Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Anne Gibson Boardroom, City Hospital **Date** 27 May 2010 at 1430h

Members

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

In Attendance

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

Guests

Dr J Middleton	(JM)
Dr B Oppenheim	(BAO)
Mrs J Dunn	(JD)

Secretariat

Mr S Grainger-Payne (SGP) [Secretariat]

Item	Title	Reference No.	Lead
1	**Apologies**	**Verbal**	**SGP**
2	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting*	**Verbal**	**All**
3	**Chair's opening comments**	**Verbal**	**Chair**
4	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 29 April 2010 as true and accurate records of discussions*	**SWBTB (4/10) 095**	**Chair**
5	**Update on actions arising from previous meetings**	**SWBTB (4/10) 095 (a)**	**Chair**
6	**Questions from members of the public**	**Verbal**	**Public**
	PRESENTATION		
7	**Public Health matters – Sandwell PCT**	**SWBTB (5/10) 098** **SWBTB (5/10) 098 (a)**	**JM**
	MATTERS FOR APPROVAL		
8	**Application of Trust Seal - MAU enabling works at City Hospital contract documentation**	**SWBTB (5/10) 111**	**GS**
9	**Digital mammography service business case**	**To follow**	**RK**
10	**Register of Interests**	**SWBTB (5/10) 104** **SWBTB (5/10) 104 (a)**	**SGP**

MATTERS FOR INFORMATION/NOTING			
11	**Quality and Governance**		
11.1	Infection control annual report	SWBTB (5/10) 109 SWBTB (5/10) 109 (a)	BAO
11.2	Quarterly infection control assurance framework update	SWBTB (5/10) 103 SWBTB (5/10) 103 (a)	RO
11.3	Quarterly cleanliness report	SWBTB (5/10) 110 SWBTB (5/10) 110 (a) SWBTB (5/10) 110 (b)	RO
11.4	Staff survey report and action plan	SWBTB (5/10) 112 SWBTB (5/10) 112 (a)	RO
11.5	National patient survey results	SWBTB (5/10) 107 SWBTB (5/10) 107 (a)	JK
11.6	Freedom of Information update	SWBTB (5/10) 097 SWBTB (5/10) 097 (a)	SGP
12	**Strategy and Development**		
12.1	'Right Care, Right Here' programme: progress report	SWBTB (5/10) 101 SWBTB (5/10) 101 (a) SWBTB (5/10) 101 (a)	RK
12.2	New acute hospital project: progress report	SWBTB (5/10) 100 SWBTB (5/10) 100 (a)	GS
12.3	Implementation plan for the reconfiguration of maternity services	SWBTB (5/10) 114 SWBTB (5/10) 114 (a)	JD
12.4	Interim reconfiguration evaluation	SWBTB (5/10) 102 SWBTB (5/10) 102 (a)	JD
12.5	Communications and engagement strategy update	SWBTB (5/10) 106 SWBTB (5/10) 106 (a)	JK
13	**Performance Management**		
13.1	Monthly finance report	SWBTB (5/10) 116 SWBTB (5/10) 116 (a)	RW
13.2	Monthly performance monitoring report	SWBTB (5/10) 113 SWBTB (5/10) 113 (a)	RW
13.3	NHS Performance Framework monitoring report	SWBTB (5/10) 117 SWBTB (5/10) 117 (a)	RW
14	**Update from the Board Committees**		
14.1	Finance and Performance Management Committee		
▶	Minutes from meeting held 22 April 2010	SWBFC (4/10) 047	RT
14.2	Governance and Risk Management Committee		
▶	Minutes from meeting held 18 March 2010	SWBGR (3/10) 024	DA

15	**Any other business**	**Verbal**	**All**
16	**Details of next meeting** *The next public Trust Board will be held on 24 June 2010 at 1430h in the Churchvale/Hollyoak Rooms, Sandwell Hospital*	**Verbal**	**Chair**
17	**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 0.2

Venue Churchvale/Hollyoak Rooms, Sandwell Hospital **Date** 29 April 2010 at 1430 hrs

Present:	Mrs Sue Davis	Dr Sarindar Sahota	Mr Robert White
	Mr Roger Trotman	Prof Derek Alderson	Mr Richard Kirby
	Miss Isobel Bartram	Mr Gary Clarke	Mr Donal O'Donoghue
	Mrs Gianjeet Hunjan	Mr John Adler	Miss Rachel Overfield
In Attendance:	Miss Kam Dhami	Mr Graham Seager	Mrs Jessamy Kinghorn
	Mrs Chris Rickards		
Secretariat:	Mr Simon Grainger-Payne		

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Mr John Cash was not able to attend the meeting.	
2 Declaration of interests	**Verbal**
Mrs Davis advised that the revised version of the Register of Interests would be presented at the May meeting of the Trust Board. The Board was advised that Mr Gary Clarke, new Non Executive Director worked for Dorcas Housing and Community Association, an organisation which contracts with Sandwell PCT.	
3 Chair's opening comments	**Verbal**
The Chair welcomed Mr Clarke and Mrs Chris Rickards to their first meeting. Mr Clarke joined as new Non Executive Director on 1 April 2010 and Mrs Rickards succeeded Miss Judith Whalley as Trust Convenor. The Board was advised that the meeting was the last at which Miss Isobel Bartram would attend as Non Executive Director, with her last day in office being 19 May 2010. Miss Bartram was thanked for her long standing contribution to the Trust and for her valuable experience and contribution to the work of the Trust Board. The Chair reported that Miss Bartram had been thanked for her attendance at Heart of Birmingham tPCT Trust Board meeting by the Chair of the PCT. Mrs Rickards added her thanks for Miss Bartram's work as Chair of the Joint Consultation and Negotiating Committee (JCNC). Miss Bartram remarked that she had enjoyed her time with the Trust and thanked all for their well wishes.	

4 Minutes of the previous meeting	**SWBTB (3/10) 073**
The minutes of the previous meeting were presented for approval. It was suggested that within section 2, that the reference to 'sitting for a parliamentary seat' should be amended to 'standing for a parliamentary seat'. Subject to this minor amendment, the Trust board approved the minutes.	
AGREEMENT: The minutes of the previous meeting on 25 March 10 were approved as true and accurate reflections of discussions held	
5 Update on actions from previous meetings	**SWBTB (3/10) 073 (a)**
The updated actions list was reviewed. There were noted to be no outstanding actions requiring escalation.	
6 Questions from members of the public	**Verbal**
There were no members of the public in attendance at the meeting.	
7 Sustainability Development Management Plan update	**SWBTB (4/10) 078** **SWBTB (4/10) 078 (a) -** **SWBTB (4/10) 078 (d)**
Mr Seager presented an update on the Trust's sustainability development management plan. Mr Trotman asked when the cost of the activities within the plan would be evident. He was advised that the majority of the actions generate a payback and there would be savings on the energy and waste budgets. A small number of schemes require some initial investment, however these are still expected to deliver savings or pay back the investment. It was noted that the transport workstream and procurement engagement with the work would form some of the key aspects of the plan. Local initiatives are also to be undertaken as part of the work. The Trust Board was asked for and gave its approval to the Trust's participation in the NHS Carbon Management Programme, with Mr Seager representing the Trust.	
AGREEMENT: The Trust Board approved the proposed participation of the Trust in the NHS Carbon Management Programme, represented by Mr Seager	
8 Blood transfusion policy	**SWBTB (4/10) 087** **SWBTB (4/10) 087 (a) -** **SWBTB (4/10) 087 (c)**
Mr O'Donoghue presented the revised blood transfusion policy, which the Trust Board was asked to note had been amended to reflect the introduction of the new blood tracking system. The policy was also noted to be critical to the forthcoming NHS Litigation Authority assessment against general risk management standards. The operation of the new blood tracking system was noted to be contained within the policy's appendix. The Chair noted that the policy instructs the user which hand	

should be used to open the door to the HemoSafe and asked whether there were any Disability Discrimination Act implications to this instruction. Mr O'Donoghue offered to determine whether there are. The Trust Board was advised that the policy had received scrutiny and approval by the Trust Transfusion Committee, Drug and Therapeutics Committee and the Governance Board. The Trust Board was asked for and gave its approval to the revised blood transfusion policy.	
ACTION: **Mr O'Donoghue to check whether there are any Disability Discrimination Act implications arising from the blood transfusion policy** **AGREEMENT:** **The Trust Board approved the blood transfusion policy**	
9 Transport of Krypton generators – single tender action	**SWBTB (4/10) 088**
Mr Kirby presented a single tender arrangement for transport services for krypton generators for the Trust board's ratification. The payment for the services was noted to be £144,000 to DSB Active Limited. Although a competitive tendering exercise for the specialist transport services had been undertaken a number of years ago, Mr Trotman suggested that a similar exercise be undertaken before the end of the next annual contract to ensure that the Trust was obtaining appropriate value for money. Dr Sahota asked whether the Trust received any income from the production of krypton generators. He was advised that in conjunction with the University of Birmingham, costs were covered, with no profit being made. The Trust Board was asked to and ratified the single tender arrangement	
AGREEMENT: **The Trust Board approved the single tender arrangement for transport services for krypton generators**	
10 Quality and Governance	
10.1 Equality and Diversity update	**SWBTB (4/10) 075** **SWBTB (4/10) 075 (a)** **SWBTB (4/10) 075 (b)**
Miss Overfield presented an update on the work of the Equality and Diversity Steering Group and the implementation of the Single Equality Scheme. Miss Bartram asked how any equality and diversity issues noted from the HR dashboard would be handled operationally. Miss Overfield advised that such matters would be picked up by the workforce strand of the Equality and Diversity Steering Group. Dr Sahota highlighted that age discrimination could be a potential issue and suggested that the Board should review a breakdown of staff by age. Miss Overfield advised that this data was available, although some further analysis around this	

information was needed.

Mr Clarke asked when disclosure of information by staff was an issue. He was advised that in particular, staff are reluctant to disclose equality and diversity information on appointment. Mrs Rickards confirmed that this was the case. Miss Overfield commented that when staff see positive steps being taken on the basis of information provided, that this may encourage information to be provided. Mr Clarke asked whether the personally-identified aspect of the information could be removed, however Miss Overfield confirmed that the information provided was not personally identifiable. Miss Bartram commented that she had experienced the same issue with students in her previous role in education. The Chair suggested that staff should be made aware of the reasons why the information is collected.

Mrs Hunjan asked whether the Trust's cost improvement programme for 2010/11 would impact adversely on the ability to deliver interpreting services. Miss Overfield advised that this would not be the case.

Mr O'Donoghue noted that the position regarding promotions was positive and appeared to have addressed the concerns raised by staff at a recent 'Listening into Action' event. Miss Overfield confirmed that this was a positive position.

In terms of recruitment, Miss Overfield advised that the Trust receives a significant number of applications from individuals overseas that it is unable to consider under national immigration policy, therefore investigations are underway to determine whether there is a means of filtering these applications from the national recruitment system.

Mr O'Donoghue asked how an Equality and Diversity issue would be triggered from the HR dashboard information. He was advised that the workforce steam of the Equality and Diversity Steering Group would consider the information, although thresholds determining what constituted an issue were not clearly defined.

The Chair suggested that there was a need to measure disability in terms of appointments more robustly.

Miss Overfield advised that there was no IT solution to determining whether an individual was an asylum seeker. There was however guidance available to determine whether a patient is an immigrant. Although concern was expressed about asking this question, by both Dr Sahota and Mr O'Donoghue, Mrs Kinghorn advised that this was an increasing requirement of the engagement agenda, particular for gypsy and traveller communities. Miss Overfield offered to determine the source of the requirement to ask whether an individual was an asylum seeker or immigrant. Mr White suggested that this may lie with the ability to offer free healthcare to patients. Miss Bartram suggested that organisations handling asylum seekers may be able to assist with the query.

Mr Adler noted that there further legislative requirements around equality and diversity as part of the new Equality Bill. He asked what plans had been put into place to handle this legislation. Miss Overfield advised that the revised Single Equality Scheme had incorporated these requirements. Dr Sahota suggested that procurement activity also needed to incorporate equality. Mr White confirmed that the standards on the PASA framework incorporate equality considerations.

It was suggested that the position of the Trust in respect of the legislative requirements of the new Equality Bill should be discussed at the next Trust Board

seminar.	
ACTION: **Miss Overfield to determine the source of the request to determine whether patients are asylum seekers or immigrants** **ACTION:** **Miss Overfield to present the Trust's position regarding the requirement of the new Equality Bill at the next Trust Board seminar**	
10.2 Progress with safeguarding adults and children agenda	**SWBTB (4/10) 085** **SWBTB (4/10) 085 (a)**
Miss Overfield presented the quarterly update on progress with the safeguarding adults and children agenda. Miss Bartram asked where child protection issues had been considered before being included in the red incident report. She was advised that the Governance Board reviewed such issues previously and continue to do so in addition to the Trust Board. Furthermore, the Strategic Health Authority will be appraised of the issue, if it is an incident for which the Trust is responsible. Mr Adler commented that the Trust's new membership of the Birmingham Safeguarding Board was positive. He suggested that it would be useful to review safeguarding trends, although Miss Overfield advised that trends and comparative information was not yet available. Any trends will be incorporated into the regular updates to the Trust Board however. It was suggested that if a concern prompts an investigation, that there should be a clear interface with the incident reporting process. The Board was advised that this interface is already in place. Miss Dhami added that a publication by the National Reporting and Learning Service (NRLS) included such matters within the set of incidents that needed to be reported to the Strategic Health Authority. Mr Adler suggested that greater thought needed to be given to which incidents are graded as red alerts. Mr O'Donoghue advised that pressure damage was now included within the set of CQUIN targets. Sores graded as three or above are to be reported as red incidents, the rest being tracked at ward level or through clinical directorates. The Chair asked how the Trust compared to other organisations with what it was being asked to report in terms of safeguarding. Miss Overfield advised that this was consistent with other organisations, particularly in relation to the safeguarding adults level. Vulnerability around a patient's finances was highlighted to be a further issue which the Trust is obliged to report. Mr Adler emphasised the need to mainstream the reporting and handling process where possible.	
10.3 CQC registration: ongoing monitoring of compliance	**SWBTB (4/10) 093** **SWBTB (4/10) 093 (a)**
Miss Dhami presented an overview of the process by which the Care Quality Commission (CQC) would monitor compliance with standards, following the recent confirmation that the Trust had been awarded registration without any conditions attached. Miss Bartram noted that the list of requirements under the 'statutory duties' regulation appeared to be vague, however Miss Dhami advised that further information was available in the detailed guidance provided by the CQC. Mr Adler	

suggested that Miss Dhami should circulate the detailed guidance and explain how the multi agency approach to the ongoing monitoring works. Miss Dhami advised that as from 1 April 2010, a mandatory requirement was introduced to report any Serious Untoward Incidents to the NPSA. If a trend of incidents emerges, then the contents of the Quality and Risk Profile (QRP) may be amended by the CQC.	
ACTION: **Miss Dhami to circulate the detailed guidance behind the CQC monitoring requirements, together with an explanation of the multi agency approach to this work**	
10.4 Register of Seals update 2009/10	**SWBTB (4/10) 083** **SWBTB (4/10) 083 (a)**
Mr Grainger-Payne presented the register of sealings that had been undertaken during 2009/10, which the Trust Board received and noted.	
10.5 National outpatient survey results	**SWBTB (4/10) 089** **SWBTB (4/10) 089 (a)** **SWBTB (4/10) 089 (b)**
Mrs Kinghorn presented the results from the latest national outpatient survey. Dr Sahota commented that it would be interesting to know if a member of staff is praised as part of this work so the Trust could follow this up. Mr Adler asked how this information was being used as part of the overall patient satisfaction survey work. Miss Overfield advised that the themes from the results are incorporated into the patient experience action plan. Mr Kirby reported that a number of the areas where the Trust was in the bottom 20% of trusts were being addressed through programmes of work already in place within the Trust. Mr Trotman suggested that an electronic display system should be installed into waiting areas to let patients know how long it will be before they will be seen by the relevant consultant or clinician. Professor Alderson observed that the results were based on only a small sample of patients, therefore may not be totally reflective of the true picture. The Chair highlighted that in house surveys present a more up-to-date view, and are often significantly larger samples.	
11 Strategy and Development	
11.1 'Right Care, Right Here' programme: progress report	**SWBTB (4/10) 090** **SWBTB (4/10) 090 (a)** **SWBTB (4/10) 090 (b)**
Mr Kirby presented the latest update on progress with the 'Right Care, Right Here' programme, which was received and noted by the Board. The Board was asked to note that the work is ongoing and work is underway to focus on the financial implications of the revised activity model of the local health economy.	
11.2 New Acute Hospital project: progress report	**SWBTB (4/10) 079** **SWBTB (4/10) 079 (a)**
Mr Seager presented the new acute hospital project progress report, which the	

Board received and noted. Mr Clarke asked whether sustainability considerations could be built into associated contracts. He was advised that in many cases such clauses are included and every effort is being made to support the sustainability agenda.	
11.3 Update on the workforce strategy	**SWBTB (4/10) 076** **SWBTB (4/10) 076 (a)** **SWBTB (4/10) 076 (b)**
Miss Overfield reported that the workforce strategy is due to run to 2015 and will be rewritten in due course. This will incorporate the preparation for and impact of staff transfers to community settings. , Mr Adler asked what progress had been made with equal pay claims arising before the Agenda for Change pay and grading system had been introduced. Miss Overfield agreed to check the position.	
ACTION: Miss Overfield to determine progress with the equal pay claims prior to the introduction of Agenda for Change	
12 Performance Management	
12.1 Monthly finance report	**SWBTB (4/10) 092** **SWBTB (4/10) 092 (a)**
Mr White reported that the year end surplus achieved was £2,279k; £10k above plan. The Board was advised that the draft accounts were being validated by the Trust's auditors, KPMG, and will be considered by the Audit Committee at its meeting in early May 2010. Mr White reported that the income and expenditure position will reflect the outcome of the recent valuation of assets by the District Valuer. This however would be treated as a non-cash technical adjustment. The statutory financial duties required of the Trust were reported to have been met by the year end and virtually all of the capital budget had been spent. The Trust was noted to have over performed on both patient-related income and other income, however this was matched by an equal over performance on expenditure to deliver the higher than planned activity. The Chair thanked all involved with the delivery of the year end position and preparation of the accounts.	
12.2 Monthly performance monitoring report	**SWBTB (4/10) 091** **SWBTB (4/10) 091 (a)**
Mr White presented an update on the Trust's performance against all key targets. He reported that all key national targets and priorities had been met by the Trust. Mr Kirby asked the Board to note that activity and in particular the number of admissions into Accident and Emergency since the start of the new year were higher than expected, which is likely to impact on the four hour accident and emergency waiting times and cancelled operations targets. The Chair asked whether work was underway with the local PCTs to stem demand. She was advised that this was receiving attention, although there was only limited work that could be	

undertaken to prevent arrivals at Accident and Emergency. Mr O'Donoghue highlighted that urgent care centres are now in place and asked what effect these facilities were having. Mr Kirby advised that both the Sandwell and Birmingham urgent care centre were up and running but this would not impact significantly on emergency admissions. Mrs Rickards asked how the intention to close beds as part of the Trust's future plans would impact and in particular whether it would exacerbate the current pressures. Mr Kirby acknowledged that this would be the case if the aligned efficiencies are not delivered. Mr O'Donoghue added that closure of beds would be challenging, although there remained a need to ensure that patients can return home without an unwarranted extended stay in hospital. The Chair noted the concern over current operational pressures. However she congratulated the Executive Directors on the overall performance against key targets in 2009/10.	
12.3 NHS performance framework monitoring report	**SWBTB (4/10) 094** **SWBTB (4/10) 094 (a)**
Mr White presented the NHS Performance Framework monitoring report. The Board was pleased to note that the Trust remains classified as a 'performing' organisation and that performance against all targets was rated as being 'green'.	
12.4 Progress against the delivery of the Trust's corporate objectives – Quarter 4	**SWBTB (4/10) 077** **SWBTB (4/10) 077 (a)**
Mr Kirby presented the final update for 2009/10 on progress with the delivery of the Trust's corporate objectives. It was noted in particular that the final rating for achievement of NHS Litigation risk assessment standards was red, however this had been declared in the Statement on Internal Control for 2009/10.	
13 Operational Management	
13.1 Staff engagement briefing	**SWBTB (4/10) 084** **SWBTB (4/10) 084 (a)**
Mr Adler advised that a forthcoming birthday party had been arranged to celebrate the second anniversary of 'Listening into Action'. He reported that at the last 'Listening into Action' sponsor group meeting, it was noted that the approach is becoming embedded successfully into the Trust. Further work is planned to continue embedding 'Listening into Action' however. The Trust Board noted the positive responses to the set of questions within the staff survey which related to staff engagement.	
14 Update from the Committees	
14.1 Finance and Performance Management	**SWBFC (3/10) 037**
The Board received and noted the minutes of the Finance and Performance Management Committee meeting held on 18 March 2010.	

15 Any other business	**Verbal**
Mr Adler advised that the plans to name the new hospital would be launched in May. A shortlist of names will be presented to the Trust Board in the summer, with the intention of selecting a name in the autumn.	
16 Exclusion of the press and public	**Verbal**
The Board resolved that representatives of the Press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1 (2) Public Bodies (Admission to Meeting Act 1960).	

Signed ……

Print……

Date ……

Next Meeting: 27 May 2010, Anne Gibson Boardroom @ Sandwell Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

29 April 2010 - Sandwell Hospital

Members present: Mrs S Davis (SD), Mr R Trotman (RT), Miss 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), Miss R Overfield (RO)

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

Apologies: None

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 21 May 2010

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status	Review Date
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	Considered by the Executive Team on 4 May and amendments to be incorporated before circulation to the Trust Board	In hand - review next meeting	24-Jun-10
SWBTBACT. 122	Blood transfusion policy	SWBTB (4/10) 087 SWBTB (4/10) 087 (a) SWBTB (4/10) 087 (b)	29-Apr-10	Check whether there are any Disability Discrimination Act implications arising from the blood transfusion policy	DOD	27-May-10	Still to be confirmed	In hand - review next meeting	24-Jun-10
SWBTBACT. 124	Equality and Diversity update	SWBTB (4/10) 075 SWBTB (4/10) 075 (a) SWBTB (4/10) 075 (b)	29-Apr-10	Present the Trust's position regarding the requirements of the new Equality Bill at the next Trust Board seminar	RO	27-May-10	Scheduled for seminar planned for 24 June 2010	In hand - review next meeting	24-Jun-10
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	Agreed that will present at the September meeting when sufficient information available to report	Future	30-Sep-10
SWBTBACT. 123	Equality and Diversity update	SWBTB (4/10) 075 SWBTB (4/10) 075 (a) SWBTB (4/10) 075 (b)	29-Apr-10	Determine the source of the request to determine whether patients are asylum seekers or immigrants	RO	27-May-10	Under investigation and will provide update as part of next Equality and Diversity update	Future	29-Jul-10
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	Included on the May agenda	Completed Since Last Meeting	
SWBTBACT. 117	Maternity services reconfiguration business case	SWBTB (2/10) 045 SWBTB (2/10) 045 (a) SWBTB (2/10) 045 (b) SWBTB (2/10) 045 (c)	25-Feb-10	Present the implementation plan for the reconfiguration of maternity services at the May meeting of the Trust Board	JD	27-May-10	Included on the May agenda	Completed Since Last Meeting	
SWBTBACT. 119	Maternity services reconfiguration business case	SWBTB (2/10) 045 SWBTB (2/10) 045 (a) SWBTB (2/10) 045 (b) SWBTB (2/10) 045 (c)	25-Feb-10	Present the timetable for the identification of a location for a new stand alone midwifery-led unit at a future Trust Board meeting	JD	27-May-10	Included on the May agenda	Completed Since Last Meeting	

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status	Review Date
SWBTBACT. 120	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	Further supporting information includes as an appendix to the Equality and Diversity report.	Completed Since Last Meeting	
SWBTBACT. 125	CQC registration: ongoing monitoring of compliance	SWBTB (4/10) 093 SWBTB (4/10) 093 (a)	29-Apr-10	Circulate the detailed guidance behind the CQC monitoring requirements, together with an explanation of the multi agency approach to this work	KD	27-May-10	Will be completed before the meeting	Completed Since Last Meeting	
SWBTBACT. 126	Update on the workforce strategy	SWBTB (4/10) 076 SWBTB (4/10) 076 (a) SWBTB (4/10) 076 (b)	29-Apr-10	Determine the progress with the equal pay claims prior to the introduction of Agenda for Change	RO	27-May-10	The claims are being administered for the Trust by Mills and Reeve LLP. The Trust is under the jurisdiction of the tribunal offices in Newcastle and are working to a process and timescales that they prescribe	Completed Since Last Meeting	

Next Meeting: 27 May 2010, Anne Gibson Boardroom @ Sandwell Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

29 April 2010 - Sandwell Hospital

Members present: Mrs S Davis (SD), Mr R Trotman (RT), Miss 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), Miss R Overfield (RO)

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

Apologies: None

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 21 May 2010

Reference No	Item	Paper Ref	Date	Agreement
SWBTBAGR.159	Minutes of the previous meeting	SWBTB (3/10) 073	29-Apr-10	Subject to minor amendment, the Trust Board approved the minutes of the previous meeting as a true and accurate records of discussions held.
SWBTBAGR.160	Sustainability Development Management Plan update	SWBTB (4/10) 078 SWBTB (4/10) 078 (a) - SWBTB (4/10) 078 (d)	29-Apr-10	The Trust Board approved the proposed participation in the NHS Carbon Management Programme, represented by Mr Graham Seager
SWBTBAGR.161	Blood transfusion policy	SWBTB (4/10) 087 SWBTB (4/10) 087 (a) - SWBTB (4/10) 087 (c)	29-Apr-10	The Trust board approved the blood transfusion policy
SWBTBAGR.162	Transport of Krypton generators - single tender action	SWBTB (4/10) 088	29-Apr-10	The Trust Board approved the single tender arrangement for transport services for krypton generators

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Public Health Report for Sandwell PCT
SPONSORING DIRECTOR:	John Middleton, Director of Public Health, Sandwell PCT
AUTHOR:	John Middleton, Director of Public Health, Sandwell PCT
DATE OF MEETING:	27 May 2010

SUMMARY OF KEY POINTS:

Sandwell PCT's annual public health report is presented.

It is suggested that two major public health emergencies are confronting Sandwell at present:

- the rise in heart disease in younger people - which may well have been the result of recession and unemployment from the 1980s and
- the credit crunch which would limit our effort to improve health now and would make worse the health of our people in years to come.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Supports a number of the Trust's annual strategic objectives.
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Annual update as part of Trust Board's reporting cycle

5% for health: The 20th Annual Public Health Report for Sandwell

1. Introduction - Still crunch time

My last public health annual report was written in October 2008 at the very peak of the international credit crunch crisis. The potential collapse of the world banking system led to government interventions in many nations, to stave off the collapse of business and industry and the threat of prolonged depression, unemployment and poverty.

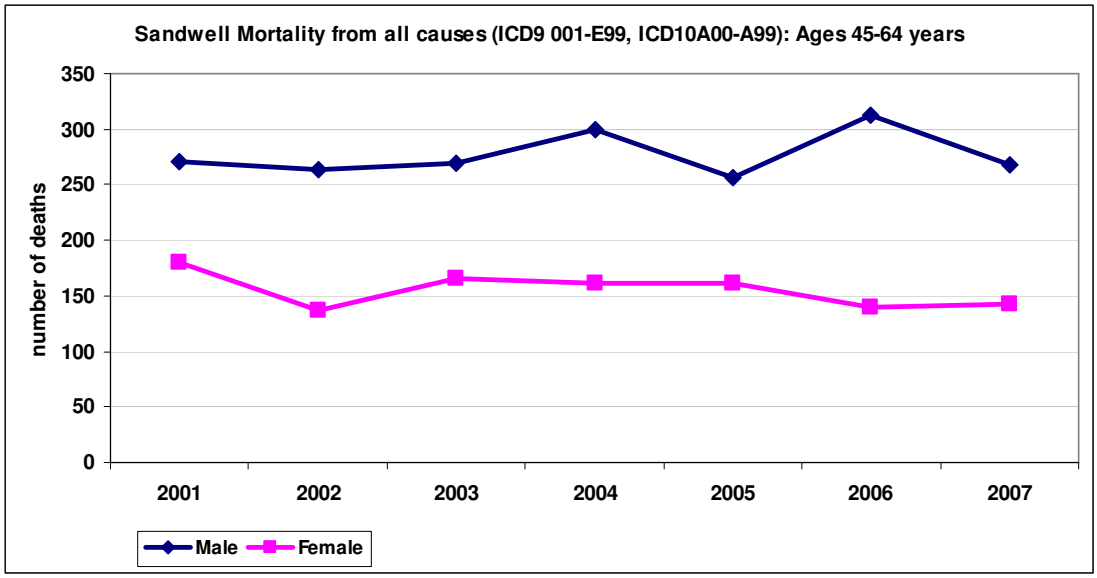
In Sandwell the credit crunch has resulted in a catastrophic rise in unemployment and dependence on benefits – to a much greater extent than in the rest of the West Midlands; the West Midlands in turn has been the most affected region in the country. In the early part of this year I was asked to do several presentations about recession and health. Much of the evidence still comes from the eighties experience but be in no doubt.

Unemployment kills

In 'Crunch time for health' I suggested there were two major public health emergencies confronting Sandwell

- The rise in heart disease in younger people - which may well have been the result of recession and unemployment from the 1980s and
- the credit crunch which would limit our effort to improve health now and would make worse the health of our people in years to come.

Some evidence for this prolonged effect of the eighties recession on the health of a generation can be found in the local statistics for deaths in middle age. The generation of young adults in the eighties have not experienced the improvements in health that we would expect - the rate of men dying before 65 appeared to increase from 2003-06 but can at best be described as remaining static. The death rates for adults 45-65 are included on the CD. This lack of improvement in the health of younger adults has been commented on in the British Medical journal this year, but needs to be further investigated.



2. Tackling health inequalities

2.1 National support team for health inequalities challenges to Sandwell PCTs

In February 2009 the National Support Team visited Sandwell to review our plans for reducing health inequalities. Their recommendations are included on the CD. Sandwell's floor target action plan was revised in June 2009 to take on these recommendations. The principle actions agreed are:

- Extending the healthy communities collaborative and communities for health programmes
- Increase diagnostic services within primary care (GP practices)
- Increase prompt referral for a range of treatments for heart patients
- Add COPD screening to cardiovascular disease (CVD) risk screening
- Set up a list of people most vulnerable in colder weather and offer a range of services to help
- Use social marketing to target smoking cessation information to priority groups such as manual workers and pregnant women
- Promoting health growth and healthy weight for children
- Improving information, intelligence and communication with the public, stakeholders and partners to get the message across that tackling health inequalities is 'everyone's business'

The summarised floor target action plan inequalities report is chapter 2 of this annual report. The floor target action plan in full, my evidence and the NST action plan are included in the CD.

2.2 Right care Right Here - the strategic model of care for staying healthy

We have also produced with Heart of Birmingham PCT a strategic model of care (SMOC) for staying healthy. This report recently received by the Right Care Right Here Clinical strategy group, presents some of our health data according to potential years of life lost. The big five causes of years of life lost up to the age of 75 are the same for Sandwell and for Heart of Birmingham patients. They are Cancer, heart disease and stroke and infant deaths, smoking and alcohol. Smoking and alcohol have been separately identified but do of course contribute to deaths from cardiovascular disease and cancers. Infant deaths contribute a smaller number of deaths – but it contributes substantially to the years of life lost.

Potential years of life lost up to age 75 by cause HoB and Sandwell PCTs 2006-08
Alcohol and smoking as separate causes

	Potential years of life lost			Number of deaths		
Simplified cause	**HoB**	**Sandwell**	**Total**	**HoB**	**Sandwell**	**Total**
Infant mortality	10442	8375	18816	139	112	251
Infectious disease	1605	1179	2784	76	55	131
Alcohol	4414	6066	10480	197	256	453
Smoking	5243	8375	13618	463	744	1208
Cancer	6387	10248	16636	477	825	1302
Diabetes	858	582	1440	62	52	114
Cardiovascular	6240	8668	14907	491	734	1224
Respiratory	1779	2611	4390	124	213	337
Accidents	2203	2112	4314	75	65	140
Self harm	810	1106	1915	22	34	57
Assault	502	359	861	12	7	19
Undetermined intent	591	714	1305	15	18	33
Other	7075	6957	14032	301	412	713
Grand Total	48147	57352	105499	2456	3526	5982

NB Deaths attributable to smoking and alcohol have been estimated from attributable fractions, averaging over age and sex
Deaths due to other causes exclude those attributable to smoking and alcohol

The big five causes of years of life lost are the same for Heart of Birmingham for Sandwell although not in the same rank order. They are:

- Infant deaths
- Cancer
- Cardiovascular disease
- Smoking and
- Alcohol

They are all in the World class commissioning objectives of both primary care trusts. The SMOC is included on the CD. It sets out a programme by which the whole health system can be involved in preventive measures to maintain and improve health. There is considerable overlap with other plans as there should be:

Major actions include:

- ✓ Preventing all the major causes of years of life lost
- ✓ Encouraging all aspects of the health system to refer to stop smoking services

- ✓ Increasing emphasis on identifying and tackling alcohol problems
- ✓ Systematic case finding and managing patients at risk of heart disease and stroke, kidney disease, chronic bronchitis and diabetes in the community
- ✓ Better and bigger provision of health information in the community
- ✓ Creation of Health promoting environments in all health service facilities
- ✓ Improving the health of health service staff and being health promoting organisations

2.3 University of Durham Health inequalities and spearheads study

Sandwell has been a part of the University of Durham spearhead qualitative study of conditions which are likely to promote narrowing of the gap of the spearhead PCTs and local authorities with the national life expectancy. The study identified characteristics which were judged likely to support or hinder reduction in inequalities in health for cardio vascular disease, cancer and teenage pregnancy. Sandwell is in the group of spearhead authorities which is not narrowing the gap with the national life expectancy.

On cancer the study judged that greater spends on cancer services would have moved us to the 'areas with champions and high spend' category. ***Sandwell response: Much more work is needed in respect to cancer with a new needs analysis and strategy in 2010 and a new champion, Dr Macherianakis.***

On cardiovascular disease, we were judged to have an approach to tackling health inequalities which did not have few major programmes but was characterised by many smaller programmes. We have a lower budget allocation relative to our target. and higher internal migration .

Sandwell response: We would argue that we have moved our coronary risk work to more major programmes in prevention and treatment. We have not seen any progress towards target budget allocation. Migration will have increased since the baseline year. So we have been doing what we can but need further help on resource allocation.

On teenage pregnancy our approach was judged to be smaller scale programmes rather than major ones, our educational achievement was poorer low GCSE pass rate) and higher deprivation. ***Sandwell response: We are working on the educational achievement, deprivation and seeking to consolidate our teenage pregnancy programmes but we recognise there is much more to be done. Teenage pregnancy at 2009 was one of the few areas where our reduction was higher than national and therefore showed a narrowing of inequality.***

The full study's first results are contained on the CD.

3. Clinical information for better health - MSDi dashboard and commentary chapter

A major thrust of the National support team recommendations and the strategic model of care is to address inequalities in health through primary care. They recommend aggressively searching out patients at high risk of dying prematurely and providing the preventive treatments we know work to reduce their risk. We have done this to great effect through our cardiovascular risk management programme in primary care in Sandwell. By December 2009, we had involved every practice in Sandwell in the risk assessment process for cardiovascular disease and the nurse intervention programme to get people on to the simple and effective treatments and into healthy lifestyle programmes that we know can be life saving. The next stage is to expand the case finding and treatment into other big killers and causes of chronic disease - chronic obstructive airways disease, diabetes, high blood pressure (hypertension) and stroke. The clinical dashboard gives us for the first time a more reliable means of determining the true levels of ill health in the community. For example:

- the prevalence of diabetes in Sandwell's community was16,188 patients, 4.8 % of the population as at August 2009
- the prevalence of chronic bronchitis on GP registers was 5806 , 1.7%

- the prevalence of heart disease 12077, 3.6% of the Sandwell patient register
- 49413 patients were diagnosed with high blood pressure, 14.6%

The other measures in the clinical dashboard are recordings of treatments which are not being delivered to patients as well as the clinical standards suggest. This approach has identified over 22,000 patients in Sandwell who require improvement to their clinical care.

By December 2009 we had completed the first round of cardiovascular case finding and treatment through all general practices in Sandwell PCTs. Since its inception the scheme has invited in 6623 people for screening. Of these 1532 have been identified and treated medically. 435 people have been referred into structured diet and activity programmes and 347 people have been referred into smoking cessation. The programme is expected to prevent 90 heart attacks per year and 30 deaths a year. This will represent a saving in the hospital charges of about £180,000 a year.

Roll out of the MSDi data extraction tool in general practice – identifying 22,000 people who would benefit from enhanced clinical care and lifestyle health interventions - has led to first wave treatment improvements through general practice - 250 extra people into treatment and lifestyle services to reduce their risk from Cardiovascular disease and 470 people into treatment to reduce high blood pressure. (Health and wellbeing board November 2009).

MSD Information manager clinical dashboard, August 2009

Clinical Dashboard

All Sandwell PCT Practices

Sandwell PCT registered population: 338,224

Diabetes	Patients	%
Diabetes register	16,188	4.8%
HbA1c >10%	1,085	6.7%
HbA1c >=7.5%	3,966	24.5%
Serum Cholesterol >4 mmol/l	2,408	14.9%
Systolic BP >140mmHg	3,672	22.7%
No U&E in last 12 months	1,975	12.2%

COPD	Patients	%
People with COPD diagnosis	5,806	1.7%
People on Tropiums and no COPD or Asthma recorded	287	4.9%
People prescribed Beta 2 agonists and no COPD or Asthma Diagnosis recorded and No steroid prescription (which may otherwise indicate asthma)	6,320	-
People on Tropiums or Beta 2 agonists (no steroid Rx) without COPD or Asthma diagnosis	6,607	-

CHD	Patients	%
18 years and above with CHD	12,077	3.6%
CHD recorded but no Beta Blocker,ACEi or Statin in last 6/12	1,050	8.7%
CHD recorded but no antiplatelet therapy in last 12 months	2,441	20.2%
CHD recorded but no U&E in last 12 months	2,259	18.7%
CHD recorded but no lipid lowering therapy in last 12 months	1,623	13.4%
Systolic BP >140mmHg	2,763	22.9%
Serum Cholesterol >4mmol/l	1,375	11.4%

Stroke & TIA	Patients	%
Stroke & TIA register	5,376	1.6%
Systolic BP >140mmHg	1,273	23.7%
No U&E in last 12 months	1,186	22.1%
No lipid lowering therapy in last 12 months	1,119	20.8%
Serum Cholesterol >4 mmol/l	607	11.3%

Hypertension	Patients	%
Hypertension diagnosis	49,413	14.6%
Systolic BP>140mmHg	13,994	28.3%
No U&E in last 12 monthts	20,418	41.3%
Probably >20% CVD risk based on default value - no statin	14,122	28.6%
>20% CVD risk - no statin data complete	1,675	3.4%
Total probable and actual >20% CVD risk and no statin	15,797	32.0%

4. Main achievements in services 2008-09

There have been substantial improvement in services for health improvement in Sandwell recently - many of these have been led by health service and other partners – for the benefit of the public's health.

Cardiovascular health and chronic disease management - this has been described above.

Health protection

- Tuberculosis cases have declined taking us below the 40/100000 'danger mark'
- Healthcare acquired infections have been massively reduced through a combination of measures - better hospital control of infection, better antibiotic prescribing, desk top reviews of all cases of MRSA.
- Immunisation rates for common childhood infections have been excellent – up to 975 in one instance
- MMR rates have climbed almost to the 90% target
- The cervical cancer prevention vaccine has proved to be very popular with children and parents alike and we have had rates of over 90% uptake

Food and fitness

- Sandwell Healthy Urban Development Unit partnership between health and town planning raising the profile of health impact of town planning and urban design
- A new community agriculture strategy agreed by Sandwell council and health and wellbeing board being implemented with a first stage new scheme at Barlow's Road, Wednesbury
- A new physical activity and sports strategy has been agreed and implemented
- Substantial progress towards increasing adult participation in sport
- Childhood obesity not getting worse.

Health & Worklessness Programme Progress

Coming to terms with the effects of the recession has made this last year difficult for everyone. Here in Sandwell, with traditional manufacturing industries suffering badly and the subsequent rise in unemployment, times have been particularly tough.

This is not good news for the health of people in our borough because we know that there is a direct link between people's health and wellbeing and employment.

The Health and Worklessness Programme was established to address these very issues. To try and help people keep healthy and avoid long-term unemployment, as well as offering innovative ways to improve skills, find work and support our population through our own ways of working.

What is 'work' and 'worklessness'?
Work does not have to mean paid employment. It can be a wide variety of activities including education, training, and voluntary work and caring for others.

Those without work often suffer deterioration in physical and mental health while being in work – or returning after illness – improves health, according to recent research.

Health services have neglected the importance of work for health for too long. All this changed in March 2008 with the publication of Dame Carol Black's review of Britain's working age population, *Working for a Healthier Tomorrow*. In it, she noted that too few NHS healthcare professionals actually have the training to deal with the links between ill-health and work. She proposed changes to improve this and the Government launched a programme of initiatives to reduce the risk of ill-health leading to unemployment or 'worklessness'.

What we are doing in Sandwell
The Health and Worklessness Programme is mainly funded through the Working Neighbourhood Fund. Our activities are ensuring those in work, and their employers, have the support they need to maintain their health and wellbeing or the skills and experience needed to move out of long-term illness and unemployment.

We are doing this through three areas of work:

1. **Promoting employment opportunities** for people in Sandwell by using our role as an employer and purchaser of goods and services.
2. **Supporting projects** that help people to become more active, acquire new skills and get ready for work.

3. Promoting change in local health services to reduce the risks of ill-health leading to worklessness

The Results

- Route-ways to NHS Health & Social Care achieved the following outcomes in its first year: 123 people engaged, of which 75 were trained. 47 gained employment in the NHS and 27 within social care, went into further education
- The scheme is continuing with Working Neighborhood Funding in Sandwell, and is being rolled out as a regional hub for the public sector with £2 million (potential of £4M) European Social Care Funding in 09/10
- Learning & Physical Disability Social Enterprises created in creative & performing arts plus a volunteer bureau have been established. 41 people are active in the arts enterprise and 16 have been assisted into work experience or voluntary work
- Apprenticeships – Development work to introduce 38 Health & Social Care Apprenticeships in 09/10
- Ready, Steady Work – 22 men from Smethwick were engaged and completed the programme with West Bromwich Albion
- Workwell – Has provided ongoing occupational health advice and support to Sandwell business community to ensure work is a healthy place to be
- Jobless not Hopeless – a survival guide has been developed and widely supported
- Cycling courses for community groups and Accord housing going well with further courses across Sandwell's Children's Centre's planned

Housing and health

- Substantial work on Housing and health strategy has been done. The report is included on the CD and will be published as part of the 2010 annual public health report.

Tobacco control

- A new tobacco control strategy
- The 'stop before your op' programme introduced by Sandwell and Western Birmingham Hospitals Trust to help people stop smoking before they go for an operation. The scheme is now being expanded to include all hospital attendances. The research evidence is overwhelming that smoking prevents good healing and leads to complications of operations. ('Stop

before the op' paper Dr Chris Chiswell and Dr Deborah Saleh pdf on CD).
- Substantial progress on tariff payments for smoking quitters for 2010 implementation; although there are risks with this
- Social marketing research informing next steps in control of tobacco and support for smoking quitters
- Partnership seminar on tobacco control driving new strategy
- Achieved 92% of our target for smoking quitters – although we missed the target by a small amount, nevertheless over 1954 people benefited from stopping smoking.

Drug services
- New facility for drug and alcohol treatment and prevention – Metro Court, West Bromwich, was opened in December 2008. It is home for Sandwell Anchor project and for the Sandwell Drug and Alcohol Action Team. Widely hailed as a much better facility for drug users and service professionals- cleaner, more spacious, safer and more dignified encouraging clients to stay longer in treatment and helping to achieve the drug treatment recovery plan objectives.
- Keeping clients in treatment and getting more into treatment (the 'recovery plan') has been accompanied by continuing falls in the level of domestic burglary - as research evidence predicts.

Alcohol
- A partnership review supported by the National Support Team with a new strategy produced
- We are on course to achieve the stretch target for the local area agreement on alcohol 2007-2010 to double the numbers of people receiving brief counselling interventions for their alcohol problems- a measure that research evidence suggests will help reduce alcohol problems.

Maternal and Infant health
- A substantial series of reviews of maternal care at Sandwell and City hospitals leading to:
- Massive reduction in Caesarean sections
- Improved indicators of obstetric and newborn care
- A proposal for an interim reconfiguration of maternity services pending the new facility at the Smethwick hospital in 2015 currently at public consultation.

- Substantial progress on breastfeeding with 60% breast feeding initiation achieved at December 2009 and 61% recording of 6-8 week breast feeding rates in primary care at the 2nd quarter of 2009-10 a doubling of data recording.
- Breast feeding strategy agreed and clinical guidelines.
- First stage UNICEF baby friendly standard achieved.

Community development -

- The community development framework has been agreed (pdf on CD)
- The community development annual report describes a wide range of health related activity generated in local communities and supported by the PCT (annual report on CD)
- The REWIND project has continued to be recognised as a national and indeed international exemplar of best practice in anti-racist training and preventing violent extremism, and continues too be supported by the PCT, the Working neighbourhoods fund and the Home Office PREVENT agenda.

Public information

- The new single contact number for all healthy lifestyle service referrals by GPs and by the general public themselves has been launched and that number is 08450114656.
- Early signs are extremely favourable that take up is accelerating.
- This was accompanied by an extremely successful launch in October with a protected learning time event for primary care attracting over 350 participants.
- The Sandwell Public Information Network (SPIN) has continued to develop web based and other information systems and undertaken important web based health information with students at Sandwell College.

Other public health research and teaching

- Two major pieces of social marketing research have been completed in relation to smoking and alcohol (summaries on CD).
- Sandwell has also taken part in the Cancer Awareness Mapping research. This will be presented in greater detail in the 2010 annual public health report (report on CD)

- The PCT has successfully set up its programme for housing and health research under the Collaboration for Leadership in Applied Health Research and Care (CLAHRC)
- The PCT has also continued to lead the work of the West Midlands Teaching public health network. (Annual report of the Teaching public health network on CD)

The PCT has championed innovation in many ways over the last three years - these innovations are summarised in the presentation made by the chief executive in 2009 and included on the CD in this report. Other corporate successes included:

✓ The high ranking we achieved on World Class Commissioning, 4th best in the country
✓ The improved outcomes we have seen in relation to the World Class Commissioning outcomes (on the CD)
✓ And the achievement of the Health Service Journal Award Primary Care Trust of the Year for 2008.

5. World class priority setting

In my last annual report I recommended a massive shift of spend towards preventive and community health measures to stop people developing the same illnesses as their parents before them. I also recommended that the health services should seek to behave as a good corporate citizen - doing everything in their power as a member of the Sandwell community to provide better jobs, education and healthier environments and maintain a safer secure community.

My recommendations reinforced the priority setting process the Primary Care Trust had been through in 'World Class Commissioning'. The full 'Invest Well' strategy is included on the CD. The five year strategy aimed to reduce the gap in life expectancy between Sandwell and nationally by 15% by 2015, by preventing 154 deaths per year in 2015. The priorities identified in the world class commissioning process were

- Reducing infant deaths, with a specific initiative to improve breast feeding rates
- Reducing teenage pregnancy
- Reducing alcohol problems

- Preventing and treating diabetes better
- Providing better support for people with neurological conditions
- Improving access to psychological therapies for people with common mental health problems
- Reducing cancer deaths by reducing smoking
- Reducing deaths from heart disease and strokes
- Improving end of life care

With these World class commissioning priorities were a complementary set of health service related activities which supported wider partnership efforts in the Right Care Right Here Programme and the Local Area Agreement.

The Right Care Right Here programme, formerly the Towards 2010 programme, had agreed a Charter for health improvement - the 20-10 Charter based on the World Health Organisation's Health 21 Charter. The charter is again presented on the CD for ease of reference. The 20 summary items are shown in the box.

Right Care Right Here
20 things we will do to improve the public's health

1. Reduce health inequalities by reducing income inequalities
2. Reduce the difference in inequality in life expectancy by 10% by 2010, and by 25% by 2020
3. Support basic skills development in adult education – especially black and ethnic minority groups, young people, people with learning disabilities and white, unemployed men over 50
4. Promote and contribute to a network of early years support: Sure Start 2010
5. Develop services for and with young people to give them the best chance of achieving good health and a satisfying role in their communities
6. Ensure people over 65 enjoy their full health potential and play an active social role
7. Ensure that people's psychosocial wellbeing improves and that comprehensive services are available and accessible to people with mental health problems
8. Reinforce our immunisation programmes to re-establish 90% plus rates for childhood immunisations to prevent the threat of measles, rubella, whooping cough, diphtheria, polio, tetanus, haemophilus, meningitis and mumps

9. Reduce non-communicable disease, such as heart disease, diabetes and cancer
10. Reduce injury from violence and accidents
11. Promote a healthy and safe physical environment
12. Promote and contribute to housing improvement which benefits health (safe and secure, accessible and supportive and affordably warm)
13. Encourage regular exercise and making active lifestyles, like walking and cycling, easier, safer and attractive
14. Create smoke free public places and workplaces, inside and outside the NHS
15. Support development of healthier food access – making good food easier to buy locally
16. Support the development of alcohol problem services in the community to treat alcohol problems earlier and reduce the harm caused by alcohol
17. Provide better, more efficient, more accessible services for people with sexually transmitted disease
18. Expand primary care services to adopt a 'whole population' approach - identifying ill health early, using register-based care and developing expertise in maintaining the health of people with chronic illness
19. Remodel services for patients with long term conditions
20. Make communities' voices heard by encouraging user-led and user-owned services

The local area agreement signed off in 2008 is also included in the CD. The 9 big areas of Sandwell partnership activity were agreed as

- A better start to life
- Successful young people
- Skills and jobs
- Reducing high volume crime
- Improving housing
- Cleaner safer streets
- Improving health
- Increasing independence
- (And achieving the statutory education targets)

35 Local indicators for these priority areas for the partnership were also agreed in 2008.

It was clear that there was a strong role for the health service in all these areas of partnership work. The health service leads on improving health and a better start to life. It plays a key role in successful young adult's programmes and in reducing high volume crime. It plays an important supporting role in the safer, cleaner streets and in improving housing - the role of the new Sandwell Healthy Urban Development Unit and the Housing and Health group being examples.

In reducing high volume crime - to reduce violent crime requires the reduction of alcohol related crime, domestic violence and safeguard adults and children - key roles for the health service the biggest single component of reducing domestic burglary has been reducing drug-related domestic burglary.

Against this backdrop of local agency partnership work and wide community consultation about what needed to be done it was clear that the health service had a vital and central role to play and needed to deploy its increased funds for the maximum benefit of the Sandwell community. Sadly our ability to really use health service influence and resource towards these agendas has been cut off at the knees.

6. Payment by results?

During 2009-10 a new formula was brought in for the HRG4 health resource groups national tariff which ensures every health care provider across the land is paid the same for the work they do. The changes to the tariff as part of the payment by results policy has meant that Sandwell primary care trust instantly had to pay out £10 million to hospitals for no extra treatments and no improvement in quality. Payment by results has encouraged more hospital activity throughout the year particularly at Dudley hospitals. A further £9 million has been paid out to hospitals at the time of writing. We have been required to pay more for coding and definition changes, for work we have not seen as priority in our published commissioning intentions and for work which we have had no evidence of benefit to Sandwell people. This has meant the vital schemes to reduce ill health have not gone ahead. This position has been confirmed nationally in the Audit Commissions report 'More for less' in which they say that more than the entire 6.5% uplift in NHS allocations to PCTs this year has been taken by acute service activity - 2.3% in the tariff uplift and 6.8% increase in income in total. (HSJ 12th November 2009)

The health system has served its own in the same way as the banking system.

Just as banking should create wealth, not create only more activity in the money markets, health services should create health, not merely more activity for the health services.

It is of course a cliché that the National Health Service is a national sickness service. What is less well understood is that the means by which we pay hospitals gives them the same income if all their patients come out of hospital alive, or in a box.

There are willing noises about preventing ill health and big aspirations for achieving this - but so far we have made little concrete effort towards putting health service investment into preventing ill health and saving lives. It is gratifying to note that the Secretary of State for Health added prevention into proposals for the Quality improvement, innovation, productivity agenda, 'QUIPP' launched this year.

7. The national debt and future funding

The nation's finances need to be brought into line after the credit crunch.. In addition to opportunities missed in the 2009-10 financial year, the NHS faces a future of reduced public funding from 2011-12. The £20 billion recurrent that the NHS is expected to find from 2014-15 is generating considerable management action, to seek to deliver the same or increasing volumes of health care activity at less cost. Higher quality is seen as a means to reducing costs. Prevention of ill health is also part of the quality improvement, performance, prevention and partnership QUIPP process. Directors of public health in the West Midlands produced their discussion paper on reducing NHS costs in the summer of 2009. They added the question of priority setting to the list of 'Ps'.

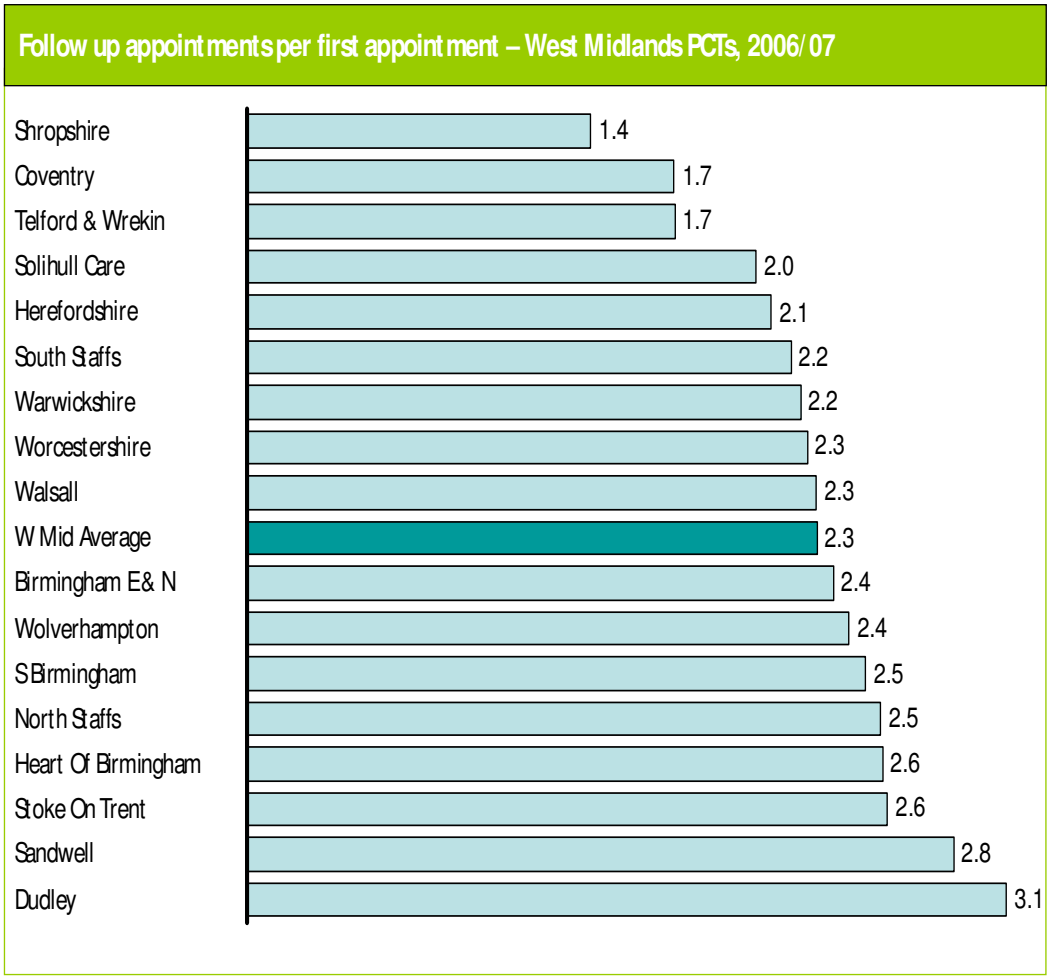
They suggested five categories of health investment choices:
Five categories (see table below):

i. Same or better care; at lower price.
ii. Better care; same price.
iii. Reduce volume of services.
iv. Stop completely.
v. Maintain or increase in order to save in the future.

Same or better care; lower price	Better care; same price	Reduce volume of service	Stop completely	Maintain or increase in order to save in the future
Follow up outpatients. Don't contract for them and allow only under certain specific circumstances. **Supply and disposal chain.** Opportunities for mass purchasing. **Care homes**. Assertive management of care homes' patients may be effective at preventing admissions. Repatriate **out of area placements.** **Generic prescribing** (still more ££s to come – Boston matrices). **Value based pricing** for pharmaceuticals.	**End of life care.** Need cultural change to encourage doctors to be open debate about care during final year of life to allow less intervention, greater palliation and increased quality of life. **Chemotherapy at home**. Reduction **adverse events.** **More value** from **QOF.**	**Treatment thresholds.** eg hips and knees – particularly in light of PROMs. **Specialised commissioning.** Will have to accept same or greater cuts as rest of commissioning – i.e. plan for 30% budget reduction. Tighten **prior approvals.**	**NHS pure research.** We can't afford it and we can't afford to implement the findings. **IVF** **Gender reassignment** **Vasectomies** **Elective surgery.** Much orthopaedics – arthroscopies, carpal tunnels etc. Lower GI – piles etc. **Other individual interventions.** On basis of QALY thresholds.(High cost drugs outside tariff). **NICE TA.** Suspend implementation unless ICER<£6000 Chlamydia screening –do it properly or not at all.	**Stop smoking.** **Early Years health promotion programmes.** **Taxation alcohol/tobacco** cheap and effective **Licensing legislation** cheap and effective. **Weight loss/weight management – evaluate** carefully and scale up the most effective.

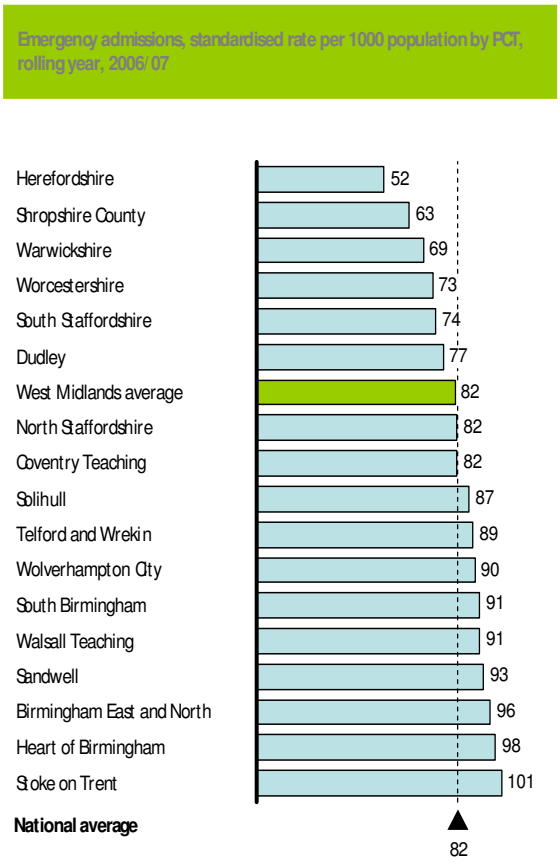
The DsPH discussion paper is included on the CD - not all of the examples will be palatable or possible - but the NHS faces massive reduction in finances which have not been seen since the 1980s and either crude cuts in budgets will take place or other choices will have to be made to increase efficiency and ensure the vast majority get the care they need. The role of prevention of ill health in order to reduce NHS costs is increasingly being emphasised. As better primary care interventions and public policy changes like the national smoking ban have come into play the number of heart attacks has fallen. Savings from prevention of home accidents and alcohol intervention are also possible. As part of the debate, the West Midlands Strategic Health Authority have also compiled more comparative data that will help us to look at unequal and uneven provision across the region. Two illustrations of the need to look critically at health service activity are shown below. The first where Sandwell features as an outlier suggesting the need for management action and the possibility of reduced costs are with the new to review outpatient attendance. Sandwell and Dudley are the two highest PCTs. This might suggest an unnecessary waste of NHS outpatient resource, over-reliance on outpatients for follow up that could be done in the community or by telephone, and not least, a waste of patient time; or it might reflect the best possible use of outpatients in the region.

Ratio of first to follow-up outpatients appointments in the West Midlands is 2.3, with some variation across the region



Source: DH Waiting list website

Two-fold variation in standardised emergency admission rates by PCT



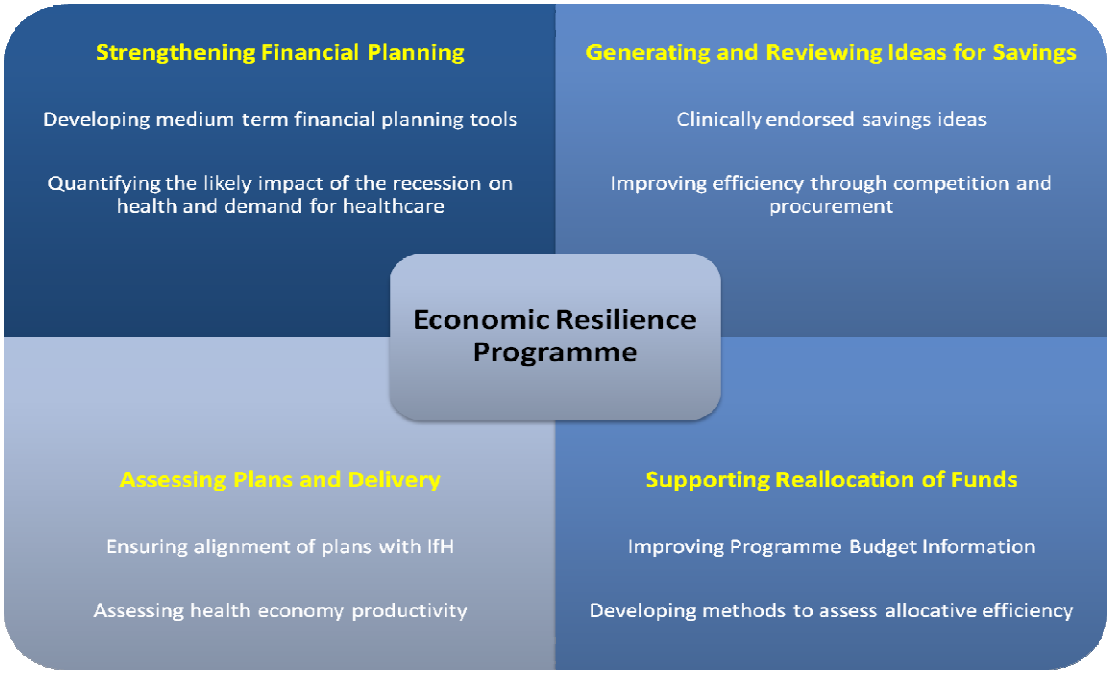
Source: NHSComparators system, SHA analysis

Sandwell, Birmingham, Walsall and Stoke have higher than regional rates of emergency hospital admission, even accounting for the age of our patients. 10 per 1000 Sandwell people are admitted to hospital more than the regional rate. This will need to change if we are to deliver our reconfigured 'Right Care Right Here' model of health services by 2016.

