendment	
3 Matters arising from the previous meeting	**SWBFC (12/09) 229 (a)**
The updated actions log was noted by the Committee.	
4 Theatre utilisation	**Presentation**
Mr Mike Beveridge, Dr Romesh Rasanayagam and Mrs Corinne Bromley joined the meeting to present an update on progress with improving the Trust's operating theatre utilisation performance. Mr Kirby advised that good progress had been made on ensuring that theatre lists start on time and most particularly in the ophthalmology operating theatres. In January 2010, the improved position seen before Christmas had been noted to continue. Dr Rasanayagam reported that by the end of November 2009, all theatre lists were being reviewed in detail and the necessary support from the relevant consultants regarding the work needed to improve the utilisation position had been gained. Mr Beveridge added that information concerning both late starts and early finishes is now sent to Clinical Directors for review. Peer pressure to improve performance is	

also playing some part in the overall trend.

Mr Trotman asked whether there was a key member of staff who had the responsibility for reviewing the entire theatre pathway from organisation on the ward to delivery of the patient to theatre and preparation for surgery. He was advised that each theatre has an assigned team leader that takes this perspective. In addition, there are a number of individuals with responsibility for the overall co-ordination and performance monitoring of a set of theatres, to which issues requiring escalation may be addressed.

Mrs Hunjan remarked that it was encouraging to hear that the plans for improving performance were being discussed, but questioned whether the definition of a late start and an early finish had been clearly promulgated and were understood. She was advised that there was now a consistent view as to what constituted a late start or early finish. Mrs Davis asked whether, in addition to this internal understanding, there was any external information that could guide these definitions. Mrs Bromley advised that there is currently no available benchmarking information, although work is underway to develop this material. Mr Kirby added that he was planning to ask if his counterparts across the region would be willing to share their performance to assist with this matter.

Mr Kirby reported that although performance with late starts was improving well, that there was further work to do in respect of early finishes. In addition to tracking the number of theatre lists that were finishing early, the aggregated time lost as a consequence is also being recorded. This information suggests that there is now less overall time lost, although it is acknowledged that there is further work to do to deliver an improved performance. Mr Trotman asked whether the effect of emergency cases on theatre lists was being taken into account as part of this work. He was advised that this was not the case.

Mr Kirby advised that the number of overall theatre sessions being used is steadily rising, although the throughput of patients per list is steady. Until the late starts performance had improved, there had been little opportunity to look at increasing the number of patients per session, although given the progress made, extra cases will now be added to some lists. The start time for some orthopaedic theatre lists has also been brought forward. Mr Beveridge advised that the planned admissions unit is now being used to undertake preoperative screening which will assist with the situation.

Professor Alderson noted that although performance had improved, there was still further work to do to address fully the issue of late starts. He asked how a late start is defined. Mr Kirby highlighted that the real issue with theatre utilisation lies at the end of the day, rather than at the beginning where late starts now account for only a small loss of theatre time. Professor Alderson asked whether cancellation rates associated with poor utilisation were measured. Mr Kirby advised that very few operations are cancelled due to a lack of time at the end of the session. Professor Alderson asked whether briefing lists are used at the start of each session. Mrs Bromley advised that they were, although there was more work to do to ensure that they are used rigorously and consistently. Dr Rasanayagam advised that a team brief and debrief system is to be introduced, although observed that care needed to be taken to ensure that these briefings did not delay the start of sessions. Professor Alderson suggested that members of the theatre team should be asked to attend promptly and as a mandatory requirement. Mrs Bromley advised that a policy was being developed and implemented to add some structure to this process. Miss Bartram asked from where the idea of a mandatory team brief originated. She was advised that the Royal College of Surgeons had suggested that

this be adopted as best practice. Mr White advised that a report concerning theatre performance reporting had been prepared by the Trust's Internal Audit function, which had provided Limited Assurance. He added that the report was due to be discussed at the forthcoming Audit Committee on 4 February 2010. Mr Kirby reported that an action plan had been developed to address the recommendations arising from the report, which will be monitored by the Trust Theatre Board. Mr Trotman concluded by acknowledging the good progress made with addressing theatre utilisation and agreed to the proposal that an update on the situation should be presented next at the May meeting of the Committee. Mr Trotman thanked the team for their information and encouraging presentation.	
ACTION: **Mr Kirby to update the Committee on progress with improving theatre utilisation at its May meeting**	
5 Trust Board performance management reports	
5.1 2009/10 month 9 financial position and forecast	**SWBFC (1/10) 003** **SWBFC (1/10) 003 (a)** **SWBFC (1/10) 003 (b)**
Mr Wharram reported that an in-month surplus of £160k against a target surplus of £124k has been achieved. In-month WTEs were noted to be 40 below plan, with the cash balance being £1.3m greater than the revised plan as at 31 December 2009. It was noted that activity and associated income levels had increased and expenditure had risen in line with this trend. The Committee was advised that the value of overperformance against contract currently stood at £7m. The commissioners to which this overperformance relates were highlighted to be Sandwell PCT, Heart of Birmingham tPCT, South Birmingham PCT (mainly for ophthalmology) and the pan-Birmingham Group. Consideration has been given to the prospect of data challenges by commissioners. Other costs noted to have been incurred during the month were in respect of the hire of a MRI scanner on a temporary basis and orthopaedic work that had needed to be undertaken within the private sector, albeit on a cost neutral basis. The WTE position was noted to have declined slightly, although expenditure associated with bank and agency staff remains high. The Committee was advised that the spread of agency and bank costs across the Trust was currently being reviewed, although it had been noted that nursing budgets were currently performing better than planned. Two significant areas where these costs are being incurred were highlighted to be medical staff and Healthcare Assistants or support staff. Miss Bartram remarked that while it was evident that agency and bank staff expenditure continued to remain high, it did provide some benefit in terms of flexibility. Professor Alderson observed that this was particularly the case for locum staff. In terms of overtime, the deficit in middle grade cover was noted to be being addressed, although some interim solutions are being introduced while new medical staff are being recruited on a substantive basis. Mr Wharram reported that capital expenditure had accelerated and the cash balance remained healthy.	
5.2 Performance monitoring report	**SWBFC (1/10) 004**

	SWBFC (1/10) 004 (a)
Mr Harding reported that there had been an increase in delayed transfers of care during December, to 23 instances, the majority of which were attributed to the restricted opening hours of social services over the winter vacation. In terms of the target regarding reperfusion following a coronary arrest, the Trust had been measuring its performance against an internal target of 90 minutes from call to balloon, although the Committee was advised that the Care Quality Commission had recently published a target of 150 minutes. Performance against the stroke care target was noted to have deteriorated during November to 46.4% of stroke patients spending 90% or more of their stay on a dedicated stroke unit. The Committee was advised that although the performance had been disappointing, processes had been implemented to ensure real time validation of the information and closer scrutiny of the position on a daily or weekly basis. There is also work underway to ensure that the required stroke care pathway is followed rigorously. An on-call manager is now alerted if pathways are not adhered to, in a manner analogous to that of a potential breach of Accident and Emergency waiting time targets. Mr Kirby reported that a major issue concerned the delays incurred by an intermediate assessment that occurs before a patient is sent to a stroke unit. It was noted that the national targets for stroke care had been revised to make them more lenient, suggesting that the issue that the Trust was experiencing may be the same nationally. Performance against the CQUIN targets was reviewed. It was noted that smoking cessation referrals had been disappointing. A proportion of the tariff, to the value of £220k, was reported to be allocated to this particular target, although this is paid on a phased basis for every 10% of the target achieved. Mr Adler advised that for the final part of the year, an opt-out system will be introduced where patients who smoke will automatically be referred to a smoking cessation service, unless they express a wish for this referral not to be made. The matter had been discussed and agreed by the Trust Management Board. The Committee noted that same sex accommodation breaches were now included in the performance monitoring report, as were outpatient cancellations. No specific targets had been set for these measures, although for the latter of these indicators, it appears that there is a relatively even split between cancellations instigated by the Trust and those as a result of patient cancellations. Performance against the rapid access for chest pain target was noted to have been 100% for both sites, resulting in a year to date performance of 99.8%.	
5.3 Foundation Trust compliance report	**SWBFC (1/10) 005** **SWBFC (1/10) 005 (a)**
As the information presented was noted to be a subset of the monthly performance management information, the Committee noted the report. The Governance Risk Rating was amber in reflection of the deterioration of performance against the Accident and Emergency waiting time target and the declaration of non-compliance against the Core Standard C11b.	
5.4 NHS performance framework	**SWBFC (1/10) 006** **SWBFC (1/10) 006 (a)**
Mr Harding presented the Trust's performance against the indicators comprising the NHS performance framework.	