There are a number of ways in which the NHS to reduce its costs, but also continue to increase its provision of treatments and services. Form least desirable to more required are:

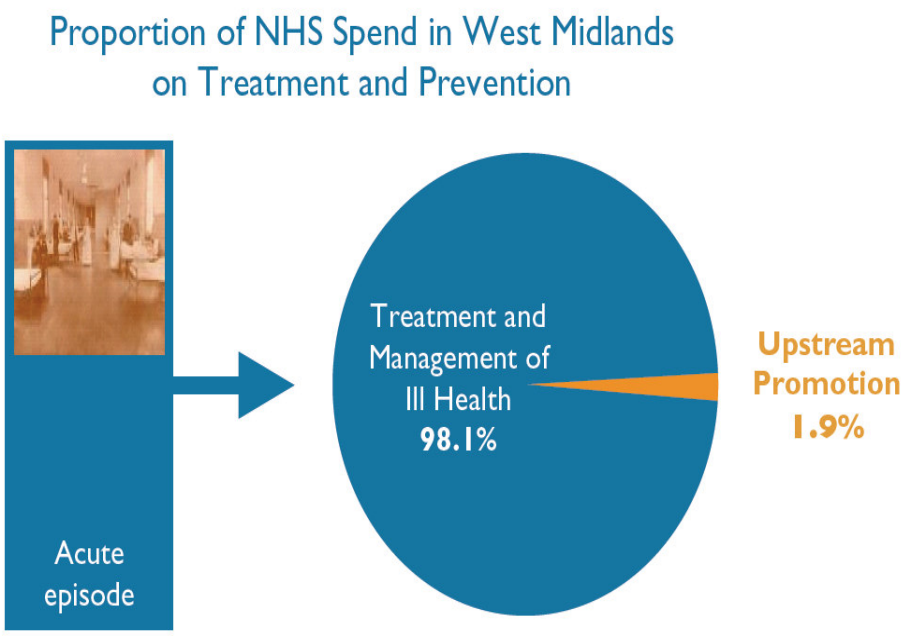
Least desirable: redundancies of staff,
Improving efficiency, improving procurement and rationalising support services
Denying access to new health technologies and expensive treatments
Cutting training budgets
Increasing generic prescribing
Decreasing use of drugs and procedures of limited value
Reducing errors

Technological and social innovation
Self care
Early intervention, where it has been shown to reduce future illness and complications
Most desirable and required: Prevention of illness and maintenance of health.



8. 5% for health

The full presentation from which these illustrations are taken is by Peter Spilsbury, Executive Director of Performance and Regulation for the strategic health authority. His presentation of these issues is included on the CD. He concludes by describing an economic resilience programme to strengthen financial planning, generate and review ideas for savings, assess plans and delivery and support reallocation of funding see figure 8.3 above. It is quite clear that the scale of savings needed by the NHS cannot be achieved by the historical and habitual budget cut - the intelligence in the service is now right for practical interventions to improve efficiency to get more done for the same amount of money or less, to use healthcare plant more efficiently and to ensure partner intervention that improves health is supported through pooled funding.



The figure 8.1 shows that the proportion of the health service budget spent on prevention in the West Midlands is only 1.9%. During the World class commissioning assessment I was asked the question how much of the PCT budget should be spend protecting health and preventing ill health? I said a lot more than we do now. The Director of Commissioning for the West Midlands cited the experience of American Health Maintenance organisations who apparently work on 5% of their total budgets for health improvement and protection. Bearing in mind that over 44 million Americans have no health insurance cover and HMO's therefore cover the 'healthier' portion of the American population, 5% might not be enough. However, Sandwell spent less than 1% of its budget on keeping people healthy, in 2007-08. An additional 4% to bring it up to 5% would represent a good first step at changing the proportion spent on maintaining health. This would represent a clear statement that we value health more and we are not prepared to invest only when people are sick.

I recommend that the PCT plans to invest 5% of its total income in health maintenance, health improvement and, health information. This would be a first step towards delivering the Wanless vision for a fully engaged public, knowledgeable about their own health, and able to protect, maintain and improve it.

This will require the PCT to invest £25 million for healthy people. This would only represent 4% extra - about £ 20 million. This is an extremely large amount of funding to invest- approximately the amount we have put into hospital services as extra funding this year.

To apply this immediately in one year would not be possible as the shortage of staff available and other management effort to expand programmes would very likely create slippage and unspent funds. ***So a planned programme for investment in health improvement and prevention of ill health should be put in place, even in the context of a reducing health service budget should be put in place over the next three years.***

In the context of programme budgeting we are suggesting that commissioners can look to redirecting some programme spend towards preventive aspects within their client group needs. By the same score we are pursuing a policy of using the CQUIN, commissioning for quality and innovation fund to see hospitals and other provider services earn some of their income by achieving health improvement targets such as getting people to stop smoking.

In some cases we are advocating spend on prevention to release funds currently committed to hospital care. To only pursue preventive schemes which release money from hospital systems, however, would be to miss opportunities for better health which can release savings in other fields of public investment eg. Teenage pregnancy and drug treatment services.

Overall, though this will serve to reinforce existing spend patterns and will not to create funds for genuinely new public policy initiatives to promote health to maintain health and create a fully engaged, 'health literate' community. Hospitals should of course, be health promoting institutions; but if we redirect hospital spend towards preventions we will still be targeting people who have already become ill- not genuinely preventing illness. There will need to be a substantial increase in the programme allocation to healthy people for this genuine health improvement to take place.

Some examples illustrate the potential uses for such investment:

8.1. Smoking prevention and tobacco control

For the first time we have fairly good data on the smoking status of around 150,000 of the Sandwell population. Although primary care offers us the potential for smoking status information for the whole population, this is the largest sample size from which to estimate smoking prevalence and we can reasonably take it as an approximation for smoking in Sandwell. We will be studying the data by practice to see how this may best be used for assisting tobacco control measures.

Sandwell PCT
Smoking Prevalence Data as at 01/10/2009
Source: MSDi data extracts

PBC Cluster	Patients aged 16+	Patients (aged 16+) Smoking Status Recorded in the last 15 months	Patients (aged 16+) Current Smokers	Percentage of patients (aged 16+) Smoking Status Recorded in the last 15 months	Percentage of patients (aged 16+) Current Smokers
Black Country Commissioning Network PBC Cluster	104,148	64,465	17,894	61.90%	27.76%
Smethwick Commissioning Alliance PBC Cluster	73,444	34,163	9,964	46.52%	29.17%
Wednesbury & West Bromwich PBC Cluster	92,660	50,733	12,262	54.75%	24.17%
Totals	270,252	149,361	40,120	55.27%	26.86%

The national goal of reducing smoking prevalence to 21% for the adult population will not be achieved in Sandwell by 2010. However it should remain our target with a date for achievement in 2013-14.

Resident population of Sandwell 287,494
231,879 Over 14
27% smokers by MSDi system: 62,607 smokers
If 21% were smokers this would be: 48,695 smokers
The difference between 27% and 21% is therefore: 13,912 smokers

To achieve 13,912 quitters at 45% success rate for supported quit attempts requires 30,915 quit attempts

Under the tariff system, at the highest tariff for the longest quit recorded £641 including 12 week payment, this is £8.9 million
Under tariff at lowest payment, £165, this is £2,295,480
Under the existing service rate at an average cost of £400 per quitter, this is £5,564,800.

These investments assume people only stop smoking if supported by the NHS and that the only way we get to the reduced smoking prevalence is by people stopping smoking. However this requires people to start smoking and it would clearly be much better if they didn't start in the first place. So we need programmes to prevent children taking up the habit. The cost for smoking quitters therefore needs to be supported by major tobacco control investment, in education, enforcement and social marketing. The estimates are done on 45% smoking quit rate which is middle range- if we get a higher quit rate we may achieve the target more efficiently. However, on the downside we should note that achieving 21% smoking prevalence would still mean there are 48,695 smokers in Sandwell.

I therefore recommend a three year programme of spend on tobacco control of £5 million average per year, including the smoking quitters and all other aspects of social marketing education and control.

There will be savings in terms of reduced hospital admissions from major cardiac and respiratory causes, but this is not the primary reason for this investment.

8.2. Cardiovascular risk reduction and the healthy community's collaborative approach

Sandwell has run a very successful healthy communities collaborative programme in Soho and Victoria electoral ward in Smethwick. This was the ward with the highest and increasing rate of cardiovascular deaths in 2006. The programme has followed a three pronged approach to combine the efforts of primary care, public health and community development and community and voluntary organisations to improve health and reduce heart disease. The model comprises:

✓ The nurse led programme of cardiovascular risk reduction for those people at 20% risk of having a heart attack in the next ten years.

✓ There is then a health trainer programme for those a t lesser risk, down to 15% risk (examples of how health trainers have worked with people to improve their health and quality of life are contained in the boxes and

✓ For the general public there is a programme of buddying support for healthy lifestyles using volunteers through existing established community organisations.

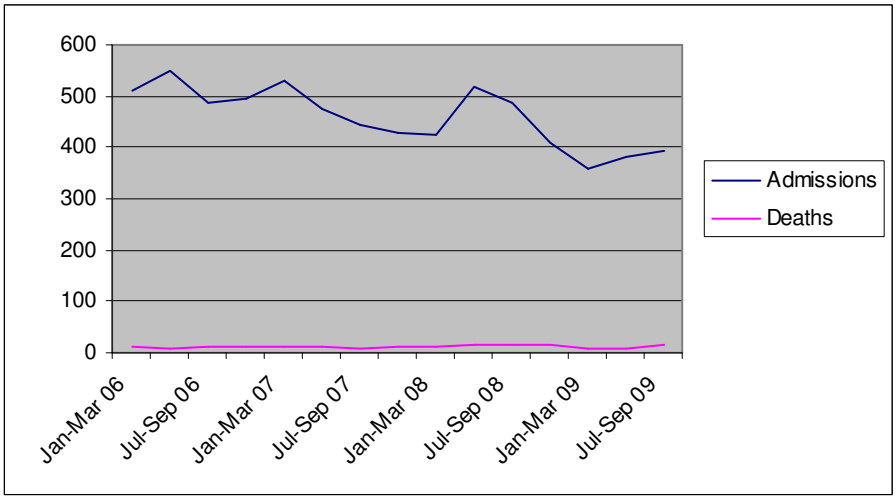
The apportioned costs of the nurse and health trainer's elements are about £100,000. The cost for the healthy communities' element was also about £100,000.

A rolled out programme for all the electoral wards of Sandwell would cost around £4.2 million per annum. A rolled out programme, targeting highest risk areas first- Great Bridge, Glebefields, Friar Park, recognising the need to recruit and train new staff and apply existing staff in redesigned services would be achievable for between £500,000 and £2.1 million. Realisable savings from cardiovascular events prevented would be about £200,000.

New evidence from hospital episode statistics suggests that there has been a substantial reduction in admissions due to coronary heart disease to all hospitals receiving. Sandwell residents: from 512 in the first quarter of 2006 to 393 in the second quarter of 2008, nearly 500 per year. Some of this may be attributable to the national smoking ban in public places, mirroring the Scottish experience. Some of it will also be attributable to our cardiovascular risk reduction programme. Whatever the reasons, it does suggest major improvement in heart disease reduction. It also suggests a need to review how the cardiovascular treatment and prevention programme is made up and what investments should be made in each aspect of care.

SANDWELL RESIDENT ACUTE ADMISSIONS 2006 to 2009
ALL Ischaemic heart diseases including MYOCARDIAL INFARCTION CASES
Selected as principal diagnosis having ICD I20 to I25

Produced on 16 Dec 09



Numbers of admissions to hospital and deaths from coronary heart disease as principal diagnosis Sandwell residents, by quarter 2006-2009.

	Male	Female	Total	died
Jan-Mar 06	341	171	512	12
Apr-Jun 06	363	186	549	9
Jul-Sep 06	304	184	488	13
Oct-Dec 06	313	181	494	13
Jan-Mar 07	348	182	530	12
Apr-Jun 07	293	181	474	12
Jul-Sep 07	278	168	446	8
Oct-Dec 07	266	164	430	13
Jan-Mar 08	268	158	426	10
Apr-Jun 08	355	162	517	15
Jul-Sep 08	309	178	487	15
Oct-Dec 08	273	137	410	17
Jan-Mar 09	245	115	360	9
Apr-Jun 09	260	122	382	7
Jul-Sep 09	263	130	393	14
Total	4479	2419	6898	179

8.3. Housing and health

Housing and Heath
Costs and benefits

Housing and Health expenditure			
Expenditure area	**Activity level**	**unit cost**	**total cost**
training	450 health staff		40,000
referral	600 referrals		
interventions	600 energy efficiency	£70 per session	42,000
	300 other interventions	170 minor @ 250	42,500
		90 moderate @ £400	36,000
		40 major @ £10,000	400,000
project management			25,000
3 healthy housing workers	300 assessments		120,000
	300 energy efficiency	£70 per session	21,000
	150 other interventions	70 minor @£250	17,500
		50 moderate @ £400	20,000
		30 major at £10,000	300,000
			1,024,000

Assumption: the Housing Health and Safety Rating System use a 'Class of Health Outcomes' matrix for the Excess Cold hazard (figure 2). The classes are defined as follows:

Class I	cold/winter related mortality	(34%)
Class II	serious hospital admission	(6%)
Class III	hospital admission	(18%)
Class IV	GP consultation	(42%)

If the most appropriate houses and occupants are identified, then the 450 interventions carried out could contribute to **preventing 153 deaths, 108 other hospital admissions** (assuming the deaths occurred in patients who did also go into hospital) **and 189 GP consultations.**

Excess Cold
Average likelihood and health outcomes for all persons aged 65 years and over, 1997-1999

Dwelling type & age		Average likelihood 1 in	Spread of health outcomes				Average HHSRS scores
			Class 1 %	Class II %	Class III %	Class IV %	
Non HMOs	Pre 1920	330	34.0	6.0	18.0	42.0	1,066 (C)
	1920-45	340	34.0	6.0	18.0	42.0	1,035 (C)
	1946-79	400	34.0	6.0	18.0	42.0	880 (D)
	Post 1979	530	34.0	6.0	18.0	42.0	664 (D)
HMOs	Pre 1920	340	34.0	6.0	18.0	42.0	1,035 (C)
	1920-45	290	34.0	6.0	18.0	42.0	1,213 (C)
	1946-79	370	34.0	6.0	18.0	42.0	951 (D)
	Post 1979	350	34.0	6.0	18.0	42.0	1,005 (C)
All Dwellings		380	34	6	18	42	926 (D)

There are realisable health savings here but it will be difficult to see reduced hospital admissions and use of GP services solely through small investments by the health service. It will be necessary to use health service spend in support of much larger housing improvements by the housing agencies - Sandwell Homes, Sandwell strategic housing and Urban Living, to shape more housing investment towards health improvement goals.

For example the NHS agrees to invest the £1 million above in a pooled budget for which housing agencies agree to invest £4 million. The £5 million pool invested towards alleviating winter deaths prevents 765 deaths and 540 hospital admissions. This enables closure of 10 hospital beds (at an average 7day length of stay). More importantly, it saves the PCT £1,188,000 for reinvestment for health improvement. It could agree to reinvest the money in housing related health improvement.

8. Investing for health

I recommend that the PCT drives a partnership discussion of the health investment needed across agencies to improve health in all these fields. For some there is a clear and predominant health service responsibility to fund. For others the health service should be seen as the lead agency and encourage pooled funding to achieve a bigger benefit than it can achieve on its own. For other areas of spend the health service is the support agency and should invest in order to stimulate health related gains from other agency mainstream investments for example in housing, or town planning. **An overall programme for health would need to include investment in:**

Health service investment

Healthy public nutrition
Increase in physical activity programmes
Tobacco control
Control of alcohol related harm and ill health
CVD risk programme/ Healthy communities collaborative
MSDi chronic disease identification and treatment
Public information
Community development
Expert patients, self help
Mental health promotion and resilience
Sexual health programmes
Partnership contributions - small health components complementing major programmes by lead agencies
Full implementation and coverage by Childrens Centres and a Surestart Sandwell, through community outreach
Anti poverty and welfare rights
Measures to create healthier environments
Reducing teenage pregnancy
Improve skills and job opportunities for young people
Measures to improve housing for health benefit
Reduce violence and crime – PCT contribution to domestic violence, alcohol, safeguarding

There is substantial evidence that healthier lifestyle interventions, addressing health problems earlier and before they manifest severe illness are among the *'best buys'* for health services - the table 8 below shows how this is especially the case for smoking, physical activity and alcohol related interventions :

Table 8. Cost per QALY League Table - Top 'Best Buys'

Health area	Intervention versus comparator in target population	£/QALY
Alcohol	Brief intervention vs no intervention in alcoholics in Australia (female former)	£197 - £269
Alcohol	Motivational enhancement therapy vs no further counselling for mild to moderate alcohol dependence in Australia	£1,352
Alcohol	Naltrexone plus counselling vs placebo plus counselling in severe alcohol dependence in Australia	£5,210
Alcohol	Motivational enhancement therapy vs social therapy in alcoholics in the UK	£18,320
Smoking	NRT and brief intervention vs self quit attempts/no intervention	£1000
Physical activity	Brief interventions in primary care to increase physical activity vs no intervention	£20 -£440
Obesity	School based obesity prevention programme vs no intervention in the USA	£2,296
Obesity	Targeting high risk patients with obesity with drugs and surgery vs no intervention in the UK	<£13,000
Smoking	Brief Smoking intervention vs no intervention in the UK (depending on age)	£135 -£6,472
Smoking	National school smoking prevention programme in the USA vs no intervention	£10,675
Statins	Statin use in secondary CHD intervention with comorbidities such as diabetes in the UK	<£9,000
Statins	Statin use in secondary CHD intervention in the UK(depending on age)	£10,000 - £16,000
Statins	Statin use in primary CHD prevention at age 55 in the UK	£13,00-£40,000
Statins	Statin use in primary CHD prevention at age 65 in the UK	£17,000-£59,000
Statins	Statin use in primary CHD prevention at age 75 in the UK	£26,000 - £99,000
Statins	Statin use in primary CHD prevention at age 45 in the UK	£10,000-£31,000
Stent	Primary stent versus PTCA for subacute IHD	£23,000
CABG	CABG/stent/abciximab versus CABG/PTCA/abciximab in IHD	>£65,565
Flu	Influenza vaccination vs no vaccination >65 years in the USA	£522
Flu	Influenza vaccination vs no vaccination 50 – 65 years in the UK	£6,174 - £10,766
Flu	Influenza vaccination vs standard care in residential care elderly population in the UK	£5057 - £21,781
Flu	Influenza vaccination vs standard care in high risk groups in the UK	£4,535- £22,502
Flu	**Influenza vaccination vs standard care in children in the UK**	£6117 - £30,825
Flu	Influenza vaccination vs standard care in healthily adults in the UK	**£6,190-£31,529**
Falls	Hip protectors use in the prevention of hip fracture vs vitamin D/calcium in the UK	£6,254
Falls	Total hip replacement surgery vs no total hip replacement surgery, 60-69 years in the USA	£640- £800
Falls	**Total hip replacement surgery vs no total hip replacement surgery, 70-79 years in the USA**	£1,067-£1,333

8.5 Lifestyles - health and quality of life expectations: the role of Sandwell Partnership

Early evidence from the lifestyle service review suggests it is difficult for local people to make life enhancing changes and that they require support to help them do this - three case studies from the health trainers programme provide an insight into how people might be helped to succeed. Evidence also suggests that people need to be supported even to take their medicines - only 4-21 % of all prescription medicines are taken properly by patients.

There is a wider social context in which these interventions take place where people have to understand the need for the treatments and understand what these treatments and lifestyle prescriptions can do to help them. Most fundamentally people have to believe that health is important and that they have to play their part in protecting and maintaining their own health – it is an issue of personal confidence and belief and it is also an issue of civic pride. Patients need a reason to believe and a reason to expect better .The fact that Sandwell people die younger than the national average should not be acceptable to our Sandwell civic partnership and it should not be acceptable to Sandwell people.

The social glue that is needed to ensure people do expect better health is the same glue that will help them expect better education, better services and better prospects.

This requires our partnerships to invest more in public information, community development and improving our public realm and to expect more form our public services, even within reducing budgets. The new Sandwell partnership vision and shared priorities supports this approach. (CD)

Total place as become the latest vogue policy initiative which offers local strategic partnerships the chance to develop shared service for client groups or on specific policy areas. It could also be used to describe the total services provided from statutory agencies and enable local delivery agencies to define local priorities and reshape shared local services. The power of wellbeing is also an untapped resource for Sandwell to call on.

Further discussion is needed about some concrete and practical means to make improvements by partnership schemes more likely.

For example the council should undertake a full assessment of its corporate building stock with partners to see what can be shared, what can be released, what can work more effectively with other facilities in an area and what should be demolished.

The council should pursue an active policy of enabling asset transfer to robust community organisations with proven tract records in governance financial management and service delivery.

Partners should revisit indicative budgets for services by smaller areas so that local people can gain an understanding of how local services are paid for and to give back accountability to local people.

The partnership should review its community development resources and seek to enhance local community resources which have been shown to be highly cost effective in service delivery. The related issue of high quality public information should also be developed more vigorously by the partnership.

The partnership and the council in particular should look at its use of the power of wellbeing to develop services for young people into employment, for lifestyle services for health, for independent living services including telecare, for street lighting, for the delivery of shared healthy town planning and public realm and for the delivery of the community agriculture strategy.

The personalisation agenda should be implemented vigorously and speedily through adult social care but with a view to health services and other services applying it also.

The partnership should also look to implement shared schemes of ‘spend to save’ initiatives particularly capital schemes which would reduce energy consumption and other use of natural resources to contribute to the reducing climate change.

9. A programme for health

We have also been challenged to look at our health investment through the programme budgeting approach. We have expanded our application of programme budgeting data for health planning.

(Chapter 4) Most recent programme budgeting data for 2007-08 is presented below in a particular type of graph called a control chart or "funnel plot". The control charts show Sandwell's position for important health conditions and compares these with the other PCTs in our 'NHS family' which are centres with industry. It also shows our relative spend on these conditions.

The first chart below (Fig 4.2 in chapter 4) shows how much Sandwell PCT is spending on Cancer per 100,000 populations. The chart indicates that for cancer mortality, Sandwell PCT is higher than the England average and outside the limits or range we would like. The colour indicates that compared to all the nineteen similar PCTs, the amount of money Sandwell PCT spends means that we are in the bottom 20%. The overall picture is difficult to interpret with Leicester City Teaching PCT, Calderdale PCT and Derby PCT all having a mortality figure close or better to the England average but with low, high and middle spending respectively. Relative to our high position for cancer deaths we should take it that we need to invest more in prevention of cancer and we should review our existing spends on early detection and better treatment for cancer.

The second chart (Fig 4.3 from chapter 4) follows the same method for circulatory diseases (Heart disease and Stroke). This shows that again, Sandwell PCT has more deaths from circulatory diseases than the England average and we are outside where we would like to be. In comparison to other PCT's we are spending in the middle. Figure 4.4 looks specifically at deaths from coronary heart diseases and indicates a similar position for Sandwell. We have a high rate of deaths, we are not where we would like to be and compared to our family of PCT's we are spending in the middle range. The chart in fig 4.5 indicates a similar overall picture for respiratory mortality in terms of how much we are spending on these conditions and how well we are performing.

The final chart (fig 4.6.) presents data on mortality for diabetes. For this programme budgeting category, while the rate of death is higher than the England average and marginally outside where would like to be, we are spending the most in comparison to other PCTs. In fact per 100,000 populations we are ranked number one so we should be expecting an improvement in years to come.

- We are very much higher than national death rates for all cancers, all circulatory diseases (heart disease and strokes) diabetes, and respiratory deaths

- For circulatory diseases and for respiratory diseases our spend levels were only at the average of our comparable PCTs - we clearly need to spend more on preventive programmes if we are to make an impact on these preventable and controllable conditions.

- For Maternity and infancy while our spending was at the average of our comparable PCTs, we will continue to invest in promoting breast feeding.

- For diabetes we spend more than our comparators but this still reflects our level of need as measured by the diabetes registers in the MSD dashboard.

- For cancer we are a low spender relative to our comparators and relative to our poor cancer outcomes.

- For mental health we are a low spender in comparison to similar PCT's and will need to invest in this area given the likely impact of the economic downturn. However there is also a need to look critically at spend in these services because they are our biggest funded programme.

A programme for investment might be constructed for healthy individuals and a fully engaged public, by disinvesting from other programme areas.

The areas of lowest comparative spend are:

Mental health
Cancer
Healthy individuals
Social care
Infectious disease

Mental health and cancer are major programmes of investment and could look internally towards reconfiguration or reinvestment. In order to create 5% for health, a 5% investment levy from each programme across the board gives a total of £20.44million. An additional 8% reduction against all the programme areas with a budget over £20 million and a spend position ahead of the average for ONS centres with

industry could generate a total investment fund for health of £25.5million.

The areas which should be looked at very critically for redirection of investment, are :

Dental Problems - 12
Problems of Learning Disability - 6
Neurological – 7
Problems of Circulation - 10
Problems of the Respiratory System – 11
Problems of Musculo Skeletal System – 15
Adverse effects and poisoning
Vision problems

This redirection of investment could be towards preventive intervention within the programme or for investment in other areas.

The programme budgeting approach is gathering pace, but there are concerns about the ability to code financially with precision. The other danger of the approach is that the judgements we make tend to be against the average for the group and so may not reflect needs for even higher spend and our aspirations for being better than 'average' in service quality. The ON's family group comparisons tend to enshrine geographical and other inequalities – for example, why not compare Sandwell to prospering London Boroughs where health spend is likely to be much higher per head than it is here. In the first instance though it will be necessary for us to secure the best possible level of financial data accuracy - as the data usage increases it will become more accurate.

Figure 4.2 from full report

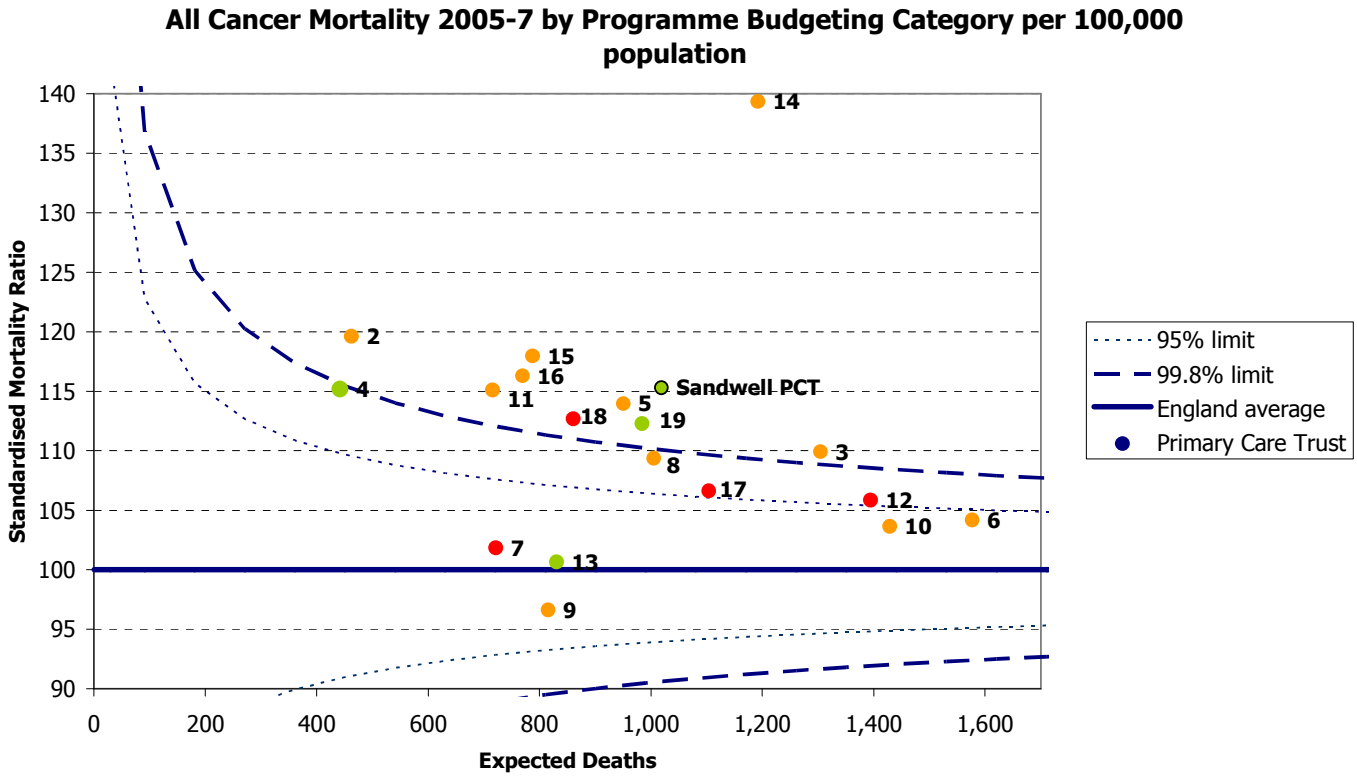


Figure 4.3:

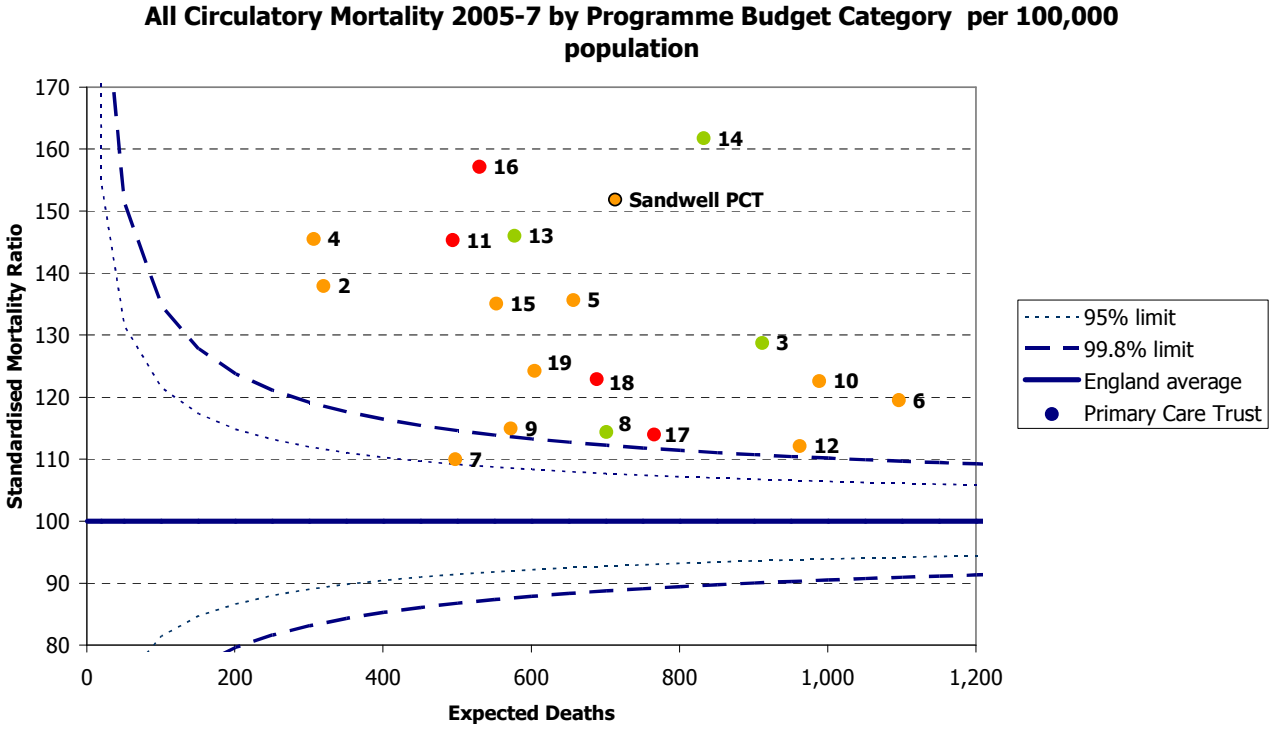


Figure 4.4:

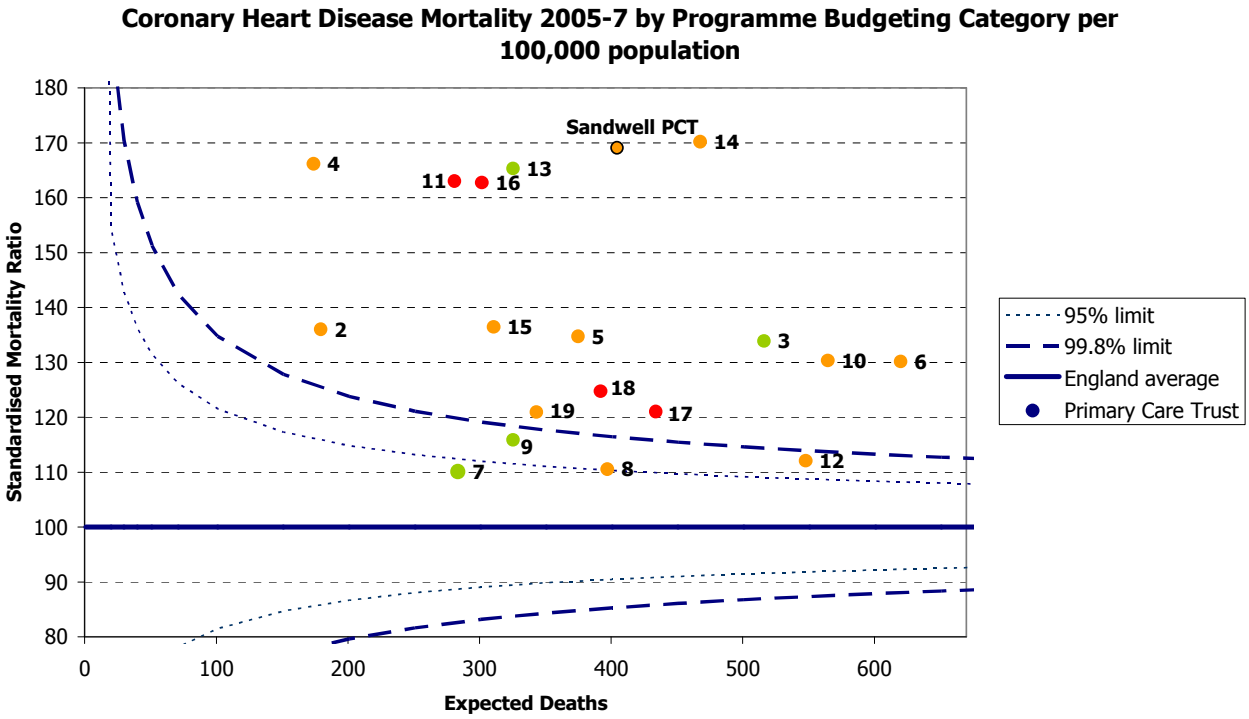


Figure 4.5

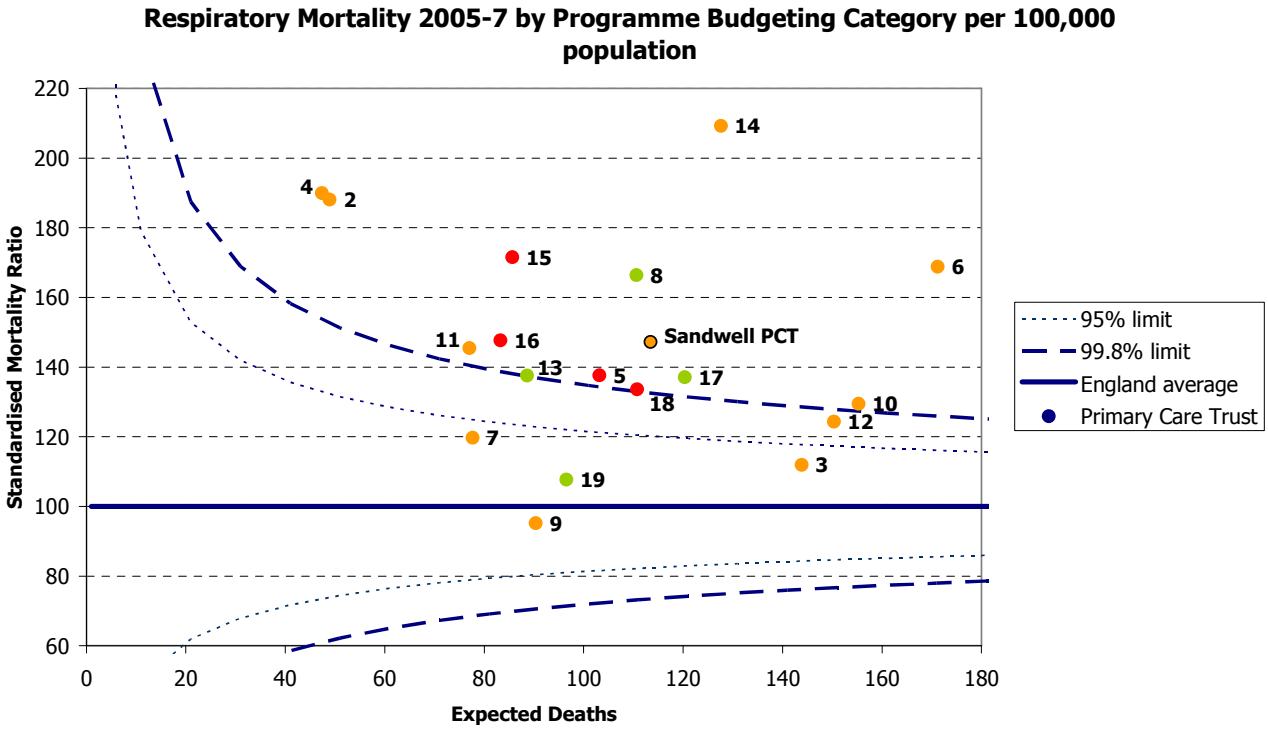
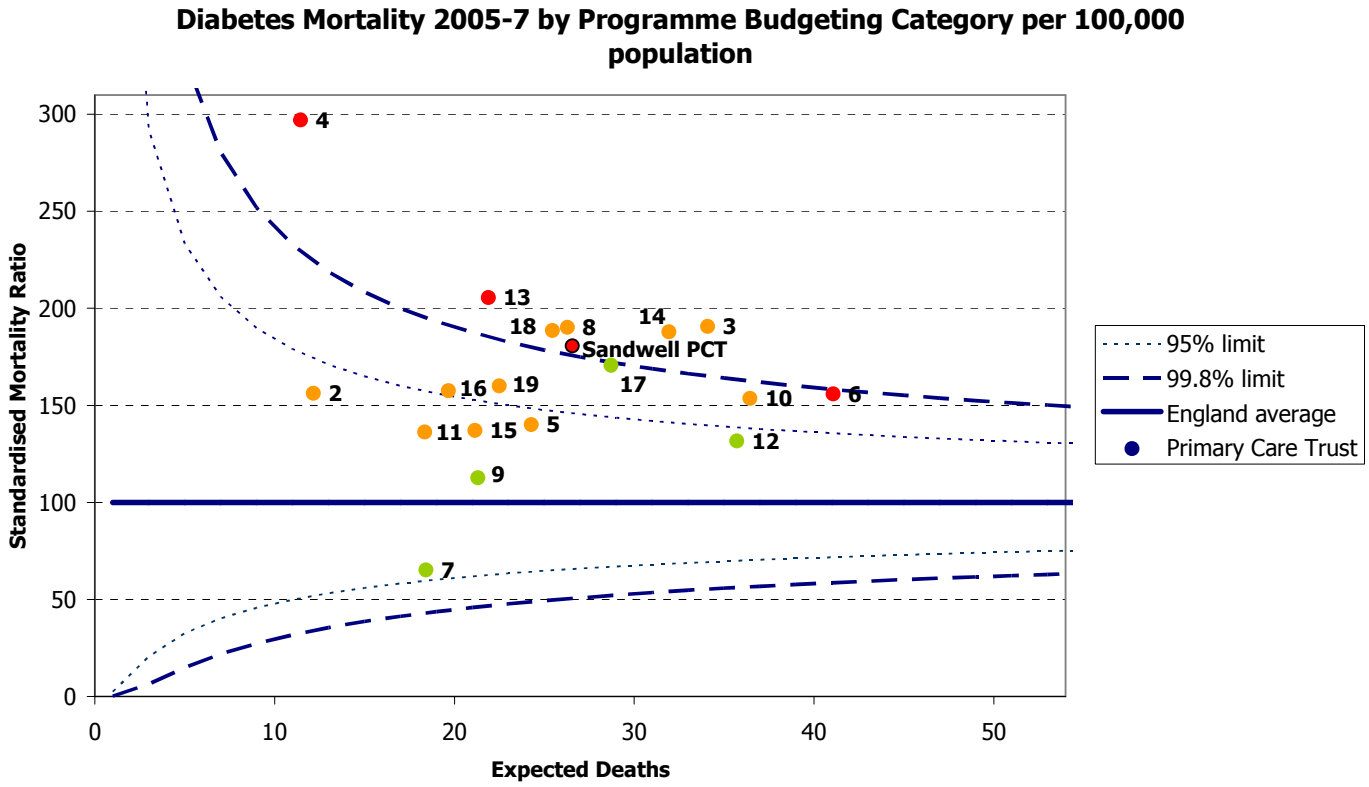


Figure 4.6


Diabetes Mortality 2005-7 by Programme Budgeting Category per 100,000 population
Standardised Mortality Ratio
Expected Deaths
0
50
100
150
200
250
300
0
10
20
30
40
50
4
13
18
8
14
3
Sandwell PCT
17
2
16
19
10
6
11
15
5
12
9
7
95% limit
99.8% limit
England average
Primary Care Trust

Footnotes:
The data on performance is presented in a particular type of graph called at the funnel plots have a characteristic funnel shape. The line of the funnel mark the out the boundaries of the normal (or target) range for the indicator (SMR in this case) examined in that chart. The funnels narrow from left to right because as population size increases less statistical variation is expected, so the range of results accepted as “normal” is less wide. Dots within the funnel are statistically consistent with the national average (or target); those outside are out of line with the national average (or target), for better or worse. There are two funnels on each chart. The inner lines define a range which we would expect 95% of results to fall inside and the outer lines a range which we would expect 99.5% of results to fall inside.

Standardised mortality ratios (SMRs): A standardised mortality ratio is calculated by comparing the number of deaths expected in a standard population to the actual (observed) number of deaths in a subject population. In terms of understanding an SMR, this is the ratio of observed to expected deaths. Ratios above 100 indicate a greater than expected number of deaths; rates below 100 a lower than expected number.

Office of National Statistics (ONS) family
1 Sandwell PCT
2 Barking and Dagenham PCT
3 Birmingham East and North PCT
4 Blackburn with Darwen Teaching PCT
5 Bolton PCT
6 Bradford and Airedale Teaching PCT
7 Calderdale PCT
8 Coventry Teaching PCT
9 Derby City PCT
10 East Lancashire PCT
11 Heywood, Middleton and Rochdale PCT
12 Kirklees PCT
13 Leicester City Teaching PCT
14 Manchester PCT
15 Nottingham City PCT
16 Oldham PCT
17 South Birmingham PCT
18 Walsall Teaching PCT
19 Wolverhampton City PCT

10. Main recommendations

I recommend that the PCT plans to invest 5% of its total income in health maintenance, health improvement and, health information. This would be a first step towards delivering the Wanless vision for a fully engaged public, knowledgeable about their own health, and able to protect, maintain and improve it.

A planned programme for investment in health improvement and prevention of ill health should be put in place, even in the context of a reducing health service budget should be put in place over the next three years. This should be played into the primary care trust's activity and finance model.

The Primary Care Trust should not adopt any new priorities; my recommendations for action are the same as those last year. There are however, new methods for interpreting our financial information about our investment, the programme budgeting approach. We also know we can reduce health inequalities by more systematic use of data and better programmes of care.

We should stick to the World class commissioning priority list set out in our strategy for 2009-2015.

We do need to see more investment is directed towards our stated world class commissioning priority areas. This investment can be financial but can also be management effort, information analysis, public information and training. Specifically in relation to the World Class commissioning goals we do need to invest more into:

Teenage pregnancy- we have not adequately supported the peer education component of the school sex and relationship programme APAUSE. The children and young people's partnership collectively need sot invest in this programme.

Smoking cessation and tobacco control as discussed above a programme spend of £5 million average per year for three years is needed to generate the level of quitters required to reduce our prevalence down to 21% of the adult population.

Alcohol: we plan to achieve our local stretch target for doubling alcohol brief interventions in three years - we need to double it again by 2013-14.

Cardiovascular disease risk reduction, diabetes, and chronic disease management - this area is particularly one which needs management effort, information analysis and redesign of services - we have an excellent health information extraction tool now with the MSDi information manager tool. The potential is there to identify individuals who need better treatment. We can do this systematically and well with some additional funding to facilitate transitions, and to train staff. We also need clear information sharing agreements with practices so that we can use the data anonymously in aggregated formats to look at health service problems by geographical area, so we can target interventions more effectively.

We need to recognise the PCT's role and relationship with other partners and pursue strategies which can support our health objectives across all the targets we are seeking to achieve - for example through better housing, welfare rights and income support, environmental improvement , safety and freedom from violence , community development and engagement and better public information. But recognise our undelivered role as statutory partner in crime and disorder, in Healthy and town planning and as good corporate citizen, particularly with a responsibility in relation to tackling and reducing climate change.

All local agencies face reducing budgets in 2010 onwards. There is therefore an even greater need for openness and accountability in the use of public funds and willingness to pool funding to achieve shared priorities.

The Sandwell strategic partnership needs to explore novel ways to develop joint services and eliminate waste, through its own Total Place initiatives, the use of wellbeing powers, asset transfer and other creative means.

For example, the council should undertake a full assessment of its corporate building stock with partners to see what can be shared, what can be released, what can work more effectively with other facilities in an area and what should be demolished.

The council should pursue an active policy of enabling asset transfer to robust community organisations with proven tract records in governance financial management and service delivery.

Partners should revisit indicative budgets for services by smaller areas so that local people can gain an understanding of how local services are paid for and to give back accountability to local people.

The partnership should review its community development resources and seek to enhance local community resources which have been shown to be highly cost effective in service delivery. The related issue of high quality public information should also be developed more vigorously by the partnership.

The partnership and the council in particular should look at its use of the power of wellbeing to develop services for young people into employment, for lifestyle services for health, for independent living services including telecare, for street lighting, for the delivery of shared healthy town planning and public realm and for the delivery of the community agriculture strategy.

The personalisation agenda should be implemented vigorously and speedily through adult social care but with a view to health services and other services applying it also.

The partnership should also look to implement shared schemes of 'spend to save' initiatives particularly capital schemes which would reduce energy consumption and other use of natural resources to contribute to the reducing climate change.

In conclusion

After many years of believing that public health interventions should take their place in annual priority setting with competing needs for health services, I now believe this is simply not possible in with the set of handed down priorities for National Health Service spend and with the perverse system of funding by which hospitals are rewarded. It is simply not possible to compete in that context and preventing ill health is left as an afterthought in health service planning. I therefore believe that a specific ring fenced budget for preventing ill health is needed, even in the context of a reducing health service budget. Existing services should also be required to demonstrate that they are redirecting their own budgets towards preventing illness and creating the fully engaged, health knowledgeable public. But there does need to be specific, ring-fenced, hypothecated funding dedicated to preventing ill health. It would be necessary for these funds to be administered through a proper governance arrangement- an enhanced health

and wellbeing board. It would also be expected that such funding would be matched through by lead partners in programmes such as housing and education to achieve additional health related goals. In the first instance, the target for this within three years, should be **5% for health**.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Execution of Contract as a simple contract – MAU Enabling Works at City Hospital
SPONSORING DIRECTOR:	Graham Seager, Director of Estates and New Hospital Project
AUTHOR:	Paul Dale, Capital Projects Manager
DATE OF MEETING:	27 May 2010

SUMMARY OF KEY POINTS:

It is proposed to sign the construction contract for building works for MAU Reconfiguration – Enabling Works between the Trust and Manton Building Contractors Ltd with a contract sum of £222,444.00 including VAT.

There is an option for construction contracts to be executed as a simple contract or as a deed. Under the law of contract, the period within which an action for breach of contract may be brought is limited to 6 years from the time of accrual of the cause of the action for contracts executed as a simple contract and 12 years for contracts executed as a "deed".

It is recommended that all construction contracts over £1m are executed as a deed.

This requires the use of the Trust's seal, under the Trust's SO/SFIs the use of the seal is a reserved matter for the Trust Board.

This paper recommends the contract is signed as a simple contract.

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 that the JCT IFC98 contract documents be signed, as simple contract documents. To sign all required pages of two sets of documents indicated within the contract and also within the attached schedule which indicates the page numbers which require signature.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Good use of resources and 21st Century facilities
Annual priorities	5.3 - Continue to improve current facilities
NHS LA standards	
CQC Essential Standards of Quality and Safety	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Not previously considered.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Register of Interests
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Simon Grainger-Payne
DATE OF MEETING:	27 May 2010

SUMMARY OF KEY POINTS:

- The Register of Interests for the members of the Trust Board is presented for noting.
- The Register is required to be reviewed at least annually as part of the Trust Board's cycle of business.
- All members have been required to sign an annual declaration of their interests, the outputs of which have been included in the new register.
- Key changes to the register include the incorporation of interests declared by the Trust's two new Non Executive Directors, Mr Gary Clarke and Mrs Olwen Dutton. The Register also reflects the recent retirement of Isobel Bartram, former Non Executive Director.

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 Register of Interests.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	None specifically, although reflects good governance within the Trust
Annual priorities	
NHS LA standards	
CQC Essential Standards of Quality and Safety	
Auditors' Local Evaluation	Supports the internal control dimension

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

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

PREVIOUS CONSIDERATION:

The Register of Interests was last reviewed by the Trust Board in September 2009.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

REGISTER OF INTERESTS AS AT MAY 2010

Name	Interests Declared
Trust Chair	
Sue Davis CBE#	▪ Chair – Cruse Bereavement Care, Sandwell ▪ Director – West Midlands Constitutional Convention ▪ Director – RegenWM
Non-officer Members	
Roger Trotman	▪ Non-Executive Director – Stephens Gaskets Ltd ▪ Non-Executive Director – Tufnol Industries Trustees Ltd ▪ Member of the West Midlands Regional Assembly Ltd ▪ Member of the West Midlands Regional Assembly Ltd – Regional Health Partnership ▪ Member of Business Voice West Midlands ▪ Member of the Advantage West Midlands – Regional Finance Forum
Gianjeet Hunjan	▪ Governor at Great Barr and Hamstead Children's Centre ▪ Governor at Ferndale Primary School ▪ LEA Governor at Oldbury College of Sport ▪ Member of GMB Trade Union ▪ Member of Managers in Partnership/UNISON ▪ Treasurer for Ferndale Primary School Parents Association
Dr. Sarindar Singh Sahota OBE	▪ Vice Chair West Midlands Regional Assembly Ltd ▪ Non-Exec Business Voice West Midlands Ltd ▪ Trustee Acorns Hospice ▪ Director Sahota Enterprises Ltd ▪ Director Sahota Properties Ltd ▪ Member – University of Birmingham Governing Council ▪ Member Birmingham & Solihull Chamber of Commerce Council
Prof Derek Alderson	Member of Council of Royal College of Surgeons of England
Mr. Gary Clarke commenced 1.4.10	Lead Officer for Dorcas Housing & Committee Support Association Ltd
Mrs. Olwen Dutton commenced 20.5.10	▪ Director – West Midlands European Centre ▪ Company Secretary – West Midlands Regional Assembly ▪ Director – ReGen West Midlands ▪ Board Adviser – Sustainability West Midlands

At the Trust Board meeting held on 26 March 2009, Mrs Davis declared that her husband had been appointed as Chair of South Birmingham PCT Provider Board

Name	Interests Declared
Officer Members	
John Adler	None
Donal O'Donoghue	Limited medico-legal work
Richard Kirby	Trustee – Birmingham South West Circuit Methodist Church
Rachel Overfield	None
Robert White	▪ Directorship of Midtech clg ▪ National Committee Member, HFMA Financial Management & Research Committee
Associate Members	
Graham Seager	None
Kam Dhami	None
Trust Secretary	
Simon Grainger-Payne	Company Secretary – Maple 262 Ltd.

RECENTLY LEFT	
Isobel Bartram left 19.5.10	None

May 2010

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Annual Report from Director of Infection Prevention and Control 2010/2011
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Dr Beryl Oppenheim – Director of Infection Prevention and Control
DATE OF MEETING:	27 May 2010

SUMMARY OF KEY POINTS:

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

Numbers of cases of MRSA bacteraemia and Clostridium difficile infections remain low in comparison with previous years, maintaining and in some cases improving on these will provide a major challenge for 2010/2011.

A key change to our activities involves a commitment to surveillance of a range of other HCAI's and infection control measures with root cause analysis of cases and actions to reduce the risks of these infections.

Audit and training continue to be prioritised as a means of delivering continuous improvements.

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

Approval	Receipt and Noting	Discussion
	X	
To advise the Trust Board of the work undertaken by the Infection Control Service at Sandwell & West Birmingham Hospitals NHS Trust for the period April 2009-March 2010.		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to receive and note the Annual Report for the period April 2009-March 2010.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High Quality Care
Annual priorities	2.1 – Continue to keep up high standards of infection control and cleanliness
NHS LA standards	2.4.9 - Infection control
CQC Essential Standards of Quality and Safety	Regulation 12; Outcome 8 – Cleanliness and infection control
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:

Executive Infection Control meeting on 17 May 2010

Annual Infection Prevention and Control Report 2010/2011

Executive Summary

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

Numbers of cases of MRSA bacteraemia and Clostridium difficile infections remain low in comparison with previous years, maintaining and in some cases improving on these will provide a major challenge for 2010/2011.

A key change to our activities involves a commitment to surveillance of a range of other HCAI's and infection control measures with root cause analysis of cases and actions to reduce the risks of these infections.

Audit and training continue to be prioritised as a means of delivering continuous improvements.

Management and Organisation

The overall organisation of infection control within the Trust continues to wok well, with the Infection Control Operational Committee now leading on developing and reviewing the action plan, reviewing new policies and ensuring compliance with all requirements of the Code of Practice. Partnership working with the Primary Care Trusts, Strategic Health Authority and Health Protection Agency through the Health Economy Group for Infection Control continues to thrive, with a number of joint projects in place.

Within the Trust the Infection Control team continue to liaise well with all relevant groups with a particular strength being our excellent access to doctors in training which we believe has paid major dividends in terms of quality measures such as improved antibiotic prescribing and reductions in numbers of contaminated blood cultures.

The team were delighted to continue with strong links to the Strategic Health Authority and Department of Health and are finalising the report into the evaluation of the impact of our rapid MRSA screening programme.

The Infection Control Team have developed a new programme of activities for 2010/2011 which has been approved by the Infection Control Operational Committee and will be closely monitored at Infection Control Team meetings. The programme involves the updating or review of a large number of infection control policies, a major commitment to surveillance of a wider range of HCAI's and related infection control initiatives, and a strong focus on audit and training.

MRSA

Mandatory Reporting of MRSA bloodstream infections

There were a total of 14 MRSA bacteraemias during 2009/2010 against a target of 23 (Figure 1). This outturn is very similar to the previous year when there were 15 cases.

From the start of the new financial year the arrangements for monitoring of MRSA bacteraemias will change and our targets will relate to post 48 hour and other Trust attributable cases only. For 2010 our target is 6, which has been the outturn for such cases over the last two years.

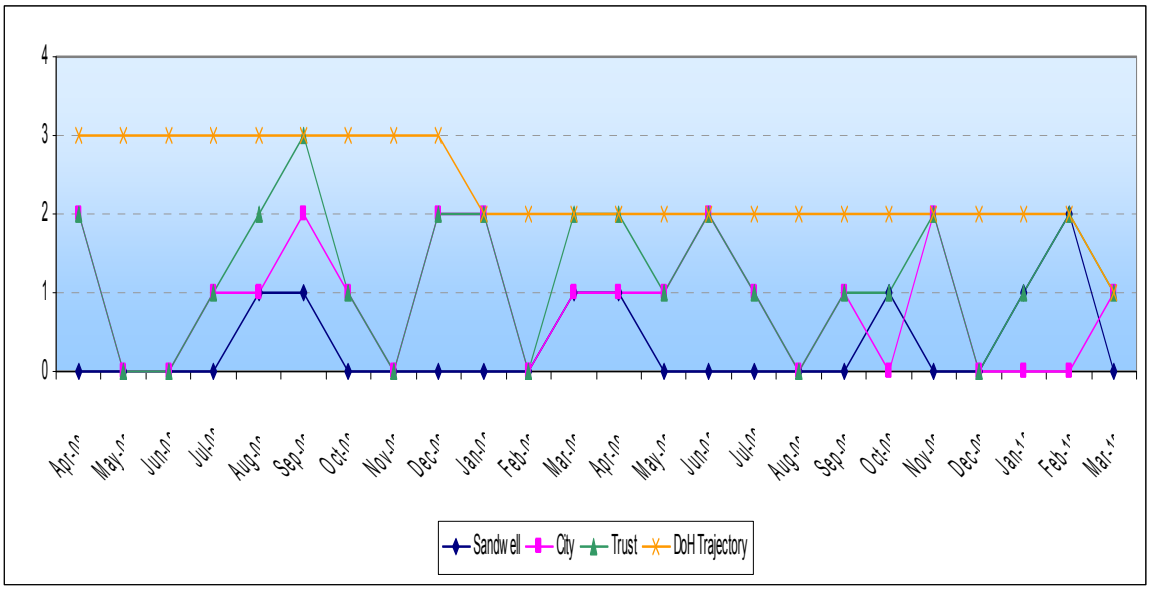


Figure 1: Number of MRSA bacteraemia cases

One of the important risk factors for MRSA bacteraemias is contaminated blood cultures as these are counted as cases for the purpose of our trajectory and are also an important quality measure because contaminated cultures can lead to unnecessary antibiotic treatment in patients and extra costs for the laboratory.

A number of initiatives to reduce the risk of contaminated blood cultures have been put into place, including feeding back the information about these to the relevant areas, ensuring that all areas have the correct equipment required for the process, and most recently, feeding back on contaminated cultures to the individual practitioner who took the culture and requiring them to have top-up training. These measures have resulted in a steady fall in the percentage of contaminated cultures with our lowest number being in March 2010 when we fell below our stated target of 3% for the first time.

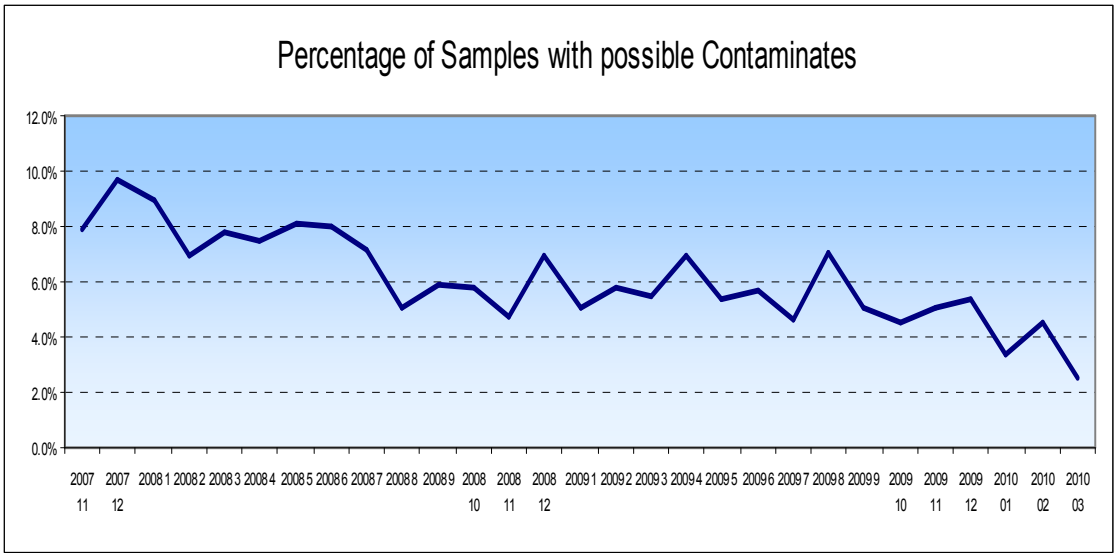
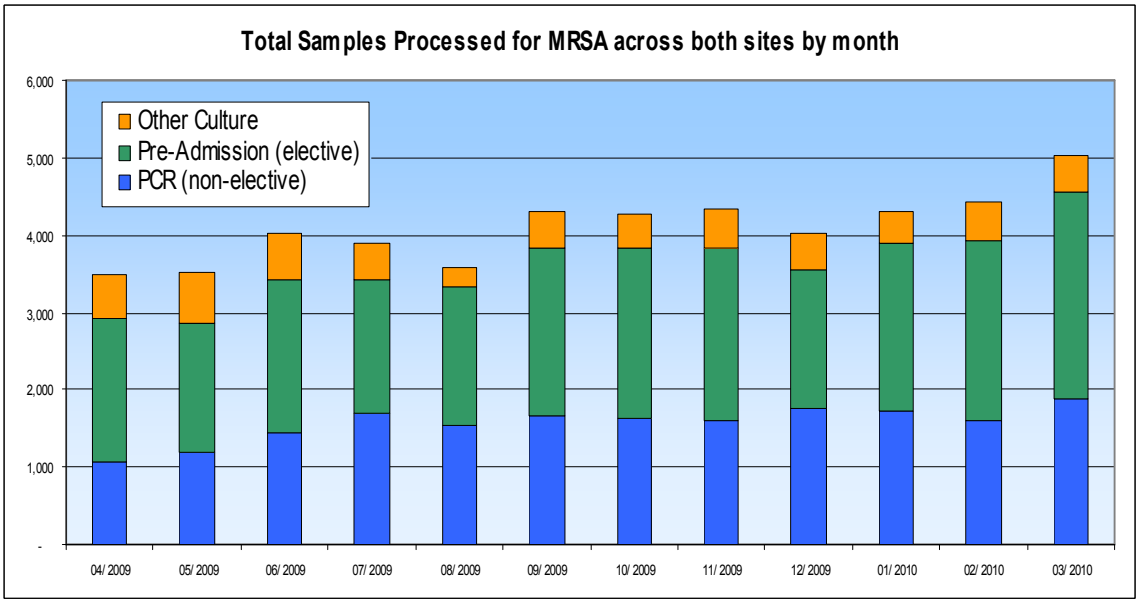


Figure 2: Percentage of possibly contaminated blood cultures

MRSA Screening and Decolonisation Therapy

MRSA screening of elective admissions became mandatory in April 2009 and we have had a successful programme of screening of these cases with decolonisation of individuals found to be positive and regular feedback of numbers screened to the relevant areas since then. Screening of non-elective admissions will become mandatory in January 2011; however we have for some time been screening most emergency admissions using a rapid point of care test. Figure 3 shows the number of cases screened each month and positivity rates. Overall the pick-up rate for elective screens has remained around 2%, with non-elective screens yielding around 6% positivity.