The Committee was pleased to note that the Trust remains classified as a 'performing' organisation, despite the amber rating. Mr Harding advised that the Department of Health had revised a number of the thresholds within this framework, including those associated with cancer waiting times and stroke care. Data for Quarter 3 was noted to be based on the revised targets and performance was highlighted to meet or achieve the targets for the majority.	
6 Financial planning update	**SWBFC (1/10) 007** **SWBFC (1/10) 007 (a)** **SWBFC (1/10) 007 (b)**
Mr White reported that in terms of financial planning for 2010/11, a number of measures had been put in place, including the 'road test' tariff. The Operating Framework had also been issued, which clarified expectations around efficiencies to be delivered. Cost Improvement Plan targets had been developed with the efficiency expectations in mind. There was however, considerable work to be done to prepare for and settle the current LDP negotiations. Outline plans for the health economy in 10/11 are due to be submitted at the end of January. A surplus of c. £2m is expected of the Trust in 2010/11 on the basis of the controls issued by the SHA. There is an expectation that the contracts with commissioners should be signed by the end of February 2010, with the budget being brought to the Board for approval subsequently. Mr White advised that by 2015/16, the 'Right Care, Right Here' planning assumptions would see acute activity fall with a significant proportion linked to procedures of limited clinical value, therefore the services will need to be adjusted over the years leading up to this. Access to the strategic transitional reserve will be required to assist with this requirement. Tariffs for four best practice pathways will be introduced and plans to align to the Trust to this development are already underway through the divisional annual planning process. In terms of CQUIN, a further 1% of tariff will be added for 2010/11, although the list of targets is as yet, unclear. Payment will not be made for any 'Never Events' that occur. To deliver the surplus and CIP, the Committee was advised that a target income of £372m income is required. Mr Trotman noted that expenditure on pay is a significant issue and asked how robust the plans were to address bank and agency costs as part of the overall financial programme as he was very concerned that pay was over budget this year and was conscious that that this should be avoided in 2010/11. Mrs Davis added her concern that the presentation of overall pay costs in 2009/10 with those planned for 2010/11 did not show a clear reduction in pay spend. Mr Kirby advised that additional capacity had been necessary to handle the operational pressures recently. An increasingly smaller group of areas did rely on agency and bank staff, including theatres, Accident and Emergency departments and assessment units. He gave assurances that the use of bank and agency staff would be addressed in the coming year, alongside the implementation of a number of operational efficiencies that would assist. The current level of overspend in Medicine and Surgery was reported to be necessary to ensure unimpeded patient flow. Mr Kirby continued that a benchmarking exercise on pay costs had been undertaken by Dr Foster, where the Trust was compared with eleven similar trusts, the results from which will be built into future capacity planning	

considerations. Mr White explained that the 2009/10 pay summary line included all forecast related pay, whereas the plan for 2010/11 was broken down into start point budgets together with a series of reserves for pay awards and activity related costs as offset by CIP targets. He was asked to ensure that future financial planning updates include greater detail on the plans to address pay costs.	
ACTION: **Mr White to include greater detail on the plans to address pay costs in future financial planning updates**	
7 Cost improvement programme (2009/10)	
7.1 CIP delivery report	**SWBFC (1/10) 002** **SWBFC (1/10) 002 (a) - SWBFC (1/10) 002 (d)**
Mr Wharram presented the monthly 2009/10 CIP delivery report, which it was noted had been reviewed in detail at the Financial Management Board meeting. It was noted that there had been little change from the previous month, with performance being adrift of plan by 0.9%.	
7.2 Quality and Efficiency programme (QuEP) update	**SWBFC (1/10) 008** **SWBFC (1/10) 008 (a)**
Mr Adler presented a summary of the progress with the workstreams forming the Quality and Efficiency Programme (QuEP). The Committee was advised that a red, amber and green rating was now used to provide an indication of progress with each of the workstreams. The Committee was pleased to hear that the pace of progress with the programme was good. The capacity review workstream was noted to be at red status, although it is anticipated that this work will be delivered by the year end as planned. The clinical directorate workstream was reported to require the identification of projects during the first quarter of 2010/11. These will be kept under review. Detailed CIP and establishment review sign off meetings are planned shortly. Mr Trotman asked that the detailed outcome of some of the workstreams be shared with the Committee when available. Mr Adler suggested that the outcome of the benchmarking work may be shared shortly. Mr Grainger-Payne was asked to add an item concerning the most appropriate means of reporting the outcome of the QuEP work to the Committee to the agenda of the next Financial Management Board for discussion.	
ACTION: **Mr Grainger-Payne to add an item concerning the most appropriate means of reporting the outcome of the QuEP work to the Finance and Performance Management Committee to the agenda of the next Financial Management Board**	
8 Minutes for noting	
8.1 Minutes of the Strategic Investment Review Group	**SWBSI (1/10) 001**
The Committee noted the minutes of the SIRG meeting held on 8 December 09.	

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8.2 Actions and decisions from the Strategic Investment Review Group	**SWBFC (1/10) 009**
The Committee noted the actions and decisions arising from the meeting of SIRG meeting held on 12 January 10.	
8.3 Minutes of the Financial Management Board	**SWBFM (12/09) 122**
The Committee noted the minutes of the FMB meeting held on 15 December 09.	
9 Any other business	**Verbal**
There was none.	
10 Details of next meeting	**Verbal**
The next meeting is to be held on 18 February 2010 at 1430h in the Executive Meeting Room at City Hospital.	

Signed .....

Print .....

Date .....