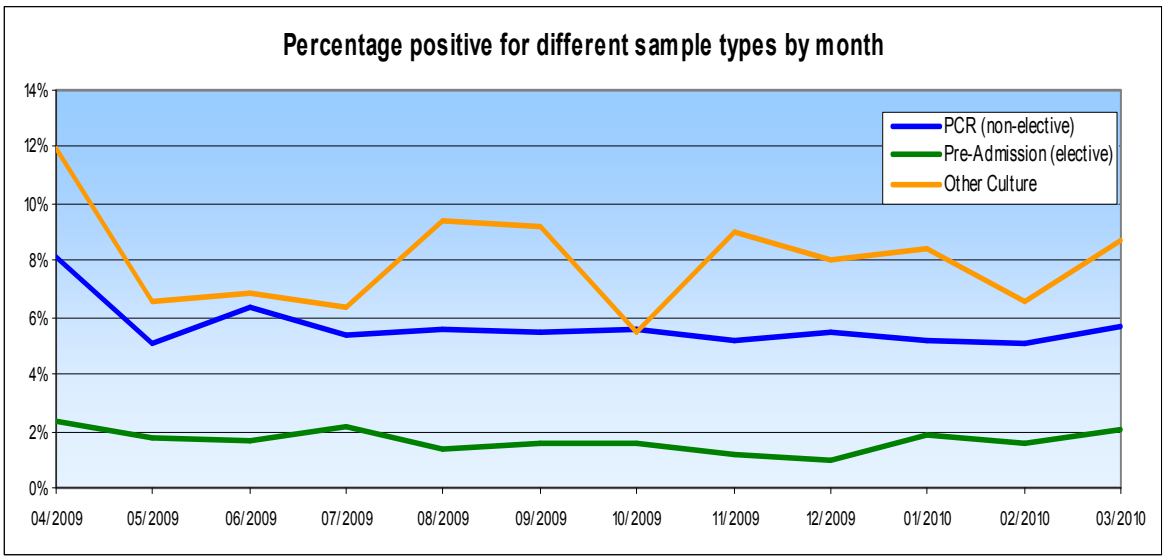


Figure 3: MRSA screening, numbers and positivity rates

Preliminary data from our evaluation of the impact of rapid screening for MRSA is just becoming available and a full report should become available within the next few months. However early information shows promising results with a large proportion of patients who require decolonisation treatment for MRSA carriage starting this within 24 hours of a positive test (Figure 4), whereas this might take more than 72 hours were conventional culture based tests used.

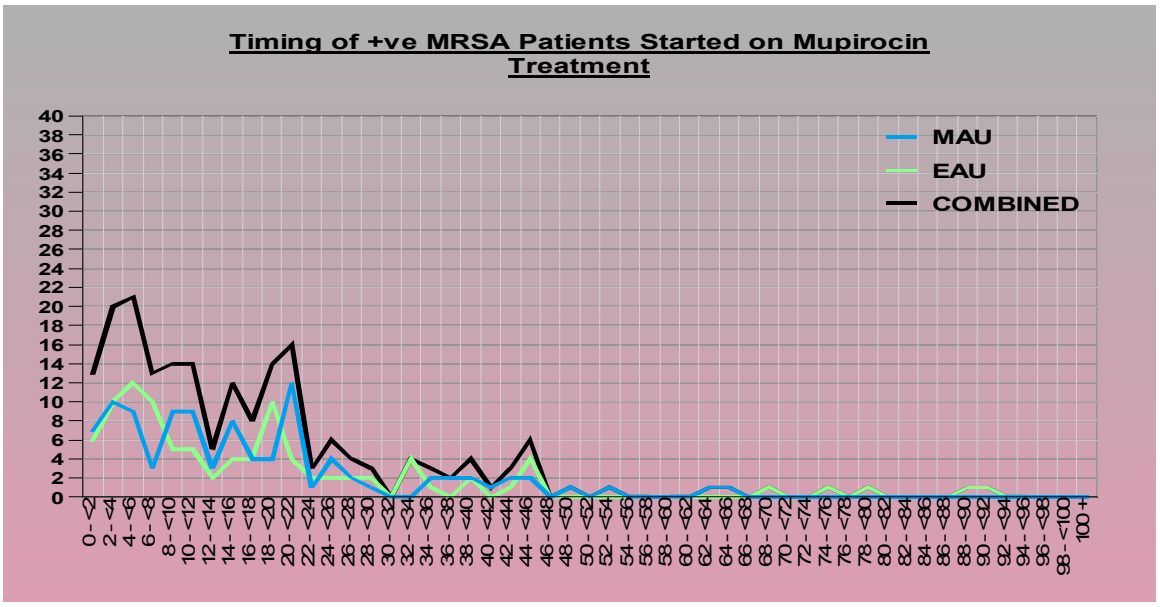


Figure 4: Timing of mupirocin prescription for MRSA positive patients

Clostridium difficile infections (CDI)

There were 158 cases of CDI occurring more than 48 hours after admission during 2009/2010 against our internal target of 220 (Figure 4). This is similar to our outturn for 2008/09 which is an excellent result considering that during 2009/10 we were using a testing regimen which detects approximately twice as many cases as the previous method.

We have published our analysis of the new testing regimen in an international journal and are pleased to see that it is influencing practice in other organisations. We have also analysed the impact of the new testing practice on our CDI cases over the year. The first conclusions are that earlier diagnosis is leading to a generally less severe picture of infection, and there is also the surprising finding that awareness of the strain type has led to a dramatic fall in the number of cases due to the 027 ribotype (Figure 5), which is believed to be both more severe and have the potential for causing hospital-associated outbreaks.

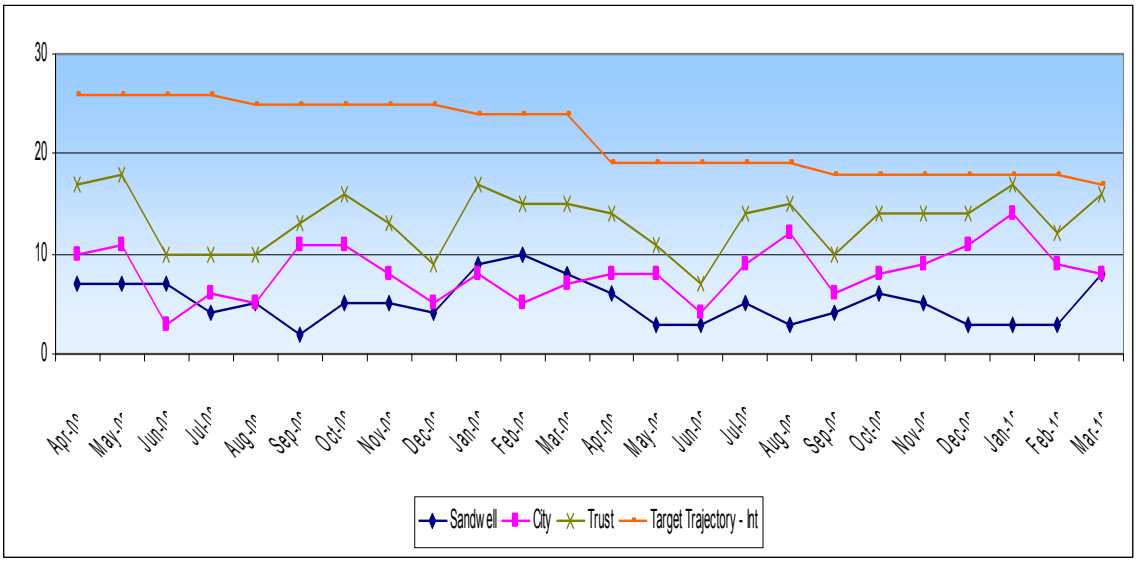


Figure 5: Numbers of post-48 hour cases of CDI

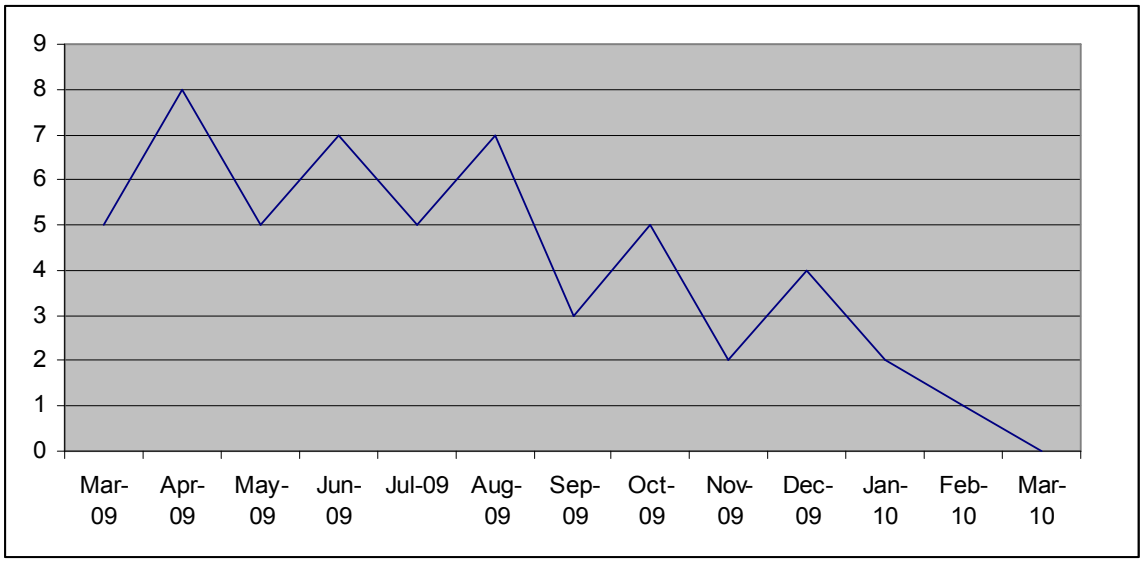


Figure 6: Number of 027 ribotype cases of CDI

Surveillance of other healthcare associated infections

It is now important to extend surveillance of healthcare associated infections beyond merely counting cases of MRSA bloodstream infection and CDI. There is general agreement that this should be encouraged and we are also hoping to develop a Region-wide minimum data set to allow comparisons between similar organisations.

Until this approach has been finalised we have decided to regularly report on *Staph aureus* (non-MRSA) bloodstream infections (MSSA) (Figure 6) and *E coli* bloodstream infections (Figure 7) as these are among the commonest serious infections occurring in hospital. Until there is widespread agreement to share this information it is of course not possible to compare our position with those of similar sized hospitals however we will undertake root cause analysis of these and look at recurring themes that might allow plans for reductions in these infections.

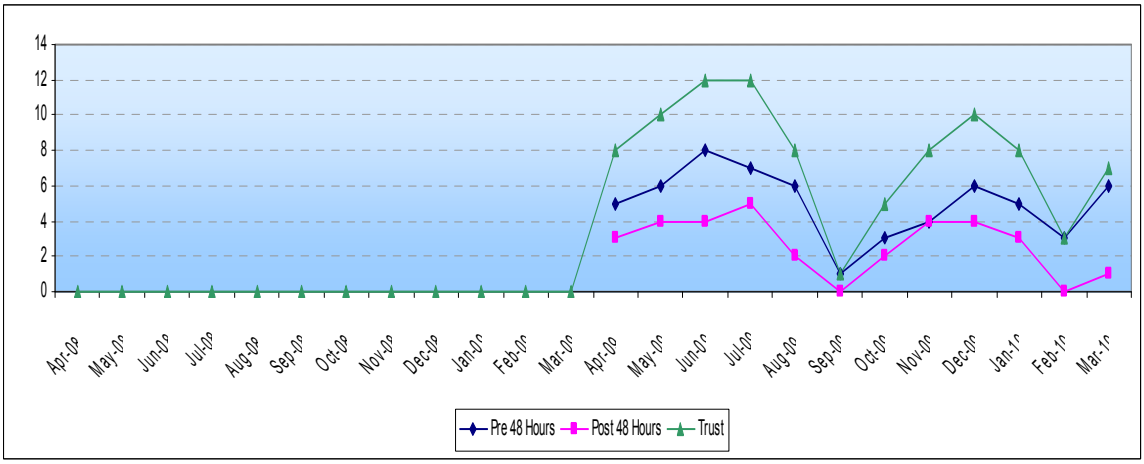


Figure 7: Numbers of MSSA bloodstream infections

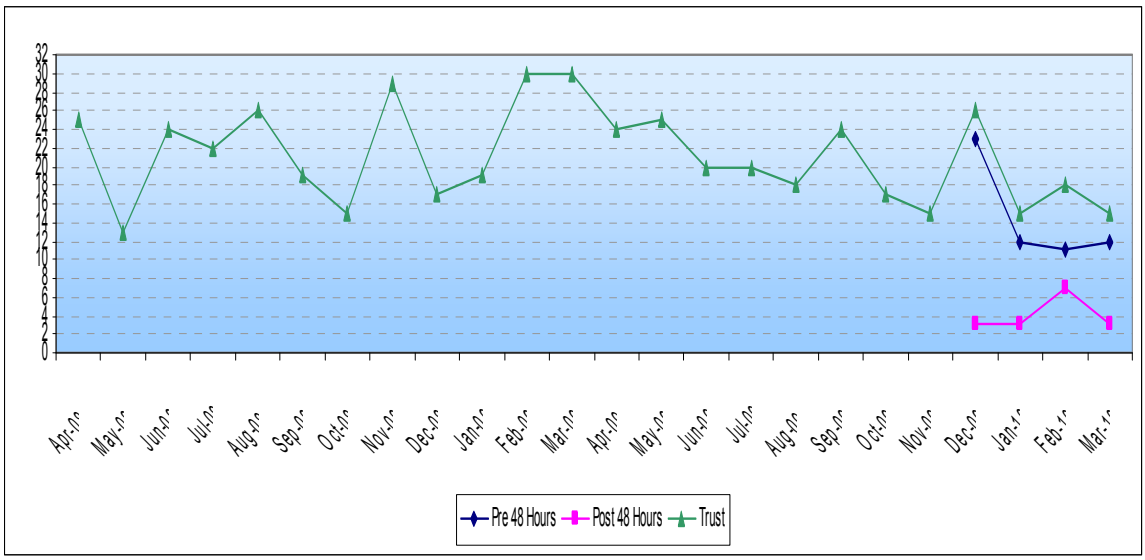


Figure 8: Numbers of E coli bloodstream infections

Antibiotic stewardship

The year has seen significant progress on the antibiotic front with a full complement of antibiotic pharmacists and excellent joint working with the antibiotic pharmacist in Sandwell PCT and improved links with those responsible for promoting antibiotic stewardship in HoB PCT. For the future this partnership working will be key to delivering improved access for patients to outpatient intravenous antibiotics where these are appropriate.

There has been a focus on revising existing policies and developing new ones where required, training, and spot check audits to assess compliance with policies. A major concern noted during audits was the lack of a consistent approach to documenting stop or review dates for antibiotic prescriptions on drug charts and we are pleased to note that there has been a steady improvement in this from less than 50% to just under 80% (Figure 9).

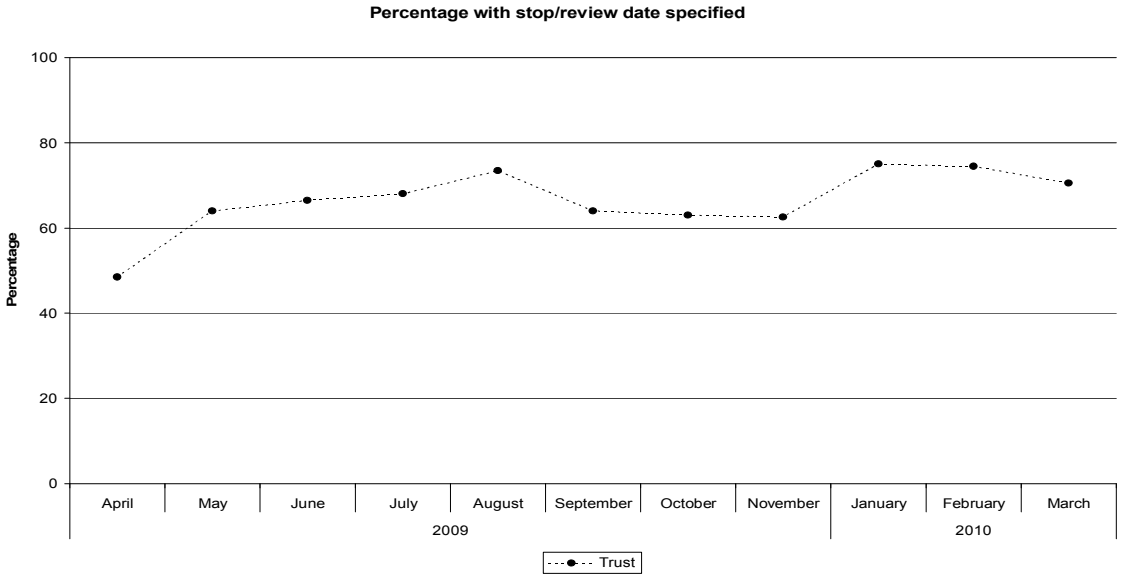


Figure 9: Percentage of antibiotic prescriptions with a stop/review date

We continue to monitor antibiotic utilisation data and this provides a powerful tool to ensure that our policies are being followed and that any changes in policy are having the desired impact. Figure 10 shows the impact of a recent policy change to reduce the use of penicillins such as amoxicillin and replace this usage with doxycycline for elderly patients who may be more vulnerable to CDI when given repeated courses of penicillins.

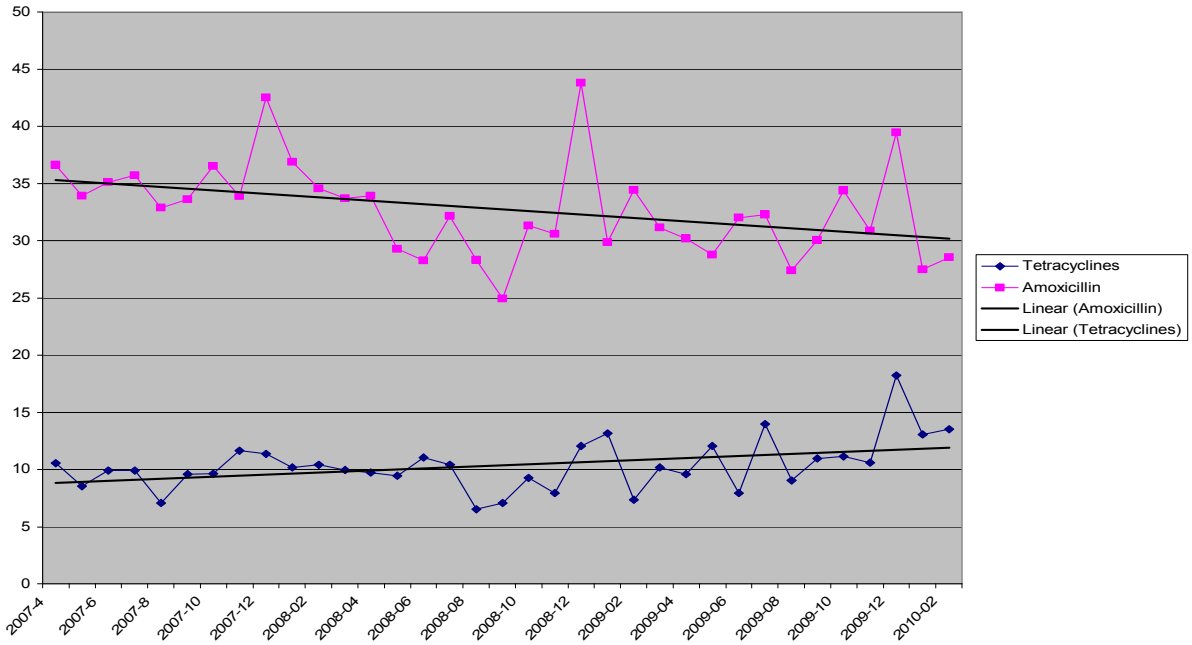


Figure 10: Comparisons of usage of amoxicillin and tetracyclines

Audit and training

Regular audit and feedback to teams of their current status with regard to compliance with infection control policies is a key aspect of our programme. The current system of electronic entry of hand hygiene audit data with instant feedback of results by e-mail to managers of the relevant areas is, we believe, unique to this Trust and allows for rapid remedial action or, where necessary, escalation upwards to more senior staff. There is a full programme of audit against all relevant infection control policies with most results showing good compliance. Where actions do arise from audits or other reviews it is anticipated that these will be transferred to the Infection Control Action Plan to be closely monitored by the Infection Control Operational Committee.

Together with Learning and Development, we have reviewed all aspects of training for infection control, particularly induction and ongoing mandatory training. Mandatory training for clinical staff is now available electronically and this has made a major impact in the ability of staff to access this and become compliant with the requirements. Induction and regular teaching for junior doctors has greatly improved our ability to deliver adherence to antibiotic policies and reductions in contaminated blood cultures as noted previously.

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:	27 May 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 and has been revised a number of times to reflect changes in the Act.

The Trust Board are asked to note the Infection Control and Cleanliness Assurance Framework which seeks to provide assurance to the Trust Board on 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.

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

Approval	Receipt and Noting	Discussion
	✓	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board are asked to note the Infection Control and Cleanliness Assurance Framework.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	2.1 - Continue to keep up high standards of infection control and cleanliness
Annual priorities	
NHS LA standards	2.2.8 - Hand hygiene training
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

The Infection Control Assurance Framework is presented to the Trust Board on a quarterly basis.

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.	Chief Nurse	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 • 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 • Handwash facilities in siderooms	Chief Nurse and Director of Estates	Green

			• 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 *Ensure that patients*		Prevention and control of HCAI should be such as to demonstrate responsibility is	• Job descriptions of all staff include control and prevention of infection	Chief Nurse	Green

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'		devolved to: • All professional groups • All specialties	• 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		Providers have a list of core policies in place	• All listed policies are in place	DIPC	Green

Have and adhere to appropriate policies and protocols for the prevention and control of HCAI. Overall Status: 'MEETS'		(List ref Act 2008 p15)	• An audit programme exists to audit compliance • Policies are widely available • Policies are included in staff training		
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 Stevens, Chief Nurse
AUTHOR:	Steve Clarke, Deputy Director - Facilities
DATE OF MEETING:	27 May 2010

SUMMARY OF KEY POINTS:

The report provides an update to the Board regarding the results from the National Standards of Cleanliness, PEAT audits and inspections for 2010.

The report provides and 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:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Continue to reduce hospital infection rates achieving national and local targets for MRSA and clostridium difficile including introducing MRSA screening in line with national guidance.
Annual priorities	2.1 – Continue to keep up high standards of infection control and cleanliness
NHS LA standards	
CQC Essential Standards of Quality and Safety	Regulation 12; Outcome 8 – Cleanliness and infection control
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	**X**	
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Usual quarterly update.

Executive Infection Control meeting on 7 May 2010

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

TRUST BOARD REPORT

CLEANLINESS & PEAT (PATIENT FOOD)

27TH MAY 2010

The report provides an update to the Board regarding the results from the National Standards of Cleanliness, PEAT audits and inspections for 2010.

PEAT

- **Main PEAT Audits (External) 2010**
  The main PEAT audits were undertaken on:

  City Hospital & Eye - Tuesday 23rd February
  Sandwell Hospital - Wednesday 24th February
  Rowley Regis Hospital - Friday 26th February

  The official scores have now been approved, see below.

Site Name	Environment Score	Food & Hydration Score	Privacy & Dignity Score
Sandwell Hospital	Good	Good	Good
City Hospital	Good	Good	Good
Eye Hospital	Good	Good	Good
Rowley Hospital	Good	Good	Good

  The 'Food' score for last year was rated 'excellent' however this year's rating only attracted 'good'.

  The reason for the rating change was due to a requirement for additional nutritional information relating to the number of patients weighed on admission and number of patients screened for the purpose of their nutritional care. The PEAT requirement is rating scores on 100% compliance, currently the Trust does not undertake these two elements for every admission.

  On reviewing the part of the audit relating directly to patient food the rating was as last year, 'excellent'.

- **PEAT Internal Inspections**
  The PEAT programme for 2010/11 has been agreed and elements are being costed following the recent approval of the PEAT funding. In conjunction with the general ad-hoc work there will be a programme of refurbishment to all the Trust ward linen rooms and Sandwell ward kitchens, food storage areas.

There has also been an allocation of funding for general ward equipment and beds. A breakdown of expenditure will be available for the next report.

- **Patient Survey**

A Facilities patient satisfaction survey has been undertaken and the results were very positive, provided are the headlines for each department from the report.

- o Ward Housekeeping
  194 (63%) felt that their ward/room was very clean, 107 (35%) felt that their ward/room was fairly clean and 5 (2%) felt that the ward/room was not clean at all.

- o Patient Transport Services
  Over 99% of patients across the Trust considered that the ambulance/vehicle was clean.

- o Linen Services
  Of the 203 patients who used hospital pyjamas or nightdresses, 168 (83%) felt that they were of a correct fit. 188 (92%) patients felt that the pyjamas or nightdresses were in good condition

- o Catering Services
  240 (85%) patients always got offered a choice of meal by being issued with a menu card whilst 31 (11%) patients declared that they 'never' had a menu card issued.

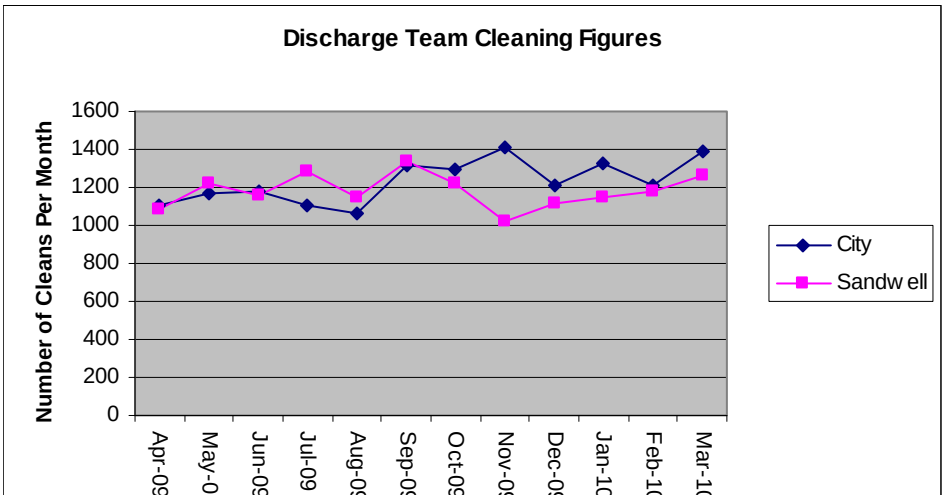
- o Security
  295 (96%) of the respondents stated they felt safe and secure in Hospital

The complete report is available on the Facilities Governance shared folder.

ENVIRONMENTAL DEVELOPMENTS

Discharge Cleaning Teams – Performance 2009/10

The discharge team is still providing a valuable asset in terms of ensuring the bed space is cleaned on discharge and in terms of releasing valuable nursing time for patient care.



Hand Hygiene Facilities

All works to improve hand hygiene facilities across the Trust in line with the CQC audit have been completed:

- Wash hand basins at ward entrances at Sandwell
- Wash hand basins in dirty utilities
- Janitorial units in Domestic Service's rooms
- Wash hand basins on City main spine

NATIONAL STANDARDS OF CLEANLINESS AUDIT SCORES

The Trust has maintained its performance for the final quarter period for 2009/10 in the cleanliness of the critical areas designated as 'high' for general wards and departments and 'very high' for theatres, MAU etc.

	QUARTER 1						QUARTER 2					
	April 09		May 09		June 09		July 09		August 09		September 09	
	V High %	High %	V High %	High %	V High %	High %	V High %	High %	V High %	High %	V High %	High %
City	95	95	93	96	94	95	97	96	96	95	97	98
Sandwell	98	97	98	97	97	97	98	98	98	97	98	97
Rowley	N/A	97	N/A	97	N/A	97	N/A	98	N/A	95	N/A	97
BTC	98	96	97	97	98	97	97	98	98	98	98	97
Target	98	95	98	95	98	95	98	95	98	95	98	95
Overall Average	97	96	96	97	96	97	97	98	97	96	98	97

	QUARTER 3						QUARTER 4					
	October 09		November 09		December 09		January 10		February 10		March 10	
	V High %	High %	V High %	High %	V High %	High %	V High %	High %	V High %	High %	V High %	High %
City	97	94	96	94	96	96	97	94	96	96	97	98
Sandwell	95	96	94	98	94	96	95	96	96	96	97	95
Rowley	N/A	96	N/A	98	N/A	99	N/A	98	N/A	99	N/A	98
BTC	98	95	98	96	98	98	98	96	98	96	98	96
Target	98	95	98	95	98	95	98	95	98	95	98	95
Overall Average	97	95	96	97	96	97	97	96	97	97	97	97

- **Ipsos MORI Report**
  Recommendations and an action plan from the report have been circulated to the Infection Control Committee and will be discussed at the next meeting on 24th May 2010. Feedback will be provided with the next board report.

A copy of the recommendations, current position and action is attached.

CLEANLINESS GENERAL/INITIATIVES

- **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 have been transferred and the system is now operational. Training has now been undertaken and the first audits commenced the beginning of March 2010. Update to be provided for the next report.

- **Decontamination**
  The bed store and wash down facility has been commissioned at Sandwell and is now fully operational. The area is also the base for the porters following the rationalisation of Site Services (Porters and Security).

- **Patient Dignity**
  There is a recognized problem in the Trust with patient nightwear, Facilities have been trying to address the issue with our linen suppliers, there is also a national initiative being driven by the Department of Health to develop a quality product, however there seems to be problems and inevitable delays with both schemes.

  A business case will be presented to SIRG that may give the Trusts an opportunity to purchase and maintain patient nightwear in-house by expanding the laundry facilities at Rowley Hospital.

STEVE CLARKE
DEPUTY DIRECTOR - FACILITIES

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

IPSOS MORI REPORT

Overview:

There are three main themes which help shape perceptions on cleanliness in hospitals are: i) hospital environment, ii) personal hygiene and iii) accountability issues, listed are the recommendations, current status and way forward for each category.

Recommendation	Current Status	Action/Way Forward
Hospital Environment:		
▪ Continue to refresh walls, ceilings and doors in white washed or light pastel colours to instill a feeling of brightness.	Part of the PEAT programme	Continue redecoration programme.
▪ Limit clutter and things that could be seen as just 'lying around'.	De-clutter Programme.	Re-introduce.
▪ Improve the visibility of cleaning staff and of the assurances/checks that are made.	NSoC Audits.	Quality Assurance checks. Publicise results?
▪ Remove empty tea cups and used crockery quickly.	Ward Services/Nursing responsibility.	Review procedures.
▪ Clean up spills quickly.	Ward Services/Nursing responsibility.	Review procedures.
▪ Remove dead flowers, old papers and empty rubbish bins regularly. Cafeteria facilities should have minimum dirty crockery and cutlery lying around and left over food should be disposed of quickly; Well presented and fresh food.	Ward Services/Nursing responsibility.	Review procedures. Check cleaning schedules of Cafeterias (Arches).
▪ Consider the type of food that visitors can bring to the ward to avoid strong smells for other patients.	Food should not be brought in for patients – unless this has been agreed with the ward staff.	Raise awareness at relevant forums.
Personal Hygiene:		
▪ Ensure patients are able to take a shower/bath when desired.	Facilities are available.	
▪ Allow patients and family to more opportunities to feedback if their personal hygiene needs are not being met.	Feedback through PALS, Communications & PPI groups.	
▪ Proactively ensure patients, visitors and staff are washing their hands and	Actively promoted and audited.	

Recommendation	Current Status	Action/Way Forward
using the available facilities (i.e. Alcohol rubbing dispensers and sinks with soap).		
▪ Sensory operated water taps, pedal bins, blow hand dryers and liquid soap give the impression that efforts are being made to raise standards; consider a more culturally sensitive approach to hygienic facilities – squat toilet facilities and bidets are seen to be more hygienic amongst some cultures although this may not be necessary if cleanliness standards of current facilities are increased. Ensure culturally sensitive food options, such Halal meat for Muslins and vegetarian meals for Hindus and Jains are more widely available.	Hand wash stations fitted. Cultural food options are available i.e. Halal, vegetarian etc.	Ensure all stations are fully operational. Review options for hand wash stations in wards & departments.
▪ Improve the cleanliness of the toilets and have an alert system so that accidents can be cleaned quickly; Improve staff training on why and what cleanliness rules.	Alert notices only in public toilets.	
▪ Hospital personnel taking responsibility for checking whether visitors and patients have washed their hands to build confidence that staff are 'on board' and ensuring rules are kept.	Hand wash audit programmes in place.	
▪ Encouraging patients and visitors to enforce cleanliness rules amongst hospital staff; Ensure all staff are clean in uniforms/clothes and employ good personal hygiene.	Ward Reviews. Uniform Policy. Matrons monitoring/audits.	
Accountability:		
▪ Encourage joined-up working, more involvement of cleaning staff in ward meetings and encouragement of ownership and pride in their important role.	Ward Services should/are part of an integrated part of ward team.	Promote at SNF.
▪ Demonstrate clear lines of responsibility more effectively. Patients and the public like the idea of 'matron like' managers because they relate this to someone who is directly accountable for the cleanliness and standards on each individual ward.	Promote cleaning structure/ responsibilities.	
▪ Make effective information available about what is done to maintain standards across the hospitals and wards. Pictures and contact details of those with responsibility will help to show patients and the public the lines of accountability.	Structure/ward – Team information and cleaning schedules are already displayed.	
▪ Install/improve the utilization of feedback mechanisms such as suggestion boxes so that patients and visitors can comment about the things they would like to see improved (and the things you are doing well); Make more information available explaining the way cleaning staff are contracted and their roles and responsibilities – counter perceptions that low standards are a	Structure/ward – Team information and cleaning schedules are already displayed.	

Recommendation	Current Status	Action/Way Forward
produce of contract cleaners (if this is appropriate).		
▪ Encourage all staff to be vigilant and proactive in maintaining the standards of the hospital and wards. Clinical staff ignoring something like a dirty dinner place or spilt food because it's not their job will contribute to a loss of confidence that cleaning standards are a priority.		Raise awareness at relative forums.
▪ Provision of information in a wider variety of languages, in particular languages such as Polish, Indian and Punjabi.	Trust decision not to provide information in a variety of languages.	
▪ Availability of information in an animated format (e.g. commercials or campaigns on television) as an alternative to various language options and convey messages in a fun yet effective and easily understood manner across a variety of audiences.	Hand hygiene/washing instructions are displayed.	
▪ Ensure visitors are aware of the ward rules and the hygiene standards you expect visitors to uphold to come on the ward. Increase awareness of a shared responsibility towards hospital cleanliness – cleanliness being the responsibility of hospital authorities, health care professionals, visitors and patients.	Visitor's board & visitor's policy published on entry and exit to wards.	
▪ Make information about the responsibility of cleanliness in hospitals available – through campaigns, information, internal TV in the hospitals and the media. Importantly, don't just focus on the what, explain why you are insisting on the things you are insisting on.	Structure/ward – Team information and cleaning schedules are already displayed.	
▪ Wider availability of relevant information outside hospital environments in places such as GP surgeries, dental clinics, baby clinics, health centres and school.	Communications promoted through GP Focus?	
▪ Improved education in children's schools from an early age in regards to cleanliness and infection in hospitals.		
▪ Availability of more infection specific information. Including how infections such as MRSA and C.diff develop, are spread, what their symptoms are and how they can be avoided.	Patient information leaflets. Figures widely published.	

STEVE CLARKE
DEPUTY DIRECTOR - FACILITIES

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	National Staff Survey 2009 Update
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse (Executive Lead for Workforce)
AUTHOR:	Gayna Deakin, Deputy Director of Workforce
DATE OF MEETING:	27 May 2010

SUMMARY OF KEY POINTS:

- The National Staff Survey 2009 was undertaken between the period September 2009 and January 2010. A random sample of 850 staff were selected to take part in the survey and the Trust's response rate was **54%.** The national response rate for all acute trusts in England was **51%.**

- The survey highlights some significant improvements in including reducing violence and aggression towards staff, improved communications, and that staff are feeling that LiA is really starting to make a difference.

- The key findings also highlight several areas in need of urgent improvement. The Trust's job satisfaction score of **3.40** has not changed significantly since last year and is in the **worst 20%** when compared with all trusts in England. Performance in relation to staff experience has deteriorated in relation to *'support from immediate managers'* and the following areas are listed as the bottom four ranking scores:

    - Staff feeling valued by their work colleagues
    - Trust commitment to work-life balance
    - Staff feeling pressure in the last 3 months to attend work when feeling unwell
    - Staff receiving job-relevant training, learning or development in the last 12 months

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** this report

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	- Suitability of Staffing - Quality and Management
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 National Staff Survey is a national requirement Engaging and empowering staff and improving working lives is a key trust priority
Environmental		
Legal & Policy		
Equality and Diversity	**X**	The report provides evidence to support the effectiveness of the Trust's employment policies in this area
Patient Experience		
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Trust Management Board on 18 May 2010

NATIONAL STAFF SURVEY 2009

1. Introduction

The NHS Next Stage Review recognised the importance of the National NHS Staff Survey and highlighted its potential to support greater emphasis on engaging with staff. This was undertaken for Sandwell and West Birmingham Hospitals by Quality Health between September 2009 and January 2010.

This report will set out the overall survey findings and results, highlighting areas where the Trust's performance has improved and those where further improvement is required. It will set out how staff feel about the Trust's staff engagement programme (Listening into Action), and the approach that the Trust will adopt to tackle those areas in need of improvement and more focused attention.

2. Background

This is the 7th annual national staff survey of all Trusts in England. The purpose of the survey is to establish the effectiveness of agreed national human resources policies in the context of each Trust, and to gauge the views and experiences of the 1.3 million staff in the NHS.

The Survey Advice Centre at Aston University collects data from all Trusts and produces key scores and scales weighted by occupational group on the basis of all the national responses from all Trusts, so that Trusts with large or small proportions of one occupational group will not be advantaged or disadvantaged by their particular occupational structure. The Survey Advice Centre publishes all national comparative data in public access reports which are housed on the Care Quality Commission website.

3. Key Findings

The Trust achieved a **54%** response rate to the National Staff Survey 2009. This compares well with the overall national response rate of **51%** for all acute trusts in England.

The table below sets out how our latest results compared to last years findings and how we are performing in comparison with other acute trusts taking part in the Quality Health Survey:

Section	Comparison to last year's results*	Comparison to national average
Resources to deliver (flexible working)	**Same**	**Same**
Training	**Improved**	**Mixed**
Support to do a good job (appraisals)	**Same**	**More Positive**
About the Job	**Same**	**Mixed**
The Organisation	**Improved**	**Mixed**
A worthwhile job and chance to develop	**Improved**	**More Positive**
Errors, near misses and incidents	**Same**	**Same**
Harassment, bullying and violence	**Improved**	**More Positive**
Occupational Health and Safety	**Improved**	**Mixed**
Infection Control and Hygiene	**Same**	**Same**

The following shows where the Trust has made significant improvement (by +/-%) since the last staff survey:

Training

- 14% increase in staff receiving equality and diversity training in the last 12 months
- 7% increase in staff receiving health and safety training in the last 12 months
- 7% increase in staff receiving training on infection control
- 5% increase in staff receiving training on how to prevent violence and aggression

Appraisal/Communication

- 10% increase in staff agreeing they know how their role contributes to what the Trust is trying to achieve
- 8% increase in staff agreeing that care of patients is the Trust's top priority
- 7% increase in staff agreeing that the Trust communicates clearly with staff about what it is trying to achieve
- 7% increase in staff agreeing they know how the Trust contributes to what the NHS is trying to achieve
- 6% increase in staff leaving their review (appraisal) feeling their work was valued by the Trust
- 5% increase in staff agreeing that communication between senior management and staff is effective

Staff Satisfaction

- 8% increase in staff agreeing they are satisfied with the quality of care they give to patients
- 6% increase in staff agreeing they are satisfied they are able to deliver the patient care they aspire to
- 6% increase in staff agreeing they would recommend the Trust as a place to work

Health, Safety & Well Being

- 6% decrease in staff experiencing violence from patients and relatives
- 3% decrease in staff experiencing violence from staff
- 11% increase in staff having access to counseling services at work
- 9% increase in staff saying that the last time they experienced physical violence they or a colleague reported it.
- 9% increase in staff saying they have access to counseling services at work

The survey highlights that staff experience has deteriorated in relation to the following areas:*'support from immediate managers'* and lists the following areas as the bottom four ranking scores:

- 0.8 reduction in score for staff feeling that their immediate manager provides them with support
- No change in staff feeling valued by their work colleagues (score in worse 20% of all acute Trusts)
- No change in Trust commitment to work-life balance (score in worse 20% of all acute Trusts)
- Staff feeling pressure in the last 3 months to attend work when feeling unwell (new question - score in worse 20% of all acute Trusts)
- No change in staff receiving job-relevant training, learning or development in the last 12 months (score in worse 20% of all acute Trusts)

The full national staff survey report for 2009 can be found on the Trust intranet (HR section) and on the Care Quality Commission website.

4. Staff Engagement

This year for the first time the staff survey calculates an overall staff engagement score. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The score is calculated using the individual questions that make up the following key findings, and when compared with all other acute trusts on each of the above sub-dimensions the Trust is average for KF 33 and KF36, and below (worse than) average for KF 37:

- Key Finding 33 *'staff members' perceived ability to contribute to improvements at work'*
- Key Finding 36 '*their willingness to recommend the trust as a place to work or receive treatment'*
- Key Finding 37 *'the extent to which they feel motivated and engaged with their work'*

The Trust's score for 2009 is **3.62** and is **average** when compared with all acute trusts nationally (**3.64**). It can be seen from the table below that the Trust has scored more favourably overall when benchmarked against other similar acute Trusts locally:

Comparable Trusts	Overall Staff Engagement Score	Overall Ranking
University Hospitals Birmingham NHS Foundation Trust	3.75	in highest 20%
Sandwell & West Birmingham Hospitals NHS Trust	**3.62**	**average**
Dudley Group of Hospitals NHS Foundation Trust	3.60	below average
Walsall Manor Hospital	3.59	below average
Heart of England NHS Foundation Trust	3.54	in lowest 20%

Over the last 12 months we have continued to make significant strides in adopting and spreading our approach to staff engagement, called Listening into Action (LiA), across the Trust. This has included engaging with our staff on the Trust's vision and values, driving service improvements, and what matters to our staff at work, and with patients and carers to develop and improve the quality of some of our services. The Trust's survey included a set of local questions to find out how staff feel about the organisations approach to staff engagement. The findings below show continued improvement in adopting and embedding this engagement tool and that staff feel that LiA is making a difference:

Local Question	2008	2009	+/-
% of respondents that said they have definitely heard about LiA in the Trust	70%	89%	+19%
% of respondents that said that they have heard about planned improvements/can already see improvements in services for patients being made	31%	43%	+12%
% of respondents that said they have a clear idea of what LiA is	45%	66%	+21%
% of respondents that said that LiA is giving more power to staff to change things	44%	47%	+3%
% of respondents that said that their immediate manager listens/sometimes listens to staff about improving services	69%	74%	+5%
% of respondents that said that their manager does act/sometimes acts on staff suggestions for improving services	62%	65%	+3%

% of respondents said LiA is very likely/quite likely to succeed	34%	45%	+11%

5. Staff Satisfaction Score

The Trust's score of **3.40** is **below average** (**3.48)** and is in the **worst 20%** when compared with all acute trusts nationally. The Trust's score has not changed significantly since 2008 when the trust scored rose significantly from the previous year (3.35) rose to 3.41. The survey questions that make up this score are as follows and will be a key focus in the Trust's reponse to the findings of the survey:

- The recognition I get for good work
- The support I get from my immediate manager
- The freedom I have to choose my own method of working
- The support I get from my work colleagues
- The amount of responsibility I am given
- The opportunities I have to use my skills
- The extent to which the Trust values my work
- My level of pay

It can be seen from the table below that the Trust has scored less favourably overall on the job satisfaction score when benchmarked against other similar acute Trusts locally:

Comparable Trusts	Overall Staff Satisfaction Score	Overall Ranking
University Hospitals Birmingham NHS Foundation Trust	3.51	in highest 20%
Dudley Group of Hospitals NHS Foundation Trust	3.48	average
Walsall Manor Hospital	3.48	average
Sandwell & West Birmingham Hospitals NHS Trust	**3.40**	**in worst 20%**
Heart of England NHS Foundation Trust	3.36	in worst 20%

6. Trust Response

The Trust has already started work in many of the areas that the survey has confirmed are in need of further improvement. The work being undertaken to develop the leadership framework, to further embed LiA, and work starting to develop the Trust's health and well-being strategy in response to the findings of the NHS Health and Well-being Review (Boorman) are all essential parts of the Trust's approach to improving the working lives of staff and increasing staff satisfaction and engagement. This work is being taken forward with full staff engagement.

The Trust's workforce strategy is currently being reviewed and the 10/11 work programme will include the actions required to ensure that the HR and employment policies and 'people processes' are reviewed and/or aligned to fit with the Trust's approach to organisational development. Quality of work-life balance is a key priority and the Trust's policy and approach is currently being reviewed.

Following a similar format to last year the corporate Listening into Action (LiA) event taking place on 14th May 2010 will include listening to the views from a wide selection of around 150 staff on how some of the key issues that require further improvement can be tackled and will inform the . This approach has proved to be very effective and is reflected in the Trust's excellent response this year in reducing violence and aggression.

Progress against the above directly linked to the findings of the staff survey will be monitored and overseen by the LiA Sponsor Group.

7. Conclusion

The results for this survey show some significant improvements and positive results in the right direction and highlight the significant impact that the Trust's approach to staff engagement is having. The survey also show some disappointing findings that require further interventions and focused effort in order to make improvements.

To gain further advantage the current pieces of work highlighted in the Trust response above will need to be aligned and co-ordinated as part of the Trust's organisational development plans.

8. Recommendation

The Trust Management Board is asked to **receive** and **note** this report and is invited to discuss or comment on the proposed actions to respond to the findings of this years staff survey.

APPENDIX 1

SUMMARY OF KEY FINDINGS

TOP FOUR RANKING SCORES	WHERE STAFF EXPERIENCE HAS IMPROVED
Staff reporting good communication between senior management and staff	Staff experiencing physical violence from staff in last 12 months
Staff appraised with personal development plans in last 12 months	Staff experiencing physical violence from patients/relatives in last 12 months
Staff appraised in last 6 months	Staff feeling satisfied with the quality of work and patient care they are able to deliver
Staff experiencing physical violence from staff in last 12 months	Staff having equality and diversity training in last 12 months

SWBH PERFORMANCE IS BETTER THAN AVERAGE WHEN COMPARED TO ALL ACUTE TRUSTS IN 2009

Staff feeling satisfied with the quality of work and patient care they are able to deliver (increase since 2008) in best 20% of all acute trusts

Staff agreeing that their role makes a different to patients (no change since 2008) in best 20% of all acute trusts

Staff agreeing that they have an interesting job (no change since 2008)

Quality of job design (increase since 2008)

Work pressure felt by staff (decrease since 2008) in best 20% of all acute trusts

Staff working in a well structured team environment (no change since 2008)

Staff working extra hours (no change since 2008)

Staff feeling there are good opportunities to develop their potential at work (no change since 2008) - Average

Staff appraised in last 12 months (no change since 2008) in best 20% of all acute trusts

Staff having well structured appraisals in last 12 months (no change since 2008) in best 20% of all acute trusts

Staff appraised with personal development plans in last 12 months (no change since 2008) in best 20% of all acute trusts

Staff receiving health and safety training in last 12 months (increase since 2008)

Staff witnessing potentially harmful errors, near misses or incidents in last month (no change since 2008)

Staff reporting errors, near misses or incidents witnessed in the last month (no change since 2008)

Staff experiencing physical violence from patients/relatives in last 12 months (decrease since 2008)

Staff experiencing physical violence from staff in last 12 months (decrease since 2008) in best 20% of all acute trusts

Staff perceptions of effective action from employer towards violence and harassment (no change since 2008) - Average

Staff reporting good communication between senior management and staff (no change since 2008) in best 20% of all acute trusts

Staff agreeing that they understand their role and where it fits in (no change since 2008) in best 20% of all acute trusts

Staff able to contribute towards improvements at work (no change since 2008) - Average

Staff recommendation of the trust as a place to work or receive treatment (no data for 2008) - Average

Staff having equality and diversity training in last 12 months (increase since 2008)

BOTTOM FOUR RANKING SCORES	WHERE STAFF EXPERIENCE HAS DETERIORATED
Staff feeling pressure in last 3 months to attend work when feeling unwell	Support from immediate managers
Staff feeling valued by their work colleagues	
Trust commitment to work-life balance	
Staff receiving job-relevant training, learning or development in last 12 months	

SWBH PERFORMANCE IS WORSE THAN AVERAGE WHEN COMPARED TO ALL ACUTE TRUSTS IN 2009

Staff feeling valued by their work colleagues (no change since 2008) in worse 20% of all acute trusts

Trust commitment to work-life balance (no change since 2008) in worse 20% of all acute trusts

Staff using flexible working options (no change since 2008)

Staff receiving job-relevant training, learning or development in last 12 months (no change since 2008) in worse 20% of all acute trusts

Support from immediate managers (decrease since 2008) in worse 20% of all acute trusts

Staff suffering work related injuries in last 12 months (no change since 2008)

Staff suffering work-related stress in last 12 months (no change since 2008)

Staff saying that hand washing materials are always available (increase since 2008)

Fairness and effectiveness of incident reporting procedures (no change since 2008) in worse 20% of all acute trusts

Staff experiencing harassment, bullying or abuse from patients/relatives in last 12 months (no change since 2008)

Staff experiences harassment, bullying or abuse from staff in last 12 months (no change since 2008)

Impact of health and well-being on ability to perform work or daily activities (no data for 2008)

Staff feeling pressure in last 3 months to attend work when feeling unwell (no data for 2008) in worse 20% of all acute trusts

Staff job satisfaction (no change since 2008) in worse 20% of all acute trusts

Staff intention to leave jobs (decrease since 2008)

Staff motivation at work (no data for 2008)

Staff believing that the trust provides equal opportunities for career progression or promotion (no change since 2008)

Staff experiencing discrimination at work in last 12 months (no change since 2008)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	National Outpatient Survey 2009
SPONSORING DIRECTOR:	Jessamy Kinghorn, Head of Communications and Engagement
AUTHOR:	Nick Howells, Senior Communications Manager
DATE OF MEETING:	27 May 2010

SUMMARY OF KEY POINTS:

The 2009 National Inpatient Survey was published by the Care Quality Commission on 19th May 2010.

This report highlights the key findings. A full benchmark report is available on the CQC website.

This survey is carried out annually. 413 patients completed the survey for Sandwell and West Birmingham Hospitals, a response rate of 50%.

Key 'overall' findings:

- 91% of patients rated their care as good, very good or excellent (national average 92%).
- More patients said they were always treated with respect and dignity than last year (82%, a further 14% said they were sometimes treated with respect and dignity)
- 93% of patients rated the way doctors and nurses worked together as good, very good or excellent

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

1. The Trust Board is asked to note the report

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High Quality Care
Annual priorities	The views of patients have helped set the priorities for 2010/11.
NHS LA standards	
Core Standards	National patient surveys are used as evidence for several core standards
Auditors' Local Evaluation	

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

Financial	**X**	Financial impact for next year: A new benchmarking tool will be used to compare the 2009 results with the 2010 results and linked to up to 1.5% of tariff income.
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity	**X**	There was not enough data for a meaningful demographic analysis
Patient Experience	**X**	
Communications & Media	**X**	This information was published on 19th March 2010 by the CQC
Risks		

PREVIOUS CONSIDERATION: The initial findings were circulated to the Trust Board by email.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

National Inpatient Survey 2009 - Findings

Paper by the Senior Communications Manager and Head of Communications and Engagement

May 2010

1. INTRODUCTION

The national adult inpatient survey is conducted annually and the results published by the Care Quality Commission.

This is the 7th annual survey of adult inpatients and involved 162 acute and specialist NHS trusts. Responses were received from more than 69,000 patients, a response rate of 52%. Patients were eligible for the survey if they were aged 16 years or older, had at least one overnight stay and were not admitted to maternity or psychiatric units.

The survey for Sandwell and West Birmingham Hospitals NHS Trust patients was undertaken by Quality Health and involved patients being discharged during July, or August 2009. The results were published by the Care Quality Commission on 19th May 2010.

From a sample of 850 Sandwell and West Birmingham Hospitals NHS Trust patients, 413 completed questionnaires were returned, a response rate of 50%.

Where statistically possible, the information has also been analysed by the clinical specialty of the patients responding, although the relatively small number of completed questionnaires means there is very limited potential to carry out a statistically valid analysis. The sample involved can be as small as 30 patients for a particular speciality.

As the number of patients in the national sample is very small, the Trust carries out its own surveys throughout the year which cover a much larger number of inpatients and provide enough information to look at patient feedback at ward level. These surveys have recently been revised to include several key questions from the national survey and are carried out along side carer surveys. They are able to pick up many more areas of performance in real time and are used along with regular quality audits such as hand hygiene audits to form part of the ward reviews.

2. SUMMARY OF PERFORMANCE

91% of patients rated their care as good, very good or excellent (national average 92%). More patients said they were always treated with respect and dignity than last year (82%, a further 14% said they were sometimes treated with respect and dignity), 93% of patients rated the way doctors and nurses worked together as good, very good or excellent,

The table below shows the overall scores published by the Care Quality Commission for each section of the survey compared to other trusts and to the previous year.

Areas of particular note include patients rating the trust highly on information in A&E and on leaving hospital.

However, patient ratings were less favourable in the following areas: space for belongings, help with eating meals, hand washing, nurse communication, involvement in decisions about their care, privacy when discussing treatment, pain control, and information about their operation or procedure.

The comments made by patients completing the survey show a significant variation in the quality of experiences they had, with many very positive comments but also negative views expressed.

Section heading	*SWBH Score out of 10 - 2008*	*2008 compared to other trusts*	SWBH Score out of 10 - 2009	2009 compared to other trusts	Movement from last year
The emergency / A&E department, answered by emergency patients only	***7.6***	***The same***	**7.8**	**The same**	▲
Waiting lists and planned admissions, answered by those referred to hospital	***6.1***	***The same***	**6.73**	**The same**	▲
Waiting to get to a bed on a ward	***7.9***	***The same***	**8.21**	**The same**	▲
The hospital and ward	***7.4***	***The same***	**7.86**	**The same**	▲
Doctors	***8.5***	***The same***	**8.3**	**The same**	▼
Nurses	***8.3***	***The same***	**7.9**	**The same**	▼
Care and treatment	***7.7***	***The same***	**7.25**	**The same**	▼
Operations and procedures, answered by patients who had an operation or procedure	***8.6***	***Better***	**7.89**	**Worse**	▼
Leaving hospital	***7.2***	***Better***	**6.76**	**The same**	▼
Overall views and experiences	***6.3***	***The same***	**6.23**	**The same**	▼

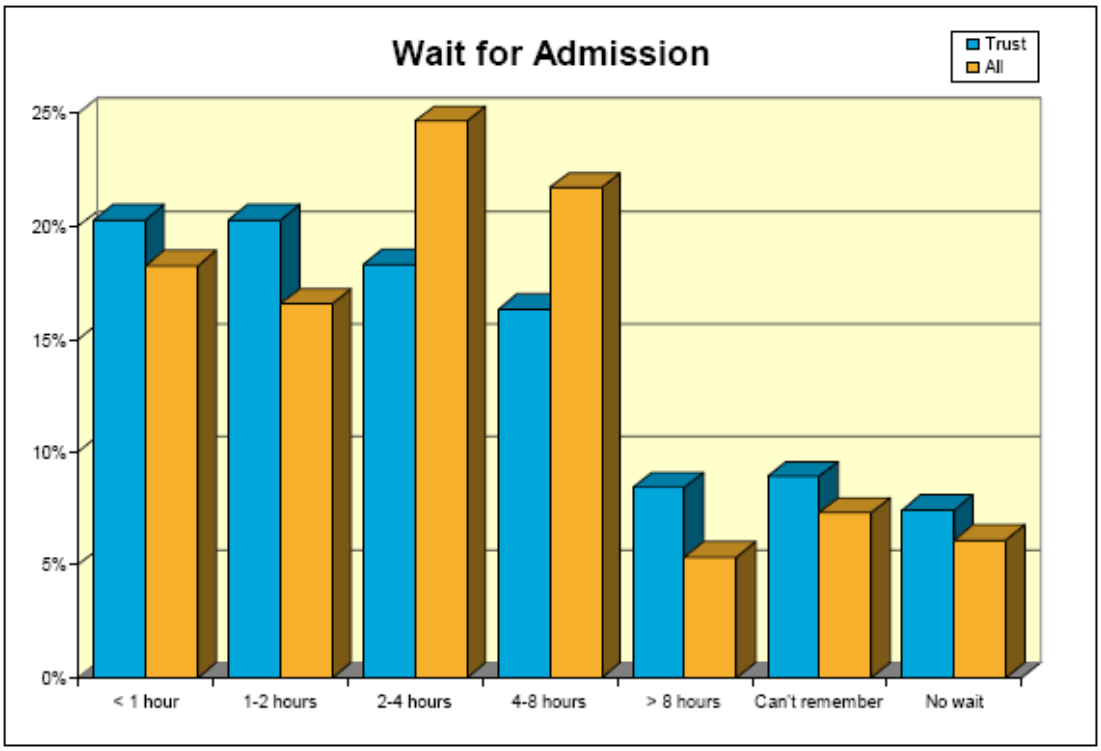
3. ADMISSION TO HOSPITAL

For the majority of patients (53%), their stay in hospital was urgent or an emergency. Of these, 92% arrived in hospital via the Emergency Department. In A&E 68% said they were given the right amount of information about their treatment or condition, although 12% said they were not given enough information.

The Trust was amongst the best performing 20% of trusts nationally for providing patients in A&E with information about their condition.

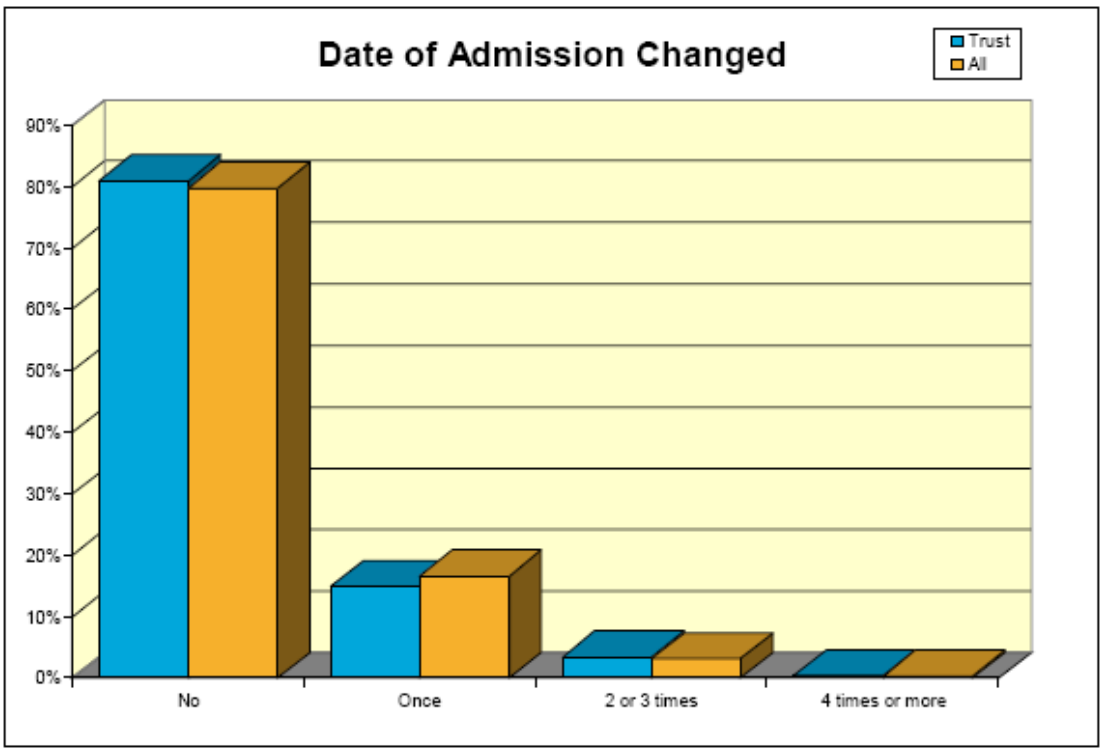
75% of patients said they were given enough privacy during treatment. Waiting times for beds had improved, with more patients than last year being admitted to a bed on a ward

within 2 hours, but 8% thought they were having to wait 8 hours or longer. 26% felt they had to wait a long time for a bed.



Most patients were referred to hospital by their GP, but 67% weren't given a choice of hospital, although only 14% said they would have liked a choice. Admission times had gone down, with most patients (58%) being admitted within 2 months.

However, this improvement was not enough to satisfy patient expectation, with 26% saying they thought they should have been admitted sooner, 6% more than last year. Two-thirds were not given a choice of admission dates; 15% had their admission date changed at least once and 4% two or three times.



4. THE HOSPITAL AND WARD

The work being done to reduce the amount of same-sex accommodation in the Trust was apparent in the survey results. When first admitted, 26% said they shared a sleeping area with patients of the opposite sex, a 12% improvement on last year, although still 10% worse than the average.

A quarter of patients moved wards and of those, 20% were still sharing a sleeping area with a patient of the opposite sex, 11% better than last year. 26% shared bathroom facilities, 6% better than last year.

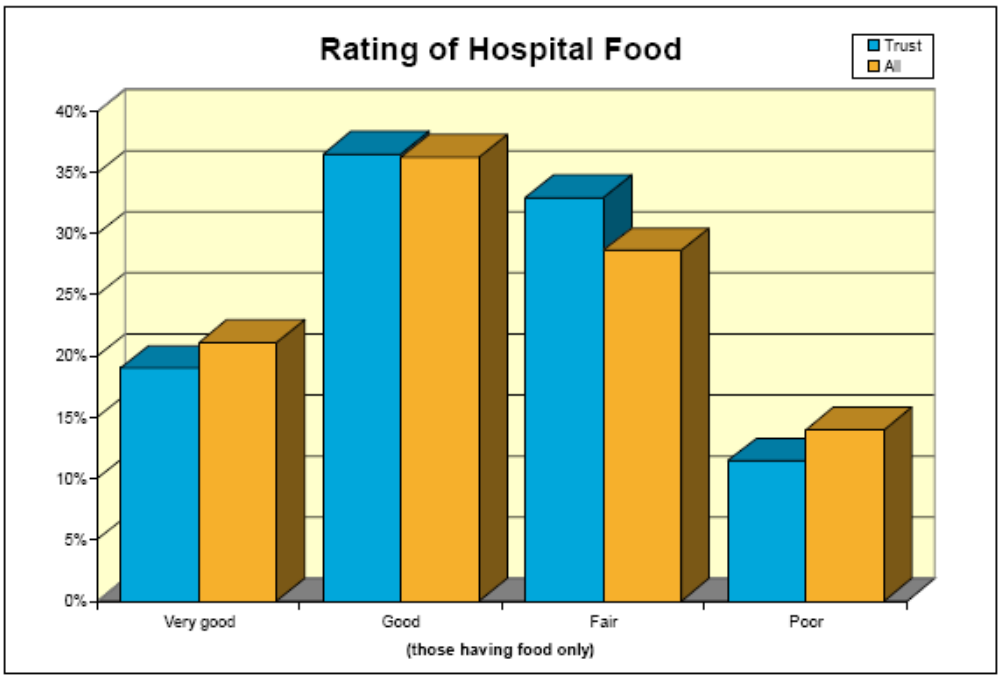
36% of patients said they were bothered by noise at night from other patients and 22% by noise from staff.

65% said their room or ward was very clean, up 5% on last year. 55% said the toilets were very clean, 4% better than last year.

23% said they had a locked area where they could put their things, 5% less than last year and 8% less than average.

94% saw posters or leaflets on the wards asking patients and visitors to wash their hands, which compares well to other trusts nationally. 96% said hand wash gels were available.

56% rated the food very good, up slightly on last year. 74% said they were always offered a choice, 2% better than last year. A further 20% said they were sometimes offered a choice of food. 54% of those who need help said they always had enough help from staff to eat their meals, a small reduction on last year, and very much less than in the Trust's own surveys which involve a larger sample of patients and show more than 80% of those who need help with meals receive it.



5. DOCTORS

When they had important questions for a doctor, 69% of patients said they got answers they could understand. 82% said they had confidence and trust in the doctors treating them. 73% said doctors didn't talk in front of them as if they weren't there, an improvement of 7% on last year. 8% of patients said they didn't see doctors washing their hands between touching patients, a small reduction on last year. A further 36% didn't know or couldn't remember. The Trust's hand hygiene audits show between 82% and 100% of doctors wash their hands at each of the hospital sites, which is on average twice as many as patients think, although there is still room for improvement.

6. NURSES

59% said that when they had an important question to ask a nurse, they got an answer they could understand, a fall of 9% on last year. 72% said they had confidence and trust in the nurse treating them, a fall of 7%. 74% of patients said nurses never talked in front of them as if they weren't there, an improvement of 2%. 56% of patients said there were always or nearly always enough nurses, the same as last year. Only 5% of patients said they didn't see nurses cleaning their hands between touching patients, a small reduction on last year. A further 24% didn't know or couldn't remember. The Trust's hand hygiene audits show between 89% and 100% of nurses wash their hands at each of the hospital sites, which is almost twice as many as patients think, although there is still room for improvement.

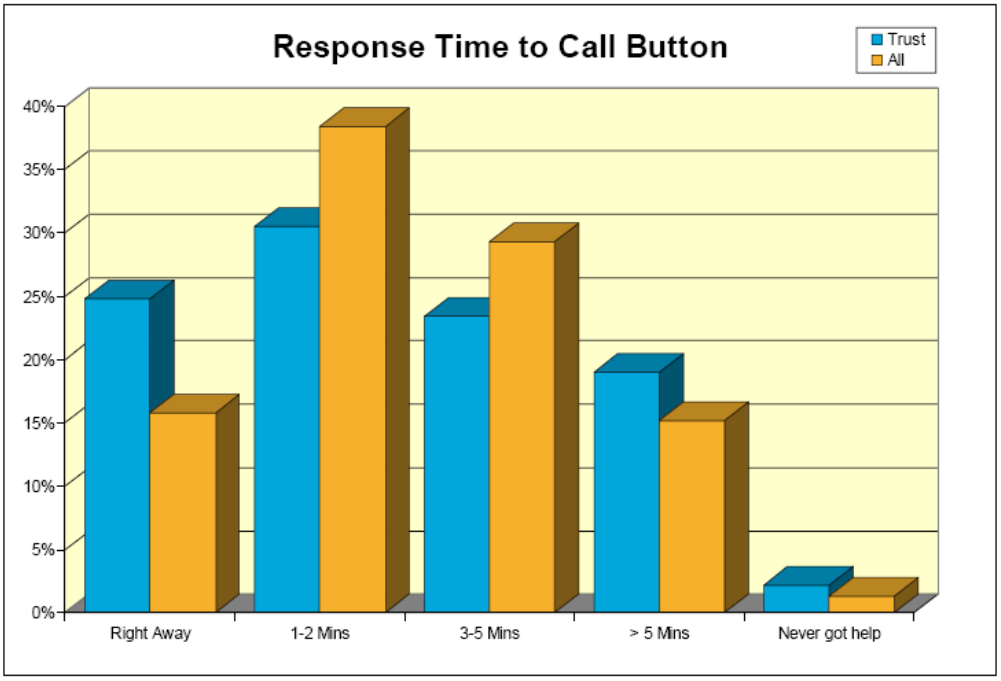
7. YOUR CARE AND TREATMENT

The number of patients who said had often or sometimes been given conflicting information by staff was very much in line with the national average, with two thirds of patients saying that this never happened to them, 7% lower than in the previous year. 78% of patients said they were given the right amount information about their treatment.

88% of patients were involved in decisions about their care, and 83% said their family or someone close to them had enough opportunity to speak to a doctor, 5% fewer than last year.

7% of patients said staff did not help them to control their pain, which is in line with the national average. 67% said staff did all they could to help control their pain, which was a reduction of 10% on last year. 26% said staff controlled their pain to some extent.

A quarter of all patients had their call button answered straight away, with 81% of all patients answered in less than five minutes. More than half (55%) of patients said they received help within 2 minutes.



8. OPERATIONS & PROCEDURES

During their stay 84% had an operation or procedure. 4% of patients said staff had not explained the risks and benefits of the procedure in a way they could understand, a small increase of 1%. 79% of patients thought the risks and benefits were thoroughly explained.

Similarly there was a small increase in the number of patients who thought staff had not explained what would be done during the procedure, with 70% saying it was completely explained, and 24% to some extent. There were similar numbers of patients who thought they had had any questions about the procedure answered in a way they could understand, but an increase of 7% in the number of patients who said they were not told how they could expect to feel after the operation (20%).

92% of patients surveyed said they had had an anaesthetic. Of those, 92% thought staff had explained completely or to some extent how the anaesthetic would work beforehand. The number of patients who did not think this was explained rose by 6%,

8% more patients (13%) said that after the operation a member of staff had not explained how it had gone in a way they understood. This is in line with the national average.

9. LEAVING HOSPITAL

The number who said they were not involved in decisions about their discharge from hospital had fallen by 3% since 2008 to 14%.

39% said their discharge was delayed, most as a result of waiting for medicines. For most the wait was between an hour and 2 hours.

Before leaving hospital 72% said they were given written or printed information about what they should do after leaving hospital, 9% better than average.

77% said a member of staff had fully explained the purpose of any medicines they were to take home in a way they could understand, 7% said the purpose was not explained, a small increase of 1% since 2008. 53% of patients said they were told about medication side effects, with the number of patients who said they received no information increasing by 9%.

There were small increases in the number of patients who were not given clear printed information about their medications, and in the proportion of patients who said they were not told what danger signals to look for.

64% of patients said their family or friends were given the information they needed, with 8% more patients saying their family or friends did not receive the information they needed than last year.

73% said staff did tell them who to contact if they were worried about their condition after leaving hospital, 3% better than average. By speciality, the best result was 88% for Ophthalmology; the worst was 49% for General Medicine.

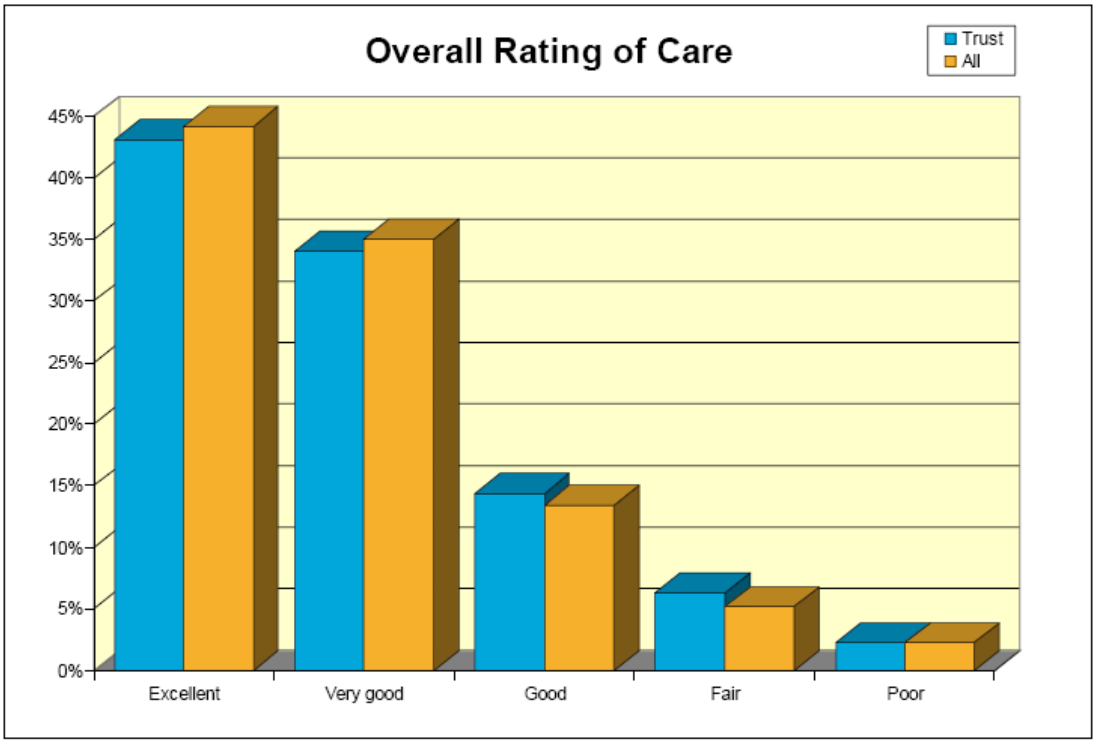
49% said they received copies of letters sent between hospital doctors and their GP, a 5% fall on last year, but 8% better than average. 61% said the letters were written in a way they could understand.

10. OVERALL

The number who felt they were always treated with respect and dignity rose to 82%. By speciality, the best result was 94% for Cardiology; the worst was 69% for General Medicine.

47% said doctors and nurses worked excellently together, an 8% increase on last year. By speciality, the best result was 65% for Cardiology; the worst was 33% for General Surgery. 93% rated the way doctors and nurses worked together as good, very good or excellent.

91% rated their care excellent, very good or good. 2% said it was poor. By speciality, the best result was 100% for Cardiology; the worst were 84% for Trauma and Orthopaedics and 87% for General Medicine.



7% were asked to give their views on the quality of care received while in hospital, in line with the average nationally.

26% said that while in hospital they had seen leaflets explaining how to complain about they had received. 8% said they wanted to complain, the same as last year.

11. DEMOGRAPHICS OF RESPONDERS

Due to the small sample size it has not been possible to highlight any variation in comments by patient demography.

12. CQC RATING

The patient experiences demonstrated in the national surveys contribute to the CQC's evaluation of the performance of acute trusts. The Trust's performance will be measured against the England average on several questions from the survey, with the tolerance for achieving set at two standard deviations. At the time of writing this report, it was not yet known which questions would be used.

13. CQUIN

From April 2010 there will be significant changes to the way in which Trusts in the acute sector are paid. In future, payments as part of the CQUIN scheme (Commissioning for Quality and Innovation) will be based on improvement in patient experience scores.

The amount that is subject to the relevant part of the CQUIN scheme is 1.5% of tariff income. It means that if a PCT is not satisfied that the Trust has improved its patient experience scores by an agreed amount, then the PCT can withhold all or part of the 1.5% CQUIN payment.

The parts of patient experience that will have to show improvement are all specific questions in the national in-patients survey, namely:

- Were you involved as much as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk to about your worries and fears?
- Were you given enough privacy when discussing your condition and treatment?
- Did a member of staff tell you about medication side effects to watch for when you went home?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Results from the 2009 national in-patient survey will provide the baseline values, which will then be compared with the results of the 2010 survey, which will be carried out this summer and is due to be reported to us in January 2011.

Currently, Ophthalmology and Cardiology are consistently the best performing specialties on the five CQUIN related questions, with General Medicine the worst performing. However, this analysis only includes the larger specialties where sufficient numbers of patients responded to enable this level of analysis.

15. NEXT STEPS

The Trust's internal surveys cover a significantly larger number of patients (at least 50 patients per ward prior to any analysis). These results show a much more positive patient experience on the wards. These are also supported by the results of regular quality audits, including a dedicated hand hygiene audit which shows a far higher compliance rate than is evident through the national adult inpatient survey.

A number of the key questions from the national report have been included into the Trust's new inpatient and carer surveys so that the experiences of all our patients can be monitored continually throughout the year, rather than relying on a single annual sample of a very small group of patients. Any concerns can then be dealt with at ward, directorate and divisional level through the regular ward, directorate and divisional reviews where targeted action will be agreed.

The Chief Nurse will incorporate the findings of the national inpatient survey into the work being undertaken by the patient experience team.

14. RECOMMENDATION

The Board is asked to NOTE this report.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Freedom of Information Update
SPONSORING DIRECTOR:	Kam Dhami, Director of Governance
AUTHOR:	Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	27 May 2010

SUMMARY OF KEY POINTS:

An update on Freedom of Information requests received between 1 April 2009 – 31 March 2010 is presented.

241 requests were received during this period, 97% of which were processed during the statutory 20 working day timeframe as required by the Act.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Governance and Risk management Committee - 20 May 2010

FREEDOM OF INFORMATION UPDATE

INTRODUCTION

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

The report covers the period from 1 April 2009 – 31 March 2010 and provides comparative information concerning the number of requests received, types of request and request originators.

THE FREEDOM OF INFORMATION ACT 2000

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

PUBLICATION SCHEME

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

REQUEST HANDLING

All requests received are processed by the Trust Secretary, regardless of where they are received in the Trust.

A database has been established to record requests, which records the date that the request has been received, the date the request was acknowledged, the date that the information was requested from the most appropriate key contact in the Trust, the date that the response is due, together with information concerning the category of request, originator and any exemptions applied.

ACTIVITY APRIL 2009 – APRIL 2010

Between 1 April 2009 - 31 March 2010, 241 requests were received by the Trust. Of these requests, 234 (97%) were processed within the statutory 20 working day timeframe. Of the 7 responses that were not issued within 20 working days, renegotiation of the deadline had been agreed with the requester for 5 to allow additional time to gather all required information. Responses to 8 requests were not issued, either because the requester withdrew the request or clarity was not provided from the requester on a matter in the request despite being asked.

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

April and June 2009 saw the highest number of requests over the period, with 26 received in each month.

Although a direct comparison of numbers of requests received in 2008/09 is not possible, it appears that numbers received per month are similar. It is evident however that the number of complex requests seems to be increasing, with more

requiring detailed analyses or containing more questions within a single information request.

Requests with an operations and workforce theme have been the most commonly received during the period. Examples include requests for information concerning A & E attendance, capacity and progress with delivery of single sex accommodation guidelines. There were also numerous requests for the organisational structures of some of the Trust's support functions.

The most prolific requesters of information under the Freedom of Information Act during the period have been private individuals and private organisations, such as pharmaceutical companies and recruitment agencies.

Of the 241 requests received, 16 individuals or companies submitted more than one request. Six requests were received from the same member of the Conservative Party. Other bodies submitting in excess of five requests during the period include the Express and Star newspaper and the Sunday Times newspaper.

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

LEARNING POINTS

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

Additionally, following several request for information concerning patients admitted into accident and emergency, it is evident that the way information is collected at City Hospital and Sandwell Hospital units varies, meaning that on some occasions information can only be supplied from one unit, while information from the other is not recorded in a way that is easily extracted.

RECOMMENDATION

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

Appendix 1

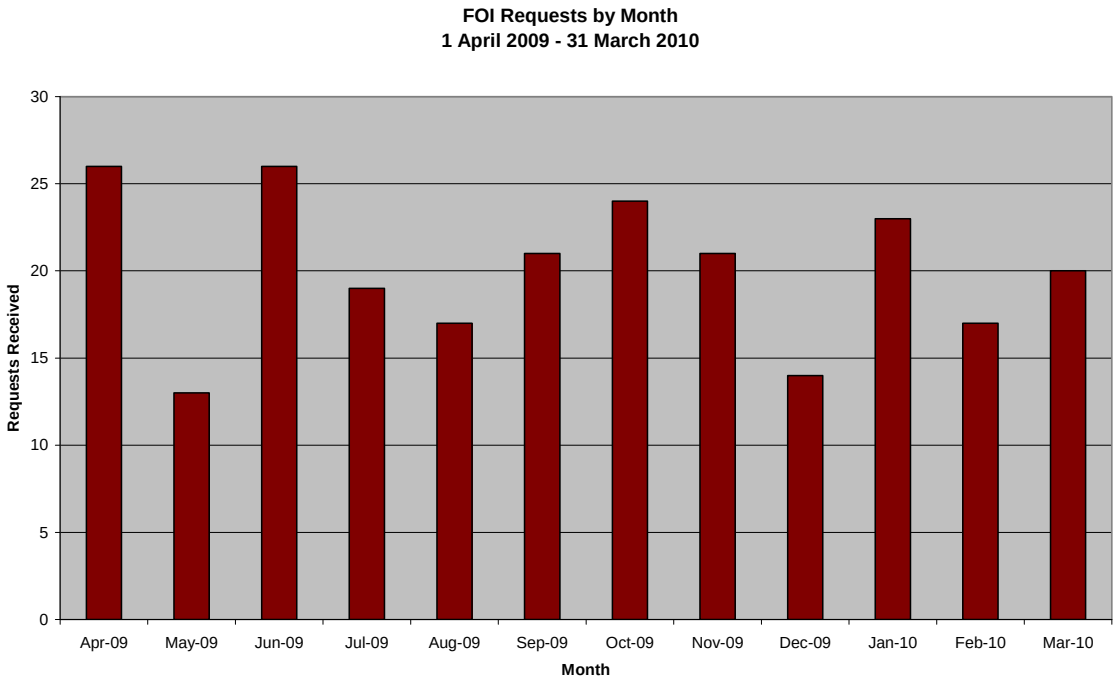


Figure 1: Freedom of Information requests by month

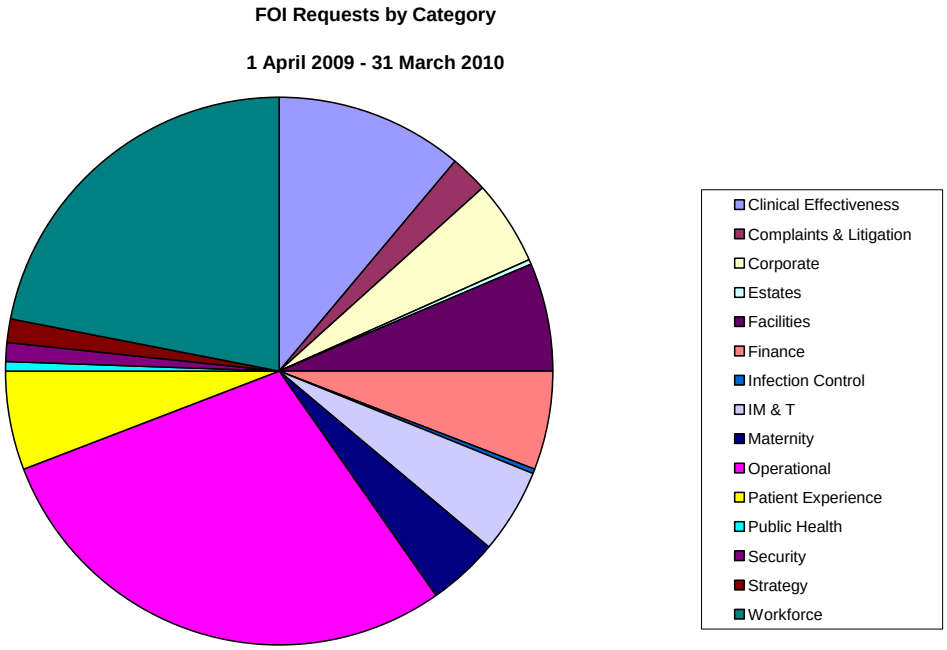


Figure 2: Freedom of Information requests by category

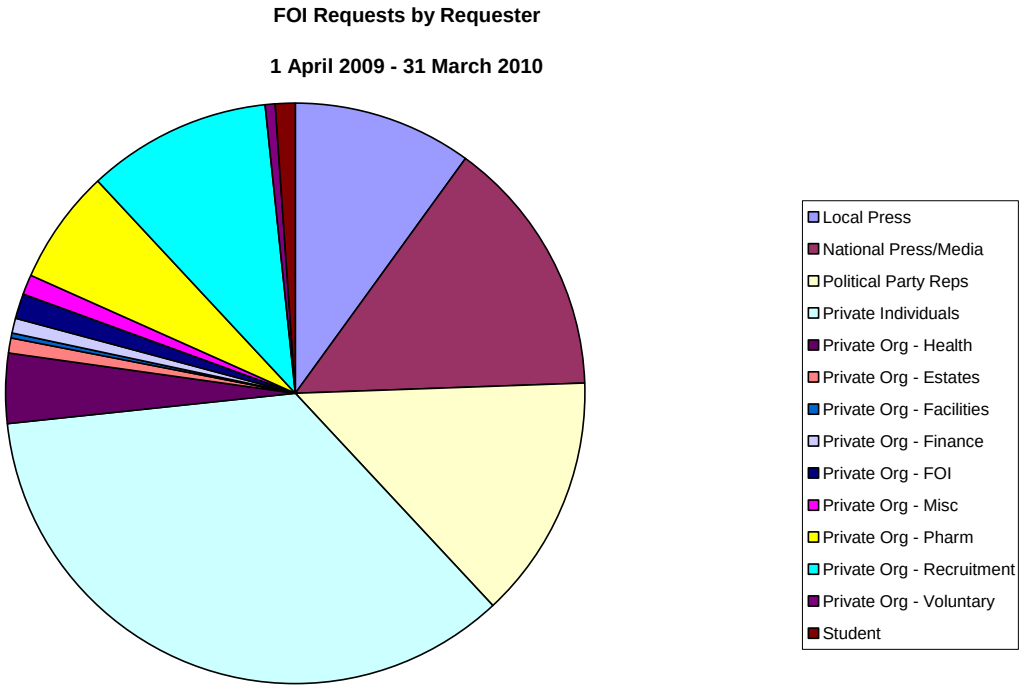


Figure 3: Freedom of Information requests by originator

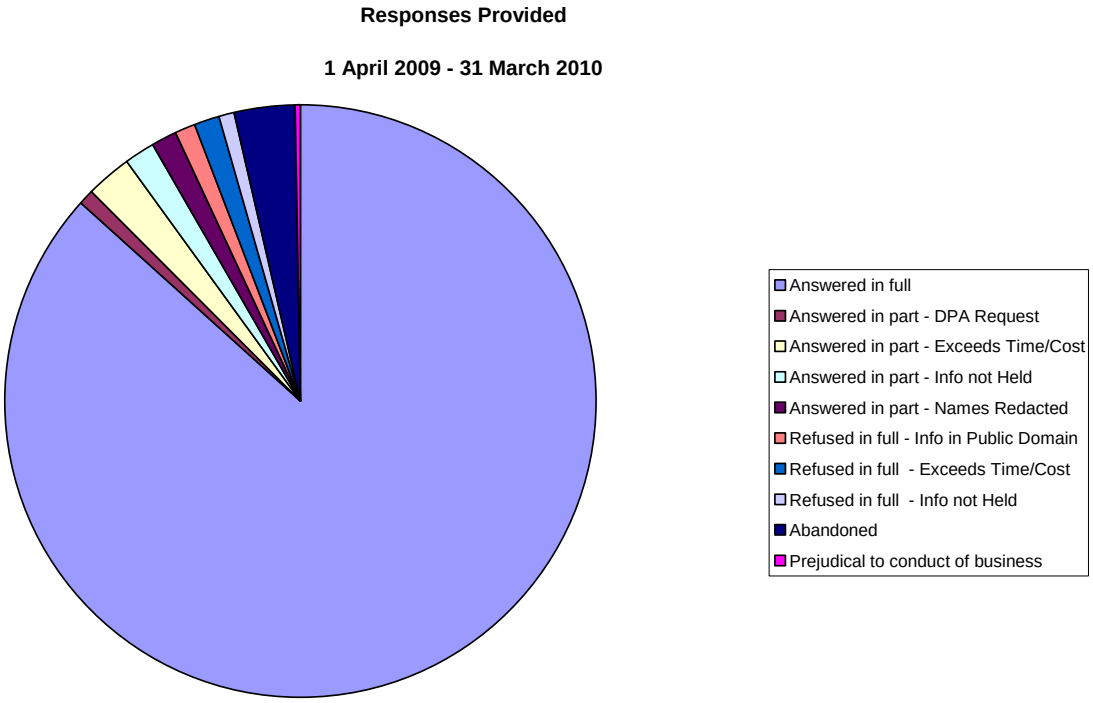


Figure 4: Responses provided to Freedom of Information enquiries

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Right Care Right Here Progress Report
SPONSORING DIRECTOR:	Richard Kirby, Chief Operating Officer
AUTHOR:	Jayne Dunn, Redesign Director – RCRH
DATE OF MEETING:	27 May 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 April 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 – February 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	
CQC Essential Standards of Quality and Safety	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Monthly progress report to Trust Board

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

RIGHT CARE RIGHT HERE PROGRAMME: PROGRESS REPORT MAY 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 April 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) Service Redesign Performance Report for April – February 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:

<u>RCRH Programme Objectives</u>
Programme Objectives for 2009/10 were agreed by the Partnership Board in March 2009 but progress on full achievement has been severely disrupted by the Programme Review commencing last summer and the development of a fundamentally different approach to service redesign. This has been reflected in the Programme Objectives for 2010/11 which were agreed by the Partnership Board in March 2010. Progress made in 2009/10 will be carried forward in 2010/11.

<u>Overall Programme Plan:</u>
Since the previous report the critical path events have been reviewed and highlighted a number of issues for further attention. These include:

- Definition of the proposed estates solution for the New Acute Hospital Project to deliver within affordability.
- A significant amount of project planning and design development activity to be progressed over the next 12 to 15 months.
- A number of primary care facility refurbishments are due for completion this month including: Balsall Heath Health Centre (HoBtPCT), relocation of GPs to Soho Phase 2 (HoBtPCT) and interim minor works at Heathfield Family Centre (HoBtPCT) with a brief being established for any further adaptations for delivery later this year.

<u>Regeneration Activity</u>
The Partnership has made a commitment to supporting the regeneration of local areas in which services are redesigned and new facilities are provided. Further to the Regeneration Event hosted by the Programme on 8th May 2009 a Vision Group was established to develop a vision statement for regeneration and to develop further work in this area. The group has representation from Sandwell MBC, Birmingham City Council, Sandwell PCT, Heart of Birmingham teaching PCT, Urban Living, Sandwell and West Birmingham Hospitals and is chaired by the RCRH Programme Director. This group has developed:

- A vision statement for regeneration in West Birmingham and Sandwell with the aim of securing agreement from all organisations to a common regeneration agenda.
- Progress has been made in mapping current and planned regeneration initiatives onto Google maps. It is intended to make the data available to the public at a later date.
- A draft specification is being developed by Urban Living for a regeneration website which will include a toolkit for health, planning and regeneration professionals and public access to a specifically tailored section, which will in time include access to the map of regeneration initiatives.
- Sandwell and West Birmingham Hospitals Trust held a workshop on 28th January 2010 to look specifically at regeneration opportunities which will arise from the New Acute Hospital Project. An action plan has since been developed and opportunities put in place for greater engagement with the potential supply chain so that the amount of goods and services produced and provided locally (defined as preferably Sandwell and Birmingham, but including the whole of the West Midlands) can be maximised.

There is general agreement that an appropriate infrastructure is required to take regeneration initiatives forward. The suggestion is that this now requires a formal governance structure, owned within local authorities, and retaining the contribution of partners, Urban Living, the Programme and regeneration agencies.

Project Performance – Appendix 3 presents the performance of the exemplar projects for the period April – February 2010 (first and second wave) whilst Appendix 2 provides some more detailed explanation around the performance.

As a result of the continued data validation process a small number of clinics have been identified for which the activity had not been previously reported. The additional activity has been retrospectively added to previously reported information in relation to Ophthalmology, Dermatology, Cardiology and Diabetes.

All projects apart from one have moved to a 'Green' rating.

The project rated as 'Amber' is *Musculoskeletal* for two reasons:

- Consultant led clinic activity for community orthopaedics has fallen steadily throughout the year with nil activity occurring in February owing to clinics being cancelled due to lack of Consultant cover;
- Community pain management activity remaining significantly below target for the year-to-date.

Three example 'context' performance reports have been developed for Urgent Care, Gynaecology Outpatients and ENT with the aim of showing activity transferred to in the context of overall SWBH activity. In summary these show:

- *Urgent Care* - a reduction in A&E attendances at SWBH during 2009/10 and an increase in urgent care activity occurring in the urgent care centres. 'Walk-in' activity for Parsonage Street and the centre located in Birmingham city centre (Boots) is not yet included.
- *Gynaecology Outpatients* - a relatively static position across the year with 5% of total activity now occurring in community locations.
- *ENT Outpatients* - 45% of activity is being provided in community locations but demand for acute outpatients is not reducing.

Service Redesign Activity :

New Service Redesign Workstreams

- *Urgent and Emergency Care Network* - A report drawing together a wide range of baseline data including activity data, public and patient involvement feedback, current profile of services, Acute Care SMOC recommendations, and best practice has been produced. The overall objective for the workstream has been identified as reducing the number of A&E attendances according to the targets identified in the Activity and Capacity Model (v5.1) through the development and use of more appropriate models of care. To deliver this objective the following 5 projects have been agreed:

- Urgent Care Centres
- Mental Health
- Social Marketing
- Single Point of Access
- Musculoskeletal Care Pathway Reviews

Project Leads and Teams are being identified for each, after which Project Initiation Documents will be generated setting out clear objectives, targets consistent with the Activity and Capacity Model and metrics for measurement that will include the ability to demonstrate the impact upon quality of care.

- *Intermediate Care* - Kevin McGee is now CEO sponsor to the workstream. Work is underway to ensure core members understand the modelling assumptions and projection of activity by year as set out in the Activity and Capacity model v5.1. The Project Lead is developing a report aimed at providing the information needed to determine the service redesign projects to be established. An option appraisal document is being produced in relation to future plans for Rowley Hospital.

- *Demand Management - Referrals/Outpatients* - The core workstream group has developed the scope of the redesign work that will reduce demand for secondary care, align to best practice and making the referral system work more efficiently. Work is continuing to collect relevant data to identify areas that can be targeted to enable processes to work more efficiently across the local health economy to inform the priorities for service redesign.

Care Pathways
A workshop was held on Wednesday 7th April to determine the priority order of care pathways for review using the Map of Medicine and agree the process for undertaking care pathway reviews along wiht the supporting governance framework. The workshop determined that the top 5 pathway review areas should be diabetes, musculoskeletal, all pathways agreed by the Programme's pilot projects, falls and hospital at home for end of life patients. The ranked list of 25 areas for care pathway review is currently being cross-checked against the priority areas arising out of the 2010/11 LDP agreements , the agreed strategic priorities of the PCTs as identified in the World Class Commissioning submissions and regional Quality, Innovation, Productivity and Prevention priorities.

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
18th May 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, 26th April, 2010**

1. Summary and Recommendation

This paper summarises the main issues and developments in the Programme since the previous report.

The Partnership Board is recommended to:

- Note that progress on delivering against the Programme Objectives 2009/10 has been disrupted by the Programme Review and that progress made in 2009/10 will be carried forward in 2010/11.
- Agree the Vision for Regeneration at Appendix 4 and note the update on regeneration activity in the Programme.
- Note the content of the remainder of the report.

2. Programme Objectives 2009/10

This section provides a progress report to the year end on the Programme Objectives for 2009/10.

2.1 Background

It is essential that the Programme has a set of objectives against which progress can be measured. Programme Objectives for 2009/10 were agreed by the Partnership Board in March 2009 but progress on full achievement has been severely impeded by the Programme Review commencing last summer and the development of a fundamentally different approach to service redesign. This has been reflected in the Programme Objectives for 2010/11 which were agreed by the Partnership Board in March 2010.

2.2 Programme Objectives 2008/09

Appendix 1 provides a summarised year end position for all Programme Objectives. This has been compiled following a detailed review with members of the Programme Team.

Colleagues will recall that the existence of the Programme and the feasibility of its delivery was thrown into considerable doubt in June 2009 in the light of the changed financial forecasts for the NHS nationally. In July 2009, the Boards of the two PCTs and the Sandwell and West Birmingham Hospitals met to discuss whether or not the Programme could continue.

The outcome was an agreement to continue to deliver the Programme, but with revised objectives, with a new set of principles (which were agreed in September 2009), with a considerable emphasis on affordability, a revised capital infrastructure plan, and a different approach to how service redesign was to be undertaken (through three new service redesign workstreams, use of Map of Medicine, Care Pathways Reviews and a programme of Medical Engagement). The new approach to service redesign has meant that the emphasis of the Programme Team has changed substantially in many areas, moving away from

the first and second wave projects (although these have been reviewed to ensure alignment within the new context). The approach now is to combine Chief Executive-led system reviews (through the three service redesign workstreams) supported by clinically-led and agreed Care Pathway Reviews. These are operating within the principles and ambitions articulated by the SMOCS Groups. This represents a very different picture from that which applied in March 2009.

Further external changes have taken place adding to uncertainty and the need to respond differently, including the decision of the three Birmingham PCTs to form a single commissioning organisation, the national development of HIECs for education and training, and the delayed roll out from the SHA of the Workforce Modelling Tool.

These changes have been far-reaching and have resulted in delivery of objectives being delayed at least, with several objectives being rendered inappropriate. All of these changes have impacted on colleagues in partner organisations and in my Programme Team, but it has been possible to maintain a focus on progressing the delivery of the Programme.

Progress has been significant in many areas, and good progress has been made, particularly in February and March 2010, based on more clarity about the future, and this is being carried forward into 2010/11.

The Partnership Board is recommended to:

- Note that progress on delivering against the Programme Objectives 2009/10 has been disrupted by the Programme Review and that progress made in 2009/10 will be carried forward in 2010/11.

3. Overall Programme Plan

This section provides an update on progress to date with the development of the Overall Programme Plan for the Programme.

- An updated version of the OPP control sheet (for Facilities Projects) has been prepared at Appendix 2. This revision includes the latest amendments advised by the respective project managers and some minor revisions to facility project details.
- The summary of critical path events has also been updated during March and an extract showing key activities for the forthcoming period is included within this report at Appendix 3. From this analysis it is clear that the following issues need further attention:
    - Definition of the proposed estates solution for the New Acute Hospital Project to deliver within affordability is critical. This is planned for discussion on Thursday 22nd April and a verbal update will be provided to the meeting. This is likely to impact directly on the functional scope, content and forward planning for the Community Hospital projects and a number of other primary and community care services and facilities, as well as for the Acute Hospital Outline Business Case.
    - There is a significant amount of project planning and design development activity to be progressed over the next 12 to 15 months to prepare for the approvals and provision of new facilities projects. It will become increasingly important to monitor progress against delivery milestone targets to track any potential changes in agreed project timescales which may impact the overall Programme.
    - Service redesign priorities have been set and agreed for Care Pathway Reviews with senior clinicians and managers following a workshop held on 7th April and details of the resulting series of projects is being established to progress with implementation
    - Balsall Heath health centre refurbishment (HoBtPCT) is due for completion this month to resume service delivery
    - GPs are due to complete their relocation to Soho Phase 2 this month (HoBtPCT). Clinic services have already begun to operate from the newly opened wing

- Interim minor works have been carried out at Heathfield family centre (HoBtPCT) and a brief for any further adaptations for delivery later this year is being established – no significant impacts to services are envisaged

- Further work is required to establish and map the timelines and critical path events for services redesign and roll-out projects, including alignment with facilities projects and activity locations.
- User names and login passwords are now being assigned for and to different user categories to access and use the ActivePlan web-resource, through which it will be possible for partner organisation colleagues to view and interrogate the Overall Programme Plan elements through information entered and updated directly by the respective Project and Programme Managers.

4. Regeneration Activity in the Programme

As members are aware, the public consultation process included a commitment to supporting the regeneration of local areas in which services are redesigned and new facilities are provided. This section provides an update on activities undertaken over the last few months.

4.1 Regeneration Event May 2009

I have previously reported to the Board on the Regeneration Event hosted by the Programme at Sandwell Council Chamber on 8th May 2009.

4.2 Vision Group

From that meeting, it was agreed to establish a Vision Group to develop a vision statement for regeneration and to develop further work in this area. The intention has been to bring all agencies with an interest together, and to provide tools and support to enable appropriate linkages to be made. This will provide a degree of common understanding and the potential for future joint initiatives. The group has met several times with representation from Sandwell MBC, Birmingham City Council, Sandwell PCT, Heart of Birmingham teaching PCT, Urban Living, Sandwell and West Birmingham Hospitals and is chaired by me. This group has developed:

- **Vision for Regeneration in West Birmingham and Sandwell**
  The statement at Appendix 4 is an attempt to secure agreement from all organisations to a common regeneration agenda. This confirms the focus of regeneration activity as having a broad base of improved place, reducing health inequalities and improving education, skills and employment. It confirms that there is recognition of the need to link initiatives in health with employment, warmer housing, capital projects and opportunities for local businesses. The focus of attention will be on the areas of the Windmill Eye (Sandwell) and Ladyport (Birmingham) around the site of the New Hospital, West Bromwich and Handsworth, Lozells and Aston.

- **Mapping of Current and Planned Regeneration Initiatives**
  A Knowledge Transfer Associate, employed in my Programme Team, working with a colleague from Birmingham City Council, has made considerable progress on mapping initiatives onto Google maps. This will allow colleagues to access details of all regeneration initiatives across the area, to include capital projects and service provision across the public, private and community and voluntary sectors. Currently, the details are being checked by all these organisations and will include details of planned start date, recruitment commencement, date open to public, contact details of lead person and organisation. It is intended to make the data available to the public at a later date.

- **Development of a specification for a regeneration website**
  A draft specification is being developed by Urban Living and it is intended that the website will include a toolkit for health, planning and regeneration professionals and public access to a specifically tailored section, which will in time including access to the map of regeneration initiatives identified above.

4.3 Sandwell and West Birmingham Hospitals Workshop on Regeneration

In addition to this work, the Sandwell and West Birmingham Hospitals Trust held a workshop on 28th January 2010 to look specifically at regeneration opportunities which will arise from the New Acute Hospital Project. An action plan has been developed as a consequence and Graham Seager has put in place opportunities for greater engagement with the potential supply chain so that the amount of goods and services produced and provided locally (defined as preferably Sandwell and Birmingham, but including the whole of the West Midlands) can be maximised.

As with the Vision Group, there was general agreement that we now need an appropriate infrastructure to take regeneration initiatives forward. While the Programme will continue to co-ordinate activities, there is a suggestion that this now requires a formal governance structure, owned within local authorities, and retaining the contribution of partners, Urban Living, the Programme and regeneration agencies.

The Partnership Board is recommended to:

- Agree the Vision for Regeneration at Appendix 4 and note the update on regeneration activity in the Programme.

5. Commissioning Review in Birmingham – PCT Review Update No. 5

The latest update is provided at Appendix 5 for information.

6. Recommendation

The Partnership Board is recommended to:

- Note that progress of delivering against the Programme Objectives 2009/10 has been disrupted by the Programme Review and that progress made in 2009/10 will be carried forward in 2010/11.

- Agree the Vision for Regeneration at Appendix 4 and note the update on regeneration activity in the Programme.

- Note the content of the remainder of the report.

Les Williams
Programme Director

2010-04-20 – 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:	**Service Redesign Performance Report**
Date:	**Monday, 26th April 2010**

7. Summary and Recommendation

This paper summarises the main issues and developments in relation to Programme service redesign activities since the previous report.

The Partnership Board is recommended to:

- Consider the design of the 'context' performance reports and provide feedback
- Note the content of the report

8. Acute to Community Activity Transfer Report (previously Project Performance Report) April to February 2009/10

As a reminder, the RAG status assigned indicates the extent to which services have transferred to community locations in accordance with 09/10 targets set. Where monthly monitoring data has not been provided, an amber or red status is assigned dependent upon the previous month's reported performance against year-to-date targets.

Given at Appendix 1 is the Acute to Community Activity Transfer report for April to February 2010.

Since the last report, the Information leads have proactively continued the data validation process that commenced during March, resulting in the identification of a small number of clinics for which the activity had not been previously reported. The additional activity has been retrospectively added to previously reported information in relation to Ophthalmology, Dermatology, Cardiology and Diabetes.

It is pleasing to report that 11 out of the 12 service areas that were previously redesigned through the pilot projects have been assigned 'green' status, the exception being Musculoskeletal (MSK). MSK continues to carry 'amber' status for two reasons:

- Consultant led clinic activity for community orthopaedics has fallen steadily throughout the year with nil activity occurring in February owing to clinics being cancelled due to lack of Consultant cover;
- Community pain management activity remaining significantly below target for the year-to-date.

It is anticipated that the redesign work that has commenced will continue through Care Pathway Reviews and projects within the work streams.

The same year-to-date performance data using the dashboard approach, with the more detailed report for MSK owing to the variance from targets, is presented in Appendix 2.

In response to the Board's request for the need for activity transferred to be seen in the context of overall SWBH activity for all former 'project' service areas, work is in progress. Three example 'context' performance reports have been developed for Urgent Care, Gynaecology Outpatients and ENT Outpatients and are included in Appendix 3. The Urgent Care impact of activity transfer report indicates a reduction in A&E attendances at SWBH during 2009/10 and an increase in urgent care activity occurring in the urgent care centres. However, the level of 'walk-in' activity for Parsonage Street and the centre located in Birmingham city centre (Boots) is required to provide a more complete picture. The Gynaecology Outpatients activity impact report shows a relatively static position across the year with 5%

of total activity now occurring in community locations. The ENT Outpatients report illustrates that 45% of activity is being provided in community locations but demand for acute outpatients is not reducing. It is recognised that further work is required which may need to extend to using comparative data from the previous year and feedback from Board members is welcomed to assist in improving the design and usefulness of the reports.

9. SMOCS Update

The arrangements to upload the eight SMOCS reports signed off by the Clinical Group to the Right Care, Right Here website by the end of April are on schedule. The revised draft of the Mental Health SMOC report is anticipated to be presented to the Clinical Group in May, as previously reported.

A report bringing together all the feedback received from HoB tPCT and Sandwell PCT's PECs has been compiled and will be presented to the Clinical Group and Strategy Group for review and any subsequent actions agreed.

4. Care Pathway Reviews

A workshop event, involving largely members of the Clinical, Strategy and Strategic Workforce Groups, was held on Wednesday 7th April to achieve two outcomes:

- determination of the priority order of care pathways for review using the Map of Medicine
- agreement to the process for undertaking care pathway reviews and the supporting governance framework

The session involved participants being provided with a list of suggested care pathway reviews for consideration that had been drawn from the recommendations within the Strategic Models of Care Groups, ideas for third wave projects that had been submitted to the Programme and proposals made by a range of clinicians and professionals at a session held on 30th September 2009. During the workshop this list was reviewed, with additions and deletions made until a finally agreed set of potential pathways for review was established. The subsequent prioritisation process involved sub-groups using a prioritisation matrix to generate scores for each pathway according to a range of criteria which were then collated to produce a ranked list of care pathway reviews to be undertaken. The results determined that the top 5 pathway review areas should be diabetes, musculoskeletal, all pathways agreed by the Programme's pilot projects, falls and hospital at home for end of life patients.

The ranked list of 25 areas for care pathway review (see Appendix 4) is currently being cross-checked against the priority areas arising out of the 2010/11 LDP agreements (including the agreement on procedures of limited value for decommissioning), the agreed strategic priorities of the PCTs as identified in the World Class Commissioning submissions and regional Quality, Innovation, Productivity and Prevention priorities. The final outcome will be a Programme plan of work designed to achieve the pathway reviews across the next 2 to 3 years.

It is pleasing to report that the first Care Pathway Review for Acute Coronary Syndrome is scheduled to take place on the 7th May. Arrangements for the other two Cardiology pathway reviews (Arrhythmia and Heart Failure) are progressing well. The Map of Medicine Manager has initiated plans to undertake Care Pathway Reviews for Diabetes and MSK, the highest ranking specialties arising out of the workshop. The most significant challenge in undertaking these reviews is identifying GPs to participate. In addition, local administration data provided by Dr Pete Davies has been added to the Diabetes pathway (Sandwell view) detailing local guidelines, support groups, advice sheets and contact details.

Map of Medicine awareness sessions continue with GPs and SWBH Consultants. The questionnaire designed to ascertain the level of awareness of the Map of Medicine and identify who currently has access and/or is using the tool in practice has been sent to the Communications Departments for both the local authorities for distribution to key individuals.

All clinicians within SWBH, HoB tPCT and Sandwell PCT are now able to access the Map of Medicine either through an icon or through Internet 'Favourites'. The arrangements to enable Local Authority staff to access the Map have been agreed and roll-out will be pursued by the Map of Medicine Manager.

5. Workstreams – Progress Update

5.1 Demand Management - Referrals/Outpatients

As previously reported, the core workstream group has developed the scope of the redesign work that will reduce demand for secondary care, align to best practice and making the referral system work more efficiently. Work is continuing to collect relevant data to identify areas that can be targeted to enable processes to work more efficiently across the local health economy to inform the priorities for service redesign.

5.2 Urgent and Emergency Care Network

The Project Lead presented a report to the workstream core group in April, drawing together a wide range of baseline data including activity data, public and patient involvement feedback, current profile of services, Acute Care SMOC recommendations, and best practice. In addition, the report proposed the overall objective for the workstream to be to reduce the number of A&E attendances according to the targets identified in the Activity and Capacity Model (v5.1) through the development and use of more appropriate models of care. The group considered 9 possible project areas, and agreed to deliver 5 projects as listed below:

- Urgent Care Centres
- Mental Health
- Social Marketing
- Single Point of Access
- Musculoskeletal Care Pathway Reviews

Work is now underway to confirm Project Leads and Project Teams, after which Project Initiation Documents will be generated for each project setting out clear objectives, targets consistent with the Activity and Capacity Model and metrics for measurement that will include the ability to demonstrate the impact upon quality of care.

5.3 Intermediate Care

Kevin McGee has taken over as CEO sponsor to the workstream. Work is underway to ensure core members understand the modelling assumptions and projection of activity by year as set out in the Activity and Capacity model v5.1. The Project Lead is developing a report aimed at providing the information needed to determine the service redesign projects to be established. An option appraisal document is being produced in relation to future plans for Rowley Hospital.

6. Recommendation

The Programme Delivery Group is recommended to:

- Consider the design of the 'context' performance reports and provide feedback
- Note the content of the report

Angela Poulton, Programme Manager

RIGHT CARE, RIGHT HERE PROGRAMME
Acute to Community Activity Transfer Report
Report April-February 09/10

Key: **CL OPs** Consultant Led Outpatients **NCL Ops** Non Consultant Led Outpatients

PROJECT	April	May	June	July	Aug	MONTH (2009/10) Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	% Over/ Under YTD	2009/10 Yearend Target	Status	PROJECT LEAD (former)	Comments
URGENT CARE - SANDWELL																		
Target (Attendances)	976	976	976	976	976	976	976	975	976	975	976	0	10,734		11,710		Gill Gadd	Activity exceeding target
Actual	865	927	1,008	865	905	1,143	1,392	1,243	884	989	900	0	11,121				SWBH	Work continues with Information Lead to enable Parsonage Street walk-in and category C activity
Variance													**387**	**4**				to be reported.
URGENT CARE - HoB																		
Targets (Attendances):																		
City	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	0	27,500		30,000		Mark Curran	Activity below target for UCC - City but primary care activity significantly exceeding target.
Actual	2,424	2,433	2,113	3,176	2,233	2,014	2,157	1,993	1,964	1,604	1,479	0	23,590				HOB tPCT	
Variance													**-3,910**	**-14**				
Primary Care (Percy Road/Greet HC)	1,083	1,083	1,083	1,083	1,083	1,083	1,083	1,083	1,083	1,083	1,083	0	11,916		13,000			
Actual	89	531	1,156	1,747	1,461	1,645	2,565	2,393	2,789	2,324	2,404	0	19,104					
Variance													**7,188**	**60**				
REHAB BEDS - SHELDON																		
Targets:																		
Community - D43 (OBDs)	647	647	646	646	647	647	647	646	647	647	647	0	7,114		7,760		Angela Young	Activity exceeding targets.
Actual	638	783	631	643	643	584	693	716	630	663	699	0	7,323				HOB tPCT	
Variance													**209**	**3**				
Care Centres (OBDs)	571	571	571	570	571	571	571	570	571	571	571		6,279		6,850			
Actual	595	657	592	662	606	625	652	650	607	661	596	0	**6,903**					
Variance													**624**	**10**				
Comm. Alternatives Rehabilitation (Patient Package)	292	292	292	291	291	292	292	291	292	292	292	0	3,209		3,500			
Actual	836	977	1,045	1,132	943	974	935	1,110	918	783	911	0	10,564					
Variance													**7,355**	**229**				
REHAB BEDS - ROWLEY																		
Targets:																		
Community Step Up - ET Ward (OBDs)	317	317	317	316	316	317	317	316	317	317	317	0	3,484		3,800		Chris Gibbs	Step-up activity continues to be below target YTD (Eliza Tinsley beds reduced during Februrary
Actual	48	231	246	285	300	266	279	312	310	342	267	0	2,886				(interim)	prior to temporary closure in March).
Variance													**-598**	**-17**			SPCT	
Community Step Down - Mc Ward (OBDs)	642	642	642	641	641	642	642	641	642	642	642	0	7,059		7,700			
Actual	1,526	1,663	1,611	1,627	1,588	1,611	1,654	1,598	1,674	1,596	1,512	0	17,660					
Variance													**10,601**	**150**				
STAR (Av Admits)	83	83	84	83	83	84	83	83	84	84	83	0	917		1,000			
Actual	60	77	75	91	62	86	88	116	116	135	107	0	1,013					
Variance													**96**	**10**				
MUSCULOSKELETAL (includes Orthopaedic beds & outpatients, Rheumatology outpatients & Pain Management																		
Targets:																		
HoB Orthopaedics Triage (NCL OPs)	545	545	545	545	543	543	546	545	544	545	545	0	5,991		6,535		Paul Hazle	Whilst some activity exceeds target others fall short of target.
Actual	641	556	902	884	739	918	1,019	1,222	1,042	970	957	0	9,850				SWBH	
Variance													**3,859**	**64**				
Sandwell COS Triage (NCL OPs)	574	574	574	574	573	574	573	574	574	574	574	0	6,312		6,885			
Actual	535	491	653	666	520	641	692	622	531	480	517	0	6,348					
Variance													**36**	**1**				
Community Rheumatology (CL OPs)	381	381	381	381	378	380	380	380	380	381	381	0	4,184		4,564			
Actual	426	410	453	496	404	468	512	458	486	451	454	0	5,018					
Variance													**834**	**20**				
Primary Care Rheumatology (CL OPs)	0	0	0	16	16	16	16	16	16	16	16	0	125		140			
Actual	0	0	0	43	35	53	56	72	60	63	86	0	468					
Variance													**343**	**275**				
Community Orthopaedics (CL OPs)	74	74	74	74	74	75	74	74	74	74	74	0	815		889			No clinic held in February owing to no Consultant available (on call & annual leave) as advised by
Actual	106	18	43	47	72	56	29	34	19	15	0	0	439					Paul Hazle.
Variance													**-376**	**-46**				
Community Pain Management (CL OPs)	59	59	59	59	59	56	59	58	59	58	59	0	644		702			
Actual	11	13	15	20	27	35	26	23	42	45	45	0	302					
Variance													**-342**	**-53**				

RIGHT CARE, RIGHT HERE PROGRAMME
Acute to Community Activity Transfer Report
Report April-February 09/10

PROJECT	MONTH (2009/10) April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	% Over/ Under YTD	2009/10 Yearend Target		PROJECT LEAD	Comments
OPHTHALMOLOGY																		
Target (CL OPs)	1,273	1,273	1,273	1,272	1,273	1,273	1,273	1,273	1,272	1,273	1,273	0	14,001		15,274		Vacant	Activity exceeding targets.
Actual	1,763	1,496	1,833	1,985	1,709	1,850	1,947	1,993	1,654	1,760	1,653	0	19,643				SPCT	SWBH Information lead has explained that data previously reported did not include activity
Variance													**5,642**	**40**				undertaken at Aston, Soho and Victoria health centres - data has been updated retrospectively from April onwards.
DERMATOLOGY																		
Targets:																		
Community (CL OPs)	267	267	267	265	266	267	266	267	267	266	267	0	2,932		3,198		Vacant	Activity exceeding targets.
Actual	377	362	422	353	241	283	331	288	200	266	209	0	3,332				HOB tPCT	HoB and SWBH Information leads have confirmed that data previously reported did not include
Variance													**401**	**14**				some community clinics being held in BTC and SGH.
Community - GPwSI (OPs)	134	134	134	132	134	133	134	133	134	133	134	0	1,469		1,602			
Actual	178	187	260	275	188	288	292	258	280	197	256	0	2,659					
Variance													**1,191**	**81**				
RESPIRATORY																		
Targets:																		
Community - Nurse-led (OPs)	80	80	90	100	100	80	80	70	60	90	90		920		1,034		Vacant	Total community activity exceeding overall target.
Community Respiratory Service - Sandwell Oxygen	*56*	*46*	*57*	*61*	*59*	*71*	*70*	*58*	*63*	*80*	*64*	0					SPCT	
Community BTC	*45*	*55*	*41*	*37*	*35*	*35*	*44*	*37*	*42*	*36*	*19*	0						
Community SGH	*78*	*68*	*66*	*86*	*71*	*74*	*89*	*106*	*48*	*86*	*89*	0						
Community HOB	*107*	*107*	*105*	*109*	*55*	*96*	*63*	*90*	*84*	*86*	*138*	0						
Actual	286	276	269	293	220	276	266	291	237	288	310	0	3,012					
Variance													**2,092**	**227**				
Primary Care - GP/Nurse/GPwSI (OPs)	0	0	0	0	0	0	0	0	0	0	0	0	0		432			The Spirometry service was due to commence in February - LES now expected to be signed off
Actual	0	0	0	0	0	0	0	0	0	0	0	0	0					by the end of April.
Variance													**0**	**n/a**				
ENT																		
Target (CL Outpatients)	822	822	822	821	821	822	822	821	822	822	822	0	9,039		9,860		Jane Clark	Activity exceeding targets.
Actual	855	867	1,039	1,064	756	927	978	765	791	579	856	0	9,477				SWBH	Data supplied / validated by SWBH Information leads. Data updated retrospectively as previously
Variance													**438**	**5**				reported included clinics that should not be reported by the programme.
CARDIOLOGY																		
Targets:																		
Community (CL OPs)	65	65	65	65	65	66	65	66	65	65	65	0	717		782			Activity exceeding targets.
Actual	83	75	77	94	53	99	86	86	58	85	66	0	862				Vacant	SWBH Information lead has confirmed that data previously reported did not include some activity
Variance													**145**	**20**			SPCT	from Rowley Regis Hospital and Clinic activity undertaken at Sai Surgery, Great Bridge.
Community (NCL OPs)	156	156	155	156	155	155	156	156	155	156	156	0	1,712		1,867			
SPCT Heart Failure Team	*254*	*246*	*365*	*600*	*325*	*364*	*307*	*369*	*315*	*348*	*326*	0						
SPCT Cardiac Rehab Team (community contacts)	*321*	*261*	*154*	*70*	*54*	*12*	*10*	*14*	*10*	*9*	*1*	0						Information lead unable to explain significant reduction in SPCT cardiac rehabilitation team activity -
HoB Heart Failure Nurse Clinics	*33*	*31*	*37*	*24*	*23*	*15*	*27*	*16*	*33*	*23*	*17*	0						investigation underway.
Actual	608	538	556	694	402	391	344	399	358	380	344	0	5,014					
Variance													**3,302**	**193**				
GYNAECOLOGY																		
Target (CL OPs)	88	88	88	88	87	87	88	88	88	88	87	0	965		1,053		Therese	Activity exceeding target.
Actual	99	105	112	124	79	91	94	104	111	76	100	0	1,095				McMahon	
Variance													**130**	**14**			HOB tPCT	
DIABETES																		
Targets:																		
Community (SWBH led OPs)	486	487	486	486	487	486	486	486	486	487	486	0	5,349		5,835		Olivia Amartey	Activity has exceeded targets overall.
Actual	343	324	400	358	306	420	319	430	303	345	324	0	3,872				HOB tPCT	Additional SWBH led clinics (Tower Hill, Soho Health Centre, Lodge Rd & Smethwick MC)
Variance													**-1,477**	**-28**				identified since last report - activity has been added since April retrospectively.
Primary Care (NCL OPs)	30	31	30	30	30	30	30	30	30	30	30	0	331		361			
RRT Diabetes Team	*88*	*144*	*218*	*164*	*128*	*174*	*221*	*213*	*208*	*162*	*203*	0						
WWB Diabetes Team	*11*	*40*	*88*	*122*	*28*	*36*	*44*	*64*	*57*	*0*	*0*	0						
Actual	99	184	306	286	156	210	265	277	265	162	203	0	2,413					
Variance													**2,082**	**629**				

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	RCRH Acute Hospital Development: Project Director's Report
SPONSORING DIRECTOR:	Graham Seager, Director of Estates and New Hospital Project
AUTHOR:	Andrea Bigmore, New Hospital Project Manager Graham Seager, Director of Estates and New Hospital Project
DATE OF MEETING:	27 May 2010

SUMMARY OF KEY POINTS:

The Project Director's report gives an update on:

- The land acquisition process
- Regeneration and supporting local business
- The IM&T Vision

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	21st Century Facilities
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

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

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

PREVIOUS CONSIDERATION:

Usual monthly update.

Sandwell and West Birmingham Hospitals NHS
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Report to:	**Trust Board**
Report of:	**Graham Seager / Andrea Bigmore**
Subject:	**Project Update**
Date:	**May 2010**

1. Land Acquisition

The Trust is preparing for the CPO Inquiry scheduled for 15th June – 24th June. Whilst undertaking this preparation negotiations are proceeding to acquire the land voluntarily.

2. Outline Business Case (OBC)

The Project Team has met with the Strategic Health Authority (SHA) to plan for the update of the OBC required for Treasury approval prior to initiation of the procurement phase of the project. An approach to the update has been agreed with SHA colleagues. This will involve refreshing the financial modelling so that it will be possible to demonstrate that the new hospital is still affordable and value for money in changed financial conditions. The team will also ensure that the narrative is updated for any changes since the Department of Health (DH) approved the OBC last summer.

A detailed project plan has now been agreed to ensure that all the work required will be finished in time for the OBC to be approved by Trust Board in September 2010. The project plan is now being discussed with the DH and Private Finance Unit (PFU) to agree the approach to approvals by DH and the Treasury. The aim is to gain approval by the end of December so that the procurement can start.

3. Regeneration: Supporting Local Businesses

The team is currently considering linking its Acute Hospital Development website to the *'Find it in Sandwell and Find it in Birmingham*' websites. This approach, developed by Sandwell MB Council, involves the following steps for each local company that signs up to the initiative:

- The company registers on the *'Find it'* website
- This triggers an invitation for the company to participate in training, which includes how to tender for contracts, how to achieve accreditation against the quality standards expected and how to develop capability in a competitive market
- During the training, and afterwards as the company achieves its accreditations, it will be able to update its own page on the website to display the company profile as it grows
- This company information provides a fantastic resource for larger companies looking for products and / or services as part of their supply chain – it reduces the risks involved in employing smaller local companies by providing evidence of their capability

This approach is already making a real difference to the capability of local businesses.

The website will also be used:

- As a procurement tool at the pre-qualification stage of tendering for contracts
- For information sharing and collaboration on innovations

Birmingham City Council has recently adopted the approach and launched their site on 13th May 2010. The Acute Hospital Development Engagement Manager presented a stand at the event to raise awareness of our plans and to discuss opportunities for the future.

The benefits of the Acute Hospital Development website linking to the '*Find it'* websites will be that:

- Businesses contacting the project office about the scheme can be directed to register by clicking on a link between our website and the '*Find it'* sites - This will initiate the process outlined above
- We will be able to access registration data to help us invite companies to events, seek advice in specialist areas and maintain records of who is interested in our scheme
- It will save us time answering queries in the project office
- During the procurement stage of the project we will be encouraging our bidders to use local companies and their use of the *'Find it'* websites will help them make the necessary contacts

We are not aware of any other health projects adopting this approach. We can claim, with justification, that we are making really positive efforts to support regeneration right from the outset.

4. IM&T Vision

The IM&T Vision has been approved by the Clinical IM&T Board and the Clinical Executive Board and will be considered by the Project Board at the May meeting.

Approval of the vision will initiate the development of an Information Management and Communications Strategy to help the Trust plan future development in time for opening of the new hospital in 2016. The strategy will be informed by a series of workshops involving clinicians and other staff to ensure that all issues have been considered and that the approach to delivery is understood.

The IM&T team will work with local health economy colleagues to ensure that systems will be able to integrate between organisations to enable delivery of the RCRH models of care.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Maternity Service- Medium Term Review : Implementation Plan
SPONSORING DIRECTOR:	John Adler, Chief Executive
AUTHOR:	Jayne Dunn, Redesign Director – Right Care Right Here
DATE OF MEETING:	27 May 2010

SUMMARY OF KEY POINTS:

In February 2010 the Trust and PCT Boards received a report on the outcome of 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 2011 until the opening of the new Acute Hospital in 2016.

In addition the Trust and PCT Boards approved the Business Case for Change and approved the Project Steering Group's recommended option for the medium term configuration of the Trust's maternity services. Implementation of the approved option will take place in the following two stages.

- The transfer of all hospital births, inpatient maternity services, consultant led maternity services and neonatal care to City Hospital with the closure of these services in Sandwell Hospital. The proposed implementation date for this is 21st January 2011.
- The opening of a stand alone Midwifery Led Unit in Sandwell. The proposed implementation date for this is October 2011.

This report presents the progress made in developing the implementation plan and in particular:

- Implementation date and key milestones for the first stage of maternity reconfiguration
- Work to identify a preferred location and timescale for the stand alone Midwifery Led Birth Centre in Sandwell
- Gateway Review
- Equality Impact Assessment work.

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 that the lead organisation for the maternity medium term review project transfers from Sandwell PCT to Sandwell and West Birmingham Hospital NHS Trust at the end of May 2010 as part of the transition from the planning phase to the implementation phase of the project.
- AGREE the project management structure for the implementation phase of the maternity medium term review project.
- AGREE the implementation date, 21st January 2011, for the first stage of implementing the medium term reconfiguration of maternity services.
- NOTE progress in developing the implementation plan and key milestones for stage 1.
- NOTE progress with planning the stand alone MLU in Sandwell to be operational in October 2011. The Project Steering Group have identified the preferred location as the Leasowes site with a permanent purpose built facility procured through a third party process by Sandwell PCT. The Sandwell PCT Board will be considering the preferred location and procurement process at their meeting in May.
- NOTE the verbal feedback from the Gateway Review that took place in May 2010.

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
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

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

Financial	**X**	Implementation of the approved medium term maternity reconfiguration 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.
Business and market share	**X**	The Business Case for the approved medium term maternity reconfiguration identified: • 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 approved medium term maternity reconfiguration 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	**X**	The project management methodology has followed the Department of Health guidance on significant service review set out in *Changing for the Better* (2008). This has involves a number of Gateway Reviews with the second of these having been held in May 2010.
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 approved medium term maternity reconfiguration 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 midwifery led 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		

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.

The Business Case for Change and a report presenting the Outcome of Public Consultation, were presented to the Trust Board at its meeting in February 2010. The reports were also presented to Sandwell PCT and Heart of Birmingham teaching PCT . The Business Case for Change was agreed and the recommended option for the medium term configuration of maternity services was approved.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MATERNITY SERVICE- MEDIUM TERM REVIEW
IMPLEMENTATION PLAN
MAY 2010

EXECUTIVE SUMMARY

Introduction

In February 2010 the Trust Board and Sandwell PCT Board considered the Business Case for Change and the outcome of the public consultation ,'*Improving Services for Giving Birth,'* on the 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 2016. Both Boards agreed the Business Case for Change and approved the preferred option for the medium term configuration of maternity services subject to further consultation and agreement with the Joint Health Scrutiny Committee around the timescale for development of the stand alone Midwifery Led Unit in Sandwell. Heart of Birmingham teaching PCT Board also confirmed their agreement to the Business Case for Change and approved option.

The approved option will, in summary, result in:

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

Since February 2010 the Project Steering Group has been developing an implementation plan for the medium term reconfiguration of maternity services. This has included more detailed planning and option appraisal for the stand alone Midwifery Led Birth Centre (MLU) in Sandwell and involved further discussion with the Joint Health Scrutiny Committee.

Implementation of the approved option will take place in the following two stages.

- The transfer of all hospital births, inpatient maternity services, consultant led maternity services and neonatal care to City Hospital with the closure of these services in Sandwell Hospital.
- The opening of a stand alone Midwifery Led Unit in Sandwell.

This report presents progress with this work and in particular:

- The preferred location and timescale for the stand alone Midwifery Led Birth Centre in Sandwell.
- The proposed implementation date and key milestones for the first stage of implementation.
- Proposed changes to the project management arrangements as part of the transition from the planning phase to the implementation phase of the project.
- Feedback from a second Gateway Review that took place in May 2010.
- Progress with the Equality Impact Assessment work.

Stand Alone MLU in Sandwell

In its response to the formal public consultation the Joint Health Scrutiny Committee resolved that whilst ideally it would have preferred the full maternity provision to remain in Sandwell, it would support Option 3 (subsequently the approved option) but with the caveat that the stand alone MLU is built and operational in Sandwell before maternity services are withdrawn from Sandwell Hospital. After careful consideration by the Project Steering Group it was concluded that this was not achievable. However it was considered important to minimise the time between reconfiguring consultant led/high risk births to City Hospital and opening the stand alone MLU in Sandwell but without delaying the reconfiguration of consultant led/high risk births. The Boards in February agreed that the Project Steering Group would undertake further detailed work to analyse and undertake an option appraisal that achieved this outcome.

The Project Steering Group identified that the reconfiguration of consultant led/high risk births could take place as soon as the additional capacity at City Hospital is open (after the refurbishment work) and that this would be between January and April 2011. It also identified that the development of a team of midwives with the required skills and experience to run the stand alone MLU in Sandwell would take 18 months after the opening of the co-located Serenity Midwifery Centre at City Hospital in May 2010 and therefore such a team would be available by October 2011. A detailed option appraisal process was developed and undertaken to identify the location of the stand alone MLU in Sandwell. A key criterion was the ability to develop and open the facility by October 2011.

Subsequent meetings were held in March and April with the Joint Health Scrutiny Committee to agree the above approach and timescales and to discuss the short listed options for the location of the stand alone MLU. A further meeting with the Joint Health Scrutiny Committee is being held on 26th May to inform the Committee of the preferred location (see below) and provide the Committee with an opportunity to comment on the case for the stand alone MLU, the maternity services medium term review implementation plan and timescales. These comments will be reported, verbally to the Sandwell PCT Board and Sandwell and West Birmingham Hospitals NHS Trust Board meetings on 27th May 2010.

As a result of the option appraisal process the Project Steering Group have identified the preferred location as the Leasowes site with a permanent purpose built facility procured through a third party process by Sandwell PCT. Delivery of the midwifery led service will be provided by Sandwell and West Birmingham Hospitals NHS Trust (from October 2011).

Sandwell PCT Board will be considering the preferred location and procurement process at their meeting in May.

Transition to the Implementation Phase of the Review

The maternity services medium term review is in transition between the planning phase and implementation phase of the project. As part of this it is proposed that the project management arrangements are reviewed and the lead organisation for this project is transferred from Sandwell PCT to Sandwell and West Birmingham Hospitals NHS Trust with a revised project management structure.

A second Gateway Review of the project has been undertaken looking at readiness for implementation. The project will be given a delivery confidence assessment of amber green rating i.e. *Successful delivery appears likely. However attention will be needed to ensure risks do not materialise into major issues threatening delivery.* There will be two rcommendations around:

- Development of a more detailed plan for the stand alone MLU in Sandwell and
- Explore further solutions to the public transport issues raised through the consultation exercise.

- Positive comments were made about the strength of the partnership working and the quality of the public consultation.

Implementation Plan

The Project Steering Group has been working with operational managers and clinical leads to develop a detailed implementation plan for stage 1 and an outline plan for stage 2. In addition to the work described above on the stand alone MLU in Sandwell, this has included the development of:

- A stake holder analysis
- Communication and engagement framework
- Capital refurbishment detailed project plan
- Information leaflet
- Staff engagement including membership of working groups
- Workforce project plan
- Further equality impact assessment work.

The proposed implementation date for stage 1 of implementation, i.e. the transfer of all hospital births, inpatient maternity services, consultant led maternity services and neonatal care to City Hospital with the closure of these services in Sandwell Hospital, is 21st January 2011. This is on the basis of the approved refurbishment work at City to increase capacity, being complete at the end of December 2010 and operational commissioning of these areas being complete mid January 2011.

Key milestones and dates have been identified in order to deliver stage 1 implementation on this date. There is ongoing work around a number of key issues and good progress is being made with these.

The above work has included completing the first phase of the Equality Impact Assessment. The second phase will be incorporated into the implementation plan.

The Trust Board is recommended to:

- AGREE that the lead organisation for the maternity medium term review project transfers from Sandwell PCT to Sandwell and West Birmingham Hospital NHS Trust at the end of May 2010 as part of the transition from the planning phase to the implementation phase of the project.

- AGREE the project management structure for the implementation phase of the maternity medium term review project.

- AGREE the implementation date, 21st January 2011, for the first stage of implementing the medium term reconfiguration of maternity services.

- NOTE progress in developing the implementation plan and key milestones for stage 1.

- NOTE progress with planning the stand alone MLU in Sandwell to be operational in October 2011. The Project Steering Group have identified the preferred location as the Leasowes site with a permanent purpose built facility procured through a third party process by Sandwell PCT. The Sandwell PCT Board will be considering the preferred location and procurement process at their meeting in May.

- NOTE the verbal feedback from the Gateway Review that took place in May 2010.

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 2016. The need to undertake a formal public consultation on these options was also agreed. This public consultation, '*Improving Services for Giving Birth,'* took place between 12th October 2009 and 18th January 2010.

The outcome of the public consultation along with a Business Case for Change was presented to Sandwell PCT Board and Sandwell and West Birmingham Hospitals NHS Trust Board at their meetings in February 2010. Both Boards agreed the Business Case for Change and approved the preferred option for the medium term configuration of maternity services subject to further consultation and agreement with the Joint Health Scrutiny Committee around the timescale for development of the stand alone Midwifery Led Unit in Sandwell. Heart of Birmingham teaching PCT Board also confirmed their agreement to the Business Case for Change and approved option.

The approved option will, in summary, result in:

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

Since February 2010 the Project Steering Group has been developing an implementation plan for the medium term reconfiguration of maternity services. This has included more detailed planning and option appraisal for the stand alone Midwifery Led Birth Centre (MLU) in Sandwell and involved further discussion with the Joint Health Scrutiny Committee.

Implementation of the approved option will take place in the following two stages.

- The transfer of all hospital births, inpatient maternity services, consultant led maternity services and neonatal care to City Hospital with the closure of these services in Sandwell Hospital.
- The opening of a stand alone Midwifery Led Unit in Sandwell.

The purpose of this report is to present:

- The preferred location and timescale for the stand alone Midwifery Led Birth Centre in Sandwell.
- The proposed implementation date and key milestones for the first stage and to seek Trust Board approval for the implementation date.
- Proposed changes to the project management arrangements and in particular seek approval for the transfer of the project lead organisation for the maternity services medium term review from Sandwell PCT to Sandwell and West Birmingham Hospitals NHS Trust as part of the transition from the planning phase to the implementation phase of the project.
- Feedback from the Gateway Review undertaken in May 2010.
- Progress with the Equality Impact Assessment work.

2. STAND ALONE MIDWIFERY LED BIRTH CENTRE IN SANDWELL

Midwifery Led Birth Centre's (MLU) embrace a social model of maternity care, where pregnancy and birth are viewed as normal physiological processes and where midwives are the 'lead professional' for

intra-partum care. They offer parents an environment that does not look or feel at all like a hospital and in fact is as close as possible to giving birth at home. The approved medium term reconfiguration of maternity services includes the development of a stand alone Midwifery Led Birth Centre (MLU) in Sandwell. For Sandwell residents the stand alone MLU will provide a real choice and the option for a low stress high quality environment in which to give birth, a home for home.

All women, who are assessed as being 'low risk' can be offered this facility, however, 'low risk' women may still choose to use the Serenity Midwifery Birth Centre (co-located MLU) or the delivery suite at City Hospital as their preferred option to give birth.

2.1 Engagement with the Joint Health Scrutiny Committee

Throughout the maternity services medium term review there have been discussions and meetings with the Joint Health Scrutiny Committee and these have influenced the work of the Project Steering Group including the development of the short listed options and public consultation document. 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 (subsequently the approved option) but with the caveat that the stand alone MLU is built and operational in Sandwell before maternity services are withdrawn from Sandwell Hospital.

The Project Steering Group carefully considered the caveat proposed by the Committee and concluded that this was not achievable but recognised the concerns raised by the Joint Health Scrutiny Committee and considered it important to minimise the time between reconfiguring consultant led/high risk births to City Hospital and opening the stand alone MLU in Sandwell but without delaying the reconfiguration of consultant led/high risk births. It was therefore agreed by the Boards in February that the Project Steering Group would undertake further detailed work to analyse and undertake an option appraisal 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) i.e. between January and April 2011.

- Enables the development of a team of midwives with the required skills and experience to run the stand alone MLU in Sandwell. This will involve developing these skills and experience through midwives working in the co-located Serenity Midwifery Centre at City Hospital for 18 months after it opens, as well as recruiting additional midwives i.e. October 2011.

- Identifies a location in Sandwell and completes any construction work required for the stand alone MLU in line with the development of a team of midwives (as above) i.e. October 2011.

Subsequent meetings were held in March and April with the Joint Health Scrutiny Committee to agree the above approach and timescales and to discuss the location of the stand alone MLU. A further meeting with the Joint Health Scrutiny Committee is being held on 26th May to inform the Committee of the preferred location (see below) and provide the Committee with an opportunity to comment on the case for the stand alone MLU, the maternity services medium term review implementation plan and timescales. These comments will be reported, verbally to the Sandwell PCT Board and Sandwell and West Birmingham Hospitals NHS Trust Board meetings on 27th May 2010.

2.2 Option Appraisal on the Proposed Location of the Stand Alone MLU

The Project Steering Group developed an options appraisal process for the evaluation of potential locations for the standalone unit.

The first stage of this process included a 'long list' of potential sites. Each was considered against an agreed set of criteria. It was agreed that the first of these: Timescale (the option had to be achievable by

October 2011, the agreed timescale for ensuring a workforce ready to deliver the service) be considered an access condition. Failure to meet this condition would therefore eliminate the option from further consideration. This ensured that the Joint Health Scrutiny Committee's challenge to the project, that the delay between closing all intra partum services at Sandwell Hospital and opening the standalone unit in Sandwell be minimised, would be met.

The sites identified for this part of the process were as follows:

Option 1 – Sandwell General Hospital Site
a) the conversion of the existing maternity delivery suite to provide a temporary solution until the community hospital is commissioned and then the relocation of the unit to another facility
b) a temporary modular building to be relocated to a town centre scheme in due course

Option 2 – Rowley Regis Hospital
a) Conversion of the Eliza Tinsley Ward to provide a permanent solution

Option 3 – Lyng Health Centre
a) Conversion of existing building
b) Land adjacent the Lyng Health Centre - Lease the land for a temporary modular building to be relocated to a town centre scheme in due course
c) Land adjacent the Lyng Health - Purchase the land for a permanent solution

Option 4 – Additional facility as part of Wednesbury Health Centre

Option 5 – Use of land or buildings at Edward Street Hospital

Option 6 – Leasowes Intermediate Care Centre
a) Provide a permanent building
b) Provide a modular building

Option 4 was eliminated at this stage as the timescale was unachievable.

Having satisfied the qualification criteria - Timescale - the options were considered against the following criteria:

- Clinical acceptability and safety
- Access - including transport routes, road access and distance from current services
- Building feasibility – Can the building meet the requirements of the design brief
- Cost and VFM (Affordable and planned expenditure)
- Access in context of spread of births across Sandwell
- Is the location suitable for lone worker, does it support 24 hr access

Following an initial appraisal of these options, the following short list of options was agreed:

Option 1: a & b – Sandwell General Hospital Site
Option 2 – Rowley Regis Hospital
Option 3: a & b – Land adjacent the Lyng Health Centre
Option 6: a & b – Leasowes Intermediate Care Centre

Option 5 was eliminates due to too many unknown or unacceptable issues and likely high cost.

The short-listed options were then taken forward for more detailed consideration by estates specialists, including Strategic Healthcare Planning, Architects, Building Surveyors and Quantity Surveyors.

A full design brief had been provided by Sandwell and West Birmingham Hospitals Trust to describe the services required. Visits were also undertaken to the Midwife Led Birthing Centre at the Samuel Johnson Community Hospital in Lichfield and the newly developed co-located Midwife Led 'Serenity' Unit at City Hospital. Following discussions with senior midwives, various changes were agreed to the design brief, and it is this revised brief that the detailed appraisal was undertaken.

The life cycle calculations for the unit have been assumed to stand over a 25 year period, with the possibility of a modular facility potentially being relocated to a town centre health facility in approximately four years.

Costs have been calculated in accordance with the Median Index of Public Sector Building Tender Prices (MIPS), however additional allowances have been included, as required.

Following initial appraisal of the options listed, it was highlighted that there are practical and clinical considerations that rule out the consideration of the Sandwell Hospital site (Option1 a & b).

The Lyng Health Centre option was also ruled out at this stage, as it became clear that the adjacent site is unavailable. It is already the subject of advance negotiations for use as a residential development by Sandwell MBC. The conversion of the building itself was not felt to be feasible due the very high costs associated with this (the lift would not be suitable for potential stretcher use, therefore requiring an additional lift on the exterior of the building to be constructed) and the extensive disruption that this would cause to clinical services. This therefore eliminated Option 3 a & b.

Consideration was also given to the option to provide the facility via a modular build (Option 6b) which could if needed be relocated to another site in the future; however, this option was eliminated as being too costly over the lifecycle of the building, as well as concerns about the quality of this build option.

2.3 Consideration of remaining options of Option 2 (Rowley Regis Hospital) and 6a (Leasowes Site)

Table 1: Lifecycle Cost Comparison

Facility	Total life expenditure	Annualised rent	Cost per m²
Option 2: Rowley Regis Hospital Existing ward size 488.95m²	£3,727,452.00	Capital: £1,026,003.00 Annual FM costs: £108,057.00	£221/m²
Option 6a: Leasowes capital development Size: 378m²	£3,768,459.00	Capital: £1,680,009.00 Annual FM costs: £83,538.00	£221/m²
Option 6a: Leasowes third party option	£3,761,100.00	3PD Rental: £66,906.00 Annual FM costs:	£177/m²

Size: 378m²		£83,538.00 Total: £150,444.00	£221/m² £398/m²

The table above shows that the facility at Rowley Regis Hospital would ultimately be the cheapest option. However, this option would require an initial capital investment, which is not currently available.

A third party option at Leasowes, whilst attracting the highest overall lifecycle value, would allow the PCT an option with minimal initial capital investment (i.e. professional services to ensure value for money). This route attracts an annual rental cost plus facilities management allowance.

It should be noted that these costs are based on retaining land ownership and granting the third party developer a long lease of approximately 100 years. If land ownership were to be sold to the developer this would result in a lower risk profile for the developer and therefore lower rental costs for the facility. It should also be noted that capital receipts for a PCT may be restricted and therefore the capital value reimbursed through a reduced rental rate or rent free period.

These options were presented back to the Project Steering Group for more detailed discussion.

The Board felt that the Rowley Regis option was the weaker of the two remaining options on the following grounds:

- The location is not central to the borough and would therefore present restricted access for women from Sandwell.
- The site may present some problems with access, in particular in the winter.
- The nearest obstetric facility would be Russells Hall Hospital in Dudley. As ambulance services would take any women needing to transfer in labour to the nearest hospital, there is concern about potential impact on capacity of this unit. This would also lead to loss of income for SWBHT, and therefore potentially impact negatively in the financial viability of the new unit.
- The options would require capital investment which is not available at present.

In contrast, the Leasowes option was felt to provide the following positive benefits:

- The site is already owned by Sandwell PCT and has outline planning permission for a health facility
- It is in a relatively central location
- It will allow quick and easy transfer to the City Hospital site which will have sufficient capacity for any emergency transfers
- It provides excellent accessibility to the facility, being located on a road that adjoins most of the boroughs main arterial routes, good bus routes and with a station across the road from the facility.
- It would provide a permanent facility
- It is achievable through a developer led solution
- It is affordable within the original business case proposal of approximately £150,000 revenue costs p.a.

2.4 Procurement

The preferred procurement method for this site was Lift. Approaches were made to Sandwell LiftCo to ascertain the likely cost for a standalone unit such as this; however they have responded that the size of the unit would make it unaffordable and that any lease plus rate would be extremely high. They have confirmed that they would surrender exclusivity for this development.

The two remaining procurement options for this site would therefore be capital project or developer led.

Having discounted the option of a capital development and a Lift development the only realistic option available for the procurement of a new build facility is a developer led solution.

This would involve the appointment of a private developer to purchase the portion of the Leasowes site where the facility is planned and to construct the building on the PCT's behalf. The facility would be leased back to the PCT for an agree period with five yearly rent reviews. The capital receipt can be offered in a number of ways from the developer, either as a capital receipt or through a reduced rent/rent free period on the building equivalent to the Net Present Value of the land purchased.

It has been ascertained from the appointed cost managers and the district valuer that this procurement method is legitimate and should be utilised when it offers the best value for the PCT.

The Heads of Terms associated with this option are subject to a large number of variations that in discussion with an appointed developer the PCT should consider. The land can be retained and a lease granted, the developer can take responsibility for certain elements of the maintenance regime, the lease term altered, break clauses added etc. which will all affect the likely cost for the PCT but also alter the risk exposure for renting a facility over a long period of time.

Because the total value of the development is under the current European procurement thresholds a local tender can be undertaken to procure the developer. This can be actioned immediately approval is given to proceed, with minimal response periods, providing additional security to the likely development deadline.

The scheme also falls within the PCT's delegated limits and is therefore is not subject to SHA capital approval.

2.5 Preferred Option

The Project Steering Group has identified the preferred option as a permanent build on the Leasowes Site.

The Project Steering Group will present a case to Sandwell PCT Board at its meeting on 27th May seeking approval for this preferred location, investment and procurement method for the stand alone MLU in Sandwell.

2.6 Recommendation

The Trust Board is recommended to note progress with planning the stand alone MLU in Sandwell to be operational in October 2011. Sandwell PCT Board will be asked to approve the preferred location of the Leasowes site, and the preferred third party procurement process.

3. PROJECT MANAGEMENT

The maternity services medium term review is in transition between the planning phase and implementation phase of the project. As part of this transition the project management structure will be revised and a further Gateway Review has taken place.

3.1 Project Management Structure

In line with national guidelines for the reconfiguration of health services, Sandwell PCT as lead commissioner for the maternity services provided by the Trust, has been the lead organisation for the planning phase of the maternity services medium term review. A clear project management structure has been in place including a Project Steering Group with senior members from the Trust and Heart of Birmingham teaching PCT as well as Sandwell PCT.

It is proposed that the project lead organisation for the implementation phase of the maternity services medium term review transfers to Sandwell and West Birmingham Hospitals NHS Trust with a revised project management structure. Key project roles within this structure include:

- Project Sponsor – John Adler, Chief Executive SWBH
- Project Director – Jayne Dunn, Redesign Director Right Care Right Here, SWBH
- Project Manager – Gill Gadd, Service Redesign Manager, SWBH
- Clinical Lead – Mr Paul Bosio, Clinical Director for Obstetrics, SWBH
- Clinical Lead – Elaine Newell, Head of Midwifery, SWBH

The proposed project management structure is summarised in Appendix 1. The strong partnership approach followed in the planning phase will be maintained through the implementation phase through multi-agency representatives throughout the project management structure. The Project Board will report progress to the three Boards (Sandwell and West Birmingham Hospitals Trust, Sandwell PCT, Heart of Birmingham teaching PCT). A Sandwell PCT led Project Group will be established to oversee the procurement and development of the Stand Alone Midwifery Led Unit. This will report to the Board through the Capital Projects group. It is proposed that the project group is chaired by the Joint Director of Partnership and Commissioning, and include Estates Managers from Sandwell PCT and SWBHT, as well as clinical advisors.

Most of the groups and work streams identified in the revised project management structure have been running in shadow format in order to develop the implementation plan.

There would be a clear transition plan and hand over to ensure smooth transfer of project management arrangements. This would take place between the May meeting of the Trust Board and the middle of June.

3.2 Gateway Review

A second Gateway Review of the Maternity Medium Term Review and readiness for implementation took place between 11th and 13th May 2010. Verbal feedback was given at the end of the review and in summary was:

The project will be given a delivery confidence assessment of amber green rating i.e. *Successful delivery appears likely. However attention will be needed to ensure risks do not materialise into major issues threatening delivery.*

Two recommendations will be made around:

- The need to complete detailed planning with regard to specification of the stand alone MLU and method of procurement
- Further work to be undertaken to explore solutions to the public transport issues raised through the consultation exercise.

Other verbal comments were made around ensuring a commissioner focus on the project is maintained, use of the risk register as a live document and collecting baseline data against the benefits realisation plan.

Positive comments were made about the strength of the partnership working and the quality of the public consultation. A view was also given that the service model that has been developed and the approach taken could be used as exemplars for other maternity services in the region and wider.

The written report will be provided to Sandwell PCT as lead organisation for the project, by the end of May.

3.3 Recommendations

The Trust Board is recommended to:

- Agree that the lead organisation for the maternity services medium term review project transfers from Sandwell PCT to Sandwell and West Birmingham Hospital NHS Trust at the end of May 2010 as part of the transition from the planning phase to the implementation phase of the project.
- Agree the project management structure for the implementation phase of the maternity medium term review project.
- Note the verbal feedback from the Gateway Review that took place in May 2010.

4. IMPLEMENTATION PLAN

Implementation of the approved option will take place in the following two stages.

- The transfer of all hospital births, inpatient maternity services, consultant led maternity services and neonatal care to City Hospital with the closure of these services in Sandwell Hospital. The proposed implementation date is 21st January 2011.
- The opening of a stand alone Midwifery Led Unit in Sandwell with an implementation date of October 2011.

The Project Steering Group has been working with operational managers and clinical leads through the implementation groups and work streams (see above) to develop a detailed implementation plan for stage 1 and an outline plan for stage 2. In addition to the work described above on the stand alone MLU in Sandwell, this has included the development of:

- A stake holder analysis
- Communication and engagement framework
- Capital refurbishment detailed project plan
- Information leaflet
- Staff engagement including membership of working groups
- Workforce project plan
- Further equality impact assessment work.

4.1 Key Milestones for Implementation:

Table 2 below summarises the key milestones for implementation. Most of the milestones relate to stage 1 of the implementation phase of the maternity services medium term review. It should be noted that more detail and specific dates are available for the next 3 months with milestones further ahead being less detailed and with broader dates (e.g. end of month rather than specific dates). Milestones and dates will be reviewed on a regular basis and confirmed in more detail 3 months ahead.

Once Sandwell PCT Board have approved the location for and procurement of the stand alone MLU in Sandwell a more detailed implementation plan for this stage (stage 2) will be developed and further key milestones identified.

Progress to date against the key milestones is also shown.

Table 2: Key Implementation Milestones and Progress

Milestone/Action	Timescale	Progress	Comments
		APRIL 2010	
Option appraisal for stand alone MLU	Mid April	Achieved	Presented to Joint Health Scrutiny Committee 12th April 2010
Open days for co-located MLU at City Hospital	April	Achieved	Good attendance from women, partners, staff and key stakeholders

MAY 2010			
Open co-located MLU at City Hospital	5th May	Achieved	23 births (5/5-17/5/10)
Gateway Review	11-13th May	Achieved	Amber Green Rating with 2 recommendations
Clinical Steering Group workshop	10th May	Achieved	Clinical task and finish groups established
Board report outlining preferred option & detailed case for stand alone MLU in Sandwell and implementation plan	20th May	On target	
Sandwell PCT Board approval for stand alone MLU in Sandwell including site and cost	27th May	On target	
Sandwell and West Birmingham Hospitals NHS Trust Board approval of implementation date and plan	27th May	On target	
Send out tender documentation to refurbishment work at City Hospital	31st May	On target	
Information leaflet explaining service changes available for women booking with SWBH maternity services for delivery from end of January 2011	31st May	On target	
Information leaflet & letter sent to GPs & other stakeholders confirming service change from end of January 2011	31st May	On target	Include SHA, WMAS, Other local NHS trusts, Universities, post graduate training providers, other PCTs, etc.
JUNE 2010			
Transfer lead organisation for project from Sandwell PCT to SWBH NHS Trust	Mid June	On target	
Develop detailed project plan for stand alone MLU in Sandwell	30th June	On target	
Feedback to key stakeholders about approved option and timescales for maternity reconfiguration	Start in June	On target	
Commence further engagement work with women and partners around the stand alone MLU in Sandwell	Start in June	On target	
Set up communications helpline for women to answer concerns regarding changes being made	30th June		
Trust members event re:	14th & 28th		

health during pregnancy during & after reconfiguration	June		
Update GP homepage- article in GP focus	June		
JULY 2010			
Refurbishment work at City Hospital starts (on site)	23rd July		
Update external websites re changes- choose and book & birth choice uk			
Key internal stakeholders update meetings			
Update hot topics			
Staff engagement maternity & NNU	29th July		
AUGUST 2010			
Formal consultation with midwifery staff	17th August		
Formal consultation with SWBH staff representatives (via PACC) commences	TBC		
SEPTEMBER 2010			
2nd and 3rd PACC meetings	TBC		
OCTOBER 2010			
Confirm operational move plans and operational policies and equality impact assessment (EQIA)	31st October		
Antenatal Day Assessment Unit (ADAU) and Transfer Lounge refurbishment at City Hospital completes			
NOVEMBER 2010			
Sign off operational move plans			
DECEMBER 2010			
Handover of refurbished areas on Delivery Suite and M1 at City Hospital	23rd December		
Commission refurbished areas at City Hospital	20th January		
JANUARY 2011			
Transfer all hospital births, neonates, inpatient and consultant led services to City Hospital	***21st January***		
Close Delivery Suite, NNU, inpatient maternity beds at Sandwell Hospitals	***21st January***		
Start recruitment process for midwives for stand alone MLU			
Start construction programme for stand alone MLU in Sandwell			

FEBRUARY 2011			
MARCH 2011			
APRIL 2011			
Start induction and training for midwives for stand alone MLU			
MAY 2011			
Gateway Review – evaluation of phase 1 of reconfiguration and preparedness for stand alone MLU			
JUNE 2011			
JULY 2011			
Completion construction work for stand alone MLU			
AUGUST 2011			
Commissioning of stand alone MLU			
SEPTEMBER 2011			
Induction and training on site for staff who will be working in stand alone MLU in Sandwell			
OCTOBER 2011			
Open stand alone MLU in Sandwell	October		

4.2 Key Implementation Issues

Through the ongoing work of the Project Steering Group and 'shadow' implementation work streams a number of key issues have been identified where there is ongoing work. These are summarized below.

Travel options for women, partners and visitors to the Maternity Services at City Hospital:

- Identify clear travel directions, including common bus routes with frequency, service start and end times and making these available to women.
- Include questions about travel arrangements for women and visitors in a maternity patient survey that is about to be undertaken by the Trust.
- Link into the RCRH Programme work that is being undertaken 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 Arrangements at City Hospital:

- Include travel arrangements to work in a questionnaire that is being sent to maternity staff.
- Promote the Trust shuttle bus service between Hospital sites and keep the times it operates under review.
- Review of car parking capacity at City Hospital.
- A dedicated car drop off space has been identified for the Serenity Midwifery Birth Centre.

Visiting Times:

- Review visiting times to maternity services and work with women to agree the best visiting times.

Capacity at City Hospital:

- The co-located Serenity Midwifery Birth Centre at City Hospital opened on 5th May providing 5 additional birth rooms each with the ability to offer a water birth.
- A clear project plan has been developed for the refurbishment work at City Hospital to increase bed capacity and capacity on Delivery Suite in line with the approved Business Case for Change.
- Review arrangements for elective caesarean operations and work towards a dedicated list in order to ensure improved use of theatre capacity and improved patient experience.

Workforce Arrangements:

- Develop plans to increase consultant labour ward cover at City Hospital from 40 hours a week to 60 hours immediately post reconfiguration and then increase to 78 hours a week within a year.
- Liaise with the College to ensure allocation of sufficient senior middle grade trainees to allow 2 middle grade doctors, including 1 at senior level, in Obstetrics and Gynaecology to cover City Hospital at any one time.
- Review Gynaecology medical staff cover arrangements for Sandwell Hospital site.
- Review arrangements for Paediatric consultant support to the NNU at City Hospital.
- Review midwifery staff rotas, shift times, induction etc and start cross site rotation.
- Review in more detail implications for supporting services such as Imaging, Hearing Services etc.

4.3 Recommendation

The Trust Board is recommended to

- Agree the implementation date, 21st January 2011, for the first stage of implementing the maternity services medium term review.
- Note the progress that has been made in developing the implementation plan and key milestones for stage 1.

5. EQUALITY IMPACT ASSESSMENT

The project Steering Group agreed that the equality impact assessment (EQIA) would be carried out across the two phases of the project.

Stage 1 – 4:
The process commenced with a workshop for members of the steering group, facilitated by the Sandwell PCT Head of Equality and Diversity, to identify:

- The intended beneficiaries of the 3 shortlisted maternity options.
- The benefits or outcomes each beneficiary should expect to receive from the 3 shortlisted 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 EQIA directed aspects of the consultation and has been compiled into the Equality Impact Assessment Report for phase 1 of the project.

A number of benefits were identified however, the assessment process highlighted potential disadvantageous or negative impact on some groups. These areas have been collated into an action plan as part of the phase 1 report, which includes those areas addressed within the consultation, as well as areas which will need to be taken forward through implementation.

Stages 5 – 9 – Implementation:
Following agreement of on the preferred option, the following process will be completed:

Stage 5 Review proposed actions from stages 1-4 following Board approval and embed into implementation plans

Stage 6 Involve relevant groups in developing the implementation plan and ensure ongoing consultation and engagement with identified groups

Stage 7 Implement and equality action plan to address additional issues identified through stages 1-6 of the assessment through the assessment

These stages will be led by SWBHT.

Stages 8-9 – Review

Stage 8 Monitor impact of selected option in line with issues identified in phase 1 and 2

Stage 9 Publish the assessment of this monitoring.

These final stages will be the led by Sandwell PCT.

The full EQIA report is attached at appendix 2

6. CONCLUSION

Since approval of the Business Case for Change for the maternity services medium term review in February 2010 the Project Steering Group has been undertaking work to develop an implementation plan for the approved option for the medium term configuration of maternity services. This report has presented progress with this work and outlined the project management arrangements proposed for the implementation phase of the review.

With regard to the stand alone MLU in Sandwell a detailed option appraisal around location of the facility has been undertaken. The Project Steering Group have identified the preferred location as the Leasowes site with a permanent purpose built facility procured through a third party process by Sandwell PCT. Delivery of the midwifery led service will be provided by Sandwell and West Birmingham Hospitals NHS Trust (from October 2011). The Sandwell PCT Board will be considering the preferred location and procurement process at their meeting in May.

The Project Steering Group has developed an implementation plan that will result in the implementation of stage 1, i.e. the transfer of all hospital births, inpatient maternity services, consultant led maternity services and neonatal care to City Hospital with the closure of these services in Sandwell Hospital. The proposed implementation date is 21st January 2011. Key implementation issues have been identified along with the ongoing work to progress these.

The maternity service medium term review is now in transition between the planning and implementation phases and as part of this it is proposed that the project management arrangements are reviewed and the lead organisation for this project is transferred from Sandwell PCT to Sandwell and West Birmingham Hospitals NHS Trust.

A second Gateway Review of the project has been undertaken looking at readiness for implementation.

The project will be given a delivery confidence assessment of amber green rating i.e. *Successful delivery appears likely. However attention will be needed to ensure risks do not materialise into major issues threatening delivery.* Positive comments were made about the strength of the partnership working and the quality of the public consultation.

This report has also presented the Equality Impact Assessment Report for the first phase of the equality impact assessment of the maternity services medium term review. This includes an action plan for taking forward this work into the implementation phase of the project.

7. RECOMMENDATION

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

- AGREE that the lead organisation for the maternity medium term review project transfers from Sandwell PCT to Sandwell and West Birmingham Hospital NHS Trust at the end of May 2010 as part of the transition from the planning phase to the implementation phase of the project.

- AGREE the project management structure for the implementation phase of the maternity medium term review project.

- AGREE the implementation date, 21st January 2011, for the first stage of implementing the medium term reconfiguration of maternity services.

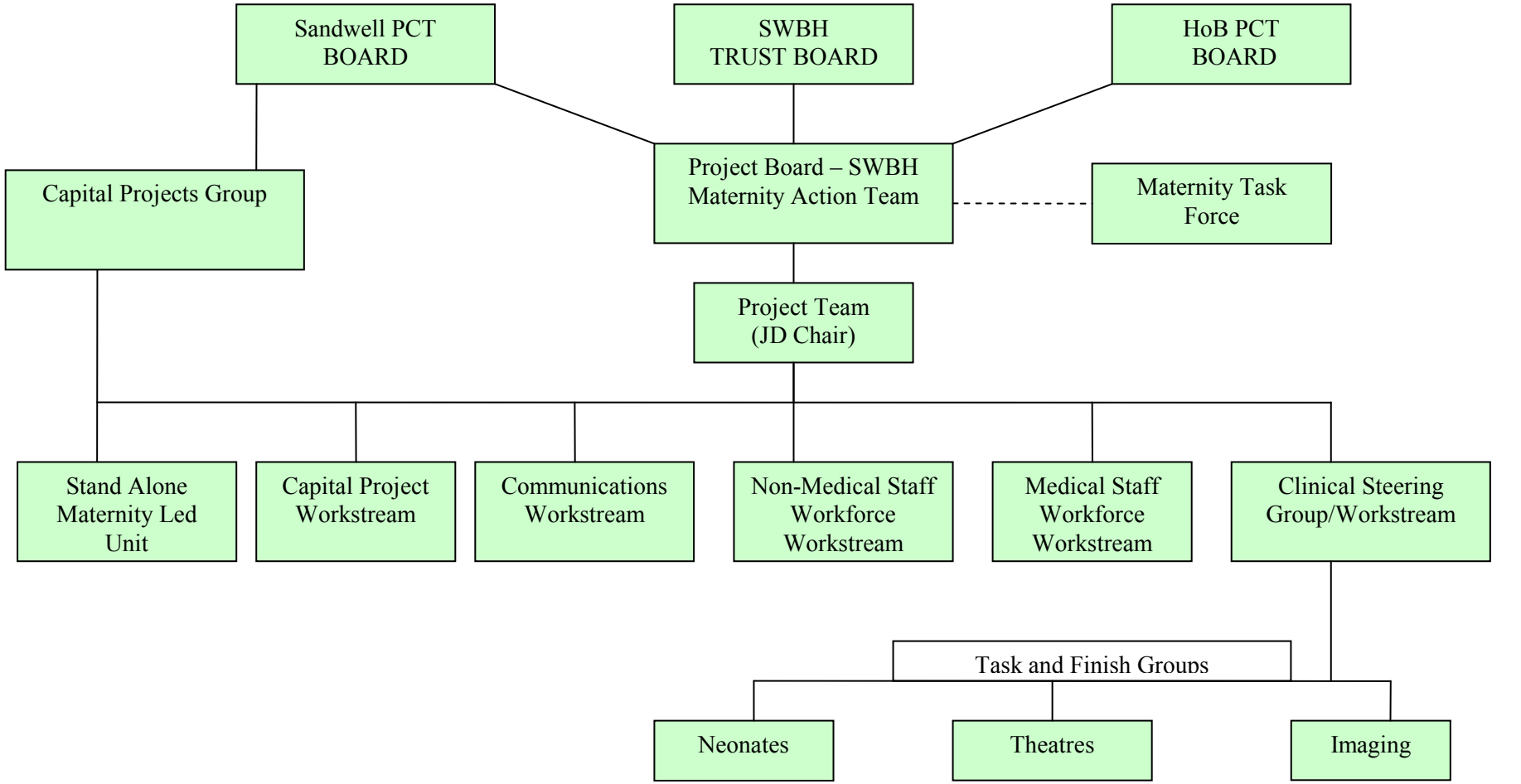
- NOTE progress in developing the implementation plan and key milestones for stage 1.

- NOTE progress with planning the stand alone MLU in Sandwell to be operational in October 2011. The Project Steering Group have identified the preferred location as the Leasowes site with a permanent purpose built facility procured through a third party process by Sandwell PCT. The Sandwell PCT Board will be considering the preferred location and procurement process at their meeting in May.

- NOTE the verbal feedback from the Gateway Review that took place in May 2010.

APPENDIX 1

MEDIUM TERM MATERNITY RECONFIGURATION
PROJECT MANAGEMENT STRUCTURE FOR IMPLEMENTATION PHASE (2)



APPENDIX 2

Sandwell NHS
Primary Care Trust

Medium Term Maternity Services Review

Equality Impact Assessment Report
Phase 1

May 2010

Equality Impact Assessment Report

Contents

1. Background

Why undertake an equality impact assessment?

The requirement to undertake an Equality Impact Assessment is specifically set out within the Race Relations (Amendment) Act 2000, Disability Discrimination Act 1995 and the Equality Act (2006). These pieces of legislation (now consolidated into the Equality Act 2010) require 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 groups with distinct characteristics protected by law and to take appropriate and proportionate action to address issues identified.

Sandwell PCT has an approved approach to equality impact assessments that has been agreed by its Board. This ensures that the commissioning of new services or changes to existing commissioned services is informed by robust equality evidence gathered as part of its equality impact assessment process.

Sandwell PCT has extended the scope of its equality impact assessment process beyond existing 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.

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

1) 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.

2) 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 equality impact assessment of medium term maternity services will assess the impact on groups in terms of:

- Race (ethnicity and language)
- Disability
- Gender and Gender identity
- Age
- Sexual orientation
- Religion and Belief
- Socio Economic Status

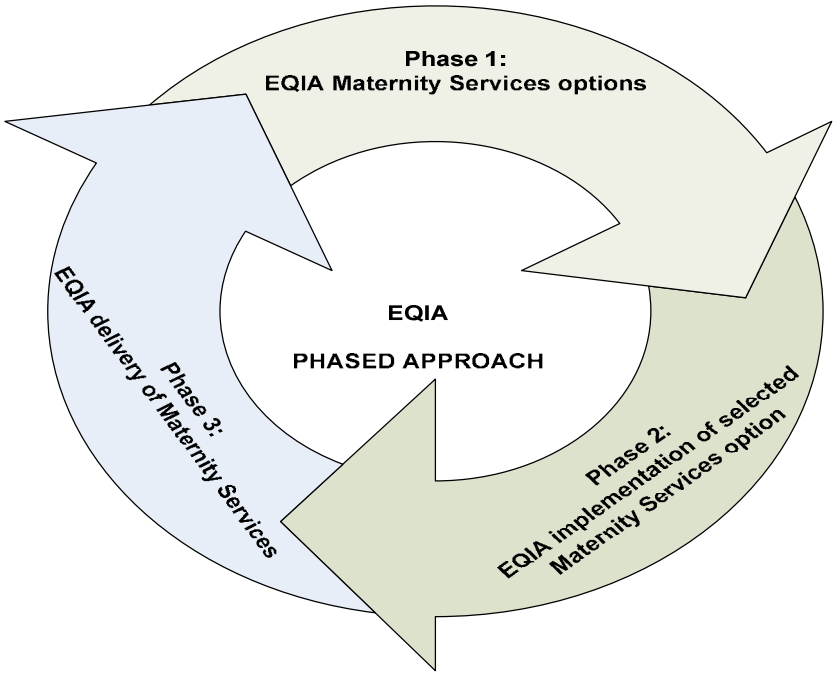
2. Methodology

What is the process for conducting the equality impact assessment?

The programme of work to review, develop, implement and deliver world class maternity services is a major long term change and service development programme with distinct phases. This has necessitated the requirement for the EqIA methodology to support this process and provide evidence that equality has been embedded into each phase of the programme.

The Medium Terms Maternity Services Review Group has identified the requirement to conduct equality impact assessments (EqIA) at each phase of this major service change. The methodology adopted is outlined below with the balance of this report providing evidence of the completion of the EqIA for phase 1.

The diagram below outlines the EqIA methodology for the proposed changes to maternity services.



Phase 1: EQIA of Maternity Services Options
This encompasses the Equality Impact Assessment of the 3 selected maternity options is to ensure that:

1. The choice of options improve and do not worsen existing or create new inequalities in access, outcomes and experience of maternity services for the groups that should benefit.

2. The impact on diverse groups, protected by equality legislation has been considered in the development of the business case for maternity services.

3. Robust evidence of the equality impact of the 3 selected maternity options informs the decision making process for the Boards of Sandwell PCT and Sandwell and West Birmingham Hospitals NHS Trust.

Phase 2: EqIA of the Implementation of the Selected Option
This phase will build upon the equality action plan developed in phase 1 and ensure relevant actions are embedded into the implementation plans for the selected option. The Maternity Re-configuration Implementation Project Team will have responsibility for the completion of Phase 2 of the EQIA, ensuring that stages 5 – 7 of the Sandwell PCT EqIA process are completed. (See table below)

Phase 3: EqIA of the Delivery of Maternity Services
This phase will require Sandwell and West Birmingham Hospitals to monitor access to its service and undertake an assessment, at an agreed and appropriate time. The assessment will evidence the level of impact that the service change has had on the equality groups that were identified through phases 1 and 2 as potentially not receiving the desired and intended benefits. In addition, the EqIA will identify any other potential equality issues arising from the delivery of the new maternity service.

The Equality Impact Assessment will form part of the quality assurance contractual requirements requested by service commissioners for monitoring purposes. Sandwell and West Birmingham Hospitals EQIA Pro-forma and process will be used to undertake this phase of the assessment.

The Equality Impact Assessment quality assurance evidence will be presented to commissioners. This evidence will be used to complete stages 8 – 9 of the Sandwell PCT EqIA process.

Sandwell PCT EqIA Methodology:

Phase	Stage	Action	Responsibility
1	1	Identify the potential impact of the options on diverse groups.	Medium Term Maternity Services Review Project Steering Group
	2	Gather evidence.	
	3	Consult relevant groups.	
	4	Propose actions to address / mitigate the findings of stages 1-4.	
2	5	Review proposed actions from stages 1-4 following Board approval and embed into implementation process and	The Maternity Re-configuration Implementation Project Team

		plans	
	6	Involve relevant groups in developing implementation plan and ensure ongoing consultation and engagement with identified groups	
	7	Implement an equality action plan to address additional issues identified through stages 1 -6 of the assessment.	
3	8	Monitor the impact of the selected options in line with the issues identified in phase 1 and 2.	Sandwell and West Birmingham Hospital (evidence)
	9	Publish the assessment of this monitoring.	Sandwell PCT

3. Beneficiaries

What benefits or impact should all groups expect?

A workshop was held with members of the medium term maternity services steering group to complete stage 1 of the equality impact assessment. The group agreed the following:

1. **The intended beneficiaries of the changes to maternity services proposed by all three shortlisted options are**:
   - Women of childbearing age in the catchment of Sandwell PCT & HOB tPCT areas.
   - Their partners and
   - Relatives.
   - Neonates.
   - Other women.
   - Staff / Workforce.

2. **The benefits that all groups should receive, irrespective of the maternity services option are identified as**:
   - Improved intra-partum care, birthing experience and more control for women.
   - Reduced levels of clinical interventions for low risk pregnancies
   - Appropriate levels of clinical interventions & senior staff input, for high risk pregnancy and emergency clinical presentations; leading to safer care for high risk women and babies.
   - Improved continuity of care.
   - Increase in the "choice portfolio" within the service model of care, with respect of antenatal and intra-partum care.
   - Reduction in risk to neonates.
   - Improved & effective working patterns for staff
   - Increased scope for staff development.
   - Improved range of working practices & opportunities for staff
   - Improved communication for patients and staff

3. **Some groups have experienced differential or disadvantageous impact from existing maternity services**.

   - Details of the groups considered to have experienced differential or disadvantageous impact are provided in the next section.

4. Evidence

Is there evidence to support the steering groups' findings (above) or additional evidence the group should consider?

The collection of evidence to inform the EqIA findings has included:

- A workshop with the medium term maternity services review steering group.
- Consultation and engagement with patients and public.
- Targeted consultation and engagement activity with identified groups.
- Desk top literary research
- Analysis of patient / service user data, health needs assessment data and staff data across Sandwell and the Heart of Birmingham PCT.

Summary:
The evidence indicates a range of benefits of the 3 selected proposed maternity service models to all groups including 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 specialised services. Black and minority ethnic women will benefit from the proposed changes as they are highly represented in high risk groups. Women with low medical risk pregnancy but potentially high level of social need, such as women from lower socio-economic groups will benefit from reduced levels of medical intervention.

It has also revealed distinct benefits for the workforce; through the possibility to extend the variety of experience for all groups within the service models that is likely to be attractive across the age profile of the workforce; thereby having a positive impact on recruitment, retention and succession planning. The ageing workforce is an issue as is the national lack of qualified trained health visitor, nursing and midwifery professionals.

Conversely, the assessment process has also highlighted potential disadvantages or negative impact on patients, service users, carers, their families and the workforce. Disability and Socio – economic status of patients and staff will impact greatly on their ability to access services due to increased costs associated with transportation (to work and to appointments) and caring responsibilities. Black and minority ethnic and 'circumcised' women will have limited choice in place of birth and antenatal care due to the rates of high risk pregnancies amongst these groups. Additionally, there may be a negative impact on women with complex social care needs due to the requirement for greater cross boundary partnership working.

This EqIA has also identified that the steering group has limited evidence about the impact of existing maternity services on travelling communities, disabled groups with sensory impairments, lesbian and transgendered women, new migrant communities (polish) and women that have experienced female genital mutilation (Somali).

As a result, a review of local, regional and national evidence has been undertaken to support the EqIA. The evidence that has been collated is presented below:

Race (Ethnicity and Language)

The positive and negative impact of the proposed maternity options on groups characterised by ethnicity and language has been identified as:

Category	Positive Impact	Negative Impact
Race (Ethnicity & language)	There is greater prevalence of certain conditions in BME groups, therefore these groups will receive increased benefits of proposed changes as they are highly represented in the risk groups identified below: • Diabetes • Tb • HIV • Fetal anomalies [associated with consanguinity]	• In the interim all groups' especially emerging / new migrant communities will lose local access to maternity/birthing services in Sandwell. • Some BME Groups have expressed Sandwell Hospital as their preferred "choice" place of birth. • Impact on travelling communities has not yet been quantified. • Geographical location may lead to access challenges, where travel outside of Sandwell may be implicated.

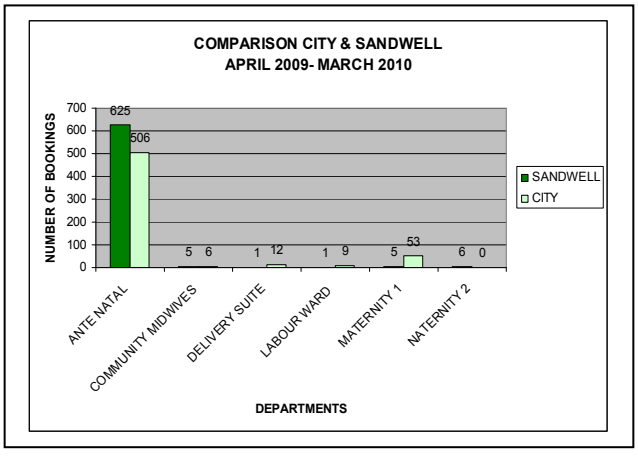
The evidence underpinning these findings is provided below:

Ethnicity

A rich level of diversity exists within the populations of Sandwell and the Heart of Birmingham. In Sandwell, 20.3% of the population is from Black and Minority Ethnic groups; by contrast, the Heart of Birmingham has the largest Black and Minority Ethnic population amongst all PCTs in the country, representing 68% of the population.

Language

There are over a hundred different languages spoken within both PCT areas. In response, both PCTs have interpreting and communication services in place that enable service providers to book interpreters for pre-booked appointments. Both trusts offer interpreter bookings up to 24hrs in advance. Heart of Birmingham PCT has access to in-house interpreters, whilst Sandwell PCT contracts with freelance interpreters. Both interpreting services use external agencies to provide language and BSL interpreting services when in-house or freelance interpreters are not available.



Between March 2009- April 2010, Sandwell and West Birmingham hospitals booked 1224

interpreter sessions for antenatal and maternity service patients across both hospital cites. The majority of bookings were for interpreter support within Sandwell hospital.

According to a Skill for life survey (2003), 1 in 5 adults in the Heart of Birmingham area can only read and write English to a pre-GCSE standard (entry level).

Migration
The diverse populations of both PCT areas include migrants who will have recently entered the UK. Migrants are not a homogenous group and include economic migrants, asylum seekers, refugees, refused asylum seekers, illegal immigrants and individuals who entered the UK with visa clearance for study, tourism, visiting family, employment or marriage.

Nationally, outcomes for migrant women are known to be poorer than for the indigenous population of England and Wales. In 2007, the highest infant mortality rates in the region were in women born in Pakistan, with 9 infant deaths per 1,000 live births. Other groups with high infant mortality rates in the UK are women born in Africa (excluding East Africa) with 7.9 per 1000; New Commonwealth with 6.5 per 1,000; East Africa with 6.2 per 1,000; Bangladesh with 5.6 per 1,000 and Caribbean with 5 per 1000.[1]

Gypsy and Travellers
Both Sandwell and Heart of Birmingham have sizeable gypsy and traveller communities, though official UK or local figures are not known. Gypsy and Travellers are not a homogenous group and have different languages but share a common cultural identity. There have been a number of reports produced identifying health issues for this group. Inability to access antenatal services was identified as a contributory factor to maternal deaths (Why Mothers Die 2002); excessive prevalence of miscarriage, still births and neo-natal deaths was reported by Parry et al (2004)[2] ; poor access to maternity services and lack of continuity of care for those who are highly mobile was identified in a report on Maternity Services and Travellers (2006).

Recessive Gene Disorders
The prevalence of recessive gene disorders in certain communities has been identified as the most likely explanation for higher levels of congenital abnormalities in some ethnic or religious groups within the PCT boundaries. Consanguinity ie marriage with close relatives or within an extended family is evident in some ethnic or religious groups. Whilst consanguineous couples will have the same risk of congenital abnormality as the general populations; where there is a history of genetic abnormality due to recessive gene disorders, couples at risk have a 1 in 4 risk of an affected child in each pregnancy.

Risk Prevalence
Certain BME communities have higher risk prevalence to certain conditions such as diabetes, Tuberculosis, HIV and Fetal Anomalies. Substantial national and local evidence exists on these issues, and for this purpose it has not been replicated here.

Workforce
As of January 2010, Sandwell and West Birmingham Hospitals employed 62 medical staff in Obstetrics and Gynecology and 51 in Nursing and Midwifery roles across both cites. The majority of obstetrics and gynecology staff are Asian (43.5%) and White (37%). The majority of

[1] Office for National Statistics
[2] The Health Status of Gypsies and Travellers in England, Parry et al (2004) Department of Health.

nursing and midwifery staff employed at Sandwell classify themselves as White (57.6%) compared to 44% at City hospital. The largest non-white groups at Sandwell are black groups representing 27% of all staff. The Indian (12%) ethnic group is the largest non-white group in City hospital; however, over a third of staff at City hospital have not disclosed their ethnicity.

Sandwell:

Communities

In Sandwell, the Indian (9.1%) group is the largest non white minority ethnic group followed by Black Caribbean (3.3%). In addition, over 50% of mixed groups and 40% of the Pakistani and Bangladeshi groups are under the age of 20, in comparison to 25% of the white population. These groups will require access maternity services in the future.

The picture of racial diversity varies across the wards in Sandwell with the greatest concentrations of black and minority ethnic communities in the East and centre of the borough in the wards of Smethwick, Soho and Victoria, St Paul's and Central West Bromwich at between 40-55%; the greatest concentration of white groups are in the West of the borough in the wards of Friar Park, Princes End, Rowley, Tividale, Black Heath, Cradley Heath & Old Hill at between 90-95% of the populations.

The ethnic profile of Sandwell is changing rapidly. By 2029, the BME population of Sandwell will have grown to be 30% of the population. The largest increases are in the Bangladeshi, and Pakistani populations that double in size due to a higher birth rate[3].

The impact of migration is an issue within Sandwell. There are over 2,000 people newly registered with GPs (1.3% of the total population from Poland), with data from National Insurance registrations that show 2,070 people from Poland registered to work in Sandwell in the last two years. These new residents are predominantly of working age although there are substantial proportions of younger people

The best data on the difference in health states of our ethnic populations is from admissions to hospital. This is the only part of the health system where the collection of a person's ethnicity is above 90%. When the data for Sandwell residents is examined by ethnicity by admission method, the BME communities have the highest maternity admissions. The White population have a higher COPD ratio but the BME communities have higher asthma ratios, reflecting the different age profiles. Diabetes admissions are higher in the BME populations than in the White population

Patients and Service users

Nearly 40% of all births in Sandwell are to Black and Minority Ethnic women. The largest groups are Indian (13.4%) and Pakistani (8.8%). Approximately 23% of all births are to women born outside the United Kingdom, the majority from Pakistan, India, Bangladesh and Jamaica. Between the periods 2002–05, there have been sizeable increases in the numbers of births to mothers born in Poland, Nigeria, Philippines and Somalia.[4]

[3] Sandwell Joint Strategic Needs Assessment V6 2008
[4] M-Connect 2008

Birth weight is a strong indicator not only of a birth mother's health and nutritional status but also a newborn's chances for survival, growth, long-term health and psychosocial development. In Sandwell over one in ten babies are less than 2.5kg, compared to less than one in 12 across England. Ethnicity is considered a contributory factor.

Heart of Birmingham

Communities

The ethnic profile of wards within the Heart of Birmingham varies considerably, with pockets where the communities are largely White – Oscott (90%), Perry Barr (70%) and Ladywood (60%) and wards where the communities are largely black and ethnic minority, such as Soho, Aston Sparkbrook and Lozells with 70 – 85% of the populations.

Patients and Service Users

In 2007, 85% of all babies were born to women whose ethnicity was non European. 1 in 3 mothers have Pakistani ethnicity, and about 1 in 10 are Bangladeshi and with similar numbers of Indian mothers. About 1 in 5 mothers are African or African – Caribbean.

Across the West Midlands in 1997-2005, African Caribbean and Pakistani women had significantly higher infant mortality than European women, and Indian women had a non-statistically significant higher infant mortality rate. Many infant deaths are associated with prematurity and congenital abnormalities; when these are excluded Pakistani and Indian women no longer have an increased risk of infant death than European women. However, infants of African Caribbean women continue to have a significantly increased risk of death.[5]

The population of Heart of Birmingham PCT is mobile and diverse. In 2007, 55% of infants were born to first generation migrant mothers. The largest concentrations of new mothers are women born in Pakistan (19%), New Commonwealth (11%) and Bangladesh (6%). [6]

Infant mortality rates for Heart of Birmingham by maternal country of birth indicate that the highest rates of Infant mortality are not from women born in Pakistan, but those born in the 'Rest of the World'.[7]

More infants in the Heart of Birmingham die or suffer serious disability as a result of congenital abnormalities than other regions in the West Midlands. [8] It is estimated that more than 12 per 1000 conceptions in the Heart of Birmingham have recessive disorders, compared to just over 4 per 1,000 conceptions in Sandwell and the Strategic Health Authority region. In the PCT, congenital malformations cause around 18 infant deaths per year, 12 deaths could be prevented by reducing genetic risk in the population.

Around 300 women in the HoB region continue to smoke during pregnancy and rates in White/European women are very high. Evidence from the Perinatal Institute in 2007 identifies that 34% of white/European women continue to smoke at delivery, compared to 14% African/Caribbean and 2% Asian women. Additionally, some women who claim not to smoke

[5] Perinatal Institute (2005) Stillbirth and infant mortality, West midlands 1997-2005: Trends, Factors, Inequalities.
[6] Office for National Statistics
[7] Office for National Statistics
[8] Based on data originally collected as part of the Birmingham Birth Study . Bundy,S. & Aslam.(1993)

present with high carbon monoxide readings related to Shisha smoking. The exact rate of Shisha smoking in pregnant women is not known.

`Many women who died, particularly the vulnerable and socially excluded, found it difficult to access or maintain access with the services, and follow-up for those who failed to attend was poor. Inadequate translation services for those who could not speak English were also a recurring feature'.
Why Mothers Die 2002

Disability

The impact on disabled groups of the proposed maternity options is identified below:

Category	Positive Impact	Negative Impact
Disabled groups	All 3 selected options are likely to have a positive impact: • For those with complex care needs. • For those with physical disabilities as the environment will become fully DDA compliant. • Disabled access in MLU [is not currently available] • Patients with Mental ill-health and/or Learning Disability will receive all the benefits options propose, resulting in overall better care and birthing experience. • Increased access to MLU post delivery as appropriate. **(option 1 / 2 / 3)**	• Travelling to access antenatal specialist services. **(option 1/ 2 / 3)** • Travelling for disabled partners. **(option 1/ 2 / 3)** • Inadequate number of disabled parking spaces. **(option 1/ 2 / 3)** • Mental Health - potential issue in terms of: o Continuity and consistency of care. o Experience immediately post birth [mother and baby unit] not addressed within the portfolio of options. **(options 1 / 2** • Needs also exist for improved integrated pathways and community management. **(options 1 / 2)** • The impact on service users with sensory impairment has not been defined and requires further consultation.

The evidence underpinning these findings exemplifies a national concern in terms of poor disability data collection.

Definition
Disability is described by the Disability Discrimination Act (1995) as 'A physical or mental impairment which has substantial and long term adverse effect on a person's ability to perform normal day to day duties'.

Research
The Disability Discrimination Act (DDA) 1995 identified the most significant barriers for disable people's access to NHS services to include:

- Inappropriate attitudes, behaviour and lack of disability awareness of NHS staff

- Poor access to services
- Unmet communication needs
- Inadequate or inappropriate help from carers.

A recent UK study funded by the Department of Health[9] on physically disabled parents' experiences of maternity services reveals that these barriers are equally relevant to maternity services. It reveals that physically disabled people embarking on parenthood face a number of challenges. In addition to working to provide the best start for their babies before and during pregnancy, through birth and into parenthood, they often also face a challenge in getting appropriate information and support to enable them to plan and prepare for birth.

The study highlighted concerns by disabled parents as to:

- Lack of continuity of care by midwives during ante-natal and post-natal periods
- Hidden disabilities being overlooked
- Persistence of negative attitudes towards disabled people
- Lack of appropriate information on pregnancy, child birth and parenting for disabled people.
- Opportunities to exercise choice restricted due to disability
- Being considered 'high risk' because of being disabled.
- Lack of disability friendly environments

A report by the Disability Rights Commission[10] indicated that people with mental health problems have higher rates of obesity, smoking, heart disease, high blood pressure and respiratory disease, diabetes, stroke and breast cancer than other citizens. Individuals with Learning disabilities will have higher rates of obesity and respiratory disease and high levels of unmet needs.

Patients and Service users

Accurate statistics on disability service users within both PCT boundaries are not routinely available. Data is difficult to collect as unlike fixed characteristics such as ethnicity, a person may become disabled at any point during their lifetime. Within the UK, 10.8 million people describe themselves as disabled, however, it is estimated that the actual figure is much higher as many people who fit within the DDA definition, may not view themselves as disabled. There are 1.7million disabled parents in the UK (Morris and Wates 2006) and only 17% of disabled people are born with an impairment. Twenty per cent of those with a disability are under age 45. Research highlights that 24% of deaf or hearing-impaired people miss appointments, and a further 19% miss more than five appointments because of poor communication.

Data on the numbers of patients with Long Term Conditions (LTC), may offer an indication of levels of disability and perceived need within both PCT patient boundaries. The levels of long terms illness in the Heart of Birmingham is higher than the national average for England. At least 1 in 5 adults in HoB report a limiting long term illness which restricts their daily life. In addition, chronic disease registers managed by GPs under the Quality Outcomes Framework indicate over 75,000 entries with Long Term conditions (excluding Mental Health), accounting for an estimated 29,000 people. It is estimated that 60% of patients with LTC are over the age of 65.

[9] Empowering parents (2009), Disability, pregnancy and parenthood International 2002-09
[10] Closing the Gap (2004), Disability Rights Commission

Gender and Gender Identity

The impact on men and women of the proposed maternity options is identified below.

Category	Positive Impact	Negative Impact
Gender	• The principle beneficiary will be women. • Increased range of opportunities & career development for midwives with associated positive impact on women. • Trans-gender [presenting male with female organs] – no differential impact. • Standardised training, use of policies & protocols and practical application in the work setting	• Geographical impact on travelling for partners, carers and extended families. **(options 1 / 2 / 3)** • Network of women with Sandwell as their preferred choice, will need to be addressed. **(option 1 / 2)** • Staff with childcare/dependent responsibilities may be disadvantaged by changes to base of work. **(options 1 / 2 / 3)**

The evidence underpinning these findings is provided below:

Patients and Service Users
Just fewer than 10,000 babies were born to women registered with GPs in Sandwell and Heart of Birmingham PCT during 2007 – 08. Proposed changes to current services will have positive impacts on women who use the new improved services as they are aimed at addressing gaps in current service provision.

There are concerns and Issues for patients and service users related to travelling and caring arrangements. These issues are linked to socio-economic status rather than Gender and will be considered in the related section.

Staff
As of January 2010, Sandwell and West Birmingham Hospitals employed 62 medical staff in Obstetrics and Gynecology and 51 in nursing and midwifery roles across both cites. The majority of obstetrics and gynecology staff are Women (61%), data for nursing and midwifery roles was not available.

Religion and Belief

The impact on groups in terms of religion and belief is identified below:

Category	Positive Impact	Negative Impact
Religion and Belief	All 3 options proposed, support the cross fertilisation of knowledge of diverse faiths and experience amongst the workforce **(options 1 / 2/ 3)**	• Female Circumcision / Genital Mutilation [FGM] – o Service users will not have choice in place of maternity care **(option 3)** o Sandwell staff may require training to recognise and refer patients with FGM. o There is a perception by service users that staff of City have the more knowledge & experience of FGM.

Communities

Diversity in culture, religion and belief influences health care beliefs and practices amongst Sandwell and Heart of Birmingham's diverse communities. All 3 maternity service options are considered to have a beneficial impact on the cross fertilisation of knowledge and experience amongst staff and service users.

Within Sandwell 70% of the population (2001 census) classify themselves as Christian, 7% Sikh, 5% Muslim and 2% Hindu. In contrast, within the Heart of Birmingham there is no overwhelming majority religious group, with 44% of the population (2001 census) classify themselves as Christian, 25% Muslim, 8% no religion and 7% Sikh. This data does not take into account the changes in the population profile of both areas since 2001, especially within Birmingham as a result of recent migration.

It is important to note, that not all faiths are homogenous, and there are various denominations with different traditions of interpretation, ritual and practices, moral guidelines and rules. There are also varying levels of personal compliance ranging from nominal to strict observance.

Female Circumcision/ Genital Mutilation (FGM)

The World Health Organisation (2000) defines FGM as procedures involving the partial or total removal of the female external genitalia or other injury to the female genital organs for cultural, religious or non therapeutic reasons**.** Worldwide, 100 million to 140 million girls and women have undergone some form of FGM, the majority from Africa and an estimated 2 million or more undergo some form of FGM every year worldwide. In Somalia, where between 90% to 98% of women are infibulated, one in every 100 women giving birth dies as a result of this procedure.

In the UK 86,000 women and female children, mostly first-generation immigrants, refugees and asylum seekers living in Britain, are estimated by FORWARD (Foundation for Women's Health, Research and Development) to have undergone FGM). Around 3 - 4,000 FGM acts may be performed each year (Powell et al., 2002). A further 7,000 children and adolescents under 16 are at risk annually. They are often taken to their countries of origin so that FGM can be carried out. FGM is illegal in the UK.

Whilst accurate statistics about women who have undergone FGM in both PCT areas is not available, there is growing concern amongst communities (where FGM occurs) and health professionals about its impact on the health of women, especially during pregnancy and childbirth.

FGM is often erroneously linked to Islam and is practised in some communities where Islam predominates. Some Muslims consider that Islam demands the practice to ensure spiritual purity, although many Islamic scholars disagree with this stating that FGM is not mentioned in the Qur'an. However, it is clearly a ritual practice that predates the Prophet Mohammed and the Islamic religion. FGM transcends religious, racial and social boundaries (Webb, 1995). A minority of followers of other faiths, Christians, Animists and Jews practise it (Maurad and Hassenein, 1994).

There are 4 known classifications of FGM:

1. Excision of the prepuce (the fold of the skin surrounding the clitoris), with or without excision of part of the entire clitoris.
2. Excision of the clitoris with partial or total excision of the labia minora (the smaller inner fold of the vulva).
3. Excision of part or all external genitalia, and stitching or narrowing the vaginal opening (infibulation)
4. Unclassified, which includes pricking, piercing or incising of the clitoris and/or labia; cauterisation by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the opening of the vagina (angurya cuts) or cutting of the vagina (gishiri cuts): introduction of corrosive substances or herbs into the vagina to cause bleeding or to tighten or

narrow the vagina; and any other procedure that can be included in the definition of female genital mutilation.

Type 3 FGM (infibulation) can cause particular dangers in childbirth including, prolonged or obstructed labour and perineal laceration due to tough, unyielding scar tissue. Clitoridectomy (type 1) does not usually cause obstruction unless there was infection at the time of mutilation. Similarly, the neonatal problems occur mainly because of obstructed or prolonged labour which, if unchecked, can cause fetal distress, anoxia (lack of oxygen to the body's tissues) and fetal death.

The Royal College of Nursing educational resource on FGM for midwives and nursing staff (2006) identifies the need for raising awareness about the socio-cultural, ethico-legal, sexual health and clinical care implications involved in FGM as essential. It emphasises that education and training needs to be provided for all health and social care professionals who may work with affected women and girls and with their families. It is also important to consider the issues of ethnicity, custom, culture and religion in a sensitive manner. Professionals should explore ways of resolving problems about the continuation of this practice in ways that involve clients with their full participation.

Age

The impact on groups in terms of age is identified below:

Category	Positive Impact	Negative Impact
Age	• Options impact positively on all women of childbearing age. • Teenage pregnancy – No change in level of community support available. – High risk teenage pregnancy will have increased access to specialist services. – Low risk teenage pregnancy will benefit from improved continuity of care and access to MLU. • Older women 35+ benefit from improvements in specialist services. • Variety in service model will be attractive to the full range of Staff age profile, across Sandwell & City. • Changes in working practices, likely to be more attractive to younger staff. • No differential for neonates. Positive implications for babies born at 34 weeks + with increased access to neonatal services andunit.	• Additional travel for teenage parents. • Potential impact and consequence for travel for partners, supporting parents and relatives • Travel for intra-partum care/births **Staff** • 40% over 45yrs & increased likelihood of retire @ 55yrs. • Changes in working practices [shift from medical to social engagement] impact re requirement in change in mindset, working practices and training. • National concern regarding lack of sufficiently trained midwives and subsequent recruitment, retention and succession planning.

The evidence supporting these findings indicates that:

Teenage Pregnancy

In the West Midlands in 1997-2005, infants of mothers aged under 20 were almost 1.2 times as likely to die in infancy than infants to mothers aged 30-34. A

separate review of existing research suggests that babies of mothers under 18years old are twice as likely to die. [11].

In 2007, there were 129 births to teenage mothers in the Heart of Birmingham and halving pregnancy rates in the area is estimated to prevent one infant death per year. Teenage pregnancy remains high in Sandwell, having not come down significantly in the last 10 years with 80% of teenage births to 15-19 year olds from White groups.The rate of teenage pregnancy in Sandwell is 62.2 per 15-17 year old women, compared to 41.3 per 1,000 across rest of England. The wards with the highest rates, in 2003-5 the most recent period for which data was available are Princes End (108.5 per 1,000) and Tividale (92.0). The 'other' ethnic group accounts for 7% of births followed by Black Caribbean groups at 4% of all teenage births. [12]

The cost of travel and child care for teenage parents is an area of concern highlighted in the assessment. This will be considered in the section on socio-economic status.

Workforce

A national shortage of health visitors will have an impact upon recruitment and retention rates, especially as current staff enter retirement age. Additionally, changes to existing patterns of working may place greater pressures on staff roles and responsibilities.

[11] Heart of Birmingham PCT Public Health Report 2009-10 (2010)
[12] Sandwell CMDS 2008

Sexual Orientation

The impact on lesbian, gay, bi-sexual and trans groups is identified below:

Category	Positive Impact	Negative Impact
Sexual Orientation	No differential impact was identified **(options 1 /2 3)**	• Perceptions of staff towards same sex couples • Access to staff training **(options 1 / 2 / 3)**

There is lack of evidence of the impact of maternity services on Lesbian, Gay, Bi-sexual and Trans groups as data is not routinely collected. No differential impact of the proposed changes has been identified for LGBT women using ante-natal and maternity services.

Evidence does however support concerns that staff attitudes, perceptions and behaviour towards same sex couples may have a negative impact on LGBT groups; this is closely linked to the opportunities for staff to access training. The Department of Health (2007)[13] identified concerns of LGBT groups that healthcare workers may refuse or limit partners visiting rights or refuse to involve them in discussions about their care and treatment.

Community
There are an estimated 3.6 million LGBT people in the UK who form approximately 5% of the total UK population. LGBT people demonstrate higher rates of anxiety and depression than heterosexuals and lesbians and bi-sexual women may be at more risk of substance dependency than other women.[14] This has a significant impact on the health of both mother and baby.

National research shows that discrimination has a negative impact on the health of LGBT people in terms of lifestyles, mental health and other risk factors. Many will suffer discrimination, harassment and victimisation as a result of their sexual orientation. Equally, homophobic bullying is an increasing problem in schools and between 30% and 50% of young people attracted to people of the same sex will have directly experienced homophobic bullying. Recent research indicates that only 25% of older LGBT people believe that health professionals are positive towards LGBT people.

[13] Improving access to health and social care for LGBT people (2007), Department of Health
[14] Meyer, IH (2003) Prejudice, social stress and mental health in LGB populations.

Socio-Economic Status

The impact on groups in terms of Socio- Economic status is identified below:

Category	Positive Impact	Negative Impact
Social Economic	Individuals from lower socio-economic groups, have a greater proportion of high level needs, are therefore likely to receive greater benefits from proposed service models. • High social risk & low medical risk likely to benefit greatest. **(options 3)** • Individuals affected by low socio economic factors, are less likely to have support for births & will benefit from access to Midwifery Led Unit. [MLU] **(option 3)** • Cultural norms and uptake of home births varies amongst the small scale communities. Options provide scope for increased choice/access/ benefit from Midwifery Led Unit. **(option 3)**	All 3 options will have a disadvantageous impact in terms of: • Increased costs and travel times and to access services. • Routing of public transport may disadvantage groups where direct routes are not available. • Information & communication of changes to significant proportion of population with low levels of literacy rates;. • Women with complex social backgrounds i.e. social services may result in negative impact on cross boundary access to partner services. **Staff –** • Implication for commuting arrangements and travel times. • Literacy levels amongst lower level banded workforce my become apparent during change management process and impact on re-deployment options. • Implications for those with responsibility for dependents ie cost of childcare and travel. **(Options 1 / 2 / 3)**

The evidence is presented below:

Sandwell
Sandwell is the 14th most deprived local authority in England. 15 of its wards fall into the most deprived 10% nationally. The eastern side of Sandwell is the most deprived. Across Sandwell there is a wide variation in life expectancy. A man in Tipton can currently expect to live to 73, whilst one living in Oldbury Town can expect to live to 76.5, three and a half years longer. For a woman the difference is even greater. A woman in Tipton can currently expect to live to 78.2 years, whilst one in Oldbury Town can expect to live to 82.2 years a difference of 4 years.

The most common population group in Sandwell are those who are 'upwardly mobile families living in homes bought from social landlord's (27.3%) and those in 'close knit, inner city and manufacturing communities' (24.0%). Both of these groups are found in far higher percentages than the rest of England.

There are strong links between health and work: A person's health affects their ability to get a job and keep it. Many people who end up on benefits have a health condition. There is also growing medical evidence that working is usually good for people's health. Sandwell has considerably less people employed than the rest of the country. Only two-thirds (66.4%) of the people of working age are in employment, compared to three quarters (74.3%) across the rest of the country. More of those economically inactive want a job, 18.4% of men and 29.3% of women.

People in Sandwell are amongst the lowest third for pay in Great Britain. The average full-time worker in Sandwell earns £70 less a week than the average. The average hourly pay is £1.55 below the average. Just over one in five people (22.1%) in Sandwell work in manufacturing, unlike the rest of Great Britain where it is just over one in ten (10.9%). Many people in Sandwell work in Elementary occupations (14.5% compared to 11.4% across England) and Process, Plant and Machine Operatives (7.1% compared to 13.4% across England). There are far fewer people working in the professional and managerial occupations.

Almost one in five of the working age population are defined as being out of work and on benefits (Job seekers allowance, lone parents on income support, incapacity benefit claimants, others on income related benefits) compared to 11.8% across England. Sandwell has a far higher percentage of the working age population on Incapacity Benefit (IB) than its peers with nearly one in ten people claiming. The percentage claiming has not changed over the last six years, both in Sandwell and nationally

Heart of Birmingham
The neighbourhoods that make up the Heart of Birmingham are particularly deprived. Two thirds of residents (200,000) live in neighbourhoods classified as amongst the fifth most deprived (worst 20%) in the country. Nearly 80% of

households in the area are characterised by low income, high unemployment, high deprivation, large Asian families living in semi detached or private rented terraced housing, or single young persons living in social housing estates.

Life expectancy in the area is improving, with both men and women living over 2.5yrs longer than they did 10 years ago. However, life expectancy for men in the area is still 3.75 years less than the rest of England. There is variation in life expectancy amongst wards, with women in Perry Barr expected to live 6 years longer than those in Nechells.

Unemployment rates are higher for men in the area and recent data suggests that unemployment in the PCT area has risen by 24% during February 2008 – 09. Of those who work, more families in the area earned incomes less than £20,000, with few earning incomes over £37,000. High proportions (26%) of people in the area have semiskilled manual occupations. Around 16,000 PCT residents claim incapacity benefit, many of whom have mental health problems.

Travel and Transportation

The connections between transport and health are multiple, complex, and socio-economically mixed. Poorer families tend to have lower mobility and research indicates that over a twelve month period, 1.4 million people fail to attend, turn down or choose not to seek medical help because of transport problems (SEU, 2002). There are also an estimated 9.5million disabled people of driving age in the UK and this figure is expected to increase[15].

A study on social exclusion transportation in New Deal areas highlighted that car owners are at a considerable advantage. Only if public transport was "adequate", would it be possible for the occupants of the New Deal areas to access centralised health and shopping facilities without a disproportionate expenditure of both of time and money[16].

The study focused on "socio-spatial" exclusion, i.e. the concentration of social categories excluded in certain "deprived neighbourhoods". In these areas, while it is clearly not possible to establish a direct line of causation between "social exclusion" in a general sense, and transport, it is quite clear that the two are connected. Where transport is good, and people can easily leave the depressed area to go about their business, however, If transport were better, the spiral could be more pronounced. But if jobs and services - including, crucially, financial facilities - were locally available, many of the existing transport systems, with few improvements, might prove sufficient**.**

[15] Tong et al (2007). Data gathering on disability and driving statistics. Department for Transport
[16] Social inclusion and the provision of Transport (2007). Department for Transport

Research over the years has consistently highlighted that women's feeling of vulnerability and concerns for personal security restrict the places and times that they travel. According to the Department for Transport research carried out in 2002 into *People's perceptions of personal security and their concerns about crime on public transport* (2004), while men still tend to be more positive than women about their personal security on public transport, the gender differences have reduced slightly in recent years. In 1996 39% of women described themselves as public transport users with no fears for their personal security. This increased to 43% in 2002. In contrast, for men this decreased from 56% in 1996 to 47% in 2002.

Young men and women tend to mirror their adult counterparts in terms of the locations in which they feel unsafe. Similarly, perceptions of black and minority ethnic transport users reflect the same gender patterns in terms of daytime/ darkness and perceptions of security of the different modes of transport as their white counterparts. [17]

Bus use is highest for 17-20 year olds, accounting for 16% of trips in this age group. Car availability is strongly related to income. In 2005, 53% of households in the lowest income quintile had no car compared with 10% in the highest income quintile. The proportion of households in Great Britain without access to a car fell from 30% to 25% in 2005. In 2005 84% of men lived in a household with a car, compared with 78% of women.

[17] Gender Auditing Guidance (2002) Mobility and Inclusion Unit Department for Transport

Involvement and Consultation

Who has been involved in this EqIA?

The Eqia has involved members of the Medium Term Maternity Services Review Steering Group.

Name	Role	Organisation
Andy Williams	Director Of Commissioning (SRO phase 1)	Sandwell Primary Care Trust
Jayne Dunn	Redesign Director, Right Care Right Here. (Project Director Phase2)	Sandwell and West Birmingham Hospitals NHS Trust
Gillian Gadd	Service Redesign Manager. (Project Manager)	Sandwell and West Birmingham Hospitals NHS Trust
Janine Brown	Joint Director of Partnership and Commissioning (Project Director Phase1)	Sandwell Primary Care Trust
Jayne Salter-Scott	Patient and Public Involvement and Service Modernisation Manager (consultation lead)	Sandwell Primary Care Trust
Elaine Newall	Head of Midwifery	Sandwell and West Birmingham Hospitals NHS Trust
Paul Bosio	Clinical Director and Consultant	Sandwell and West Birmingham Hospitals NHS Trust
David Coles	Senior Commissioning Manager	Sandwell and West Birmingham Hospitals NHS Trust
Shirley Weston-Hayles	Strategic Commissioning Manager	Sandwell PCT
Saba Rai	Head of Equality and Diversity	Sandwell PCT

Which groups have been consulted?

Essential to carrying out an EqIA, is the involvement of and consultation with relevant groups. Attached is an extract from the public consultation report by Merida Associates:

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.

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.

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.

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.

- 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 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%
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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

What has been the outcome of the involvement and consultation activity?

The outcome of the steering group consultation activity has informed the development of a robust consultation and engagement plan with target groups.

The outcomes of the public engagement and consultation activity have been embedded into the equality action plan for Phase 2 implementation.

What further consultation is required?

No further consultation is required for this phase of the service change.

4. Monitoring and Publication

Monitoring
Responsibility for monitoring the EqiA action plan will rest with:

The Maternity Re-configuration Implementation Project Team

Publication
The findings of Phase 1 of the EQiA will be published on 27th May 2010 at the Sandwell PCT Board Meeting.

Copies of the EqIA report will be available from 28th May 2010 on the Sandwell PCT web site. Hard copies can be made available upon request by contacting Sandwell PCT Communications Department.

5. Equality Action Plan

How will the issues identified by the EqIA be addressed?

CONSULTATION ACTION PLAN					
EqIA Issue	**Equality strand**	**Proposed Action**	**Time scales**	**Lead**	**Resource implications**
Strengthen and extend the consultation and engagement plan	Race, disability, gender, socio-economic group	To extend the current consultation plan to include groups identified by the EQIA	COMPLETED 19th January 2010	Jayne Salter Scott PPI Manager. Sandwell PCT	to be confirmed
Disseminate consultation and engagement findings to all groups	All groups	Disseminate outcomes.	June 2010	Jayne Salter Scott PPI Manager. Sandwell PCT	to be confirmed

IMPLEMENTATION ACTION PLAN					
EqIA Issue	**Equality Strand**	**Proposed Action**	**Time scales**	**Lead**	**Resource Implications**
COMMUNICATION					
Consider the needs of	Disability	To be completed by the Phase 2	31st May	Jayne	To be

IMPLEMENTATION ACTION PLAN					
EqIA Issue	**Equality Strand**	**Proposed Action**	**Time scales**	**Lead**	**Resource Implications**
disabled service user groups, ensuring appropriate access to information and opportunities to exercise choice.		project group	2010	Dunn, Phase 2 project director	confirmed
Take account of literacy levels when developing information and communications	Socio-economic groups	To embed requirement into the information and communication strategy			to be confirmed
Sandwell hospital as preferred 'choice' for place of birth	All	To be completed by the Phase 2 project group			
CONSULTATION AND ENGAGEMENT					
Ensure implementation projects involve representatives from target groups.	all target groups	To be completed by the Phase 2 project group		Phase 2 project director	to be confirmed
Ensure on-going consultation and engagement with groups identified within the EqIA	All target groups	To be completed by the Phase 2 project group			
TRAVEL AND TRANSPORTATION					
Ensure the needs of diverse group identified in the EqIA are considered in travel, transportation	Socio Economic status, Disability	To be completed by the Phase 2 project group		Phase 2 project director	to be confirmed

IMPLEMENTATION ACTION PLAN					
EqIA Issue	**Equality Strand**	**Proposed Action**	**Time scales**	**Lead**	**Resource Implications**
and parking plans					
WORKFORCE TRANING, DEVELOPMENT & SUPPORT					
Ensure staff training across sites considers RCN guidance for: gypsy and travelers		To be completed by the Phase 2 project group		Phase 2 project director	to be confirmed
Ensure staff training across sites considers RCN guidance for: Female Genital Mutilation		To be completed by the Phase 2 project group			
Ensure workforce plans consider childcare and caring responsibilities of staff moving between locations		To be completed by the Phase 2 project group			
Ensure diversity of workforce reflects the diversity of service users.		To be completed by the Phase 2 project group			
Implement robust training on equality and diversity		To be completed by the Phase 2 project group			
DATA COLLECTION AND MONITORING					
Equality data collection is undertaken across all equality strands, capturing data on staff and service users		To be completed by the Phase 2 project group		Phase 2 project director	to be confirmed
CONTINUITY OF CARE					

IMPLEMENTATION ACTION PLAN					
EqIA Issue	**Equality Strand**	**Proposed Action**	**Time scales**	**Lead**	**Resource Implications**
Consider cross boundary issues for people with complex social care / services needs.	Socio-economic status	To be completed by the Phase 2 project group		Phase 2 project director	to be confirmed
Ensure continuity and consistency of Care for groups with mental health and disabilities.	Disability	To be completed by the Phase 2 project group			

APPENDIX 3

DOCUMENT HISTORY

Version	Date	Author	Summary of Changes
Version 1	***20.05.10***	***Final Version 1 agreed by John Adler for presentation to Trust Board***	
Draft 3	20.05.10	Jayne Dunn (Redesign Director, Right Care Right Here, SWBH)	Updated to incorporate: • Review of Sandwell PCT Board paper to ensure consistency • Inclusion of EQIA report
Draft 2	18.05.10	Jayne Dunn (Redesign Director, Right Care Right Here, SWBH)	Updated to incorporate: • Discussion at Project Steering Group on 18.05.10 • Information re stand alone MLU
Draft 1	15.05.09	Jayne Dunn (Redesign Director, Right Care Right Here, SWBH)	Initial Draft of Document

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Shaping Hospital Services For The Future -Progress Report
SPONSORING DIRECTOR:	Richard Kirby , Chief Operating Officer
AUTHOR:	Jayne Dunn, Redesign Director Right Care Right Here
DATE OF MEETING:	27 May 2010

SUMMARY OF KEY POINTS:

The approved changes associated with the interim reconfiguration of services in Paediatrics, Neonatal services, General Surgery, Trauma and Orthopaedics and Pathology have now all been fully implemented and are part of mainstream working.

This report summarises the current position with each of these areas and summarises the key findings from evaluation work to date. It also outlines further actions and next steps to consolidate and build on the changes.

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 approved changes associated with the interim reconfiguration of services in Paediatrics, Neonatal services, General Surgery, Trauma and Orthopaedics and Pathology have now all been fully implemented and are part of mainstream working.
- An external evaluation was undertaken for Paediatrics and the full Evaluation Report for Paediatrics is published on the Trust's web site.
- Progress with the actions and next steps in relation to the new configuration of Paediatric and Neonatal services will be monitored as part of the Divisional Review process.
- An external body will be commissioned to undertaken an evaluation, including patient satisfaction feedback, for reconfiguration of General Surgery and Trauma and Orthopaedics, 12 months after implementation with a report being presented to the Trust Management Board meeting in September.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

Financial	**X**	The interim reconfiguration changes required capital and revenue investment.
Business and market share	**X**	Paediatric and Neonatal activity has increased. Emergency General Surgery and Trauma activity has shown a slight decrease.
Clinical	**X**	The interim reconfiguration changes all had clinical drivers for change and have resulted in changes to the configuration of clinical services.
Workforce	**X**	The interim reconfiguration changes all had drivers for change relating to workforce. Recruitment to nursing posts in Paediatrics and Neonatal services has improved and there has been an improvement against national standards for nursing levels in Neonatal services.
Environmental	**X**	Significant capital investment in refurbishment work was made in the following areas: • Paediatric Assessment Unit (City) • Paediatric Wards (Sandwell) • Neonatal Units (City & Sandwell) • Surgical Assessment Unit (City) • Pathology (City and Sandwell)
Legal & Policy		
Equality and Diversity		
Patient Experience	**X**	The report presents findings from patient/parent satisfaction surveys in Paediatrics and Neonatal services.
Communications & Media	**X**	The evaluation reports for Paediatrics and Neonates are on the Trust website.
Risks		

PREVIOUS CONSIDERATION:

There have been previous reports relating to Interim Reconfiguration to Trust Board.

Previous progress and evaluation reports were received by the Interim reconfiguration Project Board (now dis-established).

This report was presented to the Trust Management Board at its March 2010 meeting.

SHAPING HOSPITAL SERVICES FOR THE FUTURE
PROGRESS REPORT TO THE TRUST MANAGEMENT BOARD

1. Introduction

During 2006 the Trust identified four priority areas where significant change was required in terms of configuration of clinical services across the two acute hospital sites before completion of the 'Right Care Right Here ' Programme (previously Towards 2010 Programme) and the new Acute Hospital.

The four priority areas were:

- inpatient paediatric services;
- neonatal intensive care services;
- inpatient surgical services;
- pathology.

Following a period of public consultation, the Sandwell and West Birmingham Hospitals NHS Trust Board at its meeting in May 2007 approved the proposed changes and implementation took place on a phased basis over a period of time between November 2007 and May 2009.

This paper summarises the current position with each of these four priority areas and summarises the key findings from evaluation work to date. It also outlines further actions and next steps to consolidate and build on the changes. The progress with these actions and next steps will be monitored as part of the Divisional Review process.

2. Inpatient Paediatric Services

In summary the new configuration of Paediatric services is:

- 24 hour Paediatric Assessment Unit (6 beds) plus a single inpatient paediatric unit (47 beds with the capacity to increase to 54 at times of peak demand) at Sandwell Hospital;

- 24 hour Paediatric Assessment Unit at City Hospital (12 beds);

- Extended community children's outreach service to include City as well as Sandwell Hospital with increased operational hours;

- Outpatients and day cases at both sites.

This new service configuration was implemented in November 2007 and the Trust commissioned the Health Services Management Centre (HSMC), Birmingham University, to undertake an evaluation of the changes 12 months after implementation. Whilst the full evaluation report can be found on the Trust website, the key findings and recommendations are summarised below.

The evaluation highlighted the following achievements:

- Sustaining the delivery of a service focussed on the needs of children and their families
- Maintaining high levels of activity
- Appropriately reducing length of stay for children
- Providing a pleasing environment
- Working effectively with colleagues in A&E

- Ensuring access for members of the BME community
- Continuing to develop good relationships with children and families.

A number of issues were highlighted as needing further clarity. It was also noted that the process of change had been difficult for many staff and there were ongoing issues around the geographically separate parts of the service finding ways to work more closely together. It was noted that many of those involved supported the evaluation as an opportunity to understand the impact of the changes and identify how to develop the service further.

The Trust was recommended to:

- Continue to seek to develop the understanding of parents, children and possibly GPs about why these changes were necessary and, more importantly, what the future will bring
- Improve access by:
    - Improving appointment letters and information
    - Ensuring that patient notes are always available at the appropriate time and place
- Understand and meet the complex needs of patients with learning disabilities
- Continue to blend two different cultures and develop a strong team of Consultants, well supported junior medical staff and nurses who are supportive of all parts of the service
- Ensure appropriate and effective management support
- Develop a greater understanding and support between managers and front line staff
- Enhance work within the community to continue to develop care closer to home.

The Women and Children's Division has developed an action plan around these recommendations and is in the process of implementing this. Progress with the action plan will be monitored through the Divisional review process. The more general points from the evaluation need to be incorporated into future service reconfigurations e.g. early staff engagement, ongoing user engagement, attention to the organisational development required to integrate two distinct teams and cultures.

3. Neonatal Services

The new configuration of Neonatal services is:

- A Level Two service at City Hospital providing intensive care, high dependency care and special care and caring for babies from 26 weeks gestation (29 cots and 2 transitional care rooms).

- A Level One service at Sandwell Hospital providing facilities for stabilisation and special care only and caring for babies from 34 weeks gestation (8 cots).

These changes were fully implemented in September 2008. The Trust has undertaken an internal evaluation of the changes 12 months after implementation, including a parent satisfaction survey. The full evaluation report can be found on the Trust website and the table below summarises the findings against the anticipated benefits of the changes.

ANTICIPATED BENEFIT	POSITION POST RECONFIGURATION
Improved middle-grade medical cover for the Level Two unit at City Hospital with increased dedicated middle grade doctor cover for the neo-natal service.	• Dedicated middle grade cover for the neonatal service at City Hospital during the day and evening. • The Advanced Neonatal Nurse Practitioners (ANNP's) have extended their 'medical' roles with full integration into the junior tier of medical cover
Significant improvement in the quality of the accommodation for the neo-natal service at both sites but especially addressing the issues of the cramped current unit at City Hospital.	• Relocation of City Neonatal Unit into a fully refurbished area. • Relocation of Sandwell neonatal Unit into a refurbished area in the same building as Delivery Suite.
Some increase in the capacity of the service in the Trust reducing the number of mothers from our local area who need Level One or Level Two care who have to be transferred to hospitals outside our area.	• Expansion in cot numbers from 35 (21 at City, 14 at Sandwell) to 37 (29 at City, 8 at Sandwell) and 4 transitional cots.
Better use of the skilled neo-natal nursing staff available to the Trust including improving the ratio of nurses to cots in the Level Two unit.	• Full rotation of neonatal nurses cross site. • Improved recruitment to vacant posts • Improvement against national recommended staffing levels (BAPM standards) – 100% at Sandwell, 73% at City.
Improved care for the youngest and sickest babies through the concentration of expertise in a single Level Two unit.	• Increased admissions to City NNU from 372 in 2008 to 412 in the 12 months post reconfiguration. • Increase in the number of transfers from Sandwell to City Neonatal Unit (with transfer back to Sandwell Neonatal Unit when babies old enough/stable enough to no longer require Level 2 care).
c. 60 mothers and their babies a year who need the specialist services provided by a Level Two unit but who are currently cared for in the unit at Sandwell Hospital will receive their care in future in a purpose-designed Level Two unit suited to their needs at City Hospital.	Since reconfiguration: • there have been 59 in-utero transfers of babies under 34 weeks gestation from Sandwell to City. • 25 babies under 34 weeks gestation have been delivered at Sandwell. Initially this was partly due to lack of capacity at City but in the second 6 months after reconfiguration most were for clinical reasons. The babies were initially admitted to Sandwell Neonatal Unit and then transferred to a Level 2 Unit with most being transferred to City.

The evaluation report includes findings from a parent satisfaction survey (24% response rate) but in summary the main issues were:

- Parents appeared to understand and accept the need for transfer and received information about this prior to transfer.
- Satisfaction rates were over 80% for both City and Sandwell Neonatal Units but for both, over 10 % of respondents rated their experiences as poor.

- Whilst the majority of respondents rated the environments as good/very good about a third of the negative comments related to facilities. Parent facilities on both sites were upgraded at the time of refurbishment but one of the rooms at City Hospital was not open at the time of the survey and so use of the facilities had to be prioritised. This room is now open.
- Comments also related to difficulties in accessing the Neonatal Unit at City after 20.00hours, for mothers who are inpatients on the maternity ward, as the entrance doors to the access corridor are locked and so the mother's need to be escorted by a midwife.
- Over 40 % of respondents on both sites used the transitional care units and 87% of these rated the facility as good or very good. Transitional care facilities within the neonatal units were a new development as part of reconfiguration (previously this care took place on the post natal wards).

The findings from the evaluation report and parent satisfaction survey will be reviewed by the senior management team within the Women's & Children's Division and changes that are required will be incorporated into the integrated development plan for Neonatal services and progress monitored through the Divisional review process .

It should be noted that the configuration of Neonatal services will change in line with Maternity Reconfiguration. The Level 1 Neonatal service at Sandwell Hospital will be transferred to City Hospital and incorporated within the Neonatal Unit at City Hospital. This will take place at the end of January 2011. These changes will be managed as part of the implementation plan and project management structure for Maternity Reconfiguration.

4. Emergency General Surgery and Trauma

The new service configuration for inpatient services in General Surgery and Trauma and Orthopaedics is:

- Inpatient emergency general surgery and trauma service based at Sandwell Hospital;

- 24 hour Surgical Assessment Unit at City Hospital to support "front door" in addition to consultant and resident middle grade on-call plus access to emergency theatre if required;

- Inpatient elective orthopaedics, urology, breast, upper gastrointestinal and vascular services based at City Hospital. Inpatient elective colorectal surgery retained on both sites to support gynae-oncology service at City Hospital;

- Outpatient, day case and the majority of 23 hour stay surgical activity remains at both hospitals.

Within General Surgery the reconfiguration changes were fully implemented from April 2009 and in Trauma and Orthopaedics from May 2009. The evaluation undertaken to date has considered emergency General Surgery and Trauma and the focus has been an activity analysis and discussion with clinical teams The key points are highlighted below.

Emergency General Surgery

For the period April – December 2009 the summary of findings are:

- Emergency admissions have reduced by 167 cases
- The conversion rate to procedure has reduced from 36% to 28%. This may reflect the senior clinical input at an earlier point in the patient pathway.
- Average Length of Stay (LOS) has been maintained at 4.2 days despite a heavier case-mix. This is reflected in stays >15 days which have increased by 1 day.
- There has been a small increase in discharges at 0 and 1 day LOS (23 cases) with a more significant reduction >2 days (greater than the reduction in emergency admissions).
- Pre-operative LOS remains static although those undergoing surgery are being treated earlier in the day.
- The emergency theatres, predominantly Sandwell, have managed a 12.4% increase in surgical activity (142 cases).
- Transfers of patients by internal transport across site have averaged 2 cases per day versus the anticipated 5 cases per day.
- Consultant workload continues to be an issue for colorectal and upper GI surgeons and reconfiguration of elective inpatients to Sandwell is being pursued. Following ongoing discussions with the specialities of Gastroenterology and Gynaecology-oncology, it is anticipated that a business case to SIRG will be submitted in June 2010.

Trauma

For the period April – December 2009 the summary of findings are:

- Non elective activity appears to have reduced by 114 cases but may merely be a reflection of the change in recording of Patch and Plan activity.
- Average Length of Stay (LOS) compared to 2008 is down by 1.1 days and 1.0 day lower than expected for the case-mix managed.
- Patients discharged at 0 days has increased by 6.4% (149 cases) and may be partly related to the Patch and Plan process.
- Average LOS for very long stay patients >50 days has increased by 1.5 days but numbers remain small.
- Judgements on pre-operative length of stay are difficult to make due to 102 records not including an operative date. For those recorded, patients receiving a procedure within 0 days remains static and for those at 1-2 days has reduced by 177 cases (from 791 to 614). This in part may be due exclusion of the102 records.

- There is an increase in patients receiving their surgery between the period of 08.00 – 14.00 of 107 cases. This will reflect the movement of some of the previous afternoon lists to the morning and also the transfer of trauma activity that previously took place in the emergency theatre to the trauma lists.

- There continues to be operational issues with the trauma theatre and a trauma working group is meeting routinely to identify ways to improve the service.

The Interim Reconfiguration Surgical Steering Group that co-ordinated and oversaw the reconfiguration changes in General Surgery and Trauma and Orthopaedics has been dis-established as the new service configurations are now mainstreamed and the ongoing monitoring of activity and implementation of action is undertaken within the Division of Surgery A for emergency General Surgery and the Trauma and Orthopaedic Taskforce for Trauma.

A more in depth evaluation, including patient satisfaction feedback, will be undertaken 12 months after implementation with a report being presented to Trust Management Board at its meeting in September. In line with the evaluation process for Paediatrics, an external organisation will be commissioned to undertake this evaluation.

5. Pathology

Reconfiguration within Pathology was fully implemented from March 2009. As the Pathology changes have not involved any transfer of 'direct patient' services an evaluation process has not been undertaken at this stage.

In summary the new configuration of Pathology services is:

- Microbiology, Histopathology, Immunology, Toxicology and main laboratories for Biochemistry and Haematology centralised at City Hospital;

- Mini-laboratories for Biochemistry and Haematology together with phlebotomy and sample reception retained at Sandwell Hospital to support hospital inpatient work with a 24/7 laboratory service

- Blood banks maintained on both sites.

6. Conclusion

The approved changes associated with the interim reconfiguration of services in Paediatrics, Neonatal services, General Surgery, Trauma and Orthopaedics and Pathology have now all been fully implemented and are part of mainstream working.

This report has presented the findings from the full evaluations that have been undertaken in Paediatrics and Neonatal services. It can be seen that many of the anticipated benefits are being realised but also a number of issues have been identified. The clinical directorates are in the process of developing and implementing action plans for these issues. Progress with these will be monitored through the Divisional review process. It should also be noted that the configuration of Neonatal services will change in line with Maternity Reconfiguration and these changes will be managed as part of the implementation plan and project management structure for Maternity Reconfiguration.

For emergency General Surgery and Trauma the report has presented key findings from an analysis of activity and discussion with clinical teams. The clinical division for General Surgery is developing an action plan for issues that have been identified in relation to emergency General Surgery of which the most significant is the proposal to consolidate inpatient colorectal surgery at Sandwell Hospital. A business case for this, taking into account arrangements to minimise the impact on other related specialities will be presented to SIRG in June. In terms of Trauma a working group has been set up to develop and implement an action plan and this will report to the Trauma and Orthopaedics Taskforce.

A more in depth evaluation of the reconfiguration changes in General Surgery and Trauma and Orthopaedics will be undertaken 12 months after full implementation. An external organisation will be commissioned to undertake this evaluation.

7. Recommendations

The Trust Board is recommended to NOTE:

- The approved changes associated with the interim reconfiguration of services in Paediatrics, Neonatal services, General Surgery, Trauma and Orthopaedics and Pathology have now all been fully implemented and are part of mainstream working.

- An external evaluation was undertaken for Paediatrics and the full Evaluation Report for Paediatrics is published on the Trust's web site.

- Progress with the actions and next steps in relation to the new configuration of Paediatric and Neonatal services will be monitored as part of the Divisional Review process.

- An external body will be commissioned to undertaken an evaluation, including patient satisfaction feedback, for reconfiguration of General Surgery and Trauma and Orthopaedics, 12 months after implementation with a report being presented to the Trust Management Board meeting in September.

:

Jayne Dunn
Redesign Director Right Care Right Here
18th May 2010

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Communications and Engagement progress report
SPONSORING DIRECTOR:	Jessamy Kinghorn, Head of Communications and Engagement
AUTHOR:	Jessamy Kinghorn, Head of Communications and Engagement
DATE OF MEETING:	27 May 2010

SUMMARY OF KEY POINTS:

The paper provides a progress report on communications and engagement activity following the approval of the Trust's Communications and Engagement Strategy in March 2009.

It includes:

- Key achievements
- Membership activities
- Media coverage
- Updated action plan
- Priorities for 2010/11

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
2. AGREE the proposed priorities for 2010/11

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	All – actions are aligned to the strategic objectives
Annual priorities	The strategy supports the delivery of all the Trust's corporate objectives
NHS LA standards	Patient information
CQC Essential Standards of Quality and Safety	
Auditors' Local Evaluation	Use of Resources; value for money – public engagement

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

Financial		
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity	**X**	Access to information / engagement with diverse groups
Patient Experience	**X**	
Communications & Media	**X**	
Risks		

PREVIOUS CONSIDERATION: Key features of this report have previously been considered at the Communications and Engagement Governance Group (April 2010). The Trust Board receives updates twice a year.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Communications and Engagement Strategy Update

Paper to the Trust Board
May 2010

Report by Jessamy Kinghorn
Head of Communications and Engagement

1.0 Introduction

In March 2009 the Trust Board approved a new Communications and Engagement Strategy and action plan. The purpose of this report is to update the Board on the progress against the action plan and the plans for 2010/11.

2.0 Key achievements

As described in the December update to the Trust Board, highlights of the year include the success of hot topics as a method of communicating and engaging with staff, the launch of the customer care promises, media training programme, a substantial patient information audit and review, membership activities, patient and public engagement events, including one to establish the Trust's priorities for 2010/11, and the creation and launch of the Trust's brand.

3.0 Membership

The Trust has committed to building, maintaining and engaging a membership of approximately 7,500 local people. Membership stands at 7,535 to date.

The membership office is still running its two recruitment campaigns. Both campaigns aim to increase the level of membership within the specified targeted areas. So far this year the membership office has visited nine new schools and has been successful in recruiting students to become young members of the Trust. Further recruitment and engagement activities have been planned with local schools and are scheduled to take place from now through to September 2010.

A new initiative which will be piloted during June 2010 will be to work with secondary schools students in Erdington delivering an NHS Induction for health and social care.

As a key benefit of the whole class joining up as Trust members, the membership office has agreed to provide new students who are beginning their studies with an NHS induction package comprising of short talks around membership, NHS careers and health promotion, followed by guest speakers from the Trust who will provide a clinical insight into

hospital care and services. As part of the induction we will work with students to raise aspirations and create awareness of routes into the NHS.

The above scheme will hopefully be implemented in other hard to reach areas such as Ladywood, Tipton and Rowley Regis, dependant on individual school requests.

Other activities have included a healthy lifestyle and wellbeing roadshow and range of health and well being events including health promotion for young people, and seminars on patient experience, diabetes, alzheimer's, food allergies and the new hospital. Careers events, and seminars on healthy pregnancy, infection control, living with cancer, maternity reconfiguration and CPR are planned over the next three months.

4.0 Media coverage

During the last six months of 2009/10 there was a reduction in the amount of proactive publicity generated by the communications team. This was significantly influenced by the sabbatical of a communications officer at the end of 2009 and an increasing non-press workload being undertaken by the communications team that includes major pieces of work around patient information and patient engagement.

The communications team has just been restructured, resulting in the loss of one post. However, a workload review should ensure that proactive press coverage is maintained as a key function.

	Aug-08	**Aug-09**	**Sep-09**	**Oct-09**	**Nov-09**	**Dec-09**	**Jan-10**	**Feb-10**	**Mar-10**
Total	***19***	**43**	**93**	**54**	**31**	**43**	**71**	**55**	**91**
Positive	*9*	30	46	23	20	13	14	14	13
Negative	*8*	11	24	4	1	2	9	4	16
Neutral	*2*	2	23	28	10	28	48	37	62

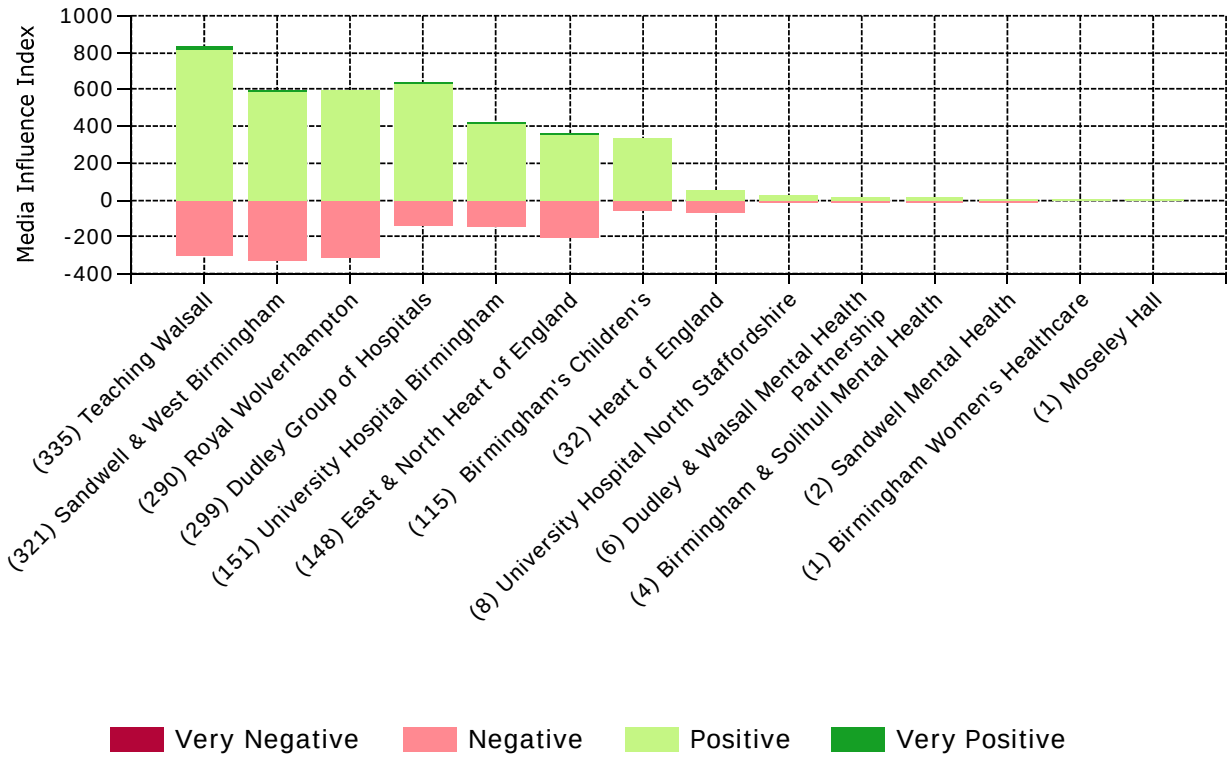
The positive cuttings generated from September 2009 to March 2010 amounting to an advertising equivalent value of almost £68,459. This does not take into consideration coverage in BME media or broadcast coverage as we currently have no mechanism in place to measure this kind of media. The total circulation of all cuttings generated for this period is almost 30million. (29,722,704).

NHS West Midlands analyses the media coverage achieved by all organisations. The chart below shows the breakdown of coverage by acute trust for February and March 2010.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Impact and tone of organisations in Birmingham

February March 2010, regional media



(x) Number of articles

Source: Millward Brown Precis

5.0 Progress against action plan

Please see progress at appendix one.

6.0 Priorities for 2010/11

Most of the actions from 2009/10 will need to be continually met during 2010/11 and beyond and their dates will be amended to reflect this. In addition, actions that were not completed during 2009/10 will be rolled over into 2010/11, along with some further actions will be carried out. Priorities for 2010/11 include:

Our patients, their carers and the clinicians responsible for their care (including GPs), will have the information they need to understand their treatment and to improve the experience they have in hospital, and their aftercare

- Roll out the monitoring of clinical communication with patients
- Develop a Board approved formal protocol for translating information
- PALS and complaints poster campaign

- Produce audio versions of patient information literature
- Produce child friendly information about hospital care

We will ensure patients and GPs have the information they need, when they need it, in the format they need, when choosing this hospital

- Review specialty content on the Trust website
- Publish patient information on the Trust website
- Develop a GP news section on GP Homepage

We will listen to our patients by establishing systems to monitor levels of patient satisfaction

- Finalise policy for patient surveys
- Produce guidelines for staff wishing to carry out patient surveys
- Roll out Speak Out and You said, we did campaign

We will uphold public confidence in the Trust and its services through managing the Trust's reputation and promoting its services and successes

- Evaluate the media training programme
- Audit the Trust's reputation with the media
- Create a strategic communications planner

We will facilitate implementation of the Trust's marketing strategy through appropriate marketing to GPs, commissioners, community and patient groups.

- Revise the marketing strategy following the appointment of the new Director of Strategy and Organisational Development
- Undertake planned engagement activities to understand how our services are perceived and how they can be improved

We will develop our approach to engagement with patients, carers, stakeholders and local people to improve our services and undertake meaningful consultation and involvement in relation to changes and access to services

- Launch an involvement and consultation toolkit jointly with the Right Care Right Here programme and Sandwell and Heart of Birmingham PCTs
- Create a calendar of patient public engagement events that complements the membership calendar
- Develop a range of patient and public forums

We will promote the concept of care closer to home, the provision of services outside the main hospitals and the Right Care Right Here Programme

- Continue to play a key role in the Right Care Right Here programme

We will engage with the public over our use of resources

- Engage with the public over the Trust's performance during 2010/11
- Engage with the public over the Trust's priorities for 2011/12
- Ask our members their views on the way we use our resources

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

- Run a naming campaign that engages with a large number of local people, including hard to reach groups
- Arrange appropriate promotion of the land acquisition

We will ensure staff have the information they need and want to carry out their work effectively and play a full part in the organisation.

- Review the way night staff and those not on email are communicated with
- Publish best practice communication guidance for staff

We will promote comprehensive staff engagement

- Continue to promote and embed the approach to leadership and staff engagement created through LiA
- Facilitate staff engagement activities

The communications crisis management and major incident response will be to a high standard

- Undertake further major incident training
- Run a communications major incident exercise for other Trusts
- Seek to observe other Trusts' approach to major incidents

We will ensure our Foundation Trust members and key stakeholders play an important role in the activities and direction of the Trust, and will listen to their views and ideas

- Launch a range of forums for members to get more involved in the Trust

We will implement a consistent brand across the organisation that reflects our values and increases awareness of the Trust

- Publish the brand identity guidelines for all staff
- Ensure new purchase orders reflect the new branding
- Promote the Trust's values
- Embed the customer care promise

7.0 Recommendations

The Trust Board is asked to NOTE the report and AGREE the additional actions for 2010/11.

APPENDIX TWO

Communications and Engagement Strategy Action plan 2009/10

8.1 Our patients, their carers and the clinicians responsible for their care (including GPs), will have the information they need to understand their treatment and to improve the experience they have in hospital, and their aftercare

Action		Date	Exec lead	Comments	Status
8.1.1	Develop and introduce standards for spoken, handwritten and printed clinical communications	**End Sept '09 *Revised Jan '09***	**MD**	Robin Burrow working with clinicians (2 days per week so due date extended). Approved by Governance Board.	**4**
8.1.2	Establish mechanisms for monitoring standards of clinical communication with patients	**End Jan '10**	**MD**	Audit tools for monitoring the quality of communication have been developed. Diagnostic tools for understanding where communication can be improved have been developed and piloted. Further work ongoing to embed this.	**4**
8.1.3	Audit clinical entries in patient records	**End March '10**	**MD DoG**	Achieved through the annual chase records audit. A case records surveillance system is being introduced across all clinical directorates with monthly reviews of case notes. This process will be embedded and performance managed through the directorate review system.	**4**
8.1.4	Improve the range of information available on GP Homepage	**End Nov '09**	**COO**	Regularly updated.	**4**
8.1.5	Set and monitor standards for telephone response times	**End Oct**	**COO**	Included in performance	**4**

		'09		report at Trust Board	
8.1.6	Audit existing patient information and prioritise areas of poor practice for improvement	**End May '09**	**Head of Comms**	Audit completed by Ushi Pragji.	**5**
8.1.7	Revise and impact assess the Trust's patient information policy and governance arrangements for patient information	**End June '09**	**Head of Comms**	Policy revised during June '09. Approved by Governance Board Oct '09.	**5**
8.1.8	Develop a Board approved formal protocol for translating clinical information and producing it in different formats, with reference to all available national guidance, and promote areas of good practice	**March '10** ***Revised Dec '10***	**Head of Comms**	Guidance for divisions developed summer '09 – presented to CEGG Nov '09. A joint piece of work is being commissioned with Sandwell and HOB PCTs and the RCRH programme to look at the actual need for translation of information rather than relying on anecdote and to ensure consistent approach across local health economy. Research expected to conclude autumn 2010 to influence Trust Board decision on translation policy.	**3**
8.1.9	Increase (where appropriate) the range of formats and languages in which patient information is available, in consultation with BME, deaf, visually impaired and other relevant groups	**End March '10**	**Head of Comms**	Audio tender for initial batch of leaflets has been awarded and a range of leaflets are in production, along with an agreement to trial translation of some leaflets. A radio documentary style annual report is also in production. EIDO language option is in use.	**4**
8.1.10	Review and revise the Patient Bedside Directory, ensuring it is available on all wards	**End Nov '09** ***Revised May '10***	**Head of Comms**	Significant delay due to late revisions and delay at the printers but expected imminently	**3**
8.1.11	Review Trust signage and develop a strategy for improved signage	**End March '10**	**Chief Nurse**	Review reported at E&D group, along with action plan. Many improvements made.	**4**

8.1.12	Make greater use of plasma screen technology	**End March '10**	**Head of Comms**	Plasma screen use reviewed and work ongoing with companies	**4**
8.1.13	Develop patient information and way-finding strategies for the new hospital, in consultation with patients and visitors	**End Nov '09**	**Head of Comms**	Patient and public workshops have taken place on way-finding in the new hospital and a way-finding strategy is under development	**4**
8.1.14	Promote PALS and Complaints services more visibly	**End March '10** ***Revised July '10***	**HoC/ DoG**	This is being promoted via the bedside directory and ties in with the new ward measure boards. A separate poster campaign has been deferred due to capacity constraints.	**3**

8.2 We will ensure patients and GPs have the information they need, when they need it, in the format they need, when choosing this hospital

Action		Date	Exec lead	Comments	Status
8.2.1	Make sure information is available in libraries, health centres and other appropriate outlets	**End March '10**	**Head of Comms**	Material is published in public areas as appropriate, including the OBC	**4**
8.2.2	Work with in partnership with the Right Care Right Here Programme to ensure that information about changes to services are promoted in our local communities	**Ongoing**	**Head of Comms**	Significant input into RCRH newsletters and adverts in local health supplements (Express and Star). Continued participation in RCRH C&E group and associated activities	**4**
8.2.3	Develop and update the information about the Trust and our services on our website	**Ongoing**	**Head of Comms**	Regular updates to Trust website carried out by team. A refresh is currently being undertaken on the website and will be visible to users in the next few weeks.	**4**
8.2.4	Review and update Trust information on NHS Choices	**Ongoing**	**Head of**	Information currently up to	**4**

			Comms	date. Changes updated as required	
8.2.5	Monitor and respond to patient comments on NHS Choices and bring the comments to the attention of the relevant Divisional General Manager	**Ongoing**	**Head of Comms**	Divisional managers forwarded responses to investigate where appropriate	**4**
8.2.6	Examine the Trust internet presence and make appropriate use of external websites and facilities to promote our services	**End March '10 - ongoing**	**Head of Comms**	This review has begun but is progressing slowly due to the time taken up with refreshing the trust website	**3**
8.2.7	Run health seminars promoting our services for our Foundation members as part of our Membership Strategy	**Ongoing**	**Head of Comms**	Numerous activities continue to take place.	**4**
8.2.8	Run specialty GP seminars as part of our Marketing Strategy	**Ongoing**	**Head of Comms / *DF / MD***	Activities continue to take place.	**4**
8.2.9	Produce an up to date consultant directory for GPs	**End Nov '09**	**Head of Comms**	Up to date consultant directory has been produced and feedback has been received from GPs to make it more effective.	**4**

8.2 We will listen to our patients by establishing systems to monitor levels of patient satisfaction

Action		Date	Exec lead	Comments	Status
8.2.10	Implement ward based surveys of patients	**End May '09**	**Chief Nurse**	First report completed	**5**
8.2.11	Make ward based patient survey information available to the wards	**End July '09**	**Chief Nurse**		**5**
8.2.12	Issue quarterly patient satisfaction reports to the Patient Experience Group and Independent Patient's Forum	**Ongoing**	**Head of Comms *Change to CN***	Relevant paperwork made available as part of CQUIN. Independent Patient's Forum disbanded. Note change of lead.	**4**
8.2.13	Develop a policy on the content of patient surveys / bank of approved questions	**End Nov '09**	**Head of Comms**	Revised inpatient and carer surveys have been agreed,	**3**

		/ CN	and further work has been done to coordinate and ensure consistent quality of other surveys taking place across the Trust. A formal policy is outstanding.	
8.2.14 Run a campaign to encourage people to give us their views	**End March '10**	**Head of Comms**	Speak out campaign was launched in Jan '10 and continues to be rolled out.	**4**
8.2.15 Support and develop a 'forum' of patients and local people	**End March '10**	**Head of Comms**	Forums include a youth group, diabetes focus group, rheumatology patient service user group, young person's sickle cell and thalassaemia group, and a parent group for sickle cell and thalassaemia	**4**
8.2.16 Provide regular feedback on patient satisfaction to staff, stakeholders and local people through Heartbeat, FT newsletter, GP Focus, press releases etc.	**Ongoing**	**Head of Comms**	Principle now well established	**4**

8.3 We will uphold public confidence in the Trust and its services through managing the Trust's reputation and promoting its services and successes

Action	Date	Exec lead	Comments	Status
8.3.1 Develop and monitor a proactive PR / media handling strategy for the Trust that sets out how we will handle adverse press enquiries, ensures we are better prepared to handle media interest following national, local or Trust publication of information or reports, outlines our approach to developing closer relationships with local media, and sets clear targets	**End May '09**	**Head of Comms**	Media handling strategy has been developed and regular communications team meetings discuss DH media diary, amongst other new initiatives. Team has targets for press releases.	**4**
8.3.2 Undertake a piece of work on reputation management following the NHS Confederation guide	**End July '09**	**Head of Comms**	Session held at communications team away day.	**4**

8.3.3	Respond promptly and effectively to press enquiries, developing media handling guidelines that further enhance our reputation for dealing with enquiries openly and sympathetically	**Ongoing**	**Head of Comms**	Guidelines developed. Very positive recent feedback from press (Midlands Today, Birmingham Mail, Central) about our reputation for openness	**4**
8.3.4	Provide communications guidance and media training to senior managers	**End March '10**	**Head of Comms**	Media training ongoing	**4**
8.3.5	Enhance the media handling ability of the communications team through training	**Ongoing**	**Head of Comms**	Media handling training programme created	**4**
8.3.6	Maximise positive publicity through external documentary and educational films	**Ongoing**	**Head of Comms**	All opportunities are explored and evaluated. Several recent examples.	**4**
8.3.7	Actively look for opportunities to promote the Trust, its services and its staff	**Ongoing**	**Head of Comms**	Increase in positive news coverage maintained since September 2008	**4**
8.3.8	Raise awareness within the divisions of the benefits of proactive PR to encourage more staff to volunteer stories	**Ongoing**	**Head of Comms**	More work undertaken with DGMs and attendance at some divisional meetings	**4**
8.3.9	Monitor media coverage and produce quarterly reports	**End July '09**	**Head of Comms**		**4**
8.3.10	Promote the Trust's positive media coverage internally	**End Aug '09**	**Head of Comms**	News items covered in Heartbeat and on intranet.	**4**
8.3.11	Look for opportunities to piggy back on DH and other national news	**Ongoing**	**Head of Comms**	DH media diary is discussed at informal press office meetings	**4**
8.3.12	Take advantage of appropriate advertising opportunities within community press	**Ongoing**	**Head of Comms**	Ongoing where appropriate	**4**
8.3.13	Develop a calendar of national and regional awards	**End Sept '09**	**Head of Comms**	Main dates have been noted – entries made for Health and Social Care Awards, HSJ awards, DH awards and AHC awards.	**4**
8.3.14	Work with divisions to encourage staff to put themselves and their colleagues forward for Trust, local and national awards	**End March '10**	**Head of Comms**	Work undertaken for HSJ, Health and Social Care and staff awards	**4**
8.3.15	Develop, deliver and monitor the infection control communications plan	**Ongoing**	**Head of Comms**	On track	**4**

8.4 We will facilitate implementation of the Trust's marketing strategy through appropriate marketing to GPs, commissioners, community and patient groups.

Action		Date	Exec lead	Comments	Status
8.4.1	Deliver the communications and engagement responsibilities within the Trust marketing strategy	**Ongoing**	**Head of Comms**	Monitored at monthly Marketing and Business Development meetings	**4**
8.4.2	Produce a schedule of content for GP Focus	**End April '09**	**Head of Comms**	Approved April '09. Reviewed monthly	**4**
8.4.3	Produce GP Focus monthly	**Ongoing**	**Head of Comms**		**4**
8.4.4	Revise the GP contacts list	**End May '09**	**Head of Comms**	An up to date list has been produced for HOB, Sandwell and BEN	**4**
8.4.5	Explore different ways of engaging effectively with GPs	**End March '10**	**Head of Comms**	Range of engagement events with GPs and consultants	**4**
8.4.6	Develop and implement communications and engagement plans for new services	**End March '10**	**Head of Comms**	Significant involvement in plans for Greet Health Centre, as well as South Birmingham Community Ophthalmology	**4**
8.4.7	Implement and promote the Trust's Customer Care promises	**End May '09**	**CEO / HoC**	Launch deferred to October '09 to coincide with Customer Care week and new corporate identity	**5**

8.5 We will develop our approach to engagement with patients, carers, stakeholders and local people to improve our services and undertake meaningful consultation and involvement in relation to changes and access to services

Action		Date	Exec lead	Comments	Status
8.5.1	Finalise, publish and roll out involvement and consultation toolkit and best practice examples for staff	**End Jan '10**	**Head of Comms**	Working with PCTs as PCTs now have lead for this area.	**3**
8.5.2	Promote areas of good practice, where clinicians and managers are involving staff, patients and local people in the development of services	**Ongoing**	**Head of Comms**	Regular promotion through Heartbeat and noticeboards, and recognition with LiA and patient engagement awards at the staff awards	**4**
8.5.3	In line with our approach to engagement (3.2.5), support departments undertaking service change to develop and deliver communications and engagement plans to provide information, consult and engage patients and local people	**Ongoing**	**Head of Comms**	Significant involvement in maternity and support for other services (such as gynaecology, ENT) to develop plans	**4**
8.5.4	Develop and monitor communications and engagement plans for surgical reconfiguration and other service change and development	**End Sept '09**	**Head of Comms**	Completed as required – surgical reconfiguration plan implemented and reported on.	**4**
8.5.5	Use a variety of methods, including exploring the use of Listening into Action (LiA) methodology to effectively engage with patients and local people around service improvement and development	**End March '10**	**HoC COO / MD / CN**	Events on paediatric services, single sex accommodation, maternity. Acute care and corporate objectives taken place.	**4**
8.5.6	Produce appropriate literature to explain service changes to patients and GPs	**Ongoing**	**Head of Comms**	Paediatric, surgical and maternity information published. Greet prospectus developed.	**4**
8.5.7	Regularly survey Foundation members about plans or considerations for changes and access to services	**Ongoing**	**Head of Comms**	Opportunities provided for members to attend / respond on customer care, annual report, single sex accommodation, maternity	**4**

				and corporate objectives	
8.5.8	Ensure the Health Overview and Scrutiny Committees and other key stakeholders are kept appraised of service developments	**End March '09 *and ongoing***	**Head of Comms**	Regular updates sent as necessary	**4**
8.5.9	Establish reading groups to review literature to ensure patients will be able to understand changes to services	***End May '09***	**Head of Comms**	Reading groups established as an when required from list of members who have volunteered	**4**
8.5.10	Review and improve the effectiveness of mechanisms to provide feedback to staff, patients and local people	**End March '10**	**Head of Comms**	Primarily using member newsletter, Heartbeat, GP Focus and press. Wider feedback scheme currently being developed	**4**
8.5.11	Participate in health promotion and public education campaigns to encourage local people to lead healthier lives and use the health service appropriately	**End March '10**	**Head of Comms**	Involvement in 'stop before the op' campaign; Particular involvement with young people around drugs, sexual health and recruitment	**4**
8.5.12	Review and update the Trust's contact list for voluntary and community groups, particularly those defined as hard to reach (6.6)	**End March '10**	**Head of Comms**	Updated in conjunction with the RCRH programme, along with a stakeholder list	**4**
8.5.13	Continue to implement the Equality and Diversity action plans and the plans of the Patient Experience and other sub-groups	**Ongoing**	**Chief Nurse**		**4**

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

Action		Date	Exec lead	Comments	Status
8.6.1	Contribute to the production of the Right Care Right Here newsletter and other communications material	**Ongoing**	**Head of Comms**	Regular contributions	**4**
8.6.2	Participate in events arranged in relation to the Right Care Right Here Programme	**Ongoing**	**Head of Comms**	Examples include regeneration exhibition,	**4**

				community events and roadshows and RCRH LiA staff engagement event	
8.6.3	Promote the concept of care closer to home at relevant Trust events	**Ongoing**	**Head of Comms**	New hospital and RCRH represented at FT membership recruitment events and other relevant roadshows	**4**
8.6.4	Promote and publicise Phlebotomy services moving into the community (blood tests in shopping centres)	**End March '10**	**Head of Comms**	Publicity in local press and in corporate publications	**4**
8.6.5	Develop communications and engagement plans for pilots of services that are moving into the community (such as Ear Clinics)	**End March '10**	**HoC / COO**	ENT comms plan developed and implemented. Others developed as required	**4**

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

Action		Date	Exec lead	Comments	Status
8.7.1	Ask a sample of Foundation Trust members for their views on how we should produce our annual report and other key publications, including the language and format we should use	**End April '09**	**Head of Comms**	159 people responded to the survey. Results presented to the Trust Board in May 2009	**5**
8.7.2	Establish an effective Governance process to ensure that Communications and Engagement activities are recorded and monitored and that engagement is taking place with diverse and hard to reach groups	**End June '09, then ongoing**	**HoC / DoG**	Communications and Engagement Governance Group established.	**4**
8.7.3	Present a bi-annual report on communications and engagement activities to the Trust Board	**End March '10**	**Head of Comms**		**4**
8.7.4	Maintain effective systems to ensure patient feedback is reported to the Trust Board	**Ongoing**	**CN / HoC**	Patient Experience reports made available to Trust Board, along with outcome of national and corporate patient surveys	**4**
8.7.5	Audit the impact of the Communications and Engagement Strategy using staff and	**End**	**Head of**	Staff survey puts trust in	**4**

	patient survey information and other quantative and qualitative information, paying particular attention to diverse and hard to reach groups	**March '10**	**Comms**	top 20% nationally for communication with staff. Patient surveys do not relate closely enough to the objectives to give a clear indication. Feedback from members is positive as is feedback from the media. A formal media relations audit is currently underway	
8.7.6	Develop and implement an engagement plan that engages with staff, patients, carers, and local people about the corporate objectives for 2010/11	**Sept '09 – March '10**	**Head of Comms**	The top priorities identified by members of the public and staff have been included in the priorities.	**4**

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

Action		Date	Exec lead	Comments	Status
8.8.1	Implement the new hospital Communications and Engagement plan	**Ongoing**	**Head of Comms**	On track	**4**
8.8.2	Keep our stakeholders, staff and Foundation members up to date with our plans for the new hospital	**End March '10**	**Head of Comms**	Regular use of communications methods with specific plans around OBC and CPO approval	**4**
8.8.3	Keep the Overview and Scrutiny Committee up to date with our plans for the new hospital	**End March '10**	**Head of Comms**	Regular emails at key times and planned visits by RCRH programme director	**4**
8.8.4	Run focus groups and workshops as part of the new hospital Communications and Engagement plan	**End March '10**	**Head of Comms**	These are incorporated into the calendar of activities	**4**
8.8.5	Develop appropriate literature about the plans for the new hospital, including a new hospital booklet	**End March '10**	**Head of Comms**	Booklet in draft form and run past 100 members of the public. Feedback incorporated but printing put on hold by the	**4**

				programme. Name literature produced.	
8.8.6	Regularly update local press on progress with the new hospital	**Ongoing**	**Head of Comms**	Regular conversations, particularly to tie into key milestones and promote engagement opportunities	**4**

8.9 We will ensure staff have the information they need and want to carry out their work effectively and play a full part in the organisation.

Action		Date	Exec lead	Comments	Status
8.9.1	Review internal communications, piloting a Listening into Action (LiA) approach with Medicine A and Facilities	**End July '09**	**Head of Comms**	Medicine A and Facilities comms pilots have taken place and consideration is being made to rolling out to other divisions.	**5**
8.9.2	Develop and implement a revised Internal Communications Plan, incorporating traditional communications methods including Heartbeat and Team Brief, as well as initiatives that come out of the LiA communications work	**End March '10**	**Head of Comms**	Revised initiatives, including hot topics, have been incorporated into the plan	**4**
8.9.3	Establish reliable information around numbers of hard to reach staff (i.e. those working out of hours shifts only or working primarily in the community)	**End March '10**	**HoC / DoW**	In hand	**4**
8.9.4	Run a Listening into Action communications event specifically for hard to reach staff	**End March '10**	**Head of Comms**	A range of facilities and estates staff have been involved, and other work has taken place. Feedback is that an LiA style event for this group of staff is not necessarily the most appropriate way of engaging them.	**3**
8.9.5	Develop the Intranet pages as a source of information	**Ongoing**	**HoC / COO**	Intranet home page updated daily. New swine flu pages created and updated with latest info, Q&As etc. Communications pages	**4**

				regularly updated	
8.9.6	Create a pilot Communications hub for staff to access the intranet and find out about corporate activities	**End Dec '09**	**Head of Comms**	Talks have been ongoing with IT and facilities about locating an intranet café but use of the facility at Sandwell and in the libraries is low and this has been de-prioritised.	**2**
8.9.7	Provide feedback on staff and patient satisfaction and views	**Ongoing**	**HoC / DoW**	Provided through Heartbeat, members newsletter, etc.	**4**
8.9.8	Introduce a policy for the use of the public folders	**End Dec '09**	**Head of Comms**	A policy has been drafted following legal advice around liability issues, and incorporating comments made by staff	**4**
8.9.9	Continue to improve induction information	**Ongoing**	**DoW / HoC**	Work ongoing with HR	**4**
8.9.10	Review and improve the use of notice boards	**End Oct '09**	**Head of Comms**	Review completed. Corporate noticeboards are regularly maintained. A plan is being developed to work with divisions next year on noticeboards maintained by departments.	**4**
8.9.11	Promote Trust expectations of staff (i.e. the code of conduct, Equality Impact Assessments and Customer Care promises)	**Ongoing**	**Head of Comms**	Customer care promises launched Oct '09	**4**
8.9.12	Promote key policies	**Ongoing**	**All / HoC / DoG**	Promoted via team brief, intranet, email and (for key policies), Heartbeat	**4**
8.9.13	Promote the principles of communications and engagement to staff with best practice guidance	**End Dec '09**	**Head of Comms**	The principles have been published but a best practice guide is outstanding.	**2**

8.10 We will promote comprehensive staff engagement

Action		Date	Exec lead	Comments	Status
8.10.1	Continue to roll out the Listening into Action (LiA) methodology and embed it within the culture of the organisation	**Ongoing**	**CEO / DoW**		**4**
8.10.2	Develop and implement a communications plan for LiA, regularly updating staff with progress	**Ongoing**	**Head of Comms**		**4**
8.10.3	Audit the effectiveness of LiA through staff surveys	**End March '10**	**DoW**	Full staff survey to be undertaken every other year. 2008 staff survey completed.	**4**
8.10.4	Provide senior management and/or communications input into several key corporate LiA streams	**Ongoing**	**CEO / HoC**	Including single sex accommodation, sustainability, customer care, branding etc.	**4**
8.10.5	Use the LiA communications stream to improve the way we communicate about LiA and other Trust issues	**End March '10**	**Head of Comms**	Ongoing review of communications methods with regard to feedback from communication LiA pilots – esp. access to information from team leaders	**4**
8.10.6	Look for opportunities to publicise LiA outside the Trust	**Ongoing**	**All**	Several presentations within the region and nationally, entering national awards, visits from Trusts looking to start LiA, HSJ	**4**

8.11 The communications crisis management and major incident response will be to a high standard

Action		Date	Exec lead	Comments	Status
8.11.1	Ensure the Communications team participate in major incident training exercises	**Ongoing**	**Head of Comms**	Communications specific training exercise undertaken and comms represented at all	**4**

				Trust exercises. Significant involvement in flu planning	
8.11.2	Develop a major incident communications training programme	**End June '09**	**HoC / COO**	First event held, major incident media handling programme for senior managers underway – maternity and swine flu issues featured to date	**5**
8.11.3	Ensure Communications participation in the contingency planning group and at appropriate meetings and training programmes	**End June '09**	**Head of Comms**	Some difficulty with dates for contingency planning group but communications department represented at pandemic flu meetings. Dates are currently being addressed.	**3**
8.11.4	Produce a communications plan for pandemic flu	**End May '09**	**Head of Comms**	Completed – and implemented	**5**
8.11.5	Run regular designated communications exercises to test the communications response	**Ongoing**	**HoC / COO**	Communications specific and Trust training events undertaken	**4**
8.11.6	Media train appropriate staff	**End March '10**	**Head of Comms**	Media training programme in place	**4**
8.11.7	Observe other organisations' communications handling at major incident exercises	**End March '10**	**Head of Comms**	There has not yet been the opportunity to do this, but other organisations have observed us.	**3**

8.12 We will ensure our Foundation Trust members and key stakeholders play an important role in the activities and direction of the Trust, and will listen to their views and ideas

Action		Date	Exec lead	Comments	Status
8.12.1	Deliver the Foundation Trust membership strategy	**Ongoing**	**Head of Comms**	Membership target exceeded. Membership activities highly successful	**4**
8.12.2	Monitor the demographics of our membership and target specific campaigns to engage with groups of people that are not fully represented	**Ongoing**	**Head of Comms**	Rowley and Erdington and Young people's campaigns	**4**

				instigated in response to demographic reports	
8.12.3	Produce an 'evolving' annual calendar of events	**Ongoing**	**Head of Comms**	Second annual calendar of events in production	**4**
8.12.4	Give opportunities for feedback from members via written correspondence, telephone, email and at meetings	**Ongoing**	**Head of Comms**	Email, freepost and freephone are widely used. Regular meetings provide feedback opportunities, and surveys have taken place on a range of issues	**4**
8.12.5	Develop surveys of stakeholders and GPs	**End March '10**	**Head of Comms**	GP feedback has been received through the GP / consultant engagement events which have provided vastly more feedback than any previous survey. Feedback is also collected at GP events and sought via GP Focus.	**4**
8.12.6	Provide regular feedback to members on how their comments are being used and promote examples where feedback has made a difference	**End March '10**	**Head of Comms**	Feedback provided via members' newsletters	**4**

8.13 We will implement a consistent brand across the organisation that reflects our values and increases awareness of the Trust

Action		Date	Exec lead	Comments	Status
8.13.1	Complete the Board 'Branding for Success' programme run by NHS Elect	**End June '09**	**Head of Comms**	The approach for this was changed. Instead of the completion of the session, NHS Elect facilitated branding workshops with around 40 staff and 140 members of the public. Feedback then incorporated into a new brand. Second session	**2**

				with Board cancelled.	
8.13.2	Develop and consult on suggestions for a new brand for the Foundation Trust	**End Aug '09**	**Head of Comms**	Consultation took place starting with getting a feel for what staff and local people felt the Trust was all about, its strengths and weaknesses and the colours, shapes and symbols that reflected it. That was followed by development of graphic ideas and extensive consultation and voting with the Trust Board, team brief, and large numbers of patients, community and diverse groups.	**5**
8.13.3	Implement a new brand in conjunction with authorisation as a Foundation Trust	**Once FT**	**Head of Comms**	Brand launched in October 2009 - ahead of FT status	**4**
8.13.4	Review the quality, look and feel of publications for external consumption	**End July '09**	**Head of Comms**	Examples gathered. Brand identity guidelines to be developed for future publications	**4**
8.13.5	Run a campaign to promote the Trust values	**End Nov '09**	**Head of Comms**	These have been promoted via Hot Topics as discussion topics for staff and their teams. Feedback has been collated.	**4**
8.13.6	Develop guidelines for the production of literature and publicity materials that do not fall within the patient information policy	**End Sept '09** ***Now Jan '10***	**Head of Comms**	An early draft as been prepared but deferred for development of the brand guidelines after the brand was introduced earlier than planned. Note revised date	**4**
8.13.7	Develop a plan for winding down stocks of out-dated material and bringing in material with the new brand and logo	**End July '09** ***Now Dec '09***	**DoF / COO / HoC**	Brand implementation plan has been developed and is overseen by a brand implementation group with representation from supplies, facilities, estates, IT etc. to pick up all issues	**3**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – April 2010
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Robert White/Tony Wharram
DATE OF MEETING:	27 May 2010

SUMMARY OF KEY POINTS:

The report provides an update on the financial performance of the Trust for the first month of 2010/2011.

For 2010/2011, the Trust has two income and expenditure related financial targets: a statutory accounts position of £838,000 surplus and a DoH control total of £2,038,000 surplus.

For the first month of the new financial year, the Trust has posted a surplus of £114,000 against its statutory accounts target and £195,000 against its DoH control total. Both are £5,000 above the planned position.

Capital expenditure in month was £260,000 and the cash balance at 30th April was £4.3m higher than planned.

A number of allocation amendments to the capital programme are proposed by SIRG for Board agreement.

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

Approval	Receipt and Noting	Discussion
X	**X**	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

NOTE the contents of the report;
ENDORSE any actions taken to ensure that the Trust remains on target to achieve its planned financial position; and
APPROVE the changes to the capital programme agreed by SIRG.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Delivery of a planned surplus of £2.0m
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	Compliance with financial management and governance standards

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

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

PREVIOUS CONSIDERATION:

Financial Management Board and Trust Management Board on 18 May 2010; Finance and Performance Management Committee on 20 May 2010

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – April 2010

EXECUTIVE SUMMARY

• During the month of April, the Trust produced a "bottom line" surplus of £195,000 which is £5,000 better than the planned position.

• Fully priced activity for April is not yet available and only limited additional income has been assumed based on a prudent view of early indications of activity levels during April.

• At month end, WTE's (whole time equivalents) excluding the impact of agency staff were approximately 108 below plan, a significant improvement on performance recorded towards the end of the previous financial year. Total pay expenditure for the month, including agency costs, was £121,000 above plan and, after taking account of the effect of agency staff, wte numbers rise to slightly in excess of plan.

• The month-end cash balance is approximately £4.3m above the planned cash profile, largely a consequence of higher than planned cash balances being carried forward at the end of the previous financial year.

• In line with previous financial years, capital expenditure in April was very low although amendments have now been proposed to the programme which fully utilises uncommitted elements and should allow more rapid progress on individual schemes.

Financial Performance Indicators

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	5	5	> Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	2	2	> Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	-121	-121	< Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	-81	-81	< Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	108	108	< Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	4,286	4,286	> = Plan	> = 95% of plan	< 95% of plan
CIP Actual v Plan £000	0	0	> 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	190	195
Capital Resource Limit	545	260
External Financing Limit	---	2,868
Return on Assets Employed	3.50%	3.52%

2010/2011 Summary Income & Expenditure Performance at April 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	341,295	28,332	28,625	293	28,332	28,625	293	341,295
Other Income	37,475	3,243	3,154	(89)	3,243	3,154	(89)	37,475
Operating Expenses	(352,059)	(29,310)	(29,512)	(202)	(29,310)	(29,512)	(202)	(352,059)
EBITDA	26,711	2,265	2,267	2	2,265	2,267	2	26,711
Interest Receivable	25	2	5	3	2	5	3	25
Depreciation & Amortisation	(16,062)	(1,338)	(1,323)	15	(1,338)	(1,323)	15	(16,062)
PDC Dividend	(7,656)	(638)	(638)	0	(638)	(638)	0	(7,656)
Interest Payable	(2,180)	(182)	(197)	(15)	(182)	(197)	(15)	(2,180)
Net Surplus/(Deficit)	**838**	**109**	**114**	**5**	**109**	**114**	**5**	**838**
IFRS Related Adjustments	1,200	81	81	0	81	81	0	1,200
SURPLUS/(DEFICIT) FOR DOH TARGET	**2,038**	**190**	**195**	**5**	**190**	**195**	**5**	**2,038**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – April 2010

Assessment of Performance

• The Trust, in common with all other NHS organisations, effectively has two income and expenditure targets against which performance will be measured.

• The first target is as reflected on the face of the Trust's Statement of Comprehensive Income and which will be reported as part of its statutory accounts. This position is fully reflective of the changes required as a result of the IFRS conversion and after the impact of any impairments incurred in year. For 2010/2011, the Trust's target measured on this basis is a surplus of £838,000.

• The second target measures performance against the DoH control total. This includes adjustments in respect of IFRS conversion and discounts the impact of any impairments. The control total for the Trust in 2010/2011 is £2,038,000.

Divisional Performance

• For the new financial year, the divisions of Medicine A and Medicine B have been merged to form the Medicine Division and Surgery and Anaesthetics and Critical Care merged to for the Surgery A and Anaesthetics Division. Performance monitoring will reflect this revised structure.

• Some shortfalls against planned positions have been recorded in month for Medicine, Facilities, Women & Childrens and Surgery B, the largest of £29,000 being in the Facilities Division. Activity levels in the month have been high and it should be noted that only a prudent estimate of additional income has been accrued in the month's financial position. This is likely to have the greatest adverse impact on the Medicine Division as the "front line" for much of the increased emergency and A&E related work.

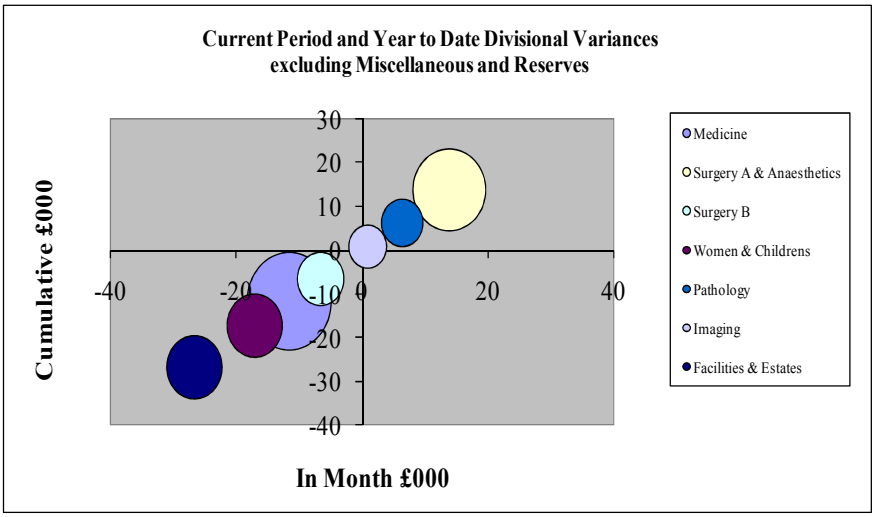
•However, it should equally be noted that changes to the tariff in 2010/2011 as well as the planned changes in activity levels linked with the RCRH programme discourage over performance. Given the likelihood of an increasingly difficult financial outlook, it is essential that all divisions are successful in containing costs within agreed plans and end the first quarter of the year in a strong financial position. It is therefore imperative that any adverse performance witnessed in April is corrected during May and June.

• Much of the increased expenditure can be related to increased activity and capacity levels with ongoing spend on bank and agency staff, primarily in medical and nursing staff groups as well drugs costs. The Medicine Division alone has had two additional wards operational during the month on the City site which is a major contributory factor to divisional financial performance.

• Some support to the overall financial position is generated by better than planned performance in the Operations and Corporate Services Divisions.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

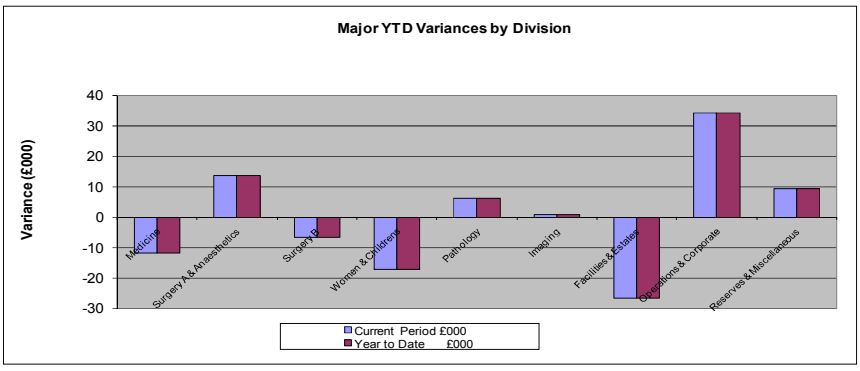
Financial Performance Report – April 2010



The tables adjacent and below show a mixed position across divisions. The Facilities Division has generated the greatest deficit with smaller deficits in Medicine, Womens & Childrens and Surgery B.

Divisional Variances from Plan

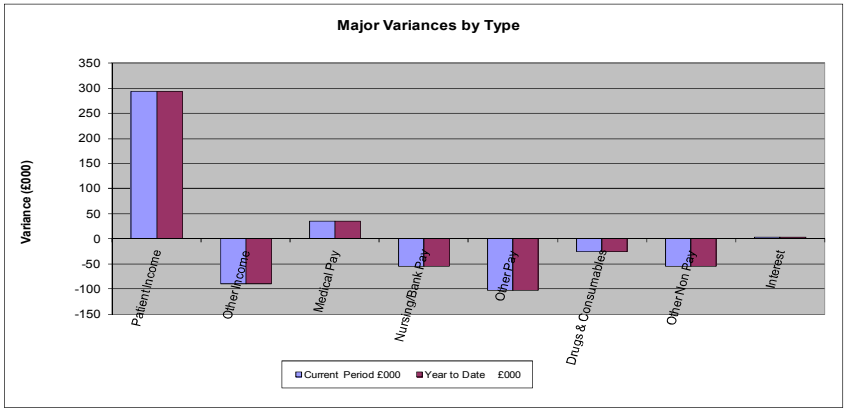
	Current Period £000	Year to Date £000
Medicine	-12	-12
Surgery A & Anaesthetics	14	14
Surgery B	-7	-7
Women & Childrens	-17	-17
Pathology	6	6
Imaging	1	1
Facilities & Estates	-27	-27
Operations & Corporate	34	34
Reserves & Miscellaneous	9	9



The tables below illustrate that overall, income continues to perform better than plan albeit only on the basis of a prudent assessment based on early indications of activity levels. Overall pay expenditure is above plan although to a lesser extent than experienced in the latter part of the previous financial year. In month, non pay expenditure remains in excess of plan, primarily driven by high drugs costs.

Variance From Plan by Expenditure Type

	Current Period £000	Year to Date £000
Patient Income	293	293
Other Income	-89	-89
Medical Pay	36	36
Nursing/Bank Pay	-55	-55
Other Pay	-102	-102
Drugs & Consumables	-26	-26
Other Non Pay	-55	-55
Interest	3	3



Sandwell and West Birmingham Hospitals NHS
NHS Trust

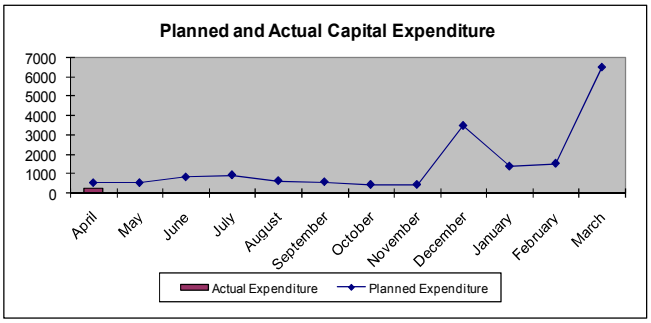
Financial Performance Report – April 2010

Capital Expenditure

• Planned and actual capital expenditure by month is summarised in the adjacent graph. Expenditure of £260,000 was incurred in April mainly in connection with ongoing schemes from the previous year.

• A number of allocation amendments to the capital programme are proposed by SIRG for Board agreement. The clarification of the plan is in accordance with the Board agreed control total and the schemes that were listed then for further prioritisation. This does not imply final authorisation as business cases are required in certain cases for SIRG and where its delegated limit is exceeded, for Trust Board.

- an additional £500k for maternity moves to fully fund service reconfiguration work
- £500k for same sex accommodation works on D5
- £450k for the Sandwell surgical day unit refurbishment
- £300k for Sandwell side room upgrading
- £70k for Sandwell chest clinic outpatient works
- £80k for the community gynaecology service

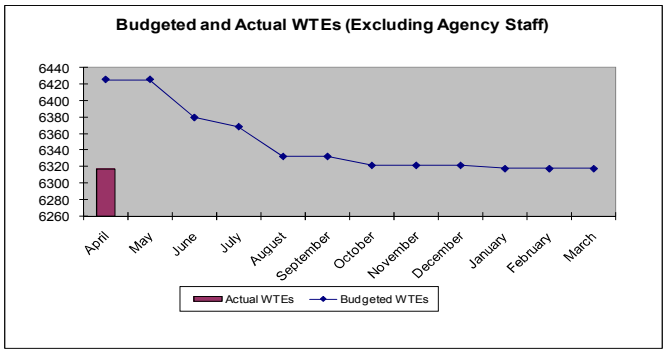


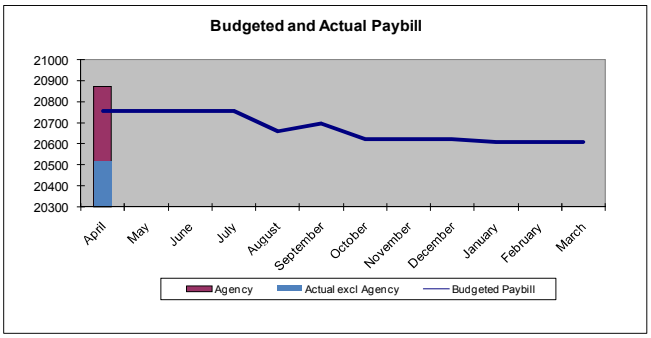
Paybill & Workforce

• Workforce numbers, excluding agency staff are approximately 108 wtes below plan for April. After adding agency numbers, this becomes approximately 3 above plan.

• Total pay costs (including agency staff) are £121,000 above budgeted levels for the month. This reflects an improvement on performance reported for the previous financial year but still represents the most significant driver of the overall financial position.

• Expenditure for agency staff in April was £360,000 which represents a significant decrease compared with the monthly average for 2009/10 of over £520,000.





Pay Variance by Pay Group

• The table overleaf 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, as was the case for the whole of the previous year, 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.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – April 2010

Analysis of Total Pay Costs by Staff Group

	Year to Date to April					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	6,042	5,990		150	6,140	(98)
Management	1,114	1,065		0	1,065	49
Administration & Estates	2,351	2,350		64	2,414	(63)
Healthcare Assistants & Support Staff	1,076	1,024	134	72	1,230	(154)
Nursing and Midwifery	7,165	6,792	291	48	7,131	34
Scientific, Therapeutic & Technical	2,980	2,869		27	2,896	84
Other Pay	26	0			0	26
Total Pay Costs	20,754	20,090	425	360	20,875	(121)

Balance Sheet

• The opening Statement of Financial Position (balance sheet) for the year at 1st April reflects the draft statutory accounts for the year ended 31st March 2010.

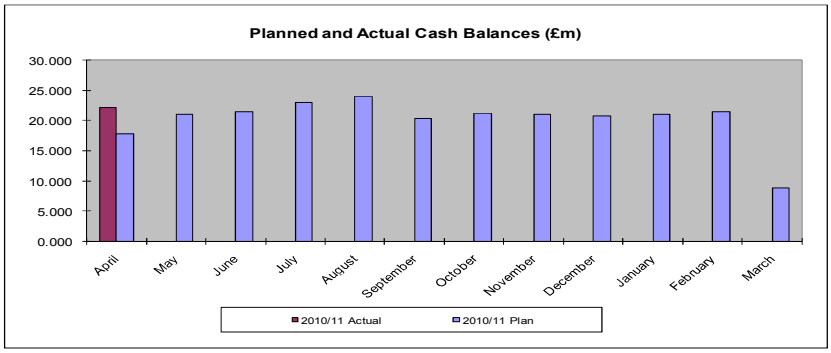
• Cash balances at 30th April are approximately £4.3m higher than the revised plan, primarily caused by higher than planned balances being held at the end of the previous financial year. Some over performance payments in respect of the 09/10 agreed position remain outstanding and the receipt of this cash will continue to improve the Trust's cash balances during the year.

Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION

		Opening Balance as at March 2010 £000	Balance as at April 2010 £000	Forecast at March 2011 £000
Non Current Assets	Intangible Assets	426	420	400
	Tangible Assets	220,300	219,237	222,138
	Investments	0	0	0
	Receivables	1,250	1,255	1,350
Current Assets	Inventories	3,439	3,384	3,400
	Receivables and Accrued Income	19,320	22,616	19,500
	Investments	0	0	0
	Cash	15,867	22,104	17,285
Current Liabilities	Payables and Accrued Expenditure	(32,301)	(40,746)	(37,215)
	Loans	0	0	0
	Borrowings	(1,698)	(1,695)	(1,690)
	Provisions	(5,048)	(5,048)	(5,000)
Non Current Liabilities	Payables and Accrued Expenditure	0	0	0
	Loans	0	0	0
	Borrowings	(32,476)	(32,335)	(30,786)
	Provisions	(2,175)	(2,175)	(2,150)
		186,904	187,018	187,232
Financed By				
Taxpayers Equity	Public Dividend Capital	160,231	160,231	160,231
	Revaluation Reserve	36,575	36,575	36,575
	Donated Asset Reserve	2,148	2,148	1,698
	Government Grant Reserve	1,103	1,103	1,043
	Other Reserves	9,058	9,058	9,058
	Income and Expenditure Reserve	(22,211)	(22,097)	(21,373)
		186,904	187,018	187,232

Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – April 2010



Cash Flow

• The table below shows cash receipts and payments for April 2010 and a forecast of expected flows for the following 12 months. This will be updated during the first quarter of the year to reflect the amended opening cash position and finalisation of 2010/11 income streams.

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW

12 MONTH ROLLING FORECAST AT April 2010

ACTUAL/FORECAST	Apr-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	Feb-11 £000s	Mar-11 £000s	Apr-11 £000s
Receipts													
SLAs: Sandwell PCT	**13,446**	13,503	13,503	13,503	13,503	13,503	13,503	13,503	13,503	13,503	13,503	13,506	13,506
HoB PCT	**7,277**	7,156	7,156	7,156	7,156	7,156	7,156	7,156	7,156	7,156	7,156	7,165	7,165
Associated PCTs	**5,332**	4,857	4,857	4,857	4,857	4,857	4,857	4,857	4,857	4,857	4,857	4,862	4,862
Pan Birmingham LSCG	**1,406**	1,260	1,260	1,260	1,260	1,260	1,260	1,260	1,260	1,260	1,260	1,257	1,257
Other SLAs	**520**	1,342	1,342	1,342	1,342	1,342	1,342	1,342	1,342	1,342	1,342	1,328	1,328
Over Performance Payments	**0**	2,000	500	500									
Education & Training	**979**	1,416	1,416	1,416	1,416	1,416	1,416	1,416	1,416	1,416	1,416	1,416	1,416
Loans	**0**												
Interest	**8**	2	2	2	2	2	2	2	2	2	2	2	2
Other Receipts	**3,388**	1,858	1,858	1,858	1,858	1,858	1,858	1,858	1,858	1,858	1,858	1,858	1,858
Total Receipts	32,356	33,393	31,893	31,893	31,393	31,393	31,393	31,393	31,393	31,393	31,393	31,393	31,393
Payments													
Payroll	**12,358**	11,958	11,848	11,808	11,712	11,712	11,675	11,675	11,675	11,663	11,663	11,663	11,779
Tax, NI and Pensions	**0**	9,113	9,113	9,113	9,113	9,113	9,113	9,113	9,113	9,113	9,113	9,113	9,204
Non Pay - NHS	**2,260**	1,881	2,250	2,043	2,043	2,290	2,110	2,357	1,616	2,164	2,164	2,505	2,000
Non Pay - Trade	**11,398**	5,642	6,749	6,129	6,129	6,870	6,331	7,072	4,849	6,492	6,492	7,515	6,500
Non Pay - Capital	**0**	798	798	595	595	595	595	595	3,595	940	940	4,422	750
PDC Dividend	**0**					3,828						3,828	
Repayment of PDC	**0**												
Repayment of Loans	**0**												
Interest	**0**												
BTC Unitary Charge	**0**	380	380	380	380	380	380	380	380	380	380	380	380
Other Payments	**103**	350	350	350	350	350	350	350	350	350	350	350	250
Total Payments	**26,119**	30,122	31,488	30,419	30,323	35,139	30,555	31,543	31,579	31,102	31,102	39,776	30,863
Cash Brought Forward	**15,867**	22,104	25,375	25,781	27,256	28,326	24,581	25,420	25,271	25,085	25,376	25,667	17,285
Net Receipts/(Payments)	**6,237**	3,271	406	1,475	1,071	(3,745)	839	(149)	(185)	291	291	(8,383)	530
Cash Carried Forward	**22,104**	25,375	25,781	27,256	28,326	24,581	25,420	25,271	25,085	25,376	25,667	17,285	17,815

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – April 2010

Risk Ratings			
Measure	**Description**	**Value**	**Score**
EBITDA Margin	Excess of income over operational costs	7.5%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	97.4%	4
Return on Assets	Surplus before dividends over average assets employed	5.1%	4
I&E Surplus Margin	I&E Surplus as % of total income	0.2%	2
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	4.1	1
Overall Rating			**2.6**

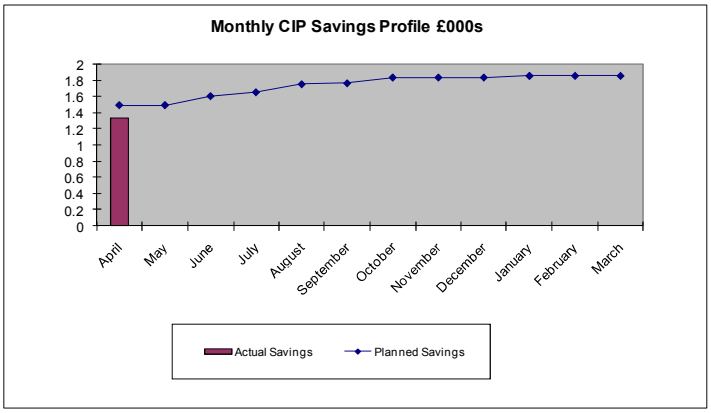
Risk Ratings

•The adjacent table shows the Monitor risk rating score for the Trust based on performance at April.
•The only significantly weak area remains liquidity which is to be expected as non Foundation Trusts do not have access to a Working Capital Facility, this being prerequisite to authorisation as an FT.

Cost improvement Programme

•The adjacent graph shows the monthly profile of the Trust's cost improvement programme and actuals achieved up to April.

•As at April, there is a shortfall against planned levels of £164k although it should be noted that there are a number a factors which may have suppressed CIP performance (e.g. the absence of fully costed SLA data). These will be corrected in subsequent months.



External Focus

• The Trust has not seen the financial report for April 2010 for its main commissioner, but results for the full year 1 April 2009 to 31 March 2010 show a small under spend of £91,000 against a budget of £557,432,000. Activity for NHS and Foundation Trusts was approximately £8,055,000 above contracted levels but this was managed within overall resources. At the end of February this over performance was valued at £6,828,000 of which SWBH was £1,213,000, Dudley Group £3,864,000 and UHB and HEFT together accounting for £1,815,000. This demonstrates that, in terms of contract performance, SWBH did not account for the pressure experienced by the PCT and in percentage terms based on contract values, the over performance was less than 1%. In terms of areas that assisted the PCT's position, prescribing costs are forecasted at £1,000,000 below previous estimates. The balance of financial flexibility came from a contingency reserve. The PCTs management of capital and cash resources appears to be in-line with budgets.

•For Heart of Birmingham PCT the picture is slightly different. A surplus of £7,373,000 was delivered from within resources (£563,904,000) similar in scale to Sandwell PCT. It accommodated a range of contract variations within an overall rate of 1.7%. Of this value over performance was seen at SWBH 1.8%, HEFT 5.3%, UHB 2.6% with activity below plan at BCH (3.5%), ROH (1.8%) and BWH (1.9%). Quite obviously, HoB is in a stronger financial position than many of the surrounding PCTs. It will, however, be held to a planned surplus in 2010/11 and must work within this for performance monitoring purposes.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – April 2010

External Focus (Continued)

•As the new coalition government formulates its detailed spending plans, more will be known regarding the settlement for the NHS. What is clear is that efficiency requirements will be looked to in future years for funding many of the pressures such as patient demographics and the introduction of new therapies and services. In this sense, the budget may not reduce in absolute terms, but there will be a shift of resources within it to meet new demands. This direction of travel was anticipated when setting the budget. Details of future spending reviews will clarify expectations further.

Conclusions

• For the first month of the new financial year, the Trust has posted a surplus of £114,000 against its statutory accounts target and £195,000 against its DoH control total. Both are £5,000 above the planned position.

• Capital expenditure in April was £260,000 mainly in relation to ongoing schemes brought forward from the previous year.

•At 30th April, cash balances are approximately £5.0m higher than the revised cash plan, primarily generated by higher than planned balances being brought forward at 1st April.

• Prudent accruals of additional over performance related income have been made based on early activity numbers. Without this, the shortfall against plan would have been significantly greater.

• There are early indications of cost pressures being manifested in a number of clinical and operational divisions (although some can clearly be linked with higher activity levels and additional capacity being open) with over spending occurring against both pay and non pay plans.

• Given the likelihood of increased financial and operational pressures later in the year and the worsening situation with general public finances, it is essential that the Trust is in a healthy financial position at the end of the first quarter of the year. Any cost pressures inherent within the current position need to be addressed urgently in order for this to be delivered.

Recommendations

The Trust Board is asked to:

i. NOTE the contents of the report;

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

iii. APPROVE the changes to the capital programme agreed by SIRG.

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:	27 May 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 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	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	Internal Control and Value for Money

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

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

PREVIOUS CONSIDERATION:

Financial Management Board and Trust Management Board on 18 May 2010 and Finance and Performance Management Committee on 20 May 2010.

SANDWELL AND WEST BIRMINGHAM HOSPITALS PERFORMANCE MONITORING REPORT - APRIL 2010

EXECUTIVE SUMMARY

Note	Comments
a	The percentage of **Cancelled Operations** during April (0.9%) is similar to the percentage reported during March (1.0%), although numerically less, due to a lower volume of Elective Activity during April. The majority of cancellations were within Ophthalmology.
b	**Delayed Transfers of Care** reduced slightly during April, but remained in excess of 4%. Of the 27 delays identified on the census date, 15 were attributable to Social services.
c	**Stroke Care** - the proportion of patients spending at least 90% of their hospital stay on a Stroke Unit reduced to 59.5% during April. The number of patients admitted with a primary diagnosis of Stroke, and the performance, was similar on both acute sites.
d	**Accident & Emergency 4-hour waits** - performance during April fell marginally short of the 98.00% operational threshold. Unit-specific performance was; City Acute 95.9%, Sandwell 99.3% and BMEC 99.6%.
e	The overall number of cases of **C Diff** reported across the Trust during the month of April was 13, with an even distribution across sites. No cases of **MRSA Bacteraemia** were reported during the month. External trajectories for C Diff and MRSA Bacteraemia were both met. The internal trajectory for C Diff, based upon last years outturn was also met.
f	**Referral to Treatment Time** data for April was not available for inclusion within the report.
g	**Sickness Absence** during April was 3.96%, and has reduced gradually since January. Absence by Division during April ranges from 0.35 - 4.42%.
h	Overall compliance with **Mandatory Training** modules is reported as 74.3% at the end of April, with compliance in Clinical Divisions ranging from 66 - 79% and in Non-Clinical Divisions ranging from 84 - 99%. The total number of PDRs undertaken reported for the month was 137.
i	**CQUIN:**
	VTE (Venous Thromboembolism) Risk Assessment - Adult inpatients (includes daycases, maternity and transfers, both elective and non-elective) who have had a VTE risk assessment on admission to hospital. Nationally mandated indicator. 90% target.
	Breast Feeding - Breastfeeding status at time of Guthrie Test (usually day 6 or 7) (*or discharge from midwifery care*). Baseline to be assessed during Quarter 1. Target is baseline plus 10%.
	Tissue Viability (Pressure Ulcers) - Comprises 3 components; Assessment on admission, Decrease in number of acute hospital acquired grade 3 and 4 ulcerations and Table Top Reviews on all ulcerations of grade 3 or 4. Measured through bi-annual audit.
	Inpatient Falls Causing Fracture - target to reduce number of inpatient falls with fracture from 22 (baseline) to 17 in 2010 / 2011.
	Brain Imaging for Emergency Stroke Admissions (within 24 hours admission) - continuation of 2009 / 10 CQUIN indicator, with target increased to 90%. April performance as indicated.
	Hip Fracture Operations within 24-hours of admission - 2009 / 10 CQUIN indicator specified target for operations within 48 hours. Target for 2010 / 11 is 70% of patients **within 24 hours.**
	Smoking (Brief Intervention in Outpatients) - extension of smoking cessation referrals to a wider range of outpatient clinics including; ENT, Vascular, Paediatrics (passive smoking), Cardiology, Respiratory, Diabetes and General Surgery if the patient is to be listed for elective surgery. Target for 2010 / 11 is 2000 referrals.
	Safer Prescribing of Warfarin - Number of patients prescribed warfarin with INR (International Normalised Ratio) within the target range. Baseline audit at 2 months, with re-audit at 6 and 10 months. Target 65% by March 2011.
	Patient Experience - Composite of response to 5 inpatient survey questions. Goal to improve responsiveness to personal needs of patients. Survey to be conducted between October and January, for patients who had an inpatient episode between July and August. Target is an improvement (increase) of 2 percentage points on 2009 / 10 baseline.
	Think Glucose - target relates to Inpatients with a secondary diagnosis of Diabetes. Final indicator value is evidence of participation in NHS Institute Think Glucose Programme.
	Parent's Consultation with Senior Clinician - parents able to discuss care of their baby with senior clinician within 24 hours of admission onto neonatal unit. Target to be determined following collection of Quarter 1 baseline data.
	Neonates Offered Breast Milk - to maximise the number of babies of <31 weeks gestation admitted to the neonatal unit who will be offered some breast milk (from mother) during the inpatient episode. Target to be determined following collection of Quarter 1 baseline
	Herceptin Home Delivery - Introduction of home delivery scheme for Herceptin Chemotherapy. Introduction of home delivery in Quarter 1, target of 95% of patients on home delivery in Quarter 2 and progress on other new initiatives during Quarters 3 and 4.
j	During the month of April a total of 4830 **MRSA Screens** were undertaken, 2312 related to Elective admissions and 2518 related to Non-Elective admissions. The number of screens is compared with a trajectory for the period derived from an annual target. The annual target takes into consideration legitimate exclusions based upon national guidance.
k	Detailed analysis of **Financial Performance** is contained within a separate paper to this meeting.
l	**Activity** (trust-wide) to date is compared with the contracted activity plan for **2010 / 2011** - Month and Year to Date.

	Month				Year to Date			
	Actual	Plan	Variance	%	Actual	Plan	Variance	%
IP Elective	1073	1011	62	6.1	1073	1011	62	6.1
Day case	4240	3660	580	15.8	4240	3660	580	15.8
IPE plus DC	5313	4671	642	13.7	5313	4671	642	13.7
IP Non-Elective	5063	5164	-101	-2.0	5063	5164	-101	-2.0
OP New	12748	12463	285	2.3	12748	12463	285	2.3
OP Review	35633	31777	3856	12.1	35633	31777	3856	12.1

Activity to date is compared with **2009 / 10** for the corresponding period

	2008 / 09	2009 / 10	Variance	%
IP Elective	1084	1073	-11	-1.0
Day case	4393	4240	-153	-3.5
IPE plus DC	5477	5313	-164	-3.0
IP Non-Elective	5408	5063	-345	-6.4
OP New	14379	12748	-1631	-11.3
OP Review	37057	35633	-1424	-3.8

m	**Bank and Agency Use** - Nurse Bank and Nurse Agency use and costs have been within targets for the month of April. Overall expenditure on Medical Agency and Medical locum staff was £435K, similar to the average per month for 2009 / 10. Overall expenditure on Agency Staff reduced to 1.72%.

SWBTB (5/10) 113 (a)

SANDWELL AND WEST BIRMINGHAM HOSPITALS CORPORATE QUALITY AND PERFORMANCE MONITORING REPORT - APRIL 2010

Exec Lead	NATIONAL AND LOCAL PRIORITY INDICATORS		Unit	December Trust	January Trust	February Trust	March S'well	March City	March Trust	April S'well	April City	April Trust	To Date	TARGET YTD	TARGET 10/11	Exec Summary Note	THRESHOLDS Green	THRESHOLDS Amber	THRESHOLDS Red	08/09 Outturn	09/10 Outturn
RW	Net Income & Expenditure (Surplus / Deficit (-))		£000s	160 ▲	258 ▼	96 ▼	→		47 ▼	→		114 ▼	114	109	2038		0%	0 - 1%	>1%	2535	2279
RK	Cancer	2 weeks	%	93.6 ▼	93.9 ▲	94.7 ▲	→		94.2 ▼	→			93.9 (09/10)	=>93	=>93		No variation		Any variation	98.6	93.9
		2 weeks (Breast Symptomatic)	%		93.2 ■	93.5 ▲	→		94.2 ▲	→			93.6 (09/10)	=>93	=>93		No variation		Any variation	n/a	93.6 (Q4 only)
		31 Days	%	100 ▲	99.3 ▼	100 ▲	→		100 ■	→			99.7 (09/10)	=>96	=>96		No variation		Any variation	100	99.7
		62 Days	%	89.1 ▼	86.5 ▼	85.0 ▼	→		89.6 ▲	→			89.1 (09/10)	=>85	=>85		No variation		Any variation	98.6	89.1
RK	Cancelled Operations	Elective Admissions Cancelled at last minute for non-clinical reasons	%	0.7 ■	1.0 ■	0.6 ■	0.4 ■	1.5 ■	1.0 ■	0.7 ▼	1.0 ■	0.9 ▲	0.9	<0.8	<0.8	a	<0.8	0.8 - 1.0	>1.0	1.0	0.8
		28 day breaches	No.	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	0	0	0		3 or less	4 - 6	>6	0	0
	Delayed Transfers of Care	Total	%	3.9 ■	2.6 ■	3.1 ■	4.5 ■	5.3 ■	4.9 ■	4.6 ▼	4.0 ■	4.3 ▲	4.3	<3.0	<3.0	b	<3.0	3.0 - 4.0	>4.0	3.1	3.0
		Primary Angioplasty (<150 mins)		64 ■	88 ■	100 ▲	100 ■	100 ■	100 ■					80	80		>80	75-80	<75	83.6	86.2
		Rapid Access Chest Pain	%	100 ■	98.3 ▼	100 ■	100 ■	100 ■	100 ■					=>98	=>98		>99	98 - 99	<98	100.0	99.7
		Thrombolysis (60 minutes)	%	no pts	no pts	no pts			no pts					80	80		>80	75-80	<75	0	no pts
DO'D	Stroke Care	>90% stay on Stroke Unit	%	64.0 ■	73.3 ▲	74.1 ▲	→		67.9 ▼	→		59.5 ■	59.5	70	70	c	=>60	31-59	=<30	36.5	62.0
RK	A/E 4 Hour Waits		%	96.2 ▼	97.8 ▲	98.0 ■	99.1 ▼	98.6 ■	98.8 ▲	99.3 ▲	96.9 ■	97.8 ■	97.80	=>98	=>98	d	=>98		<98	98.16	98.55
	GUM 48 Hours	Patients seen within 48 hours	%	87.5 ▲	87.3 ▼	80.7 ▼	→		82.5 ▲	→		86.0 ▲	86.0	=>90	=>90		=>90	80-89	<80	81.0	86.8
		Patients offered app't within 48 hrs	%	100 ■	100 ■	100 ■	→		100 ■	→		100 ■	100.0	=>98	=>98		=>98	95-98	<95	98.3	99.8
R0	Infection Control	C. Diff - EXTERNAL (DH) TARGET	No.	14 ■	17 ▼	12 ■	8 ▼	8 ▲	16 ▼	7 ▲	6 ▲	13 ▲	13	21	243	e	No variation		Any variation	163	158
		C. Diff - INTERNAL TARGET	No.	14 ■	17 ▼	12 ■	8 ▼	8 ▲	16 ▼	7 ▲	6 ▲	13 ▲	13	13	158		No variation		Any variation	163	158
		MRSA - EXTERNAL (DH) TARGET	No.	0 ▲	1 ▼	2 ▼	0 ■	1 ▼	1 ▲	0 ■	0 ▲	0 ▲	0	1	6		No variation		Any variation	15	14
RK	Data Quality	Valid Coding for Ethnic Category (FCEs)	%	95 ▲	94 ▼	94 ■	→			→				90	90		>/=90	89.0-89.9	<89	87.0	
		Maternity HES	%	5.7 ■			→			→				<15	<15		=<15	16-30	>30	n/a	
RO	Infant Health & Inequalities	Maternal Smoking Status Data Complete	%	99.0 ■	→	→	→		99.3 ▲	→				=>98.0	=>98.0		=>98	95-98	<95	99.9	99.3
		Breast Feeding Status Data Complete	%	99.3 ■	→	→	→		99.8 ▲	→				=>98.0	=>98.0		=>98	95-98	<95	97.8	99.3
		Maternal Smoking Rates	%	10.9 ▲	→	→	→		11.0 ▼	→				<11.5	<11.5		<11.5	11.5 - 12.5	>12.5	12.6	11.6
		Breast Feeding Initiation Rates	%	63.3 ▲	→	→	→		64.2 ▲	→				>63.0	>63.0		>63.0	61-63	<61.0	54.2	63.1
RK	RTT Milestones	Admitted Care (RTT <18 weeks)	%	92.8 ▼	95.5 ▲	94.1 ▼	→		93.4 ▼	→				=>90.0	=>90.0	f	=>90.0		<90.0	98.6	93.4
		Admitted Care - Data Completeness	%	99.8 ■	102.8 ■	101.3 ■	→		102.6 ■	→				90-110	<90 or >110		90-110		<90 or >110	100.4	102.6
		Non-Admitted Care (RTT <18 weeks)	%	96.7 ▼	98.4 ▲	98.9 ▲	→		97.6 ▼	→				=>95.0	=>95.0		=>95.0		=<95.0	98.8	97.6
		Non-Admitted Care - Data Completeness	%	90.9 ■	96.3 ■	97.7 ■	→		92.4 ■	→				90-110	<90 or >110		90-110		<90 or >110	98.1	92.4
		Audiology Direct Access Waits (<18 wks)	%	100 ■	100 ■	100 ■	→		100 ■	→				=>95	=>95		=>95		<95	99.0	100.0
		Audiology Data Completeness	%	102.0 ■	108.0 ■	108.0 ■	→		94.0 ■	→				90-110	<90 or >110		90-110		<90 or >110	96.0	94.0
DO'D	Mortality in Hospital	Hospital Standardised Mortality Rate	HSMR	97.8 (Sept '09)	90.0 (Oct '09)	99.7 (Nov '09)	→		98.6 (Dec '09)	→		108.0 (Jan '10)	94.1	< Lower Confidence Limit			< Lower Confidence Limit		>Upper Confidence Limit	105.1	
		Peer (SHA) HSMR	HSMR	85.7	90.4	90.6	→		89.8	→		93.5	93.6							103.9	
RO	Sickness Absence	Long Term	%	3.40 ■	3.79 ▼	3.34 ■	→		3.20 ▲	→		3.01 ▲	3.01	<3.00	<3.00	g	<3.0	3.0-3.35	>3.35	3.16	3.10
		Short Term	%	1.33 ■	1.60 ■	1.25 ■	→		1.25 ■	→		0.95 ■	0.95	<1.25	<1.25		<1.25	1.25-1.40	>1.40	1.22	1.31
		Total	%	4.73 ■	5.39 ■	4.59 ■	→		4.45 ▲	→		3.96 ■	3.96	<4.25	<4.25		<4.25	4.25-4.75	>4.75	4.38	4.41
	Learning & Development	PDRs (includes Junior Med staff)	No.	192 ▼	284 ▲	289 ▲	→		290 ▲	→		137 ▼	137	445	5341	h	0-15% variati	15 - 25%	>25% variati	4518	4748
		Mandatory Training Compliance	%	55.7 ▲	60.7 ▲	65.2 ▲	→		71.1 ■	→		74.3 ▲	74.3	100	100		=>80	50 - 79	<50	4044 (No.)	71.1

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Exec Lead	NATIONAL AND LOCAL PRIORITY INDICATORS (Cont'd)		Unit	December Trust	January Trust	February Trust	March S'well	March City	March Trust	April S'well	April City	April Trust	To Date	TARGET YTD	TARGET 10/11	Exec Summary Note	THRESHOLDS Green	THRESHOLDS Amber	THRESHOLDS Red	08/09 Outturn	09/10 Outturn
DO'D	CQUIN	VTE Risk Assessment (Adult IP)	%	→						→					90	i				n/a	
RO		Breast Feeding (At D'charge from M'wife)	%	→						Baseline to be established in Q1					Base +10%					n/a	
RO		Tissue Viability - assessment <12hrs	%	→						Measured through bi-annual au					90					n/a	
RO		Tissue Viability - Hosp Acq'd Grade 3/4	%	→						Measured through bi-annual au					Base -10%					n/a	
RO		Tissue Viability - TTR of Grade 3/4	%	→						Measured through bi-annual au					100					n/a	
RO		Inpatient Falls Causing Fracture	No.	→						→					17					n/a	
DO'D		Brain Imaging for Em. Stroke Admissions	%	85.2 ▲	84.7 ▼	86.9 ▲	→		93.6 ▲	→		91.2 ▲	91.2	85.0	90.0		=>72.0		<72.0	72.0	81.8
RK		Hip Fracture Op's <24 hours of admission	%	→						→					70.0		No Variation	0 - 2% Variation	>2% Variation	n/a	
DO'D		Smoking - Brief Intervention in OP	No.	→						→		129 ■	129	167	2000		=>167	per month	<167	7	1164
RK		Safer Prescribing of Warfarin	%	→						Baseline audit at 2 months					65.0					n/a	
RO		Patient Experience	%	→						Composite of 5 Qs - Survey Octo					09/10 +2%						
DO'D		Think Glucose		→						Participation in Think Glucose Programme										n/a	
RK	CQUIN (Specialised Commissioners)	Parent's consultation with senior clinician		→						Baseline to be established in Q1										n/a	
		Neonates Offered Breast Milk		→						Baseline to be established in Q1										n/a	
		Herceptin Home Delivery	%	→						Introduction of service in Q2					95.0		=>90		<90	n/a	
	CLINICAL QUALITY																				
RK	Readmission Rates	(Within 28 days of discharge)	%	11.9	11.4	11.7	11.1	11.1	11.1				11.5	No. Only	No. Only					11.6	11.1
		(Within 14 days of discharge)	%	8.8	8.5	8.7	8.5	8.5	8.5				8.5	No. Only	No. Only					7.3	8.5
R0	Infection Control	Savings Lives Compliance	%	100 ▲	99 ▼	99 ■	→		99 ■	→		100 ▲	100	>95	>95	j	< YTD target		> YTD target	99.0	99.0
		MRSA Screening (Elective)	No.	1611	2248	2231	→		2707	→		2312 ■	2312	2381	30000		0-15%	16-30%	>30%	6495	24710
		MRSA Screening (Non-Elective)	No.	2175	2203	2112	→		2408	→		2518	2518	2466	30000		0-15%	16-30%	>30%	n/a	18571
DO'D	Obstetrics	Post Partum Haemorrhage (>2000 ml)	No.	0 ■	0 ■	1 ▼	0 ■	0 ▲	0 ▲	0 ■	0 ■	0 ■	0	48	48		=<2	3 - 4	>4		10
		Admissions to Neonatal ICU	%	4.6 ▼	5.0 ▼	5.3 ▼	2.2 ▲	4.1 ▲	3.3 ▲	2.1 ▲	7.4 ▼	5.3 ▼	5.3	=<10	=<10		=<10	10.0-12.0	>12.0		5.5
		Adjusted Perinatal Mortality Rate	/1000	7.1 ■	5.3 ▲	2.0 ▲	21.6 ■	3.1 ▲	10.9 ■					<8.0	<8.0		<8	8.1 - 10.0	>10		10.9
		Caesarean Section Rate	%	22.0 ▲	25.8 ▼	23.1 ▲	19.9 ▼	24.8 ▲	22.7 ▲	25.0 ■	26.8 ■	26.1 ■	26.1	<25.0	<25.0		=<25.0	25-28	>28.0	27.0	23.3
	FINANCE & FINANCIAL EFFICIENCY																				
RW	Gross Margin		£000s	2402 ▲	2501 ▲	2259 ▼	→		4603 ▲	→		2267 ▼	2267	2265	26711	k	0%	0 - 1%	>1%	26436	30436
	CIP		£000s	1113 ■	1169 ■	1168 ▼	→		1254 ▲	→		1332 ■	1332	1495	20840		0 - 2.5%	2.5 - 7.5%	>7.5%	11084	15075
	In Year Monthly Run Rate		%	29.03 ▲	11.69 ▼	37.14 ▲	→		27.03 ▼	→		4.59 ▼	4.59	0	0		NO or a + variation	0 - 5% variation	>5% variation	1.4	0.44
RK	Income / WTE		£s	5087 ▲	5088 ▲	5022 ▼	→		5877 ▲	→		5021 ■	5021	5127	5127		No variation	0 - 5% variation	>5% variation	5014	5058
	Income / Open Bed		£s	32518 ▲	30217 ■	31920 ■	→		38857 ▲	→		33600 ▼	33600	32697	32697		No variation	0 - 5% variation	>5% variation	30498	32697
	Income per Spell	Total Income	£s	2994 ▲	3066 ▲	3101 ▲	→		3250 ▲	→		3063 ▼	3063	2908	2908		No Variation	0 - 4% Variation	>4% Variation	2701	2908
		Clinical Income	£s	2695 ▲	2755 ▲	2775 ▲	→		2553 ■	→		2759 ■	2759	2580	2580		No Variation	0 - 4% Variation	>4% Variation	2400	2580
		Non-Clinical Income	£s	299 ■	311 ■	326 ▲	→		697 ▲	→		304 ■	304	328	328		No Variation	0 - 4% Variation	>4% Variation	301	328
	Cost per Spell	Total Cost	£s	2980 ▼	3042 ▼	3092 ▼	→		3244 ▼	→		3052 ▲	3052	2891	2891		No Variation	0 - 4% Variation	>4% Variation	2682	2891
		Total Pay Cost	£s	1960 ▼	2027 ▼	2072 ▼	→		1841 ■	→		2012 ■	2012	1909	1909		No Variation	0 - 4% Variation	>4% Variation	1785	1909
		Medical Pay Cost	£s	564 ■	585 ■	594 ▼	→		526 ■	→		577 ■	577	555	555		No Variation	0 - 4% Variation	>4% Variation	532	555
		Nursing Pay Cost (including Bank)	£s	680 ▼	713 ▼	735 ▼	→		596 ■	→		696 ■	696	660	660		No Variation	0 - 4% Variation	>4% Variation	625	660
		Non-Pay Cost	£s	1019 ■	1015 ▲	1020 ▼	→		1402 ▼	→		1040 ▲	1040	982	982		No Variation	0 - 4% Variation	>4% Variation	897	982
		Mean Drug Cost / IP Spell	£s	134 ▼	139 ▼	126 ■	→		143 ■	→		134 ▲	134	124	124		No Variation	0 - 4% Variation	>4% Variation	120	124
		Mean Drug Cost / Occupied Bed Day	£s	52 ■	50 ■	51 ■	→		60 ▼	→		53 ▲	53	49	49		No Variation	0 - 4% Variation	>4% Variation	47	49

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Exec Lead	PATIENT EXPERIENCE		Unit	Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust	To Date	YTD	10/11	Summary Note	Green	Amber	Red	08/09 Outturn	09/10 Outturn
RK	Same Sex Accommodation Breaches	Number of Breaches	No.	917 ■	865 ▲	604 ■	→		721 ▼	→		724 ■	724	500	6000		<500 pcm	501 -800 pcm	>800 pcm	n/a	3711 (Nov - Mar)
		Percentage of overall admissions	%	8.06 ■	7.77 ▲	5.70 ■	→		5.81 ▼	→		6.77 ■	6.77	<3%	<3%		<3%	3 - 6%	>6%	n/a	6.47 (Nov - Mar)
KD	Complaints	Number Received	No.	217	→	→	→			→				No. Only	No. Only					789	
		Response within initial negotiated date	%	70.5 ■	→	→	→			→				85	85		80%+	70 - 79%	<70%	81.1	
	Thank You Letters		No.	729	→	→	→			→				No. Only	No. Only					2912	
RK	Elective Access Contact Centre	Number of Calls Received	No.	no data	no data	12866	→		14286	→				No. Only	No. Only					190434	incomplete data
		Average Length of Queue	mins	no data	no data	4.14 ■	→		2.56 ▲	→				0.5	0.5		No variation	0 - 10% variation	>10% variation	0.44	
		Maximum Length of Queue	mins	no data	no data	32.1 ■	→		39.6 ▼	→				6.0	6.0		No variation	0 - 10% variation	>10% variation	17.4	
	Telephone Exchange	Number of Calls Received	No.	81214	86311	75208	→		84026	→		74895	74895	No. Only	No. Only					1559688	1100521
		Calls Answered	%	87.9	81.4	84.0			84.1			88.3	88.3	No. Only	No. Only					82.3	83.6
		Answered within 15 seconds	%	45.1	36.2	39.8			39.0			47.5	47.5	No. Only	No. Only					39.1	43.8
		Answered within 30 seconds	%	61.0	49.3	53.9			53.2			62.6	62.6	No. Only	No. Only					55.5	58.8
		Average Ring Time	Secs	29.5	39.2	35.9			36.0			28.3	28.3	No. Only	No. Only					28.8	36.0
		Longest Ring Time	Secs	447	650	485			646			727	727	No. Only	No. Only					695	646
	STRATEGY																				
RK	Referrals	Total By Site	No.	14438 ▼	14518 ■	15500 ■	→		18390 ▲	→							No Variation	0 - 2% Variation	>2% Variation	178070	192689
		Total GP Referrals	No.	9555 ▲	9644 ■	10449 ■	→		12260 ▲	→							No Variation	0 - 2% Variation	>2% Variation	120138	126928
		Total Other Referrals	No.	4883 ▼	4874 ■	5051 ■	→		6130 ▲	→							No Variation	0 - 2% Variation	>2% Variation	57932	65761
		By PCT - Heart of B'ham	No.	4030 ▼	4064 ■	4371 ■	→		5027 ▲	→							No Variation	0 - 2% Variation	>2% Variation	49859	52645
		By PCT - Sandwell	No.	7214 ▼	7339 ■	7719 ■	→		9231 ▲	→							No Variation	0 - 2% Variation	>2% Variation	87779	96524
		By PCT - Other	No.	3194 ▼	3115 ■	3410 ■	→		4132 ▲	→							No Variation	0 - 2% Variation	>2% Variation	40453	43520
		Conversion (all referrals) to New OP Att	%	87.2	85.2	83.8	→		84.8	→				No. Only	No. Only					85.9	85.3
		OP Source of Referral Information	%	1.64 ▼	1.13 ▲	1.81 ▼	→		1.01 ▲	→		0.87 ▲	0.87	5.0	5.0		No variation		Any variation	10.0	1.4
	ACTIVITY																				
RK	Spells	Elective IP	No.	1059 ▼	1117 ■	1086 ■	423 ▲	918 ▲	1341 ▲	→		1073 ▼	1073	1011	12641	l	No Variation	0 - 2% Variation	>2% Variation	13106	13722
		Elective DC	No.	4181 ▼	4130 ■	4184 ■	2366 ■	2739 ▲	5105 ▲	→		4240 ▼	4240	3660	45747		No Variation	0 - 2% Variation	>2% Variation	50873	52729
		Total Elective	No.	5240 ▼	5247 ■	5270 ■	2789 ■	3657 ▲	6446 ▲	→		5313 ▼	5313	4671	58338		No Variation	0 - 2% Variation	>2% Variation	63979	66451
		Non-Elective - Short Stay	No.	1302 ■	1412 ▲	1385 ▲	599 ▼	829 ▼	1428 ▼	→		1296 ■	1296	1304	15712		No Variation	0 - 2% Variation	>2% Variation	12770	18769
		Non-Elective - Other	No.	4318 ■	3836 ■	3575 ▲	1728 ▲	2222 ▼	3950 ▼	→		3767 ▲	3767	3860	46502		No Variation	0 - 2% Variation	>2% Variation	56226	47072
		Total Non-Elective	No.	5620 ■	5248 ■	4960 ■	2327 ▼	3051 ▼	5378 ▼	→		5063 ■	5063	5164	62214		No Variation	0 - 2% Variation	>2% Variation	68996	65841
	Outpatients	New	No.	12585 ■	12372 ▼	12981 ■	5431 ■	10164 ▲	15595 ▲	→		12748 ▼	12748	12463	#####		No Variation	0 - 2% Variation	>2% Variation	152923	164358
		Review	No.	33118 ▼	33730 ■	34412 ■	14875 ▲	27434 ▲	42309 ▲	→		35633 ▼	35633	31777	#####		No Variation	0 - 2% Variation	>2% Variation	374867	425850
	A/E Attendances	Type I (Sandwell & City Main Units)	No.	15165 ▲	14412 ▼	13490 ▼	7102 ▲	8819 ▼	15921 ▲	6840 ▼	8645 ▼	15485 ▼	15485	16697	#####		No Variation	0 - 2% Variation	>2% Variation	191141	190254
	A/E Attendances	Type II (BMEC)	No.	2532 ■	2572 ▲	2750 ▲	→	3061 ▼	3061 ▼	→	3010 ■	3010 ■	3010	3057	35133		No Variation	0 - 2% Variation	>2% Variation	30800	34836

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Exec Lead	PATIENT ACCESS & EFFICIENCY		Unit	Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust	To Date	YTD	10/11	Summary Note	Green	Amber	Red	08/09 Outturn	09/10 Outturn
RK	Waiting Times	Inpatients >26 weeks	%	0 ■	0 ■	0 ■	→		0 ■	→				0	0		<0.03		>0.03	0.000	0.000
		Outpatients >13 weeks	%	0 ■	0 ■	0 ■	→		0 ■	→				0	0		<0.03		>0.03	0.007	0.001
		Diagnostic Waits greater than 6 weeks	No.	1 ▲	0 ■	5 ■	→		3 ▲	→				0	0		0		>0	26	3
		Revascularisation >13 weeks	No.	0 ■	0 ■	0 ■	→		0 ■	→				0	0		0		>0	0	0
	Length of Stay	Average Length of Stay	Days	4.7 ▼	4.4 ▲	4.5 ▼	4.8 ■	3.8 ▲	4.2 ▲					5.0	5.0		No Variation	0 - 5% Variation	>5% Variation	5.0	4.4
		All Patients with LOS > 14 days	No.	344	325	329	187	169	356	170	156	326	326	No. Only	No. Only					312	356
		All Patients with LOS > 28 days	No.	157	175	174	93	102	195	98	89	187	187	No. Only	No. Only					152	195
		Min. Stay Rate (Electives (IP/DC) <2 days)	%	92.3 ▲	92.8 ▲	93.2 ▲	95.2 ▼	90.5 ▼	92.5 ▼	95.8 ▲	90.9 ▲	93.1 ▲	93.1	92.0	92.0		No Variation	0 - 5% Variation	>5% Variation	91.6	92.3
	Admissions	Day of Surgery (IP Elective Surgery)	%	87.7 ▲	87.4 ▼	88.8 ▲	90.7 ▼	85.6 ▼	87.3 ▼	90.2 ▼	89.6 ▲	89.8 ▲	89.8	82.0	82.0		No Variation	0 - 5% Variation	>5% Variation	79.4	85.5
		Day of Surgery (IP Non-Elective Surgery)	%	62.7	70.0	69.3	67.2	72.0	70.0	69.1	73.7	71.7	71.7	No. Only	No. Only					70.2	69.7
		With no Procedure (Elective Surgery)	%	7.5	8.9	9.4	12.0	8.2	9.4					No. Only	No. Only					10.6	9.7
		Per Bed (Elective)	No.	5.37 ▲	4.97 ▼	5.10 ▲	4.88 ▲	6.25 ■	5.58 ▲	4.83 ▼	5.98 ▼	5.40 ▼	5.40	5.90	5.90		No Variation	0 - 5% Variation	>5% Variation	5.33	5.49
	Discharges	Pt's Social Care Delay	No.	23 ■	9 ■	15 ▼	13 ■	15 ■	28 ■	9 ■	6 ■	15 ■	15	<18	<18	b	No Variation	0 - 10% Variation	>10% Variation		
		Pt.'s NHS & NHS plus S.C. Delay	No.	10 ■	7 ■	8 ▼	5 ▼	7 ■	12 ■	3 ▲	9 ▼	12 ■	12	<10	<10		No Variation	0 - 10% Variation	>10% Variation		
	Beds	Occupied Bed Days	No.	28232 ▲	29129 ■	25455 ■	12643 ▲	15316 ▼	27959 ▲	11760 ▲	14554 ▼	26314 ▲	26314	27283	3E+05		No Variation	0 - 5% Variation	>5% Variation	342793	331946
		Occupancy Rate	%	86.4 ■	86.1 ■	85.9 ■	86.9 ■	83.9 ■	85.4 ■	85.4 ■	85.7 ■	85.6 ■	85.6	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	90.3	86.0
		Open at month end (exc Obstetrics)	No.	1000 ■	1065 ▼	994 ■	483	506	989 ▲	444	500	944 ■	944	975	975		No Variation	0 - 2% Variation	>2% Variation	975	989
	Day Case Rates	All Procedures	%	77.8 ▼	78.7 ▲	79.4 ▲	84.8 ▲	74.9 ■	79.2 ▼	85.2 ▲	75.4 ▲	79.8 ▲	79.8	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation	79.0	79.4
		BMEC Procedures	%	77.3 ■	81.2 ■	85.4 ▲	→	79.5 ■	79.5 ■	→	82.8 ■	82.8 ■	82.8	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation	79.7	79.7
	Non-Admitted Care	New : Review Rate	Ratio	2.63 ▼	2.73 ▼	2.65 ▲	2.75 ▼	2.70 ▼	2.72 ▼	3.04 ▼	2.67 ▲	2.80 ▼	2.80	2.30	2.30		No Variation	0 - 5% Variation	>5% Variation	2.45	2.59
		DNA Rate - New Referrals	%	15.9 ▼	16.8 ▼	13.8 ▲	10.8 ▲	13.4 ▲	12.5 ▲	13.1 ▼	13.5 ▼	13.4 ▼	13.4	9.0	9.0		No Variation	0 - 5% Variation	>5% Variation	12.0	13.5
		DNA Rate - Reviews	%	13.9 ▼	16.1 ▼	12.7 ▲	12.0 ▲	11.6 ▲	11.8 ▲	12.1 ▼	11.6 ■	11.8 ■	11.8	9.0	9.0		No Variation	0 - 5% Variation	>5% Variation	13.5	12.3
		OP Cancellations - Trust Initiated	No.	3259	4175	3907	→		3532	→				No. Only	No. Only					n/a	20348 (Oct-Mar)
		OP Cancellations - Patient Initiated	No.	3587	4992	3876	→		3568	→				No. Only	No. Only					n/a	22820 (Oct-Mar)
		OP Cancellations as % OP activity	%	15.0	19.9	16.4			12.3					No. Only	No. Only					n/a	14.4 (Oct-Mar)
	Diagnostic Report Turnaround	Cervical Cytology Turnaround	Weeks	0.8 ■	0.7 ▲	1.2 ▼	→		0.9 ▲	→			0.9	<4.0	<4.0		<4.0	4.0-6.0	>6.0	2.7	0.9
	Ambulance Turnaround	In Excess of 30 minutes	%	23.0 ▲	19.3 ▲	22.6 ▼	25.2 ▼	22.9 ▲	23.9 ▼	20.1 ▲	20.8 ▲	20.5 ▲	20.5	<10.0	<10.0		<10	10 - 12.5	>12.5	19.0	23.9
		(West Midlands average)	%	31.3	27.8	27.4	→		25.5	→		26.2	26.2	No. Only	No. Only					21.0	25.5
		In Excess of 60 minutes	No.	60 ▲	33 ▲	38 ▼	18 ▼	28 ▲	46 ▼	9 ▲	36 ▼	45 ▲	45	0	0		0	1 - 5	>5		46
	THEATRE UTILISATION																				
RK	Sitrep Declared Late **Cancellations** by Specialty	General Surgery	No.	6 ■	8 ■	6 ■	0	5	5 ■	3	5	8 ■	8	5	60	a	0-5% variation	5 - 15% variation	>15% variation	104	81
		Urology	No.	2 ▲	11 ■	4 ■	4	5	9 ■	1	6	7 ▼	7	4	48		0-5% variation	5 - 15% variation	>15% variation	102	48
		Vascular Surgery	No.	0 ■	0 ■	1 ▼	0	2	2 ■	0	0	0 ■	0	1	3		0-5% variation	5 - 15% variation	>15% variation	7	8
		Trauma & Orthopaedics	No.	6 ■	11 ■	0 ■	0	2	2 ▼	1	1	2 ■	2	6	72		0-5% variation	5 - 15% variation	>15% variation	75	66
		ENT	No.	5 ▼	4 ▲	1 ■	0	0	0 ▲	0	1	1 ▼	1	2	12		0-5% variation	5 - 15% variation	>15% variation	23	23
		Ophthalmology	No.	11 ■	2 ■	12 ■	1	17	18 ▼	9	8	17 ▼	17	9	108		0-5% variation	5 - 15% variation	>15% variation	153	139
		Oral Surgery	No.	3 ▲	2 ■	0 ■	0	2	2 ■	0	0	0 ■	0	1	8		0-5% variation	5 - 15% variation	>15% variation	19	24
		Cardiology	No.	0 ▲	0 ■	0 ■	0	1	1 ▼	0	1	1 ■	1	2	21		0-5% variation	5 - 15% variation	>15% variation	31	7
		Gynaecology / Gynae-Oncology	No.	3 ▲	14 ■	2 ■	3	6	9 ■	0	5	5 ■	5	5	54		0-5% variation	5 - 15% variation	>15% variation	71	63
		Plastic Surgery	No.	0 ▲	1 ▼	0 ▲	1	0	1 ▼	1	0	1 ■	1	1	12		0-5% variation	5 - 15% variation	>15% variation	21	11
		Dermatology	No.	2 ▼	0 ▲	0 ■	0	9	9 ■	0	0	0 ■	0	2	24		0-5% variation	5 - 15% variation	>15% variation	24	27
		TOTAL	No.	38 ■	53 ■	26 ■	9	49	58 ■	15	27	42 ■	42	38	422		0-5% variation	5 - 15% variation	>15% variation	630	497

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Exec Lead	WORKFORCE		Unit	Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust	To Date	YTD	10/11	Summary Note	Green	Amber	Red	08/09 Outturn	09/10 Outturn
RK	WTE in Post	Total	No.	6393 ▲	6324 ▲	6318 ▲	→		6539 ■	→		6317 ■	6317	6425	6107		No Variati	0 - 1% Variati	>1% Variati	6042	6539
		Medical and Dental	No.	759 ▲	757 ▲	752 ▲	→		825 ■	→		739 ■	739	777	790		No Variati	0 - 1% Variati	>1% Variati	755	825
		M'ment, Admin. & HCAs	No.	2025 ▲	1992 ■	2004 ▼	→		2046 ■	→		2019 ■	2019	2062	1937		No Variati	0 - 1% Variati	>1% Variati	1852	2046
		Nursing & Midwifery (excluding Bank)	No.	2404 ▲	2373 ▲	2363 ▲	→		2385 ▼	→		2342 ▼	2342	2531	2377		No Variati	0 - 1% Variati	>1% Variati	2259	2385
		Scientific and Technical	No.	973 ▼	961 ▲	970 ▼	→		1002 ▼	→		987 ▲	987	1049	1003		No Variati	0 - 1% Variati	>1% Variati	913	1002
		Bank Staff	No.	232	241	229	→		281	→		230	230	No. Only	No. Only					260	281
		Gross Salary Bill	£000s	21290 ▼	21272 ▼	21193 ▼	→		21768 ■	→		20875 ■	20875	20754	#####		No Variati	0 - 1% Variati	>1% Variati	238674	252557
RK	Bank & Agency	Nurse Bank Fill Rate	%	78.6	84.1	83.2	→		86.9	→		89.1	89.1	No. Only	No. Only	m				81.8	85.1
		Nurse Bank Shifts covered	No.	4734 ▲	4956 ▼	4969 ▼	→		5534 ■	→		4402 ■	4402	5135	61621		0 - 2.5%	2.5 - 5.0%	>5.0% Variati	69675	61621
		Nurse Agency Shifts covered	No.	729 ▼	830 ▼	538 ▲	→		509 ▲	→		300 ■	300	397	4765		0 - 5% Variati	5 - 10%	>10% Variati	4765	5388
		Nurse Bank AND Agency Shifts covered	No.	5449 ■	5722 ■	5507 ■	→		6043 ■	→		4702 ■	4702	5532	66386		0 - 2.5%	2.5 - 5.0%	>5.0% Variati	74440	67009
		Nurse Bank Costs	£000s	536 ▲	503 ▲	544 ▼	→		529 ▲	→		424 ▲	424	534	6404		0 - 2.5%	2.5 - 5.0%	>5.0% Variati	6844	6263
		Nurse Agency Costs	£000s	167 ■	225 ▼	85 ■	→		249 ■	→		51 ■	51	83	992		0 - 5% Variati	5 - 10%	>10% Variati	832	1268
KD		Medical Agency Costs	£000s	164 ▲	199 ▼	187 ▲	→		436 ▼	→		148 ▲	148	99	1192		0 - 5% Variati	5 - 10%	>10% Variati	2026	2384
		Medical Locum Costs	£000s	247 ▲	210 ▲	218 ▼	→		246 ▼	→		287 ▼	287	188	2250		0 - 2.5%	2.5 - 5.0%	>5.0% Variati	2747	2896
		Med Ag./Loc Costs as % Total Med Cost	%	→						→		7.1	7.1	No. Only	No. Only					6.6	7.0
		Med Staff Exp variance from Budget	%	→						→		2.5 ■	2.5	0	0		No Variati	0 - 1% Variati	>1% Variati	2.86	3.24
RK		Other Agency Costs	£000s	177 ▲	192 ▼	160 ▲	→		293 ▼	→		161 ▲	161	118	1410		0 - 5% Variati	5 - 10%	>10% Variati	3759	2600
RK/KD		Agency Spend cf. Total Pay Spend	%	2.39 ▼	2.90 ■	2.04 ▲	→		4.49 ▼	→		1.72 ■	1.72	<2.00	<2.00		<2	2 - 2.5	>2.5	2.77	2.47
RO	Recruitment & Retention	Permission to Recruit	wte	42	55	31	→		47	→		36	36	No. Only	No. Only					1124	813
		New Starters	wte	28	43	58	→		73	→		44	44	No. Only	No. Only					1066	1017
		Leavers	wte	65	40	66	→		121	→		54	54	No. Only	No. Only					999	928
		Inductions	No.	31	52	38	→		49	→		32	32	No. Only	No. Only					896	805

KEY TO PERFORMANCE ASSESSMENT SYMBOLS	
▲ (green)	Fully Met - Performance continues to improve
■ (green)	Fully Met - Performance Maintained
▼ (green)	Met, but performance has deteriorated
▲ (amber)	Not quite met - performance has improved
■ (amber)	Not quite met
▼ (amber)	Not quite met - performance has deteriorated
▲ (red)	Not met - performance has improved
■ (red)	Not met - performance showing no sign of improvement
▼ (red)	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

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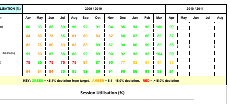
SUPPLEMENTARY DATA THEATRE UTILISATION

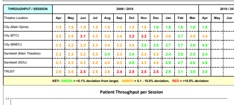
LATE STARTS (%)	2009 / 2010												2010 / 2011				
Theatre Location	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
City (Main Spine)	28	26	20	24	24	31	28	26	24	31	23	21	22				
City (BTC)	32	23	23	25	25	33	31	32	25	36	30	31	29				
City (BMEC)	44	40	37	34	41	47	42	43	30	19	22	23	27				
Sandwell (Main Theatres)	44	42	40	44	43	45	29	43	32	38	30	36	39				
Sandwell (SDU)	35	34	40	49	38	41	23	34	22	30	25	23	21				
TRUST	37	34	34	36	36	40	32	36	27	31	26	26	27				

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



EARLY FINISHES (%)	2009 / 2010												2010 / 2011				
Theatre Location	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
City (Main Spine)	58	47	46	44	42	43	51	41	44	49	43	41	42				
City (BTC)	58	68	69	63	66	54	64	61	55	55	61	57	61				
City (BMEC)	54	57	58	54	55	57	44	44	44	52	46	52	54				
Sandwell (Main Theatres)	38	58	51	35	48	39	43	40	46	35	40	34	46				
Sandwell (SDU)	70	63	68	71	59	55	56	56	67	63	65	71	68				
TRUST	55	53	55	51	50	49	48	45	49	52	51	51	54				

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



SESSION UTILISATION (%)	2009 / 2010												2010 / 2011				
Theatre Location	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
City (Main Spine)	86	93	88	89	90	92	91	94	95	93	96	100	99				
City (BTC)	84	80	78	85	81	80	83	82	88	87	86	86	87				
City (BMEC)	82	76	80	83	83	83	89	87	90	86	90	89	88				
Sandwell (Main Theatres)	91	83	87	88	86	92	89	90	92	92	95	104	90				
Sandwell (SDU)	75	85	75	75	75	84	87	90	77	82	84	84	83				
TRUST	84	84	84	85	85	89	89	91	90	86	91	89	91				

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

THROUGHPUT / SESSION	2009 / 2010												2010 / 2011				
Theatre Location	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
City (Main Spine)	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.6	1.6	1.8	1.8	1.8				
City (BTC)	3.5	3.5	3.1	3.3	3.3	3.4	3.2	3.2	3.4	3.6	3.7	3.5	3.4				
City (BMEC)	3.2	3.2	3.2	3.3	3.4	3.2	3.4	3.5	3.5	3.7	3.7	3.6	4.0				
Sandwell (Main Theatres)	2.2	2.3	2.2	2.3	2.4	2.3	2.4	2.3	2.3	2.4	2.5	2.5	2.4				
Sandwell (SDU)	4.3	4.3	4.3	4.4	4.5	4.3	4.6	4.3	4.4	4.9	4.7	4.6	4.6				
TRUST	2.6	2.6	2.5	2.6	2.6	2.4	2.5	2.5	2.5	2.9	3.1	3.0	3.0				

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

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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:	27 May 2010

SUMMARY OF KEY POINTS:

The report provides an assessment of the Trust's performance mapped against the indicators which comprise the NHS Performance Framework.

Service Performance:
The indicators which comprise this domain have been updated for 2010/2011, with revised 18-weeks RTT and Cancer Indicators, the inclusion of Reperfusion Indicators and the removal of Revascularisation, Inpatient and Outpatient maximum waits indicators.

The Trust underachieved in April in 3 areas; A/E 4-hour waits, Delayed Transfers of Care and Stroke (Stay on Stroke Unit), and although final RTT data for April is not yet available, is projected to underperform in RTT Admitted Care in Trauma & Orthopaedics.

Financial Performance:
The indicators which comprise this domain remain unaltered. Underachievement is indicated in April in 3 areas; Better Payment Practice Code Value, Better Payment Practice Code Volume, and Creditor Days.

Foundation Trust Compliance Report – The 2010 / 2011 Monitor Compliance Framework contains an updated set of Key Performance Indicators. The Trust underperformed in 2 areas (both weighted 0.5); A&E 4-hour waits and MRSA elective Screening. The weighted score for the period was 1.0, with an Overall Governance Rating of AMBER / GREEN.

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

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

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

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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

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

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

PREVIOUS CONSIDERATION:

Finance and Performance Management Committee on 20 May 2010.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2010/11

Operational Standards and Targets

Indicator	Weight	Thresholds		April 2010	Score	Weight x Score
		Performing	Underperforming			
A/E Waits less than 4-hours	1.00	98.00%	97.00%	97.80%	2	2.00
Cancelled Operations - 28 day breaches	1.00	5.0%	15.0%	0	3	3.00
MRSA Bacteraemia	1.00	0	>1.0SD	0	3	3.00
Clostridium Difficile	1.00	0%	>1.0SD	13	3	3.00
18-weeks RTT (Admitted)	1.00	90.0%	85.0%	>90.0%*	3	3.00
18-weeks RTT (Non-Admitted)	1.00	95.0%	90.0%	>95.0%*	3	3.00
18-weeks RTT - achievement in all specialties (Admitted & Non-Admitted)	1.00	0	>0	>0*	0	0.00
Cancer - 2 week GP Referral to 1st OP Appointment	0.50	93.0%	88.0%	>93.0%*	3	1.50
Cancer - 2 week GP Referral to 1st OP Appointment - breast symptoms	0.50	93.0%	88.0%	>93.0%*	3	1.50
Cancer - 31 day second or subsequent treatment (surgery)	0.33	94.0%	89.0%	>94.0%*	3	0.99
Cancer - 31 day second or subsequent treatment (drug)	0.33	98.0%	93.0%	>98.0%*	3	0.99
Cancer - 31 day second or subsequent treatment (radiotherapy)	0.33	96.0%	91.0%	>96.0%*	3	0.99
Cancer - 62 day referral to treatment from screening	0.33	90.0%	85.0%	>90.0%*	3	0.99
Cancer - 62 day referral to treatment from hospital specialist	0.33	85.0%	80.0%	>85.0%*	3	0.99
Cancer - 62 day urgent referral to treatment for all cancers	0.33	85.0%	80.0%	>85.0%*	3	0.99
Reperfusion - Primary Angioplasty (within 150 minutes of call)	0.50	75.00%	60.00%	>75.00%*	3	1.50
Reperfusion - Thrombolysis (within 60 minutes of call)	0.50	68.00%	48.00%	no patients*		0.00
2-week Rapid Access Chest Pain	1.00	98.0%	95.0%	100%*	3	3.00
48-hours GU Medicine Access	1.00	98.0%	95.0%	100.00%	3	3.00
Delayed Transfers of Care	1.00	3.5%	5.0%	4.30%	2	2.00
Stroke (Stay on Stroke Unit)	1.00	60%	30.0%	59.50%	2	2.00
Sum	**15.00**			*projected		**37.44**
Average Score						**2.58**

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

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

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2010/11

Financial Indicators

Criteria	Metric	Weight (%)		SCORING 3	SCORING 2	SCORING 1	2010 / 2011 April	Score	Weight x Score	May	Score	Weight x Score	June	Score	Weight x Score
Initial Planning	Planned Outturn as a proportion of turnover	5	5	Planned operating breakeven or surplus that is either equal to or at variance to SHA expectations by no more than 3% of income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to SHA expectations by more than 3% of planned income.	Operating deficit more than or equal to 2% of planned income	**0.00%**	**3**	**0.15**						
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	**-0.01%**	**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.	**6.96%**	**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**						
	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.	**7.05%**	**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**						
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	**0.54%**	**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	**7.05%**	**3**	**0.15**						
Finance Processes & Balance Sheet Efficiency	Better Payment Practice Code Value (%)	20	2.5	95% or more of the value of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the value of NHS and Non NHS bills are paid within 30days	Less than 60% of the value of NHS and Non NHS bills are paid within 30 days	**82.00%**	**2**	**0.05**						
	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	**77.00%**	**2**	**0.05**						
	Current Ratio		5	Current Ratio is equal to or greater than 1.	Current ratio is anything less than 1 and greater than or equal to 0.5	A current ratio of less than 0.5	**1.01**	**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	**23.00**	**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	**42.31**	**2**	**0.1**						
						Weighted Overall Score			**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

Finance and Performance Management Committee – v0.2

Venue Executive Meeting Room, City Hospital **Date** 22 April 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				
Dr S Sahota		**Guests**		
Mrs G Hunjan		Mrs J Cooper	[Item 4.1 only]	
Mr G Clarke		Mrs H Lemboye	[Item 4.1 only]	
Mr J Adler		Mr S Power	[Item 4.1 only]	
Mr R White		Mr G Seager	[Item 4.2 only]	
Mr R Kirby		Mr K Reynolds	[Item 4.2 only]	
		Mr P Foley	[Item 4.2 only]	
		Mr P North	[Item 4.2 only]	

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received apologies from Derek Alderson.	
2 Minutes of the previous meeting – 18 March 2010	**SWBFC (3/10) 037**
The minutes of the previous meeting were accepted as a true and accurate record of discussions held on 18 March 2010.	
AGREEMENT: The minutes of the previous meeting were approved	
3 Matters arising from the previous meeting	**SWBFC (3/10) 037 (a)**
The updated actions log was noted by the Committee. It was agreed that the updated 'Better Care, Better Values' report would be considered at a future meeting of the Committee	
ACTION: Mr Grainger-Payne to schedule a discussion regarding benchmarking onto the agenda of a future meeting of the Finance and Performance Management Committee	
4 Divisional performance	
4.1 Surgery B	**SWBFC (4/10) 044 Hard copy cover sheet**
Mrs Jackie Cooper, Mrs Hilary Lemboye and Mr Shaun Power joined the meeting to	

present an update on the financial performance and key activities of the Surgery B division.

The Committee was advised that the majority of the division's work is ophthalmology, but also covers audiology, ENT and oral surgery.

The division's surplus as at end February 2010 was £90k, with a forecast end of year position of a surplus of £1m. Income was reported to have over performed by £1.6m which had been offset to some degree by additional expenditure in pay and non pay areas.

Mr Trotman asked for further detail of the bad debts relating to the area. Mr Power advised that an allocation had been made from corporate reserves, some of which had been used to cover bad debts.

It was reported that a portion of Surgery B's surplus had been used to compensate for under performance in other areas of the Trust. Mr Wharram advised that some of the Trust's data challenges had been around outpatient with procedure cases, including a number within ophthalmology. Mr Trotman asked for further detail of these data challenges. He was advised that 2009/10 was the first year where the outpatient with procedure tariff has been used, however the definition of which cases fell into this category had not been fully clarified. Mr Wharram added that the tariff had not been used in 2010/11 commissioning contracts.

Dr Sahota asked whether there was any outstanding payments due from any other acute trusts. He was advised that there was and in particular from local Foundation Trusts, although the issue was not particularly relevant to Surgery B.

Mr Trotman asked, given the increase in referrals for ophthalmology work, what the current position was concerning rescheduled outpatient appointments. He was advised that the position had improved considerably and the NPSA alert related to glaucoma was being observed whereby every effort is being made to ensure that these patients' appointments are not cancelled. Mrs Cooper remarked that the division had performed well, considering the challenges and much higher level of activity than planned. The premises within which the division's work is undertaken was noted to be at or beyond capacity, particularly given that the Birmingham and Midlands Eye Centre (BMEC) was originally designed to treat 35,000 patients per year, when numbers currently stand at nearer to 100,000 patients.

Dr Sahota observed that the operations cancelled by the Trust were largely attributable to the ophthalmology area. Mrs Cooper advised that the overall level of cancellations had reduced in ophthalmology and any cancellations usually relate to emergency and VR work. At present nine VR theatre lists per week are run.

Mr Trotman noted that elective surgery in ophthalmology was underperforming and asked for the reasons behind this. Mr Kirby advised that this reflected the imbalance between demand and capacity. He acknowledged that there was still much work to do to reduce the level of cancelled and rescheduled outpatient appointments, despite the improving performance.

The Committee was advised that oral surgery provides a further area of income, where referrals have doubled in-year due to an increase in the number of referrals from dentists. These are not urgent referrals however, Dr Sahota remarked that this could be impacted by the ceasing of work requiring anaesthesia at Birmingham Dental Hospital. Mrs Cooper advised that the Trust is not able to provide inpatient facilities at present, however the majority of dental surgery is undertaken by University Hospital Birmingham NHS Foundation Trust.

A further area of income for the division was highlighted to be accident and

emergency work, where again there had been an increase in demand for services. The division's Cost Improvement Programme for 2010/11 included a scheme to increase income from accident and emergency work and streaming patients who attend accident and emergency into urgent care clinics. Other areas of the CIP include reduction in premium rate working, particularly in accident and emergency and ENT areas. Pay issues were discussed and it was reported that the division had over spent to handle the higher level of activity, however this had been offset to some extent by the associated increase in income. Medical staff costs were noted to be high as there is currently insufficient substantive resources to handle the demand. Pressures regarding job plans for consultants was also highlighted as an issue. Theatre capacity is likewise constrained. Mr Kirby reported that South Birmingham clinics have been developed using locums, which are planned to turn into substantive positions when there is a sustainable flow of work. In accident and emergency, some junior doctors have been lost as a consequence of the need to comply with the European Working Time Directive. Mrs Davis asked why premium rate working was used so widely within the division. She was advised that there is difficulty in recruiting middle grade doctors, therefore these positions need to be covered by locums employed on premium rates. Dr Sahota asked what the division's links were with Aston University. He was advised that there are good links with the university and accommodation had been investigated within the premises, however was found to be unsuitable. Dr Sahota suggested that the bank of doctors at the university may be approached to assist with the division's work. Mrs Cooper advised that there was not a significant amount of suitable resource for the Trust to use in this respect, however agreed that she would consider this further. Non pay overspend was noted to relate predominantly to drugs. Photo dynamic therapy (PDT) was reported to have been superseded by the Lucentis technique for age-related macular degeneration. Mrs Davis suggested that there may be a need to investigate diversion schemes for patients self-presenting at accident and emergency in an attempt to bypass the standard assessment process. Mrs Cooper advised that it would be a challenge to turn these cases into an income stream. The detail of the division's 2010/11 CIP was discussed, where it was reported that £260k would be saved from accident and emergency reconfiguration; there would be a reduction in premium rate working; restructuring departments and individual posts across the division was underway; and procurement savings, particularly around BMEC theatres and hearing aid supplies are planned. Mr Trotman asked whether the capacity issue would be addressed in the coming months. Mr Kirby advised that the new hospital facility assumes continued growth in the area, however until then space is being sourced elsewhere in the Trust and South Birmingham clinics have shown that work may be undertaken successfully outside the acute environment, therefore similar options are being investigated. Clinics are also being run at weekends and in the evenings to provide additional capacity. In addition to these measures there may be a possibility that extra temporary resources will need to be used however. Mr Trotman thanked Mrs Cooper and colleagues for their informative and detailed presentation.	
4.2 Estates	**SWBFC (4/10) 045** **SWBFC (4/10) 045 (a)**

Mr Graham Seager, Mr Kevin Reynolds, Mr Phil Foley and Mr Paul North joined the meeting to present an update on the financial performance and key activities of the Estates directorate.

Mr North reported that as at the end of Month 11, the area had a surplus of £110k. In terms of income, the variation in the SLA with Sandwell PCT had generated a deficit of £16k.

Regarding pay costs, the directorate was noted to carry some long term vacancies, with work being currently covered by external agencies.

The energy surplus was highlighted to be £240k at present, with a prediction for a higher amount by the year end. Mr Foley explained that gas consumption was 8% less than planned, although the consumption of electricity had remained static. The introduction of flat screen monitors and low energy lighting mitigated to some degree the increase in energy costs. Gas costs were reported to be based on consumption rather than a tariff. The position was also better than planned, given that some energy-related schemes for which funding allocations had been set aside were actually met by the Department of Health. Further reductions in energy use are planned over coming months. Mr Trotman asked out of the planned £290k energy savings in the area's CIP, how much would be met by a reduction in energy tariffs. He was advised that the Trust is able to trade in carbon units, which will deliver a benefit when these are sold unused. It is assumed however that an 8% reduction in heating costs will be achieved by lowering the ambient temperature across the Trust. Mr Trotman asked how this would affect patients. Mr Seager advised that although temperature sensitivity varies between individuals, non-patient areas would be mainly targeted with this plan. The minimum legal temperature in which staff are to work is 19 degrees, therefore there is considerable scope to lower temperatures.

In terms of pay and non-pay, the position was noted to be positive. A national benchmarking exercise had been undertaken and as a department, Estates received funding £1.7m below the lower quartile, demonstrating that the area is efficient. The CIP for 2009/10 was highlighted to have been achieved.

Regarding the CIP 2010/11, key initiatives were reported to concern estates rationalisation. Workforce redesign is also planned, whereby some vacancies would be shed as planned. There is confidence that the 2010/11 CIP target can be delivered.

Dr Sahota asked whether the maintenance of buildings was reported within the 'other costs' line on the income and expenditure analysis. Mr White reported that there was an allocation for buildings maintenance within the pot for statutory standards. It was suggested in future versions of the report, that a breakdown of the 'other costs' line is required. The £20k savings for maintenance costs within the 2010/11 CIP was reported to relate predominantly to medical engineering contracts.

The areas's cost pressure requirements were reported to have been resolved, which will support ongoing PEAT and environment initiatives. This is necessary to fully comply with the requirements of the hygiene code.

Much work is underway concerning sustainability and energy management and a sustainability manager has been appointed on an 'invest to save' basis. Funding has been applied for within the 2010/11 business planning process to cover enhanced maintenance of low tech medical devices to comply with current standards, including NHS LA risk assessment standards. It is expected that this

funding will have a positive impact on patient experience. Dr Sahota asked whether consideration had been given to recruiting graduates from a national scheme. Mr Reynolds advised that government trainees had been taken on, although no formal apprenticeships had been recruited. Mr Adler added that apprenticeships had been taken on in other areas of the Trust. Mr Trotman thanked Mr Seager and colleagues for the informative presentation.	
5 Trust Board performance management reports	
5.1 2009/10 month 12 financial position and forecast	**Hard copy paper**
Mr Wharram reported that the statutory accounts had been submitted to the Strategic Health Authority and Department of Health. The surplus delivered was highlighted to be £2,279k, £10k better than planned. A deficit of £28.5m will be reported however, driven by the revaluation of assets following a recent exercise undertaken by the District Valuer. The reduction in assets value was reported to be £80m and would be treated as a technical adjustment in the statutory accounts. The allocation of £50m for revaluation reserves had been used to mitigate the position to some degree, with the portion remaining being posted as a deficit on the accounts balance sheet. In terms of capital expenditure, almost the entire allocation had been spent, with a significant proportion having been used in the second half of the financial year. The position ensures that the Capital Resource Limit had been met. The end of year position for cash stands at £15,867m, meaning that the Trust undershot its EFL by c. £8m. The paybill across a number of divisions was noted to have been volatile in some instances. The WTE position and paybill have increased over the year mainly due to an increase in the use of agency staff. Returning to the revaluation of assets, Mrs Davis expressed concern at the position and asked whether this would impact on the ratios required to apply for Foundation Trust status. She was advised that this was not the case and did not impact on the income generation or operating surplus. Limited information suggests that those trusts with an older estate have been affected most significantly by the revaluation exercise. A saving on depreciation and capital charges was noted to be a positive consequence of the situation. Mr Adler remarked that the WTE position was disappointing. He was advised that agency staff numbers had declined in March and procedures for recruitment of staff are stringent, therefore the position would be investigated further. Mrs Hunjan asked whether the significant cash balance was an issue. She was advised that this was not the case. Mr White thanked Mr Wharram and team for their work to complete the annual accounts against a very challenging deadline. Mr Trotman added his thanks.	
5.2 Performance monitoring report	**SWBFC (4/10) 039** **SWBFC (4/10) 039 (a)**
Mr Harding reported that there had been an increase in the number and percentage of cancelled operations in March across a number of specialities. It is thought that the higher than planned activity levels had produced this performance. Delayed Transfers of Care increased at both sites by 4.9%. In Birmingham a shortage in social worker availability had not helped the position,	

although vacancies are expected to be filled shortly. Discussions have been held with both local authorities with a view to resolving the issues. Performance against the stroke care target was noted to have improved and as the position for March had been understated, year to date the performance stands at 62%, meaning that overall the target had been achieved. The MRSA infection control target was reported to be only six cases that were attributable to the Trust, meaning that the threshold for these infections was not exceeded. The referrals to treatment times targets were noted to have been largely met, although the issues in trauma and orthopaedics persist. It is uncertain as to how this performance will impact on the CQC evaluation, although it is not anticipated to prompt an adverse assessment. Mr Kirby reported that on the basis of data recently reviewed, the backlog of orthopaedics patients is now growing, although future performance against the targets may be temporarily impacted when measures are taken to eliminate the backlog. Mr Trotman remarked that the Trust Board had sanctioned £200k expenditure to treat patients privately on a cost neutral basis and asked whether the identified patients had been seen. He was advised that the majority had been treated. It was agreed that a discussion around the orthopaedics performance should be scheduled for a future meeting. The Committee was advised that the six CQUIN targets had been met by the year end. Dr Sahota asked why there was a higher level of caesarean sections undertaken at City Hospital than at Sandwell Hospital. He was advised that this was due to more high risk women being seen at City Hospital. Mandatory training compliance was reported to be 73.5% and PDR performance was 88%. Mr Harding advised that at the end of the year, the CQC will evaluate the Trust against a set of 23 indicators, many of which do not have defined thresholds. Of the 23 targets, there is potential for the Trust to meet all, although four may be challenging. As such it is expected that the Trust would receive a 'good' or better rating for Quality of Care. Mr Clarke asked in relation to complaints, why a number are not responded to on time. Mrs Davis suggested that this concerned the ability to renegotiate the deadline for responses to be issued. Mr Adler confirmed that this was the case and added that complaints generally take longer to handle than previously as the responses are more detailed, yet result in fewer referrals to the Ombudsman and dissatisfied complainants. Mr Clarke noted that it appeared that telephone response rates appear to be poorer than desired. Mr Harding advised that technological improvements now mean that there is less reliance on manual answering of phones, however the situation would be monitored. It was noted that the contact centre information was omitted from the report and Mr Adler asked for this to be reinserted in future versions of the performance report. Mrs Davis asked whether the time taken to answer redirected calls could be measured. She was advised that there would be difficulty in measuring this. Mr Trotman asked whether there was a measure of the number of calls being returned to the switchboard. He was advised that this was not the case at present however may be possible. It was agreed that an improvement plans for the switchboard and contact centre may be needed and Mr Kirby was asked to consider this.	
ACTION: **Mr Grainger-Payne to schedule a discussion around orthopaedics**	

performance at a future meeting of the Finance and Performance Management Committee **ACTION: Mr Harding to reinsert contact centre information to the monthly performance monitoring report** **ACTION: Mr Kirby to consider arranging an improvement plan for the contact centre and switchboard**	
5.3 Foundation Trust compliance report	**SWBFC (4/10) 040** **SWBFC (4/10) 040 (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 green.	
5.4 NHS performance framework	**SWBFC (4/10) 051** **SWBFC (4/10) 051 (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 and the overall rating remains green.	
6 Cost improvement programme (2009/10) – delivery report	**SWBFC (4/10) 042** **SWBFC (4/10) 042 (a) -** **SWBFC (4/10) 042 (d)**
Mr Wharram advised that the Cost Improvement Programme had been fully achieved. There had been minor variation in divisional performance in Medicine, however this was compensated by better than planned performance in other areas.	
7 Quality and Efficiency Programme (QuEP) update	**SWBFC (4/10) 046** **SWBFC (4/10) 046 (a)**
Mr Adler presented a summary of the progress with the workstreams forming the Quality and Efficiency Programme (QuEP). The Committee was advised that the programme was progressing well. The capacity workstream was noted to be at amber status, which is reflective of the delay in closing the Elisa Tinsley ward at Rowley Regis Hospital. Likewise the coding and counting workstream was noted to be delayed due to a lack of managerial capacity to handle this work at present, although there is an expectation that this will be addressed shortly. The delay in the shared services workstream was noted to be reflective of the uncertainty around the HPC tendering exercise. The red status assigned to the estates workstream concerns the ongoing issued whereby the funding to cover impairment costs due to be incurred for estates rationalisation is yet to be identified.	
10 Minutes for noting	
10.1 Minutes of the Strategic Investment Review Group	**SWBSI (4/10) 001**
The Committee noted the minutes of the SIRG meeting held on 9 March 10.	

10.2 Actions and decisions from the Strategic Investment Review Group	**SWBFC (4/10) 043**
The Committee noted the actions and decisions arising from the meeting of SIRG meeting held on 13 April 10.	
10.3 Minutes of the Financial Management Board	**SWBFM (3/10) 035**
The Committee noted the minutes of the FMB meeting held on 16 March 10.	
11 Any other business	**Verbal**
Mr Trotman advised that this was to be the final meeting at which Miss Bartram would attend as Non Executive Director. He thanked Miss Bartram for her contributions and regular attendance at the Committee and wished her well for the future.	
12 Details of next meeting	**Verbal**
The next meeting is to be held on 20 May 2010 at 1430h in the Executive Meeting Room at City Hospital.	

Signed .....

Print .....

Date .....

MINUTES

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Governance and Risk Management Committee – Version 0.1

Venue Executive Meeting Room, City Hospital **Date** 18 March 2010; 1030h – 1230h

Members Present

Miss I Bartram [Chair]
Mr R Trotman
Mr J Adler
Mr R White
Mr D O'Donoghue
Miss K Dhami
Miss R Overfield

In Attendance

Mr S Parker
Mr A Seeley
Miss H Arscott
Miss D Dunn

Secretariat

Mr S Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received apologies from Professor Derek Alderson, Mrs Ruth Gibson and Mr Dally Masaun.	
2 Minutes of the previous meeting	**SWBGR (1/10) 009**
The Governance and Risk Management Committee approved the minutes of the meeting held on 21 January 2010 as a true and accurate reflection of discussions held.	
AGREEMENT: The minutes of the previous meeting were approved	
3 Matters arising from the previous meeting	**SWBGR (1/10) 009 (a)**
The updated actions list was noted by the Committee.	
4 Trust response to the Mid Staffordshire NHS Foundation Trust report	**Verbal**
Miss Dhami reported that all members of the Trust Board had been advised to read the recent report into issues at Mid Staffordshire NHS Foundation Trust. In terms of handling the report, a baseline assessment and action plan will be prepared against the recommendations, in the same way as those for other national reports received by the Trust. The Committee was advised that at the forthcoming Board Seminar, a discussion will be held to consider the information that the Board currently receives and then	

agree what other documents the Board might like to see on a regular basis and in what format. It was noted that the recommendations are broad and therefore an action plan will be developed, which will assign Executive leads to each action. Mr White advised that keeping the public informed was a key issue raised in the report and therefore highlighted that there should be adequate transparency through public board meetings.	
5 Dr Foster real time monitoring alerts	**SWBGR (3/10) 019** **SWBGR (3/10) 019 (a)**
Mr Parker presented an update on any new mortality alerts that had been received by the Trust from the Dr Foster intelligence system and from the Care Quality Commission, as advised by the Imperial College. The report also presented progress with addressing previous alerts received by the Trust. The overall position for January – December 2009 was considered, where it was noted that more positive than negative alerts had been received. Mr Parker advised that the Mortality Steering Group considers additional procedures that had not formally prompted an alert, but the risk of doing so was high. An update on the alert concerning peripheral and visceral atherosclerosis (PVA) was provided, where 13 deaths had been reported against an expected 11 deaths. The situation is being monitored closely and an action plan has been developed, with many of the actions allocated to the Clinical Director responsible for emergency and elective surgery/colorectal. An ischaemic bowel action plan has been developed, with each case being reviewed on an individual basis. Furthermore, if the risk department receives an incident involving ischaemic bowel, the Clincial Director is notified. Clinical coding has been reviewed to establish whether the coding of such incidents is comparable with that of other trusts. Dr Foster links have also been approached to ask if they would be prepared to replicate the internal query. Through the use of an automatic notification system, the Clinical Director is advised if the coding department is asked to code a spell against ischaemic bowel. The Committee reviewed progress with addressing other alerts, including primary angioplasty, where the Clinical Director for cardiology is examining cases involved, the outcome of which is due to be presented at the May meeting of the Mortality Steering Group. In terms of the alert concerning non Hodgkinson lymphoma, the Clinical Director for Haematology is currently developing an action plan, much of which seeks to address issues concerning how end of life decisions are made. There is currently no code used for palliative care and the Trust has a different lymphoma profile to other Trusts given the uniqueness of the ethic mix in the population. Mr Trotman asked whether the expected number of cases was set nationally or whether there is an adjustment for regional nuances. Mr Parker advised that expectations are set based on the risk profile of the group of patients. Miss Bartram asked whether very small numbers of cases might skew the position. She was advised that wide confidence intervals would be applied in such circumstances, but nevertheless some cases that otherwise may not have been detected could be picked up. It was recommended that Dr Foster alerts that do not involve mortality need to be included within a general report on Dr Foster alerts. Mr Parker advised that a mortality project pilot had been running since December	

2009, although securing the necessary IT systems to support this work had been difficult. There is now greater confidence in the technology however, therefore the pilot will be run for a further three months. The first report from geriatric medicine at City Hospital, where deaths have been reviewed using the new framework will be presented to the Trust Board in due course. Mr Adler reported that at the recent meeting of the Medical Staff Committee, it was noted that the review of all deaths in geriatric medicine had been very time consuming, however the rigour of systematically reviewing all deaths was necessary. The Committee was advised that the majority of deaths are attributable to a small number of specialities, such as geriatric medicine, as would be expected.	
6 Clinical Audit Forward Plan	**SWBGR (3/10) 020** **SWBGR (3/10) 020 (a)**
Mr Parker presented a progress update against the Clinical Audit plan for 2009/10. Ongoing audits were highlighted, including the National Heart Failure audit, which is a national priority to be achieved, with a requisite number of cases needing to be submitted. The delay with this work was reported to have been resolved and all data quality markers have now been met. Although cases needed are up to December 2009, a number may also be sent retrospectively. The Committee was advised that a number of audits had not been completed as planned or had been abandoned. Delays in audits were noted to be largely associated with data collection issues, although these are being addressed. Mr O'Donoghue noted that in terms of the healthcare records audit, the lessons learned reported are of historical interest. Mr Parker agreed, but advised that records audits are now undertaken monthly using the annual template, which provides more timely information.	
7 Quarterly Health and Safety update	**SWBGR (3/10) 018** **SWBGR (3/10) 018 (a)**
Mr Seeley presented an update on health and safety matters. He advised that many policies had been amended in preparation for the NHS LA risk management assessment and had been subsequently approved by the Trust Management Board. In terms of organisational issues, risk assessment workshops have been established. The DSE assessors courses has not been delivered as planned, therefore needs to be addressed in the coming months. Two health and safety notices were reported to have been issued and a violence and aggression notice issued triggered plans to ensure that there is adequate support provided to victims who have been assaulted. Health and safety files have been distributed to most divisions and departments. Some of the latest enforcement actions from the Health and Safety Executive have been reviewed by the Health and Safety team, a number of which related to activities undertaken in the Trust. Mr Adler asked whether lessons learned from these notices had been considered. He was advised that this was the case. The Committee was advised that there has been a 20% reduction in reported Health and Safety incidents. The top three categories of incident were noted to	

relate to patient accidents that are non-clinical and patient falls. Verbal abuse and security incidents were also noted to be high. Regarding the severity of incidents, it was noted that the number of green incidents had reduced, suggesting an under reporting of incidents. Miss Dhami advised that to achieve a better level of reporting, more work should be undertaken to ensure that feedback is given to those reporting incidents. Mr Adler observed that the reporting culture at University Hospital Birmingham NHS Foundation Trust was good and suggested that work be undertaken to establish whether there are any points of good practice that may be gleaned. It was agreed that this matter should be an agenda item at the next meeting. Mr Seeley reported that a dedicated fire safety management team has been established to handle specifically incidents related to fire. Regarding moving and handling, a decrease in incidents in this area was noted, with a particular reduction in needlestick injuries seen. It was highlighted that needlestiick injuries to non-clinical staff are treated as red incidents. In terms of patient accidents, the Committee was advised that the majority of incidents relate to falls. The number of slips, trips and falls was noted to have increased markedly during the quarter, mainly due to a change to the reporting, whereby all falls are now reported, not just those resulting in harm. Mr Seeley advised that many of the security incidents concern theft, but also include baby tags, which are automatically triggered when a baby tag is not returned to the neonatal unit or is lost. Mr Adler asked how prevalent car crime was in the Trust. He was advised that this was not a significant issue. Violence and aggression incidents were noted to have reduced, which Mr Seeley suggested was reflective of the conflict resolution training that had been delivered. Physical violence incidents had increased however. A small decrease in RIDDOR incidents was highlighted.	
ACTION: **Mr Grainger-Payne to add an item concerning incident reporting practice to the agenda of the next Governance and Risk Management Committee**	
8 Safety alerts	
8.1 Quarterly update	**SWBGR (3/10) 023** **SWBGR (3/10) 023 (a)**
Mr Seeley presented a position statement outlining the Heath and Safety incidents received. Incidents NDA021 and NPSA01 were reported to have been addressed. Mr Adler emphasised the need to resolve alerts that remained outstanding after a considerable time. He asked that the matter be considered by the Executive Team and asked Miss Dhami to prepare a proposal to address the situation. Mr O'Donoghue remarked that although adverse incident management is effective, further rigour needed to be applied to management of safety alerts. Miss Dhami suggested that a corporate system or policy may be required to address this matter. It was agreed that the situation would be considered at the next meeting of the Adverse Events Committee.	
ACTION: **Miss Dhami to discuss management of safety alerts at a future**	

meeting of the Adverse Events Committee	
8.2 Safety alerts NPSA/2009/024 – standardising wristbands	**SWBGR (3/10) 021**
Mr Seeley advised that the Trust was not compliant with the NPSA safety alert concerning standardising patient wristbands, in that the Trust uses two wristbands, rather than one. It was highlighted that the current practice represents an enhancement on the NPSA guidance and is supported by the Chief Nurse. Mr Adler asked whether there was any risk that having two wristbands could cause confusion. Miss Dhami agreed that this was an issue that should be considered further, particularly considering that the Trust has a number of visiting doctors and locums. It was noted that a policy has been developed around the use of wristbands, however does not explicitly state that the policy represents a deviation from NPSA guidance. It was agreed that a report should be presented at the next meeting to outline the rationale behind the deviation.	
ACTION: Miss Overfield to present a report at the next meeting outlining the rationale behind the deviation from the NPSA guidance around patient wristbands	
9 Integrated risk, complaints and claims report	**SWBGR (3/10) 012** **SWBGR (3/10) 012 (a)**
Miss Dunn advised that in terms of complaints, there had been a continued increase in the number of contacts and formal complaints. In a quarter of all cases, the target date for the response to be issued had to be renegotiated due to unforeseen complexity or the need for additional information to be received. One percent of all complaints were reported to be graded as red. A summary of all red and amber complaints is due to be presented to the Trust Board in the same way that red incidents are. The revised format of responses was noted to have reduced the number of dissatisfied complainants. The Committee was advised that there had been an increase in the number of complaints around delays and cancelled appointments, for outpatients in particular. In terms of claims, although there had been a slight decrease during the quarter, overall, the trend is towards a higher level. The type of claims mirrors the health and safety issues reported. In terms of lessons learned, any issues are highlighted and action plans developed to address the situation. Monitoring of action plans is in place and an automatic report is generated to flag up to General Managers that action plans have not been received for certain cases. In terms of actions arising from claims, by the time a claim is registered, a significant amount of time may have elapsed and changes will have occurred naturally, therefore a senior clinical advisor has been established to review any claims immediately and flag up any points of learning. Miss Bartram observed that a high number of claims relate to the Women and Child Health division. Miss Dunn advised that there was an expectation that the number of claims in the areas would fall, given the reconfiguration and restructuring work that had been completed in the area to date. In relation to risk management, Miss Arscott advised that 1964 incidents had been reported, which represented a reduction on the same period during the previous year. The number of clinical incidents and health and safety incidents rose however. Fifty two red incidents were reported during the quarter. There had been a slight increase in the number of amber incidents. Mr O'Donoghue suggested that incidents may be more usefully considered in terms of the number per occupied	

bed days, which may be helpful in forming a view of differences between areas as well as a comparison with other organisations. It was further suggested that the most appropriate measure may be gained from reviewing the practice of the NPSA. Mr Trotman noted that failure to provide planned care constituted a significant part of the incidents concerning aspects of care. Miss Dhami advised that incidents within this category are routinely reviewed by the Adverse Events Committee. Mr Trotman suggested that assurance was needed that key themes arising from the incidents were being addressed. Mr O'Donoghue highlighted that a key theme appeared to concern transfer issues arising from reconfiguration, however the situation was being reviewed at present.	
ACTION: Miss Dhami to consider what measure would be most appropriate to use to provide a comparison between incident rates in different parts of the Trust and with other trusts	
10 Risk management strategy – progress against priorities	**SWBGR (3/10) 016** **SWBGR (3/10) 016 (a)**
Miss Dhami presented progress against the priorities set out within the risk management strategy. It was highlighted that there is further work to undertake around feedback on incidents, where electronic reporting was being considered.	
11 Trust risk register	**SWBGR (3/10) 015** **SWBGR (3/10) 015 (a)**
Miss Dhami presented the trust risk register, which it was noted had been considered by the Governance Board. Six new risks had been added. Mr Adler asked whether there was sufficient assurance that the action plans to mitigate the risks around Sandwell Emergency Department were sufficiently robust to effect such a significant reduction in the risk scores. He was advised that this was the case.	
12 Assurance Framework update – Quarter 4	**SWBGR (3/10) 022** **SWBGR (3/10) 022 (a)**
Mr Grainger-Payne presented the final update on progress with the actions to address the gaps in assurance and control against the risks to the delivery of the Trust's corporate objectives. The Committee noted that following the application of treatment plans, two risks remain at red status: the achievement of NHS Litigation Authority Level 2 standards, which concerned the agreed postponement of the assessment; and the delivery of Mandatory Training. Mr Grainger-Payne highlighted that following a recent interim internal audit of the Assurance Framework, additional detail had been added to the elements of the Assurance Framework concerned with sources of external assurance and key controls in place.	
13 Update on progress with the plans for NHS LA assessment	**Verbal**
Miss Dhami advised that the planned assessment against Level 1 general standards had been postponed by the NHS LA, however was now scheduled to take place on 25/26 March 2010, in conjunction with the Level 1 assessment against maternity standards. Following this assessment, guidance will be sought as to the most appropriate timing for an assessment against Level 2 general standards. Twelve	

months of evidence needs to be available to demonstrate that the various policies have been embedded. New policies that have been developed include those around consent, transfer, blood transfusion, DNA CPR and mandatory training. Mr Adler emphasised the need to avoid any further delay with the assessment and stressed that any 'hot spot' areas needed to be addressed as a matter of priority.	
14 Infection Control quarterly update	**SWBGR (3/10) 011** **SWBGR (3/10) 011 (a)**
Miss Overfield presented the latest update on infection control measures and initiatives, highlighting that the report had been considered by the Trust Board. Infection controls rates within the Trust were highlighted to be within regional and internal trajectories. The Committee received and noted the report.	
15 Update on progress with 'High Impact Nursing Actions'	**SWBGR (3/10) 017** **SWBGR (3/10) 017 (a) -** **SWBGR (3/10) 017 (d)**
Miss Overfield presented an update with the implementation of 'High Impact Nursing Actions', advising that falls and pressure damage were included within this set of measures. These indicators are reported in the context of bed days as opposed to 'raw' numbers. There is however, no national benchmarking information available against which the Trust can be compared. Where internal trends have been detected, a targeted approach has been adopted. High end injurious falls for instance have been reviewed in detail and in all cases it is apparent that appropriate support was in place. Areas where patients are most likely to fall have been identified. Likewise, pressure incidents appear to be being properly managed, with no evidence of poor practice. Specialist resources for falls and pressure damage are in place.	
16 Register of Interests	**SWBGB (3/10) 014** **SWBGB (3/10) 014 (a)**
Mr Grainger-Payne presented the latest version of the Directors' Register of Interests advising that it was due to be refreshed shortly and presented to the Trust Board. Mr Trotman noted that there was a slight amendment required to Dr Sarindar Sahota's interests.	
ACTION: Mr Grainger-Payne to amend the register of interests in line with comments made at the meeting	
17 Minutes from the Governance Board	**SWBGB (2/10) 035**
The Governance and Risk Management Committee received and noted the minutes from the Governance Board meeting held on 5 February 2010.	
18 Minutes from the Clinical Quality Review Group	**SWBGR (3/10) 013**
The Governance and Risk Management Committee received and noted the minutes from the Clinical Quality Review Group meeting held on 3 February 2010.	
19 Any other business	**Verbal**
There was none.	

20 Details of the next meeting	**Verbal**
The date of the next meeting is 20 May 2010 at 1030h in the Executive Meeting Room, City Hospital.	

Signed ……

Print ……

Date ……